Trauma-Informed Forensic Practice

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The Impact on Staff of Trauma-Informed Work in Forensic Settings

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THE IMPACT ON STAFF
OF TRAUMA-INFORMED
WORK IN FORENSIC SETTINGS

Michelle Smith

Introduction

When considering a trauma-informed approach to working within forensic services, focus generally centres on how we can shape services for the benefit of our service users. This is undoubtedly of paramount importance, but what is often less considered is the notion that to do this effectively we need to ensure that support systems for staff and organisations operate along the same trauma-informed principles. There has been a wealth of knowledge developed over the last few decades regarding trauma and its overarching impact. Notable contributions have been made from neuroscience, which have helped us to understand the intricacies of the impact of trauma on developing brain processes and the long-lasting impact it can have across generations. An understanding of the triune brain system and associated bottom-up approach to trauma described by van der Kolk (2014) helps us understand that addressing embodied impacts of trauma is crucial alongside the effects on disrupted emotional processing and cognitive connections. It is suggested that the process is no different when considering the impact of trauma in forensic staff populations.

This chapter will focus specifically on the impact of trauma-informed working on staff within the critical occupation of forensic services. It will firstly aim to review what we mean by the terms critical occupation and trauma, and explore the specific traumatic impacts reported when working within forensic services, summarising the literature in this area. It will seek to describe and clarify the variety of terms used within the literature to describe traumatic impacts within critical occupations (secondary traumatic stress, compassion fatigue, vicarious trauma, burnout). It will conclude by suggesting an approach to addressing traumatic impact which is framed...
by well-evidenced trauma-informed stages – creating safety, facilitating emotional processing, and maintaining cognitive connections. This is based on the principle that we need to model as practitioners what we intend to offer to our service users. It will include an integration of applied models of boundary management, resilience, and psychological formulation as well as offering suggestions for a trauma-informed service model. It will also describe an approach to the management of human public services, which attends to integral trauma processes at individual, organisational, and public policy levels.

**Critical Occupations**

Critical occupations have traditionally been defined as those involving the performance of a critical role in the protection of society, combined with an exposure to incidents that may have a critical impact on physical and mental health (Parrish Meadows, Shreffler, & Mullins-Sweatt, 2011; Paton & Violanti, 1996). This has often included roles within the military and emergency services such as police, fire and rescue, emergency medical services. While these roles clearly include aspects of public protection and exposure to trauma, wider definitions include a range of other public service roles such as prison officers, healthcare staff, and social workers. It should be noted, however, that decisions about inclusion as a critical occupation are often guided by historical and social contexts. What may be considered a vital occupation at one point in time within a given social context may not be included at later time points. The Covid-19 pandemic has demonstrated this very clearly, with critical occupations being extensively widened to include a greater range of key public services – education, food production, sale and distribution, transport and border staff and utilities, communication and financial services (Department of Education, 2021).

The definition of critical occupations currently extends to include work roles within the forensic arena such as prison officers, probation officers, forensic psychologists, forensic psychiatrists, and mental health professionals (Clarke, 2004). Forensic professionals have a core focus on public protection in their role of forensic risk assessment and in the discharge of this, often face constant and relentless exposure to events that can cause psychological and physical health-related issues and burnout (Clarke, 2004; Paton & Violanti, 1996). Examples include direct involvement with individuals who either demonstrate verbal and physical violence towards others, or to themselves; exposure to the use of illicit substances or contaminated equipment for such misuse; exposure to traumatic material from the life history of individuals within the criminal justice system; working in secure and often intimidating and dangerous environments; managing pressures on reduced staff to client ratios and the resulting impact on risk and safety; fear of the risk and magnitude of making mistakes and associated stress levels. This inexhaustive list of direct and indirect events can have a detrimental effect not only for individuals but also for the development and maintenance of services (Elliot & Daley, 2013; Wright, Powell, & Ridge, 2006).
Trauma

