A trauma-informed approach to forensic mental health involves re-examining and changing many of our assumptions and the way we work with and think about colleagues, service users, and the organisation. This chapter describes the development and implementation of a trauma strategy within Forensics in a large UK mental health trust, building on existing good practice around trauma-informed care (TIC). This involved a process of drawing these practices together, learning from each other and developing further through a common trauma-informed framework, changing habits and routines, embedding core trauma-informed practices and foundation values in our services, education and development, and an organisational commitment to promote resilience in our staff. The strategy equally intended to promote our service-users feeling of safety and being supported, with increased engagement with staff who understand trauma reactions and responses, having care experiences that do not add to previous trauma or re-traumatise, with improved outcomes.

For TIC to truly become a part of our everyday working and thinking, there are key elements that are crucial. TIC does not occur via application of an isolated set of practical interventions and approaches; instead, a shift in the culture of the organisation is paramount. An agenda to change practice to be more trauma-informed needs to use processes that, in themselves, reflect the principles of TIC to support that shift. Moving away from “What’s wrong with you?” towards “What has happened to you?” based practice, and applying compassionate thinking thereafter, requires an all-systems culture change from blame to just.

TIC is an organisational response to meet the needs of traumatised people within the organisation. It understands that so many of the people working and living in our services have had traumatic events in their lives. We already recognise that people have had and do have difficulties and past trauma, and we have processes to capture that
information and ensure that it is documented. But what do we do with this information then? How does it relate to people’s everyday experiences of being in our services and how is it translated into the approach and care that is provided to both our staff and service users? There is a tendency to acknowledge the trauma and view it as a silo event, one that happened years ago which renders it somewhat irrelevant to current experiences and behaviours. As a case in point, a colleague once asked, “people have had worse trauma than him, so why does he behave so badly now?” Trauma-informed services recognise that our past experiences can and do impact on how we experience day-to-day events. For our service users, there must be an awareness that being in our services can be traumatising; seeing others frightened or angry, loss of agency and empowerment, diagnosis and loss of family contact are a few of many potentially traumatising and re-traumatising examples. For our staff, we must remember that they too can have past experiences of trauma in their personal and working lives, and that they too can be traumatised or re-traumatised by their work. With so much of the work within forensic services revolving around individual trauma and adverse experiences, both within the service user group and in our staff, developing and embedding a trauma-informed agenda is both highly relevant and paramount.

A trauma-informed and formulation-driven whole system approach to care is indicated. Furthermore, it is not sufficient to think that we can transform our service users’ experiences of care without transforming the experiences of the people who work with them. Change is needed at all levels of our system to enable wider trauma-informed principles to become embedded within our forensic culture. A willingness within our systems to consider and reflect upon the impact of trauma on one another is a key element. It is essential to be curious and less assumptive that we know what is going on for the person, and to have compassionate and open conversations with the people who know themselves and their histories best. Historically, the traditional medical model of care has led and dominated our services; however, the determination of a diagnosis and application of medically orientated interventions is increasingly viewed as too narrow and limiting to address the spectrum of service users’ experiences and needs. Simultaneously, the evidence base for understanding and adopting trauma-informed principles, not only at service user level but also at an organisational level, has grown significantly (Bloom, 2013; Harris & Fallot, 2001; SAMSHA, 2014).

