18

TRAUMA-INFORMED COMMUNITY SERVICES

Karen Orpwood and Sue Ryan

Service Delineation and Exclusion

This chapter is about community services that people with a forensic history may access, but not limited to community forensic services. In thinking about forensic practice in the community, the services most obviously of relevance would be community forensic services (under the NHS – National Health Service), and the Probation Service (PS – under the criminal justice system). Users of forensic services, as part of our society, should have equality of access to all services of relevance to their needs and difficulties – something that is not commonplace. It has been noted elsewhere in this book that those with forensic histories have experienced high rates of childhood adversity of all kinds, a variety of different traumatic experiences that can leave them susceptible to struggles with their psychological well-being, relationships, and social functioning. The authors will use their collective experiences of working with individuals across a range of different criminal justice services and NHS Trusts to illustrate pertinent issues and reflections. However, each “case” is a composite of a number of people who have entered community services and any resemblance to an actual person is coincidental.

We started this chapter with some uncertainty about the population and services we were going to be thinking about. Between us, we have worked in prisons, probation, adult mental health and forensic mental health settings in both community, inpatient and secure settings. Reflections about who fell within the scope of this chapter were not so straightforward, because most of the people we have worked with in these various settings had a great deal of similarity in terms of the psychological problems, trauma, and adversity they struggled with. What seemed to make the difference was where they could become a user of services. People were deemed either too risky for mental health services, not risky enough for forensic services, or not have the right “disorder” or sufficient level of “readiness” or stability to meet the different service criteria. Many people are still not reached by forensic services and fall right through the gaps, often replicating early life experiences of rejection and dismissal. Those people may often be struggling to manage substance misuse, financial
difficulties, and broken relationships with a lack of structure, routine, or sense of purpose. They are ultimately socially excluded.

There is a clear division between services: health and criminal justice are separate, and so people are categorised as “in” or “out” of either group, or in both (which gets complicated), or neither. The evolution of this dichotomy may be interesting to consider but falls out of the scope of this chapter. In the UK and many, though not all, other similar countries, behaviour or presenting problems are largely viewed as being either primarily about mental health-based problems, or law-breaking, criminal behaviour. This split may be considered to reflect differences in the evolution of how social groups set and perpetuate certain rules and norms and has obvious practical utility. However, there may be unintended consequences/unwelcome side effects of this split, and where the fault lines lay may be one of the most significant challenges to being “trauma informed”. Why does the category that someone falls into matter?

Aside from the authors’ practical decisions about what services fall into and outside of the scope of this chapter, it reflects the very real decisions made every day about the people within the community at risk of offending or with a history of offending, and whether they fall into or outside of the remit of a service. It is a central problem in being truly trauma-informed with forensic clients, or indeed with people in general whenever, and however, they present with distress or distress-driven difficulties.

The degree of struggle is undoubtedly layered by the experiences of trauma in early and later life. Almost every client that we have worked with in forensic community services has experienced trauma within their early lives and often repeated incidences thereafter. These experiences are often unacknowledged by systems and families, and at times its impact is dismissed by the clients themselves. The alternative is to consider how society may have contributed to shaping individuals, compounded by culture, socioeconomic status, race, education, gender, and sexuality in addition to their family experiences. Such reflections can be emotionally difficult and draining and bring to the surface the uncomfortable fact that we are all more similar than different and, faced with similar experiences, we may too have taken similar steps.

Working with trauma in the community with forensic clients raises many dilemmas. There is often a profound sense that individuals are wholly “bad”. This is often the perception of society and infiltrates into the systems that provide services, commissioning, budgets, cultures, and staff perceptions about who is “deserving” and worthy of investment. Once an individual has offended, they are often no longer described as a person, but as the sum of their offending behaviour (offender/criminal/perpetrator), which is likely to have a major impact upon their sense of self, perception of hope and may be a possibly conscious or unconscious way to humiliate or punish the individual from an organisational or societal perspective. Individuals are often raised in systems that have shaped their world view and their view of self as being wholly responsible for their childhood selves, negative self-concepts embedded at their core. This is true not only of criminal justice systems who label clients as “offenders” but also of clients who enter health systems who then become “patients”.