Definitions of trauma have expanded over years with the developing insight gained from a wealth of research in the area. Times of adversity and challenge in life are commonplace and can often cause temporary distress for individuals. When we refer to trauma in this chapter, we define this as a response to “an inescapably stressful event” (van der Kolk & Fisler, 1995; p.505) or series of events, which overwhelms individual or systemic mechanisms of care which usually offer “a sense of control, connection, and meaning” (Herman, 1992; p.33). Research has demonstrated the cumulative and long-term impact of developmental trauma in terms of childhood adversity (Felitti et al., 1998) and adverse childhood experiences (ACEs) are highly prevalent within the population of individuals who commit offences (Bellis et al., 2015; Farrington, 2003; Levenson, Willis, & Prescott, 2016; Scottish Government, 2018). It is also clear that trauma-informed principles have been integrated across a range of health, social, and educational services to date and are now starting to be considered across forensic services (British Psychological Society, 2019). This is creating a paradigm shift which more visibly acknowledges the difficult dialectic between accepted functions of forensic roles – risk management and compassionate care. Traditionally, forensic professionals have considered trauma in terms of its integration within psychological formulations of service users, to better understand their offending behaviour as a response to their traumatic experiences. Johnstone and Boyle et al. (2018) widened this idea with the introduction of the Power Threat Meaning Framework and enabled it to be applied to professionals and service users alike. The framework was originally developed to challenge the notion that emotional distress and mental health problems are illnesses to be treated within a purely medical model. However, the principles are specifically noted as applicable to those within the criminal justice system. The framework considers that negative power experiences occur for everyone, on an individual and systemic level, and can create both threats and interpretations which result in a range of behaviours, some of which can be viewed as survival strategies or threat responses. This allows us to consider that trauma experience and emotional distress are not exclusive to individuals accessing forensic services. Indeed, if we consider wider, collective definitions of trauma that include racial trauma, poverty, and social deprivation that create pervasive, lifelong cross-generational impact, how can we possibly conclude that staff working in forensic services are immune to this in a different way to that of our clients? These are undoubtedly universal experiences. Following this argument, it is entirely possible that the undeniable tensions experienced by forensic staff in the constant juggling of responsibilities in their role may be associated with the deleterious impacts noted in the literature.

Trauma Impact in Forensic Professionals

Terminology

The research literature notes a range of impacts on staff of working in forensic services, and different concepts have been proposed over the last few decades to describe
these. One of the notable issues with this impact literature is the interchangeable use of terms across studies such as secondary traumatic stress, compassion fatigue, vicarious trauma, and burnout. These describe related yet distinctly different impacts, leading to difficulties in achieving an overarching understanding and creating confusion. It is important to create clear and distinct understandings of the definitions of these terms before looking at what studies can tell us about how forensic staff are affected by their work.

Secondary Traumatic Stress (STS) and Compassion Fatigue (CF). Originally introduced by Figley (1995), these terms have been used interchangeably in the literature and reshaped over time to describe professionals’ sense of being psychologically overwhelmed by their observations of trauma, the depth of suffering experienced in working with this, and their perceived need to support individuals experiencing trauma (Barros et al., 2020). It is suggested that these terms are not only applicable to professionals but can include others such as carers, lay people, and loved ones (Branson, 2019). Both STS and CF are considered to result in psychological distress including avoidance, unwanted mental images, and over sensitivity to trauma-related stimuli, and can be akin to PTSD presentations (Devilly et al., 2009). It is suggested that STS and CF are acute phenomena and that they may result from shorter term or even a single exposure to trauma (Branson, 2019).

Vicarious Trauma (VT). Vicarious trauma describes the longer-term impact on the cognitive schemas, beliefs, expectations, and assumptions of the self and others that are internalised by professionals working with traumatised individuals. It has been described as a transfer of traumatic stress from survivor to therapist following the process of bearing witness to their stories (Hernandez, Ganggsei, & Engstrom, 2007) and has a distinct cumulative process (Pearlman & Saakvitne, 1995). It was introduced by McCann and Pearlman (1990) as part of their constructivist self-development theory, which sees the effects on therapists as an interaction between the characteristics of the situation, the individual’s psychological needs and cognitive schemas. Branson (2019) reports that it presents as similar to the symptoms of primary trauma and has impacts across four areas: intrusive imagery, arousal, avoidance behaviours, and negative cognitions. It has been related to ethical professional practice impacts in terms of decision-making, emotional containment, and managing professional boundaries (Branson, 2019).