Any shift towards such understanding and change must be underpinned by investment and commitment at every level of an organisation. The efficacy of TIC requires full integration of knowledge about trauma into policies, procedures, and practises to help reduce re-traumatisation, enhance recovery, and promote staff well-being. Embedding core trauma-informed approaches into everyday practice, to shape the foundation values in our services, provide education and development, and to drive organisational commitment to create the conditions that promote resilience in our staff and service users, constitutes some of the necessary changes. Promoting such work within services via a multi-model approach provides permission to be curious and ask questions; thus, fostering relationships within the leadership teams to support such a broad agenda is crucial.
The move towards trauma-informed services is evident within the United Kingdom and beyond, and the calls for such approaches from those living and working within our services are becoming louder. The drive towards this agenda is clear across many organisations and consequently there are more and more data and narratives relating to service user and staff experience to inform strategy and practice. Broadly, TIC views training, development, supervision, and support for staff as essential. This attention to staff needs has the potential to reduce burnout and staff turnover, improve staff resilience, staff sickness, and reduce re-traumatisation (Sweeney, Clement, Filson, & Kennedy, 2016). In addition, there is good evidence that TIC can influence a reduction in restrictive practices such as seclusion, long-term segregation, physical and mechanical restraint, and enforced medication (LeBel & Goldstein, 2005).

Background

To establish trauma-informed principles and responses within an organisation, it is important to consider what that might look like to the people who use and work within our service. Garnering the interest and passion of the larger group of people already working toward TIC in their own areas and creating a “community of interest” with those people who want to influence and engender this agenda is key. A narrative of wanting change and being curious about what that could look like was becoming clear within services dominated by disenfranchised staff tired of a culture of “That’s just how we always do it”. To consolidate and link these interested parties, two separate conferences were held: the first for interested staff and a second for service users and carers. Facilitated by the two trauma agenda leads, the conferences acknowledged existing good practice, as well as gaps in our service, and captured the hearts and minds of those people involved. Establishing best practice and asking the question “what is possible?” opened an avenue in the trauma-informed arena for curiosity and change. Involving service users and carers provided rich information about how it felt to be on the other end of an organisation. Hearing the voices of our service users disrupted some of the pre-sumptive narrative around “what we do and how we do it” and allowed for a more thoughtful approach informed by all stakeholders. Following the conferences, a working group (LEEP: Lived Experience Expert Panel) was established from the Peer Support Development team to ensure the continued involvement of people with lived experience.

The trauma conferences aimed to shine a light on and demonstrate the importance of TIC within our forensic services. To undertake the work and embed TIC into clinical practice, the conferences started the conversation about where this strategy could be piloted. Ultimately, it was agreed that nine teams would be put forward from within the forensic services in the initial phase. From these discussions, came five key arms that were deemed vital to the strategy by the community of interest. Agreed collaboratively, the key arms were: staff health and well-being, education and development, clinical scoping, a TIC framework, and an internet-based virtual hub to bring together staff, their knowledge, expertise, and shared experiences.
**Staff Health and Well-being**

Stress and unaddressed trauma in staff can have a significant impact on healthcare culture and the ability to respond effectively to the needs of service users. The impact this has on staff burnout, sickness, and retention are well known (Health and Safety Executive 2001), and processes in place within the organisation, such as exit questionnaires, staff sickness returns, and staff surveys, capture this information. Within this arm of the strategy, there was to be a focus on how we could ensure the impact of the work was viewed as equally important to clinical outcomes. To achieve this, the trauma agenda highlighted two elements: to create a culture and provision to support and educate staff about good and effective trauma-informed clinical supervision, and to assert the role of trauma-informed reflective practice as a key structure to be invested in within our service. Furthermore, a separate ‘reflective practice’ agenda aligned with TIC has been developed to ensure that these elements are equitable for all, with recognised standards and acknowledged and invested in by the leadership team.

In 2017, a post-incident peer support (PIPS) framework was rolled out across the Forensic directorate (Hiett-Davies, Milburn, & Regal, 2017). This framework was developed in response to National Institute for Health and Care Excellence (2015) which recommended the general, practical, and social support and guidance to anyone following a traumatic incident, whilst the government commissioned report on *Thriving at Work* (Stevenson & Farmer, 2017) recommended the establishment of a framework to coordinate support for those employees at higher risk of stress or trauma. The framework encompasses three elements of support following defined types of significant incidents which have a structure of providing social and organisational support, normalisation and signposting. Staff were trained to facilitate defusion for staff involved (immediately post-incident), peer support de-brief for staff within two weeks of an incident, and service user review for service users following an incident. The framework’s purpose is to provide time for staff to begin to process the incident and gain immediate support from their peers, facilitated by trained staff and designed to support coping in the immediate term. The service user review ensures that the views of the individual involved are gathered and discussed, and that a plan to further support the person is generated collaboratively. The PIPS framework and the associated training needs are promoted within the trauma agenda.