What both labels can often lead to is a distancing, where the person and their identity can become clouded and hidden behind the very label(s) that the systems place upon them. However, there is a shift in how trauma is being better understood, from
“what is wrong with you” to “what has happened to you”; however, it is far from being embedded within systems and minds and feels at its infancy of development, despite its first being referenced in 1991 (Perry & Winfrey, 2021).

The splits between categories of “person” and “problem” and the “othering” of people described as “offenders” and “patients” invites or perpetuates the false beliefs that, in truth, these issues and people are “separate”. Society seeks to separate themselves from individuals who commit abusive acts, who are often subject to myths, categorised and labelled (Craissati, 2019). Having both criminal justice and mental health services as well as those that appear to cross the divide or overlap should, in theory, reduce the impact of “othering” and categorising for users of these services. However, the authors’ experiences in working with forensic clients are that this is seldom the case. Central to being trauma-informed is having policy, practice, and culture that places the person first and seeks to avoid re-traumatisation, as well as offering a holistic response to the complexity of an individual’s experiences and difficulties (McCartan, 2020). A trauma-informed approach and service would have a compassionate curiosity about what a person has experienced which has resulted in their distress becoming unmanageable, spilling over into their functioning and relationships with others. By labelling and distancing ourselves from those who have been traumatised and become traumatising, we are failing to understand the person within their context and are at risk of relating in ways that cause re-traumatisation.

**Adult Mental Health Services in the Community**

Darren, who said he had an “anger management” problem as well as self-harming behaviours, was rejected from primary care mental health services as he did not fit the commissioned service criteria in terms of the nature and complexity of the issues, or what interventions they offered. As he reported increasing hopelessness and suicidal ideation, he was referred to secondary care mental health services. In assessment he spoke about his difficulties with “anger” and how these had manifested in a range of problems, including a number of criminal convictions, and that he felt “stressed” and ashamed and wanted help. As there had not been serious violence, he had no input from the probation service, and he was not sufficiently violent or “mentally ill” to be eligible for the community forensic mental health service (something many areas do not even have). He was told by community mental health team (CMHT) staff that his anger and aggression were about his choices, that he was not “mentally ill”, but presented with antisocial personality traits, so he was not eligible for secondary care mental health, and he “needed to manage himself better”, the subtext seeming to be that he did not “deserve” help such as medication or talking therapy. Another unhelpful implication was that, if he were considered to be “mentally ill enough”, then his aggression might be judged differently and that he might be deemed more worthy of support. The CMHT did not consider the meaning of his behaviour. Darren was fundamentally invalidated by this view of him. His shame was reinforced. There was little sensitivity about how he might have heard this perspective. Services were withheld, his behaviour was judged as “wrong”, and an over-simplistic perspective was provided. His self-control was assumed to be the fundamental issue and he
Trauma-Informed Community Services

was expected to better control his anger, and if he did not, then criminal justice was the way forward. This mirrors the cold, harsh invalidating environment of his early years. In his pain and anger, he lashed out at those he felt had hurt him, his punishment being criticism, rejection, and shame. Just as he had been frightened of his parents’ rage and violence, the team were frightened of his. He felt uncontainable and the system and society further rejected and isolated him so he was left to navigate a rejecting system alone. Such re-enactment is typical in the life experiences post-trauma for people who have struggled to heal (De Zulueta, 2006).