Burnout. Burnout is a much wider concept which applies across a range of occupations and results from the demands of the work role with limited access to supportive resources (Maslach, Schaufeli, & Leiter, 2001). In forensic services we can understand this more clearly as the long-term psychological strain of undertaking supportive work with individuals or groups with complex problems. Maslach and Leiter (2016) describe this as a prolonged response to chronic interpersonal stressors on the job and note the factors which distinguish burnout as (a) overwhelming exhaustion; (b) feelings of cynicism and detachment from the job; and (c) a sense of ineffectiveness and lack of accomplishment. Branson (2019) notes the similarity between burnout and VT, due to them both developing through a process of accumulation of experiences. There has been a greater focus in occupational psychology literature on the dialectic of burnout and the more positive conceptualisation of engagement using
conceptual models of job stress such as the *Areas of Work Life model.* This focuses on the six areas of workload – workload, control, reward, community, fairness, and values – to understand the adaptations required to increase engagement and reduce burnout (Leiter & Maslach, 1999; Leiter & Shaughnessy, 2006).

**Impact Studies**

The impact of working with individuals across forensic settings, both secure and in the community, is widely accepted as complex across the forensic practitioner community and this is reflected in the literature. However, there is a paucity of empirical studies specifically focused on forensic professionals when compared to those of other critical occupations (Gil-Monte, Figueiredo-Ferraz, & Valdez-Bonilla, 2013).

Studies of non-forensic critical occupations such as mental health workers indicate that exposure to traumatic material associated with work-related stressors can result in negative outcomes in terms of psychological distress but the literature is divided in terms of the specific prevalence and weight of specific contributions to resulting STS, CF, VT, and burnout (Devilly, Wright, & Varker, 2009; Lee, Lim, Yang, & Lee, 2011; van Minnen & Keijsers, 2000).

Critical occupation studies with emergency service personnel such as fire and ambulance workers, some of which also include forensic staff such as police personnel, highlight increased levels of psychological strain in these roles. Organisational and traumatic stress reactions have been found to predict levels of strain similarly for police and fire personnel, but overall, organisational stressors are noted to offer a better predictor of job satisfaction than trauma symptomology for fire, ambulance, and police personnel (Brough, 2004). Furthermore, it has been found that longer serving police officers working with victims of sexual trauma showed greater levels of CF, STS, and burnout, indicating that greater exposure to traumatic material increases negative impact (Turgoose et al., 2017).

Staff working within community forensic services in forensic interviewing or support roles (child exploitation, child abuse, or sexual assault centres) have been found to display increased levels of STS, VT, and burnout. Impacts are felt within direct contact, outside of the professional role and also personally (Burns et al., 2008; Middleton et al., 2021), with experiences of intrusive images and thoughts outside of work, protective feelings towards children, dissociation, and an inability to discuss traumatic material (Burns et al., 2008). Organisational factors are reported to contribute to these experiences with job support, funding pressures, and increased caseloads being crucial factors (Starcher & Stolzenberg, 2000). A combination of personal and organisational factors has been cited to ameliorate these impacts, including supervision, training, peer support, and shadowing (Horvath et al., 2020), as well as humour and a combination of organisational, psychological, and social support (Burns et al., 2008).

Studies involving forensic staff in mainly secure environments include a range of professional groups such as prison officers, forensic psychiatrists, forensic psychologists, nurses, mental health workers, and therapists. Overall, they suggest a clear risk of increased levels of STS, CF, VT, and burnout, at mild, moderate, and severe levels, depending on the focus of study and methods used. However, their presence in staff...
is dependent upon a complex interplay including individual characteristics, organisational factors, and personal events outside the work context (Clarke, 2013). A range of contributing factors have been identified to explain the variation in findings in the literature. These include amount of exposure to traumatic events (van der Ploeg, Dorresteijn, & Kleber, 2003); gender and length of experience (Gould et al., 2013); levels of demand, control, and support within role (Dollard & Winefield, 1998); levels of role conflict and negative experience of work (Gallavan & Newman, 2013); levels of compassion satisfaction (Munger, Savage, & Panosky, 2015); levels of avoidance, intrusion, and hyperarousal in individuals (Cramer et al., 2020; Newman, Eason, & Kinghorn, 2019); personal trauma (Adams & Riggs, 2008; Knight, 2010); workplace stress other than specific traumatic exposure (Pirelli, Formon, & Maloney, 2020); maladaptive coping strategies (Barros et al., 2020); and difficulties in self-identifying issues and managing these (Johnson et al., 2011). Comparison studies across forensic and non-forensic critical occupations have demonstrated similar findings with a clear presence of STS, CF, VT, and burnout across both in comparison to the general population (Carleton et al., 2019), significant impact on job satisfaction and personal life (Bourke & Craun, 2014), and reductions in role performance dependent upon individual, organisational, and social factors (Bakker & Heuven, 2006).