**Development and Education**

Developing a trauma-informed training package is integral to a trauma-informed service. Providing staff with the understanding and tools needed to respond with compassion, care, and curiosity is vital. To engender a narrative around what has happened for the individual provides a space in which colleagues can think and work proactively with the person, rather than simply rely upon reactive responses in difficult moments. Compassion for the other can be difficult to maintain when staff stay only in the moment and encounter a set of behaviours and presentations which in turn may generate fear, stress, or dismissive responses. Creating a training set, through which the thread of compassion runs, pays attention to the phenomena evident in many staff,
namely compassion fatigue, over-reliance upon restrictive practices, disrupted boundaries, and disengagement. Consequently, a two-day trauma awareness training package was developed and delivered to each of the nine “seeded” teams. The team training approach was important to ensure that the whole team, rather than individuals or an individual discipline, committed to the trauma-informed agenda. This whole system approach was adopted for the purpose of bringing together and training all staff involved in service user care to enable the embedding of a trauma-informed culture across the clinical environment. Provision was made to deliver two sets of this two-day training to each team to ensure that all staff from every discipline could attend and engage, and in total 206 staff were trained from our forensic services.

The training included an understanding of the impact of trauma on the individual and how it might have affected them. This encouraged thinking about some of the presentations our staff experience, how these behaviours may have developed over time, and how these might constitute forms of protection throughout that person’s life. Attachments and how these are formed and the impact that difficult and chaotic attachments might have on the person we see now were also discussed. Throughout the training, emphasis was placed on how our staff might feel and respond to someone in distress, and honest conversations about how it is to be on the end of that distress were encouraged. It was interesting to note that, pre-training, from the evaluation feedback from the teams, staff consistently reported that they did not feel that they had the skill set required to work with trauma and felt that their role consisted of the reactive containment and management of service user behaviours. Staff narratives around loss of compassion, seeing a person as “difficult and risky” and forgetting the person’s own story and what has happened to them, were also regular themes. Indeed, a clear sense of guilt, anger, and a loss of self-worth, empathy and motivation permeated the commencement of training sessions. However, such dialogue invariably changed over the course of the two days as staff became more energised and motivated towards change. The training provided interventions and approaches that can help in moments of distress, and tools such as grounding, sensory techniques, and distress care plans to address the person’s own experience were taught. Use of formulations and the concept of the window of tolerance (Ogden, Minton, & Pain, 2006) and how these should inform distress care planning were introduced to the groups for them to better understand and cater for the individual’s whole life, experiences, and presentations.

Clinical Scoping

From the initial conferences, a scoping exercise highlighted the breadth and range of interventions and approaches already being offered across forensic services, and we now have a comprehensive map of local provision and expertise. This provided a foundation for exploration of where best practice occurs and where the gaps in provision were. Future provision and possible developments were also derived from this work. The act of drawing together the knowledge and expertise within forensic services and developing a community of interested people allowed for that expertise to be shared, and diluted traditional silo working. Links can now be made across
the services to people with specific areas of expertise and information disseminated through the virtual hub. New possibilities around the use of video training and video conferencing have come to the fore, and although this may reduce face-to-face contact, it has broadened the training arena and made this agenda more accessible for more people.