Darren had a history of complex trauma relating to adversity and abuse during childhood, and trauma during his early adult life. What he labelled “angry”, perhaps due to gendered ways of describing the difficulties of one’s inner life, could also be understood as overwhelming negative affective and cognitive states, including PTSD symptoms that he was unable to regulate, and which frightened him, causing him to become harmful to himself, the environment, and others. Darren’s difficulties could easily have been described instead as emotional instability, intense reactions in the context of interpersonal issues, distress, and fear, as well as rage, feelings of anxiety, depression, and hopelessness. His presentation was very similar to many of the female service users the authors have met over the years, whose difficulties have been conceptualised as complex trauma or, more contentiously, “borderline” or “emotionally unstable personality disorder” and mental health problems secondary to it.

However, in relation to other people the authors have known, a diagnosis of personality disorder too can often mean that this is a diagnosis to exclude rather than include, despite the paper Personality Disorder: No longer a Diagnosis of Exclusion (National Institute for Mental Health in England, 2003) and services are still failing to include and meet the needs of this population who are still viewed by some as being less deserving of support and compassion and as more responsible for their difficulties than those perceived to be “mentally ill”. NHS England & NHS Improvement & the National Collaborating Centre for Mental Health have in the last few years published a series of reviews and strategies relating to adult mental health, recognising that “the model of care is not in need of fundamental transformation and modernization” (NHS England & NHS Improvement & the National Collaborating Centre for Mental Health, 2019; p.2).

Darren was offered psychological therapy with the CMHT. Psychological formulation allowed both him and the team to see what had happened to him, connecting the trauma to his distress and the difficulties this led to. This enabled the team to empathise with him, following which he received further assistance (Wilkinson et al., 2017). Darren experienced validation. He came to understand that he has been the victim of trauma, that his “anger” actually reflects complex reactions to situations that evoke past traumas and, in that context, is quite understandable. His aggressive actions have functioned to protect himself from anticipated harmful treatment by others and helped him feel a sense of power and agency in this respect. He learned to trust a little and to cope better; he developed hope, and his functioning and experience of life significantly improved. He did end up receiving what could be described as a trauma-informed service; his needs were listened to and understood, and the service responded from a position of flexibility. Furthermore, his psychological support was
formulation-led, collaboratively designed, and responsively delivered. This approach would be in keeping with the Power Threat Meaning Framework (Johnstone & Boyle et al., 2018).

What might have been? Had Darren been rejected by all services, where might his deteriorating presentation taken him? Perhaps to the point that he was too risky for mental health services at all, and created another victim, and then managed under criminal justice, with his needs as a victim, subsumed under those relating to his being a perpetrator.

Other service users came to mind, from mainstream, and specialist mental health services, who have been users of multiple services, some of which can be contracted out to other providers. With each service trying to protect itself in relation to commissioning, criteria, and caseload, falling between the cracks is easy. Fragmented services use different systems and often fail to communicate effectively. Holding an individual client in mind is all but impossible sometimes, as is monitoring someone’s deteriorating situation. We can both think of many people who have died or seriously harmed others as a consequence. If someone is in a mild road traffic accident, the emergency services will initially attend to deal with acute and immediate risk; then for treatment and any rehabilitation or functional or social needs, the person sees other health professionals, in order of priority and specialism. Perhaps this model works relatively well for physical health problems (ignoring the social context of the person with a physical health problem and any psychological or emotional impact of it), but for problems with psychological and emotional health, it does not. One cannot “carve up” the person and their problems to fit the organisation of services. This is fundamentally how mental health services function, using a psychiatric approach that “diagnoses” psychological and social issues and clusters them together as discrete and separate entities. This approach has been challenged by many (Bentall, 1990; Boyle, 1990; Johnstone & Boyle et al., 2018) as invalid, unreliable, and not taking account of the cause or social context of an individuals’ circumstances. Kinderman (2019) has proposed a social and psychological approach to well-being and health in which the person, their difficulties, context, and history are understood and involved in consideration of what may be able to assist their needs. In this case, “person” is not “put before protocol” (McCartan, 2020).

The individuals who came to mind when considering Darren did not come under a forensic service, but they were no different from cases the authors have known in prison or secure forensic hospitals, or supervised by probation or community forensic teams following serious violent crime. If there is a difference, in addition to them crossing the barrier into offending, it is that those in prison and sometimes secure hospitals did not even make it as far as an assessment.