It is clear that with such a mixed and complex picture regarding the impact of working in forensic roles, more research is required (Bradford & de Amorim Levin, 2020). Existing literature highlights the impact of forensic role conflict between risk management and compassionate care. Holding the idea of an individual as both a victim of and perpetrator of trauma can often create cognitive dissonance for the practitioner which is difficult to tolerate for prolonged periods of time. The impact on professional competence has been highlighted (Johnson et al., 2011), including the maintenance of interpersonal boundaries (Rocchio, 2020), varying interpersonal styles (Lambert, Chu, & Turner, 2019), and the importance of personally managing self-awareness, reactions to shame, and fear over rejection from others (Johnson et al., 2011). However, it is not an insurmountable task and despite the wealth of evidence for negative impact, there is growing evidence for positive impact. Cramer et al. (2020) identified the good health of mental health staff in their recent study of a forensic psychiatric setting and Gould et al. (2013) reported use of mostly adaptive coping skills in correctional officers despite the presence of burnout within this population. Brovko and Foote (2011) demonstrated a potential resiliency effect in their reported study of forensic professionals, and Silveira & Boyer (2015) has noted the presence of increased hope and optimism when working with victims of interpersonal trauma. The concept of vicarious resilience may help to explain this. Engstrom, Hernandez, & Gangsei (2008) introduced the idea that there could be positive experiences which arise from work undertaken with survivors of trauma. Hernandez, Gangsei, and Engstrom (2007) identified it as a natural process which has not been previously defined or described and which requires further exploration. They propose that, with the correct environment, vicarious resilience offers the chance for staff to learn together with their clients and strengthen the conscious attention to positive effects, creating transformation in a strengths based manner (Hernandez, Gangsei, & Engstrom, 2007).
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Clearly there is an argument for increased focus on the impact for staff in forensic environments. Across different forensic settings, staff are holding an important critical role, within very challenging environments, with an often traumatised service user population. They are also carrying a range of personal, professional, organisational traumatic experiences themselves and can experience role conflict within their work. Research evidence suggests that their ongoing attempts to manage such role conflict and balance the complex risk versus treatment dialectic in an ethical/professionally boundaried way can have a profound impact on decision-making and ethical judgement and yet many have significant resources which can aid their resilience and lead to positive job satisfaction and outcomes.

Trauma-Informed Service Development

With clear traumatic impact for staff in forensic settings evidenced over time and the need to support them to manage this impact positively, an obvious question arises: why has this not been wholeheartedly integrated across forensic services before now? One contributing factor could be the parallel process dynamic which is referred to in the Sanctuary Model (described in detail below). This references the collective transference and counter-transference process of emotions, cognitions, and behaviours that can occur between service users and professionals and shape the way organisations operate at the most senior levels in terms of decision-making. Forensic systems are often set up to take a blame-focused approach to service users and staff who struggle with boundary management and resilience, and this seems to be founded on a long-standing culture where provoking shame is embraced over the safe, supported expression of vulnerability, within a holistic understanding of the person in the system. Recent developments in shame literature generally have indicated that shame responses which incorporate blaming tend to be less effective than clear boundary setting and accountability (Brown, 2010), and limit compassionate leadership of services (Brown, 2018). Another factor could relate to the fact that the forensic psychology discipline and wider correctional policy has been led by a paradigm that views forensic professionals as collective experts in terms of risk assessment and treatment, dominated by the Risk Need Responsivity model (Bonta & Andrews, 2016). Within this paradigm, “experts” are presumed not to have the same vulnerabilities as service users and thereby the system operates on a version of power that is defined by “power over” rather than “power with” or “power to”. With the advent of wider frameworks integrating health and well-being perspectives such as the Good Lives Model (Ward, 2002), where power is collaboratively shared with service users and their experiences, this is being challenged in terms of equality and diversity. It seems clear then, that this shield of expertise is an illusion and protects individuals, organisations, and policy makers from truly integrating the vulnerability of physical, emotional, and cognitive impacts of exposure to trauma in forensic settings. The danger is that this is not a tenable long-term strategy and transformation is required.