**Virtual Hub**

The virtual internet hub was developed to provide a portal for organisational engagement and communication, providing links for the community of interest and beyond. Having a central place for staff to link to, share good practice and learn from others, and to export good practice from one service to another is seen to be key. Educational and training needs can be addressed through the hub, with all playing an important role in sharing expertise and providing learning opportunities for others. The hub is accessible to all staff and has links to and from other relevant sites, such as staff health and well-being, clinical practices, and suicide prevention. It is essential that “being trauma informed” is not a stand-alone practice and does not sit in isolation across a system. Creating a truly trauma-informed service ensures that trauma and trauma-informed practices and thinking constitute a thread that runs through and touches all aspects of the organisation. The production of the hub pays attention to this and has generated unity through promotion of the agenda and instilling the idea that being trauma aware and responsive is everyone’s business.

**Trauma-Informed Framework**

Identifying what we mean by TIC, what it looks and feels like, the core practices and foundation values that are embedded in our services and how this links to personal recovery and staff health and well-being are a central part of the work. To establish this, we need to ensure that we have the knowledge, skills, and impetus to develop and maintain TIC, and to create a culture in the organisation to enable this to flourish. Achieving this supports the goal of good recovery and ameliorates the impact of vicarious trauma and re-traumatisation for both staff and service users. Using a trauma framework allows staff to work with a structure that enables them to plan their trauma-informed service. They can view and action plan against each element as separate entities in a practical way, whilst working towards bringing them together as a whole. The purpose of this approach was to ensure that attention to trauma became less additive and more integrative.

**The Five Pillars of Trauma-Informed Care**

The framework is comprised of the behaviours and processes that reflect each of the five pillars of trauma-informed care outlined by Covington (2016): Safety, Collaboration, Trustworthiness, Choice, and Empowerment. These pillars formed part of the staff and service-user evaluation and from these a benchmarking tool was developed. In addition, a set of standards for the teams to work towards was created.
Safety: Environmental and Psychological

Environmental safety involves working towards ensuring that people within our services feel safe in their environment. This requires staff to take a step back and really look at their service, what does it look and feel like? Many teams recognised that their services were built around a risk-orientated formula: chairs that were too heavy to move, tables bolted down, rooms that were bare, restrictions on many items, staff using toilets to get away from work in order to cry because they had nowhere else to go, and little attention paid to the sensory ambiance, as the usual smell, look, and sounds were no longer noticed. Environments could be modified to be conducive to feelings of safety, and the positive impact this might have on the traumatised individual was not considered.

TIC is underpinned by psychological safety. This is a critical factor in collaboration and learning. When people feel psychologically safe, learning and positive change can take place. Rather than focusing on self and self-protection, we can work and learn together and focus on joint goals once we feel safe expressing opinions and offering solutions without fear of judgement or criticism. There is a clear relationship between psychological safety and engagement, and consequently this is a crucial element when working collaboratively with our service users who struggle to trust and engage with others, who often do not feel that they have a voice or that it will be heard. Developing a psychologically safe service works on the premise that the individual’s views and thoughts will be respected and paid attention to, and that this is understood and felt by the individual. From a learning perspective, opinions and questions are viewed as constructive, and not knowing or understanding is acceptable. Generally, our services expressed a view that they felt psychologically safe. However, closer examination revealed examples where staff and service users did not feel safe. Ward rounds were one such example; traditionally hierarchical, consisting of a mixture of disciplines who carry authority, nursing staff reflected at the conference that at times they felt intimidated in this arena or felt that they were there to simply advocate for their service users without having a voice themselves. A direct consequence of this was that the views of the service users were not heard adequately either. Staff were less likely to ask for help, give feedback, share innovative ideas, or discuss problems, leading to a much less cohesive and collaborative discussion with shared goals and outcomes at its heart. This lack of psychological safety (and therefore, inclusion) was also felt by service users. Fears around reporting mistakes, questioning practices, and querying decisions were shared by staff and service users, with such fears often as a direct result of previous negative experiences. More generally, service users reported that they did not feel part of the decision-making process, and some felt that their views were never listened to or even considered. In such instances, there was little opportunity for shared learning or collaborative working as a team.