Forensic Services in the Community

A significant part of working in forensic services in the community involves collaborating with The Probation Service (PS), a criminal justice agency. The PS’s remit is public protection through addressing the factors relevant to criminal behaviour, providing support and rehabilitation to enable offenders to desist from crime. For
the last few years, people who are supervised by probation have been referred to as “offenders”, with probation officers being called “offender managers”. This has now been changed and users of services are now referred to as “people on probation”; crucially, their humanity is recognised. Offender managers contribute to rehabilitation and risk management, monitor and enforce or sanction breaches of requirements. McCartan (2020) suggests “a trauma informed approach … seeks not to re-traumatise with blame and sanction” (p.8), which is somewhat antithetical to what is required of PS. To what extent is it realistically possible to reconcile these positions? Consideration of being trauma informed in the context of probation is very recent, with training and guidance only just beginning to emerge.

Despite the organisational context, individuals within probation services try to relate and respond to service users in a way that is less punitive or driven by enforcement. It is not unheard of for a probation officer’s phone number to be the only number, or one of very few, that a person using the service has to call, and for the probation officer to be the only visitor or correspondent they have in prison. The relationship with a probation officer may be the longest and most stable relationship that some service users have had, and the probation officer may know the most about them. The service user may experience their probation officer as a proxy-parent, with all the desires and fears of their actual primary caregivers, a vessel into which they can put their projections. The probation officer has a huge challenge to enforce, monitor, and focus on risk, as well as holding the other pole of the person, their trauma experiences, and be mindful of how their person might experience them in relation to this.

How can services divided into Health, Social Care, and Criminal Justice be open to hearing the shifting needs of complex individuals and to change when things are no longer working, instead of prescribing them, and requiring people to fit into boxes defined by others? (Wilton & Williams, 2019). Organisations can and do traumatise and trigger or perpetuate trauma (Goldsmith, Martin, & Smith, 2014); even when they aim to do what they feel is best by someone, there can be a paradoxical effect.

**Reintegration into the Community?**

Some clients within forensic community services may always have resided in the community, serving lesser sentences for less serious offending. However, many are arriving back to the community from often lengthy custodial sentences that have led to them losing many of their life skills in custody due to limited opportunities. Their ability to emotionally and relationally develop has been compromised by the loss of connections to families and society, and by exposure to prison environments where survival requires masking of real selves, vulnerabilities, and fear. They may have experienced traumatic events within the prison system and their experience of the system may have led to them becoming mistrusting and hostile, with a wariness and defence against further hurt.

Upon release, this newfound freedom can often reveal overwhelming emotions of hope and expectation of self and others. What has been yearned for is interlaced with
fear of failing, disappointment, and worries about how to navigate life and where they “fit” into society that has often changed beyond recognition. The hurdles are many; basic needs are the priority, but complex issues arising from traumatic histories and traumatising patterns in relating to others can make the future feel bleak. Although some are able to find a way to be accepted back into families, into society, and find a level of self-acceptance that enables them to lead less destructive and damaging lives, many continue to live lives where they are not afforded opportunities or acceptance but are faced with a multitude of hurdles which can be hard to keep overcoming.

Forensic services in the community are one part of a multi-layered system working with individuals who have multiple needs and difficulties. A client can have physical health issues, be financially compromised, have housing difficulties (lack of adequate housing, barriers to securing private tenancies due to limited finances and lack of guarantors), substance misuse dependence, social needs, and child protection involvement. Many clients face these challenges with a traumatic history that manifests in deeply engrained emotional dysregulation and disconnection, limited ability to mentalise, and lack of sense of self and identity. Service users are referred primarily for issues relating to their offending behaviour, and therapists need to formulate how such issues link into their current struggles and how their past has contributed to their offending behaviour. This is a complex process for complex issues that must be addressed within time-limited therapies from which they may be suddenly discharged for missing appointments or misusing substances. The task can be to understand the many layers of complexity, work in the here and now, and prioritise and help scaffold agencies around a client to assist with the multi-layered needs. Many clients in community forensic services may not enter into the service to address any traumatic experiences, but to find ways to assist them to understand why their issues have developed and learn alternative ways to regulate and contain their strong feelings.