The following approach, I propose, draws together suggestions for individual staff across three integral areas of trauma processing by using established applied models.
evidenced within forensic services. It addresses physical and emotional safety (creating safety bubbles) through use of an applied boundary management model; provides a tool for understanding and managing the emotional impact of forensic work (emotional processing) using a well-evidenced resilience model; and facilitates cognitive processes and risk-related decision-making (cognitive connection) using a trauma-informed formulation framework. All of these can be facilitated easily through existing established supervision networks and training systems. It additionally considers two approaches for the systemic development of organisations and public policy at both a micro and macro level: the Sanctuary Model (Bloom & Farragher, 2010; Bloom, 2013; Bloom & Farragher, 2013) and the Human Learning Systems Approach (Lowe et al., 2021). While a comprehensive evaluation of each approach is beyond the scope of the current chapter, an overview and introduction of each will be offered with recommendations for further reading.

**Professional Boundaries (Creating Safety Bubbles)**

Professional boundaries can be described as the limit or edge of appropriate practice (Gutheil & Gabbard, 1998). They can be considered across three main areas, often referred to as the security triad in forensic settings. They include environmental or physical boundaries (e.g., walls or gates in a prison), procedural boundaries (e.g., policies and operational processes), and relational boundaries (e.g., interpersonal relationships between staff and service users). The complex interplay between physical, procedural, and relational boundaries in balancing the dialectic between risk management and compassionate care in forensic settings is clear in the literature and can create risks and significant consequences (Davies & Nagi, 2017). These can include boundary inattention (forgetting forensic context), boundary crossings (minor lapses in judgement), and boundary violations (breach of policy/code of conduct) (Love & Herber, 2001). Applied models of boundary management such as the Boundary Seesaw Model (Hamilton, 2010) have been developed as a way to understand and manage such boundary risks and could usefully be incorporated as part of trauma-informed service design and delivery.

The Boundary Seesaw Model (Hamilton, 2010) was developed by drawing from cognitive analytic therapy (CAT; Ryle & Kerr, 2002), and dialectical behaviour therapy (DBT; Linehan, 1993) and the continuum of professional behaviour related to regulatory codes to understand observed boundary behaviour demonstrated by staff in a service for those diagnosed with severe personality disorder. The concept of a seesaw is used to describe a continuum of care and control with over-involved behaviours (Pacifier role) or under-involved behaviours (Security Guard role) at either end of the seesaw and care with explicit limits (Negotiator role) in the middle. Hamilton (2010) suggests that staff are likely to move along the seesaw with their professional interactions through safe, risky, and danger zones at some point. However, the key to effective boundary management is knowing the non-negotiable limits at the ends of the seesaw and being aware of these smaller boundary shifts so that they do not progress to larger boundary crossings or clear boundary violations, and balance is maintained at the pivot point of the seesaw. There is a recognition within
this model that forensic staff are, because of the nature of their role and the population with which they work, operating more often at the edge of these boundary zones. It is important that boundary shifts and crossings are well attended to, documented, and reflected upon within services and, as Davies and Nagi (2017) highlight, supervision is vital to this collaborative observation process. Hamilton (2010) describes equally valuable systemic processes which, if implemented, can help to manage boundaries effectively at an organisational level. These include the development and communication of clear organisational values and procedures related to boundaries; an ethos of shared responsibility for boundary management; staff training, processes for boundary management reviews; monitored meaningful activity schedules for staff-service user interactions.

**Resilience (Emotional Processing)**

Definitions of resilience in the academic literature focus around two core themes; recovery, or the ability to bounce back after adverse experiences and sustainability, or a continued journey of recovery and growth (Reich, Zautra, & Hall, 2010). Conceptual models of resilience appear to take one of three different approaches: compensatory, protective, and challenge. Compensatory approaches view resilience as having a neutralising effect on the exposure to risk, where risk and compensatory factors equally contribute to the eventual outcome. Protective approaches see risk and protective factors interacting together to mediate negative outcome and moderating the exposure to risk. The challenge approach considers that the presence of risk factors (as long as they are not too extreme) can help with adaptation (a notion similar to the idea of herd immunity). Concepts of survival, recovery, and thriving are interlinked when considering resilience and also need to be examined. Survival relates to the idea that a person or system will continue to function; recovery indicates a return to baseline operation while thriving indicates the potential for transformation and cognitive shift with a stronger sense of self (O’Leary, 1998). Survival, recovery, and thriving concepts may indicate the stage of resilience response for an individual or organisation (Ledesma, 2014).