Collaboration

It is important that people are given the opportunity to make a meaningful contribution to their care and work, providing a sense of agency, empowerment, and choice.
A cohesive approach to helping people feel safe is informed by a shared understanding of what works best for individuals and works towards reducing the intensity and frequency of moments of overwhelm and distress. There must be a consistent process of engagement to access people’s views and inclinations, and an understanding and recognition of the centrality of this. Within our services, there was a willingness to work collaboratively with service users; however, staff reflected within the conference that the nature of our forensic care stymied their capability to truly work in this way. Examples of “having to manage and respond” to difficult and risky behaviours appeared to negate staff ability to collaborate with the person. In those moments, the culture of “doing to” came to the fore, apparently at the expense of utilising the opportunities for collaborative crisis-planning (outside of episodes of overwhelming distress). Environments were created based on staff assessment of risk rather than working collaboratively to create an environment which felt safe to the people who stayed there. Assumptive thinking based on “what we have done before works” formed a basis for managing risk, and a pre-set activity timetable excluded those who were not interested in what was on offer or felt threatened within groups. Teams worked in collaboration with service users to develop care plans but recognised that, ultimately, the multi-disciplinary team would decide on the course of treatment for the individual. Meanwhile, plans to manage violence and aggression, self-harm, security, and other forensically relevant risk areas tended to be developed and held by ward staff.

**Trustworthiness**

Trust is the foundation to developing meaningful relationships and delivering TIC. It creates the conditions necessary for care to be received and to flourish in a meaningful way. There must be clear and concise expectations of all, with transparent communication upheld. There was a recognition from those at both the conferences that services are often unpredictable and in flux. From these forums it was reported that it was commonly perceived that there were no clear pathways of care and no expectations of behaviours or expected responses. Service users reported that they were not routinely kept informed of changes to their care timetable, and were not informed of changes to their routine. Furthermore, staff reported that communication between management and staff was not always clear or well circulated, and there was a feeling that decisions were made by senior figures that were not in the best interests of staff. Naturally, this impacted on staff ability and willingness to trust that their leaders were open and transparent and held their staff in mind when making decisions that impacted on them. In some areas this had created a them and us culture, with a loss of cohesiveness and increase in suspiciousness and cynicism around the motives of each party. This dynamic within the staff team was paralleled within the service user and staff dynamic.

**Choice**

People’s preferences must be sought and prioritised. There needs to be an awareness that people who are distressed and overwhelmed may have difficulty in processing
information and then making good, adaptive choices. Equally, it must be recognised that at times they may believe that their voice has been denied, invalidated, or not been heard, and that their past experiences may shape this belief. We need, therefore, to create different ways to provide the same information, with good choices, and that this is available as required in a non-shaming and non-threatening way. From the conferences, our services recognised that often there was no such information available for people, and what information there was, was in a “one size fits all” format. There was also an acknowledgement of a “doing to, not doing with” culture that was underpinned by a power imbalance apparent to all. Routines and regimes that gave people little space for choice were reported to dominate our forensic services. Simple, everyday staff practices like knocking on service user doors and walking in before receiving a response, assuming that service users consented to be subjected to rubdown searches without asking them, set seating plans for meals and rotas to use the laundry were just some of the opportunities to provide choice that were often missed. These regimes enable systems to run smoothly and basic interventions and activities to be attended to. However, we can forget that, for our service users, these day-to-day interventions are the basis for many of their interactions with others, and that providing them with choice can provide a sense of safety, worth, agency, and empowerment.