Working within such services requires a level of flexibility, awareness of the above, and willingness to try to meet a client where s/he is at and understand what may or may not be possible for them at the point they attend for therapy. This may be a different focus to what the referrer has wished for and it can mean that part of the work involves exploring how to meet the differing expectations of referrer and service user so that work can be truly collaborative, building upon their strengths and knowledge. Society, services, and therapist may have a desire to help people never offend again, which is of course a priority, but in order to do so, we also need to focus on enabling people to feel a greater level of self-understanding and self-compassion, and through this, enable them to be more attuned to the emotional and relational states of others (Bateman & Fonagy, 2016). This takes time, and for some may mean multiple contacts with services to enable them to settle into society and within themselves. It requires maintaining hope (Farrall & Calverley, 2006), despite an individual’s best or less than best efforts, that they may be able to reach a more fulfilled and less destructive life at some point in their future, if not now.

Exploring trauma with a client in the community without the physical constraints of the secure setting can be challenging. The dilemmas for a therapist to consider involve considering the ethics of doing no harm and whether the client can tolerate such work without the stability of a residential environment. Can the client manage
not to revert to old patterns of substance dependence, self-harm, or suicidality or acting out their fear and hate onto others? We have found that some cannot, which may mean that they disengage or are discharged from services or are returned to custody. However, many can make meaningful change, reach a degree of awareness, increase their coping and functioning, and appreciate that they can achieve a level of stability and become connected to parts of themselves that enable their value to be seen by themselves and others.

Working with Tom

Tom was 45 at the point of being referred. He had recently been released from prison after committing a violent offence against a female. He had made advances towards her and when thwarted, he had punched her in the face, breaking her nose. He was inebriated and high on cocaine at the time. She was not previously known to him and he had not committed an offence towards a female before, although had many convictions for acquisitive crime, fraud, violence towards males, and breaching previous licence conditions.

Tom had served five years in custody for this offence and, although had engaged in a specific course to address his thinking and substance misuse, he had not had any opportunity to explore his past and the impact upon his present. He had spent most of his life oscillating between custody and the community. When in the community he had always depended upon alcohol, cocaine, and cannabis to help him feel energised, confident, and what he felt was “normal”. Substances also enabled him to numb the pain, to forget and detach.

Tom came to the psychology service as he wanted to stay out of custody and recognised that his behaviour at times was out of control. His risk factors included his aggression to women and substance misuse and were issues that the system and referrer felt were outstanding. He hated the system and those who worked within it and was extremely mistrustful of individuals within it. He would often inform practitioners of all the reasons why psychologists could not be trusted, how he would be unlikely to engage and was not hopeful that anything could be done. Yet he had attended and, in some respects, laid his cards on the table. Despite his wariness, mistrust, and challenge, he was open, a little unsettled and on edge, but had shared his anxieties of how he expected the therapist to be unreliable, ineffective, and damaging and was offered a space to be heard, validated, and begun to be understood. From that first session the therapist aimed to create a safe, collaborative, and “good enough” experience of therapy and felt a pull to provide a more corrective experience for him.