One process-based model of resilience, taking a protective approach, which has been developed specifically from research with intervention facilitators in secure prison settings, is the Model of Dynamic Adaptation (MDA; Clarke, 2004). The MDA highlights a range of factors which interact to result in either positive or negative psychological outcomes. These include factors relating to the person, the critical occupation, and additional dynamic factors. Person-specific static factors tend to be fixed or change in expected ways such as age, whereas person-specific stable factors demonstrate limited change or do so over time, experience or with support, such as coping style or emotional sensitivity. Critical occupation factors focus on organisational components such as the physical environment, risk of exposure to critical incidents, policies and procedures, and organisational support. Dynamic factors are unpredictable and can quickly change – the events that sometimes occur without any control such as a bereavement or a change in team members. Clarke (2013) suggests that this model of resilience can be applied functionally to any critical
occupation and encourages ongoing research to explore the contributing value of all the differing factors – some may be unique to a particular setting while others may be common across critical occupations. It is suggested here, that if applied systematically within forensic services, alongside the boundary seesaw model, this could offer support for emotional processing of traumatic events at an individual and organisational level.

**Power Threat Meaning Framework (Cognitive Processing and Decision-Making)**

Psychological formulation is a tool for practitioners to work together with service users to make sense of the distress and difficulties with which they present (Johnstone & Dallos, 2013). While previous chapters have applied aspects of this in detail, the current chapter will provide a brief overview and offer reasoning for its inclusion as part of the trauma-informed approach for forensic professionals and organisations. The publication of the Power Threat Meaning Framework (PTMF) as an approach to formulation has offered a meta framework drawing from a variety of theoretical approaches and evidence to integrate more a social and contextual lens to the understanding of psychological distress than has previously been available (Johnstone & Boyle et al., 2018). It approaches formulation by asking a series of questions related to exploring the following areas:

- **Power**: What has happened to you? This includes power experiences across many areas – biological/embodied, interpersonal, coercive, legal, economic, social/cultural, ideological.
- **Threat**: How did it affect you? This includes core threats, needs, and power within relationships, within the body, emotional, economic, social/community, environmental, across knowledge, and meaning construction and within the development or maintenance of identity.
- **Meaning**: What sense did you make of it?
- **Threat Response**: What did you have to do to survive?
- **Power Resources**: What are your strengths?

This is designed to facilitate a collaborative and empowering overarching formulation by asking “What is your story?”. The benefits of integrating the PTMF within trauma-informed forensic service development alongside the Boundary Seesaw Model and Model of Dynamic Adaptation is that it has application to service users, individual practitioners, teams, services, organisations, and public services at the widest strategic level. The model’s theoretical basis and philosophical approach takes a radically different view, to traditional medical models, of how our current society and culture understands distress. If formulation is undertaken at each level using this framework, it may allow for more collective responsibility for transformational change at the cognitive processing level and works towards shifting culture change towards compassionate risk management within forensic settings.
The Sanctuary Model

The Sanctuary Model provides a scaffolded structure to aid the development of trauma-informed organisations which provide safe moral climates (Bloom & Farragher, 2010). It recognises that everyone has vulnerability to trauma, includes system-wide interventions for adversity and stress across all levels of an organisation, and provides ways to shape services in a more trauma-informed way (Bloom, 2013; Bloom & Farragher, 2013). It incorporates clear understandings regarding the significant effects of trauma exposure on individuals and systemically to organisations that become traumatically overwhelmed. Bloom (2010) posits that there is a parallel process dynamic which, due to the significant inter-relationship of individuals, groups, and organisations, means they develop similar emotional, cognitive, and behavioural ways of operating. In forensic services, the complex interplay between service users managing their traumatic experiences through the use of violence to others and/or self, and the inherent pressures on staff holding both risk management and care, while already balancing their own traumatic lived experience, mean that trauma responses bounce backwards and forwards between them. Place this within a wider system which is operating itself within an environment loaded with social and economic strain and the trauma responding becomes more complex. The Sanctuary Model suggests that these parallel processes must be addressed fully if organisations are to remain healthy and effective in their delivery of trauma-informed services to those who access them. It recognises the process of traumatisation and re-traumatisation especially when services have more authoritarian approaches and indicates the moral injury inherent in this. It suggests that if the correct moral climate can be created, then a parallel process of recovery can be achieved for all.