Empowerment

Every person should be seen as an individual with unique experiences and a personal history. By recognising people’s strengths and building skills, we can maximise their empowerment. It is clear within our forensic services that there is a power imbalance between staff and service users. Service users are not free to leave, see their family as they wish, or choose how they eat their own meals. They cannot decorate or design their rooms as they want them to be. Equally, there are many examples where loss of empowerment for staff is evident. Inflexible working, processes and procedures to adhere to, decision-making not always at “ground level” can leave a staff team feeling disempowered. Rules, regimes, and restrictions are important to any organisation because they provide boundaries, containment, consistency, and safety for all. However, within this element of the strategy we look at ways in which we can increase a sense of empowerment for our staff and service users. We want to create a culture where identifying and developing skills is a priority. We can empower people by collaboratively looking at where they have strengths and how we capitalise on those; creating activity timetables that are person-centred and strengths based; and having conversations about what the person enjoys rather than what we have to offer. We can ensure that staff have access to training that is relevant to their skill set and interests, and put processes in place to make sure that clinical supervision provides a safe space for discussion and ensures that identified goals are acted upon.

Implementation of Process into Practice

The initial phase of engagement for the strategy encapsulated both the conferences and fostering relationships with senior leaders via various forums and written
communications. This resulted in nine forensic inpatient teams being nominated as leads for the trauma-informed agenda, forming a starting point to embedding the work across all forensic services. These teams were based across the forensic directorate within high, medium, low secure settings and prison in-reach. They covered a cross section of the service user population, including Women’s Services, Male Mental Health Admission/Acute Services, Personality Disorder Services, and Intellectual Disability Services. Each team appointed two staff “champions” with whom the trauma agenda leads would work closely with, having secured a commitment for protected time for those champions from their respective service leads.

A pre-intervention evaluation of TIC was co-developed by the agenda leads and undertaken by Lawday & Lawday (2019) to establish current areas of need across the identified teams in relation to TIC. The measures were selected following a review of published literature relating to milieu rating scales/ward atmosphere, as well as validated measures of trauma-informed practice, and a “walk through” of each service. Every team staff member was asked to complete anonymous, pre-evaluation assessments relating to ward atmosphere:

- **The Essen Climate Evaluation Schema** (Schalast & Tonkin, 2016) a 17-item questionnaire corresponding to 1 of 3 subscales: patient cohesion, experienced safety, and therapeutic hold/support.
- **Attitudes Related to Trauma-Informed Care** (ARTIC: Baker, Brown, Wilcox, Overstreet, & Arora, 2016), with 7 subscales consisting of underlying causes of problem behaviour and symptoms, responses to problem behaviour and symptoms, on-the-job behaviour, self-efficacy at work, reactions to the work, personal support of TIC, and system-wide support of TIC.
- **Professional Quality of Life Scale** (ProQOL: Stamm, 2009) comprising of 3 subscales: compassion satisfaction, burnout, and secondary traumatic stress.
- **Bespoke benchmarking tool** measuring staff and service users’ experience of safety, collaboration, trust, choice, and empowerment (Covington, 2016).
- **Trauma awareness training questionnaire** immediately post-training consisting of 16 questions based around the training they had received and its impact on themselves, their team, and their service users and repeated 18 months later at post-evaluation.

The walk-through of services was conducted by the agenda leads and a member of the LEEP team and occurred from the admission point for service users. This provided an insight into how the service felt from an environmental and psychological perspective, aiming to highlight good practice as well as barriers to promoting safety.

The next phase of the strategy was to introduce the champions to the information from the pre-intervention assessments and benchmarking tool. These were used by the teams to create an action plan, based on highlighted areas around the five pillars, where each team wanted to improve. The action plan called for the teams to evidence their trauma-informed practices against the trauma strategy standards, as developed by the agenda leads (adapted from McGuire & Carlisle, 2018; Mersey-care NHS Foundation Trust). Based on the five key pillars (separating “safety” into two elements of psychological and environmental), the set of nine standards also incorporated staff
well-being, staff development, and crisis planning. By employing this set of trauma-informed standards, each team was empowered to work towards establishing and then providing evidence of the shifts and changes that they had made. Further areas for development were then identified and planned for by the teams.