This was the beginning of providing a space and experience that was trauma-informed, understanding the client where he was at and appreciating why he had become so aggrieved. The assessment was to begin to understand him and his context and how this could be repeated, or not, by adapting the approach, compassionately connecting and beginning to collaborate about his hopes for the sessions, how they aligned and differed from the referrer’s, and how he could be placed at the forefront of the intervention plan whilst also holding in mind the public protection and the need to share pertinent themes from discussions with the referrer. Contracting was
key, openness and honesty, recognition of fallibility, and a willingness to work through those tentative moments and times when a thick skin was needed. However, the therapy was one part of a bigger picture. Had this been the whole intervention then Tom would not have continued to engage with the therapist for over 12 months. Tom shared some of his early experiences which involved deceit, abuse, and uncertainty and whilst doing so, pertinent parts of his narrative were noted on a piece of paper in the room and in doing so, a collaborative way of working was created that was visible and contained. Through reaching a collaborative understanding of what had occurred, how it had impacted upon him, and what he carried with him as an adult in his relationships and intrapersonally, he began to develop trust and hope that things could be different. There were no moments of enlightenment, quick fixes, or significant changes. Therapy involved a long period of Tom “working through” enduring pain and a toil of emotion when his trauma was triggered repeatedly by encounters that he had with people in the system, including in the therapeutic relationship which left him feeling exposed and threatened. The primary task was relational – not a series of discrete interventions but a process of relating to and “being with” him to share, understand, and notice what he did in relation to others. Additionally, therapy enabled him to develop a greater sense of who he was in relation to another and in doing so, gently enabling him to better understand what he carried with him that was helpful and what repeatedly caused himself and others distress, often by making use of moments that were live in the room. Therapy helped increase his awareness, choices, and ability to connect to himself and others and work with “the system” rather than to feel or be set up or further traumatised by it. Working in this way enabled him to experience someone in the system as being able to help rather than harm him and was an experience that he could build upon and carry forward in his future experiences of relationships.

The Offender Personality Disorder Pathway

The Offender Personality Disorder Pathway (OPD Pathway: Department of Health/National Offender Management Service, 2011) is designed for/at the population of people within criminal justice and forensic mental health services who are likely to have a severe form of personality disorder (a controversial construct) that is clinically linked to significant risk of harmful behaviour towards others. It was developed for the many individuals within secure settings, mostly in prison, whose needs were unmet by the system. Despite the name of the pathway, there is a move away from diagnosis to formulation (Skett, Goode, & Barton, 2017) to help understand the person's needs and presenting difficulties within their context. This should include their individual experiences, social and environmental factors, protected characteristics, attachment and relationship history, and physical variations. These factors alongside temperament impact upon an individual’s ability to cope with and respond to stress and can lead to overwhelming distress and unbearable feelings (British Psychological Society, 2018).

The OPD strategy pays attention to specific interventions but crucially focuses upon the environmental aspects of the system. It recognises that improving the culture,
relationships, and activities in an environment can positively impact upon how individuals feel and behave, and the relationships that they form. While this may seem obvious, it appears to be missed within many prisons and secure setting that house people who have been traumatised and traumatising. Through developing psychologically informed planned environments (PIPEs) (National Offender Management Service/Department of Health, 2012), specialist intervention services in prisons and supporting and training staff, individuals may be able to make changes and begin to understand that they have potential, strengths, and contemplate hope.

The OPD strategy recognised that many individuals who would meet criteria for the OPD pathway (via a screening tool that identifies features associated with the construct of antisocial personality disorder, Mawby, Newman, & Wilkinson-Tough, 2020) would be stuck in the system, often feeling persecuted by it with little opportunity to make meaningful change. Due to capacity and demand, if an individual is not motivated to engage with interventions in the criminal justice system, they can often be left to “reconsider their position”. In this position they are often unsupported and labelled “hard to reach” or “not motivated”, rather than the system recognising that it has not found a way to reach or motivate them. A major asset of the pathway is that individuals are given a possible “pathway” and hope. They are understood as needing a whole system to help them to change and their engagement difficulties are understood within the systems within which they reside rather than solely within their person. The pathway is not perfect, but it provides a more realistic opportunity for some who have previously little hope of progression. Although the pathway has a whole systems approach spanning custody to community, it recognises that there is much investment needed in the community, where the vast majority of individuals with forensic histories will return.