The model is founded on what is referred to as the four pillars. The first of these is theory which refers to the extensive empirical and theoretical evidence which underpins the model. Its theoretical basis is drawn from trauma theory, but also integrates business theory, systems theory, and empirical work from the development of UK Therapeutic Communities. The second pillar refers to the Sanctuary commitments which are akin to a moral compass which guides the operation of decision-making and problem solving. All members of a community adopting the Sanctuary Model adopt these values and they shape the operational guidance of norms in the culture which is created. The third pillar refers to a shared language which is adopted to refer to four key domains of recovery: Safety, Emotions, Loss, and Future. The final pillar refers to the Sanctuary toolkit which is a range of practical tools and skills designed to help the community to build a more effective practice of the Sanctuary commitments and to create community connection and potential for new behavioural habits.

If forensic settings wish to introduce changes to existing systems and services in line with a more trauma-informed approach, the Sanctuary Model offers a clear, robust, well evidenced and tightly structured template. Its value structure is in line with all previous components (Boundary Seesaw Model, Model of Dynamic Adaptation, Power Threat Meaning Framework) in that it stresses collaborative, shared
responsibility with a view of working in an empowered manner with individual service users, staff, and with the organisational culture.

**Future Directions**

Working within forensic settings offers both challenges and opportunities and it is clear from the impact literature and the experiential knowledge of practitioners that staff and organisational well-being depend upon culture, climate, and the development of individual strengths. There is a building evidence base over time for the significant negative effect for staff of working in such challenging environments but also much potential for working with this in a positive, strengths-based manner. It has been suggested that a public health framework would be the most useful approach to take. Molnar et al. (2017) has outlined four stages to undertake this:

1. Define the problem and measure its scope
2. Identify the risk and protective factors for negative outcomes
3. Develop interventions and policies
4. Monitor and evaluate interventions and policies over time

Molnar et al. (2017) offers this caveat: “Without a concerted response from researchers, policymakers, and organization leaders, these professional groups are left vulnerable to the shared burden of trauma, accrued from chronic or acute hardship, known as VT or STS” (p.138).

The development of clearer trauma-informed models of working with forensic clients and supporting staff and organisations in the process have been outlined as a suggested way forward within this chapter. There needs to be a radical shift in systemic culture at the macro, public management level in order to integrate trauma-focused perspectives and processes. Human Learning Systems (Lowe et al., 2021) is a relational, systems-focused way of addressing the complexity of public services and offers the potential for such transformation.

Many forensic service users have also accessed a range of other human public services during the process of living with and processing aspects of their experienced trauma, for example social services, NHS, voluntary and charitable organisations. The Human Learning Systems approach includes all of these within its scope and defines public service activity as all those purposeful activities that support human freedom and flourishing (Lowe et al., 2021). In this way the task of human public service management becomes more aligned to previously mentioned notions of “power to” and “power with”, which are clearly more trauma-informed than traditional approaches. It takes the position that New Public Management (NPM), an approach implemented in the 1980s with a focus on markets, managers, and metrics (referred to as the 3Ms), fundamentally does not fit with the operation of public service and can be dehumanising. It has a theoretical basis in complexity theory and offers a paradigm shift to the way public services are managed at the macro level, based on continuous learning and adaptation with a shared
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responsibility for the health of the system which is developed. It posits that three core shifts are required to achieve this:

- **Motivation** – staff need help and support within their practice rather than incentivisation and targets.
- **Learning and adaptation** – learning is the mechanism for improved function, adaptation, and improvement in a system.
- **System health** – this focuses on the quality of relationships since service users interact with the whole system not just individuals within it.

It offers opportunities to think about how we strategically develop forensic services at a wider system level including public policy structures which, despite attempts at integration, often remain very divided. It could also offer a shared opportunity for learning, experimentation, responsibility and accountability to the transformation of public sector management which could bring together the variety of services across health and social care, criminal justice, education and employment in a meaningful way for the benefit of the service user.

**Further Reading**

Further information on the Sanctuary Model is detailed in the following three texts for those looking to implement structured trauma-informed approaches in forensic services:


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