**Trauma Awareness Training Evaluation**

Each delegate was provided with a questionnaire immediately post-trauma awareness training to capture staff’s initial thoughts and impressions. This questionnaire was designed to capture both the practical aspects of the training as well as the content. Each delegate was asked if they were willing to participate and all returns were anonymous. A further post-training questionnaire was included in the service evaluation format six months later. Every member of staff from the teams was asked to complete this. From this information a thematic analysis was completed to provide a snapshot of the impact of the training. Of the staff group, responders to the follow-up training questionnaire, 33% had received the training. This reflects the reported high turnover of staff due to natural progression and movement across services and trusts and reinforces the importance of training for trainers to ensure sustainability.

**Evaluation**

Details of the evaluation are reported by Lawday and Lawday (2019; 2020). Both the pre- and post-intervention evaluation was sent out to staff via trust email and all data received was managed and analysed by the principle researcher. Overall, there were 113 staff respondents at pre-intervention, 51 staff respondents at post-intervention. (There was a notable reduction in responses compared to the baseline period. Possible reasons include demands of the role during the Covid-19 pandemic response, staff absence or turnover, acuity of clinical need.) Service users received their evaluations via the post to their wards and were supported by staff or agenda leads and LEEP members, and were requested to complete the questionnaire which focused on their views of the service based on the five pillars. Pre-intervention there were 47 service user respondents and 47 service user respondents post-intervention.

All measures were repeated in the post-intervention evaluation which occurred 18 months later. The benchmarking tool asked questions relevant to the five pillars of TIC, at pre- and post-intervention. At post, all questions saw an improvement on average, in particular the Choice and Collaboration questions. Statistically significant improvement for all five pillars of TIC was found. There was also significant positive change on six of the seven subscales of the ARCTIC measuring attitudes to trauma amongst staff. On the Professional Quality of Life Scale, average staff ratings of compassion satisfaction had increased, while reported levels of burnout and secondary traumatic stress had reduced.

Service user responses post-intervention saw a slight deterioration in average scores, in particular on the trust, choice, and empowerment benchmarking survey scales. Unfortunately, the measures were taken during lockdown due to Covid-19, which is likely to have significantly affected the sense of choice and empowerment.
that service users felt at the time. The positive changes in other areas were tested for statistical significance. There was a statistically significant difference in the scores for pre-responses compared with post-responses.

Focus groups with employees from each of the nine seeded teams were also arranged following the intervention. In each session facilitators sought the opinions of participants in relation to their experiences of being part of the introduction of TIC in their service. These were designed to gather the narrative of the staff teams with a standard set of questions to each and were facilitated by the agenda leads. A series of seven prompt questions were used and the outputs of every discussion were recorded in written format and then thematically analysed to give a snapshot of how TIC has impacted within those sites.

The focus groups highlighted increased compassion for each other and their service users as a priority and an important shift in their working, being able to consider what has happened for the other and responding with compassion rather than blame. There was an overwhelming focus on better team cohesion, psychological safety, a shared language, and better service user outcomes. Staff reflected that there was an increase in curiosity and desire to understand the drivers behind the person’s behaviour or trauma response, with a willingness to ask questions and discuss different approaches to care without fear of criticism. Working towards ensuring that care for all in our service is sensitive to needs and is experienced as safe, predictable, and consistent was a running theme throughout. Within the focus groups, staff identified being able to recognise the impact of traumatic events on colleagues and themselves. Staff described being more empathetic towards their colleagues, being able to approach each other to offer support more readily. Having a shared language and enhanced understanding promoted better communication and contributed to a change in culture.

Teams had shifted their practices around staff and service user well-being, giving consideration to their environment. Staff reflected within the focus groups that they had not previously considered the environment as having an impact on our service users or themselves. Stepping back and viewing their environment through “fresh” eyes influenced and altered their perception. Several teams considered the entrance to their ward area and the route new admissions are taken on to arrive there. One team reflected on a new admission who had arrived distressed having been driven past the main entrance and round the back of the hospital to arrive at the side door to the ward, believing he was being taken to a concentration camp.