In the community, specialist workers support offender managers to reflect upon the people they are working with in core offender management services. Through psychological formulation, offender managers are assisted to better understand what has happened in an individual’s life and how such experiences may be driving unhelpful patterns of relating. Formulation also enables the worker to consider their responses to working with an individual, how they may enable the relationship to develop, and what interventions may be useful for the individual going forward. The pathway has also invested in creating Intensive Intervention and Risk Management Services (IIRMs) in the community, an acronym which coincidentally or unconsciously may suggest a more hesitant and less certain approach to this work, which may reflect the evolving and involving nature of the development of the delivery model and the recognition to the lack of evidenced-based models for working with this population.

The first IIRMs was developed and piloted in Merseyside in 2008 (Nathan, Centifanti, Baker, & Hill, 2019) although it was not referred to as such until 2014 when this name was developed. The service continues to provide a pathway out of custody towards a more hopeful future for some. Its success and support from commissioners and key stakeholders have enabled the service to mature, develop, and contribute to the growth of IIRMs nationally. There are now two IIRMs within the North West of England, Resettle in Liverpool and Evolve in Manchester. Although both are very different in their funding, resources, and intervention model, they share principles of
being a shared approach between health and justice, a recognition of complexity of need and risk, and in providing intervention to offer stabilisation. There is a practical focus, opportunity for skill and relational development, and for some an opportunity to engage in trauma-focused work. IIRMs are in their infancy but working within them feels that there is a movement to do something different, away from punishing, rejecting systems, but that this is a small part of greater systemic change that is needed.

Working in forensic community services is without doubt difficult. The service and individuals within it can act as a “container” for the risk and associated anxiety. There are many factors that impact upon a person’s desire to enter into working in this field and there are many which contribute to their willingness to remain working within it. We have chosen to work in services that fit our own values. Our disconnect with the medicalisation of distress has led us to ways of working that are “psychologically informed”, as the OPD pathway promotes. The support, value, enrichment and safety of a team, and shared organisational approach are also factors in these innovative services. This undoubtedly brings challenges, frustration, and much need for compromise, but are invaluable to this work, provided all are signed up to the shared values and approach.

The Challenge of Change

Trauma is endemic in our society, yet people who are marginalised and disempowered in our society experience more of it (Wilton & Williams, 2019). The authors have written this chapter during the Black Lives Matters protests, and the COVID pandemic, which has disproportionately affected people of colour, and people of lower socioeconomic and health status – a population in which people of colour are also disproportionately represented. How can we effectively notice and hear the trauma-related needs of this group? We know that in the UK people of colour are more likely to suffer from poverty, poor educational and occupational opportunities, to receive criminal convictions and custodial sentences, to suffer mental and physical health problems, and to die early. How can these socially and politically derived sources of trauma be recognised by systems, both health and criminal justice, that tend to locate the main source of an individual’s problems within them (De Zulueta, 2006), as if it is divorced from their context (Johnstone & Boyle et al., 2018). Furthermore, under the current systems, infused as they are by predominately white, Eurocentric philosophical assumptions, how can the traumatic experiences of the population who carry ancestral cultural and religious beliefs make use of these services, whose rigid and limited definitions and criteria exclude different expressions of trauma? Lifelong adverse experiences, commencing in childhood, are a monumental social problem, especially for the population of people minoritised in our society, that our systems seem inadequate to address in their current form (Williams, 2020).

There is a disparity between what is needed in a trauma-informed context for the cases like those discussed in either health or criminal justice services, and what is offered. There are problems with the options given to or taken away from survivors of trauma depending on how the sequelae of trauma manifests. When our services look at people with a history of violence, they rightly see the risk of further victims and
“what’s wrong with” them. But, in holding only that pole, they miss the other, their vulnerability, and how they have been hurt. This vulnerability, “what’s happened to them”, where it remains unhealed, drives or fails to regulate the part of them that can harm others, and is intrinsically linked to risk. It is a fallacy to separate the two into different service pathways, as so often ends up being the case in the community. One wonders how many incidents of harm might have been avoided had people who were not as lucky as Darren been helped by mainstream services. Similarly, how many incidents of harm might have been avoided if people like Tom had not been worked with only in terms of his criminal behaviour as opposed to holistically, earlier in their lives. We need a cultural shift and a system level change to have trauma-informed services in our society (Kings Fund, 2019) and a trauma-informed society.

Can the culture be further changed and embedded with the development of the Power Threat Meaning Framework (Johnstone & Boyle et al., 2018) and the Manifesto for Mental Health (Kinderman, 2019) as an alternative to the medicalisation of trauma reactions? These proposed approaches mean that people’s adverse experiences are acknowledged, heard, understood, and responded to from within a limited framework to be trauma-informed, as opposed to the current situation in which the reverse is true (Wilton and Williams, 2019).

This population is invariably complex; trauma may only ever be partially addressed and interventions may be insufficient to fully mitigate risk. To work with this population, staff and services need the capacity to hold the whole person in mind, the victim, the vulnerability, the perpetrator, and the risk. Practitioners need to be containing and contained by their team, the wider service and, on an organisational and political level, by concentric circles of containment. There have been many occasions when we or our colleagues have spoken about the impact of other people’s harsh and negative comments about the population we work with, and the media often reports on individuals who have been released from prison or secure hospital and harmed someone, as well as criticism of the workers like us who try to support them. As we finish our chapter, the inquest into the deaths of two people killed in a terrorist incident in London in November 2019 by man deemed suitable for release from prison has just ended. The media have criticised criminal justice staff who held on to hope for the people they work with, perpetuating the view that the capacity for violence is something that is solely within a being, and that people like us should be infallible in our capacity to accurately discern it. It can be a very hard job.

Many practitioners leave this work, perhaps overwhelmed by how disturbing it can be, or tired of the stress of the responsibility; how much it hurts when things go wrong; the stress of the organisational response to incidents; or the pathology that can end up being re-enacted within and between teams and services. When we reflect on what enables and motivates us to stick with it, it is our enduring belief that what we do is what it is fundamentally right, even if we as individuals are not always right. We believe in each person’s capacity to create a life worth living, to find a way to live with the harm done to them and to make a positive contribution to the lives of others despite the harm they have caused in the past. We have been fortunate to have received a lot of creative, evocative, and memorable learning experiences, worked with inspirational figures and skilled and supportive colleagues, and contained by
quality supervision and supervisory relationships that have stretched, challenged, and been kind to us. We have reflected upon the many people that we have worked with, been impacted by them, some carried in our minds from very early in our careers. We have memories of those who did not make it, their bodies and at times their minds unable to cope with this life. We have also been shaped by others who have at times abruptly reminded us of when we have got things wrong, when the system has harmed them and those around them or been immovable and infuriating. We have also connected with individuals who have progressed through a system that has needed many people to help them work through and towards their future.

**Further Reading**

De Zulueta, F. (2006). *From pain to violence: The traumatic roots of destructiveness.* John Wiley & Sons Ltd. For readers wanting to understand how trauma and violence are linked.

Dowsett, J., & Craissati, J. (2008). *Managing personality disordered offenders in the community: A psychological approach.* Routledge. For readers wanting a working understanding of the core principles of working with this complex, traumatised client group in the community, as well as references for further relevant reading, research, and theory.


Williams, P. (2020). *Community empowerment approaches. The key to overcoming institutionalised racism in work with black, Asian and minority ethnic (BAME) people in contact with the criminal justice system.* Clinks. For readers who want to know more about the problems faced by racially minoritised groups in the context of criminal justice.

**References**


Williams, P. (2020). *Community empowerment approaches. They key to overcoming institutionalised racism in work with black, Asian and minority ethnic (BAME) people in contact with the criminal justice system*. Clinks.