Other teams focused on the immediate surroundings within the ward environment, re-configuring rooms that could be used as a sensory or a quiet room. Putting up curtains that had otherwise been viewed as potential for being used in “risky” ways and reconsidering service users’ experience of mealtimes, bedroom spaces, and lounge areas. Several teams turned their attention to mealtimes and redesigned the eating area to make meals a more pleasurable experience rather than simply a process of eating.

Many teams changed previous pathways of care to develop a trauma-informed pathway, adopting interventions and approaches from pre-admission to transition and discharge with a focus on safety, engagement, and feeling contained as opposed to risk, ward activity timetables and restrictions. Teams rethought the process of
engagement and the views they held of service users who were “dis-engaged”. These teams created more flexible timetables which allowed service users to have choice in activities and whether these were with groups or individual. These were tailored to the service user needs and built entirely around staff understanding of the individual’s capacity and ability to engage with others.

The analysis from both training evaluations was equally positive, with staff reporting a sense of being heard and invested in. Post-training, all teams reported that trauma training significantly impacted on service user care and outcomes while 54% of staff felt that their practice would improve following the training. With the knowledge and understanding around the presentations and behaviours that staff work with every day, good use of clinical interventions such as formulation, distress signature, collaborative care planning, sensory work, creation of pathways through service, and being with and listening to were given as some examples of change to practice. Staff reflected within the training evaluation that they had re-thought risk assessments and risk management plans through the lens of distress rather than risk alone, having a positive impact on restrictive practices. All teams shared examples of this shift of focus and described better outcomes for both the staff and service user. Several teams had changed their risk management plans to incorporate trauma and ensure that the service user experiences were understood in the context of how they might present. Staff reflected that changing the focus of risk to a more balanced view of both risk and distress enabled a reduction of re-traumatising responses from staff. This shift in focus promoted service user empowerment where they could tell their story, be understood, and supported in a way that was helpful to them. Teams were embedding the use of formulations to develop collaborative care plans which truly address the persons’ difficulties and how they want to be supported. Following the training staff reported a re-framing of their role and understanding the importance of day-to-day containment and engagement in the persons’ recovery which had a positive impact on their feelings of empowerment and being valued within the team. Staff reported feeling that they had a purpose and motivation to change, were skilled with something to offer and empowered to make change, and were confident in their own ability and willingness to share and receive good practice ideas.

The focus groups, trauma-informed standards, training and evaluations enabled our forensic services to achieve genuine TIC that demonstrated measurable positive differences to the lives of the people they work with as well as to their own working lives. It is evident that these trauma-informed areas are the beacons of our forensic service and stand as evidence of the positive impact of TIC. They have demonstrated positive change to their culture, a culture that had previously been underpinned by the ethos that “this is how we have always done it”; those practices and approaches have been re-thought and reconsidered through the trauma-informed lens.

Next Steps

There remains much work to do to better establish TIC across an organisation. There are more changes that need to happen to ensure that being trauma informed is not seen as a “silo” but as an approach and way of thinking that spans and influences all
areas. A full commitment from organisation leads to support the trauma agenda is vital, with their visible investment to communicate the trauma strategy both internally and externally as a core part of business. Much thought and investment are needed to ensure that training packages are both sustainable and relevant to staff teams. A “train the trainers” programme is in place and all champions of the TIC teams will be trained to ensure sustainability within their service. Equally, we will see our champions working closely with other teams within their services, supporting them through the benchmarking tool to action planning and achieving the standards. The author continues to work closely with and align trauma-informed work with all other relevant areas of the organisation such as staff health and well-being, just and restorative culture, influencing policies and procedures, training department, suicide prevention, Quality Improvement, as well as our Positive and Safe Violence Reduction department to name a few. Instilling trauma awareness and knowledge within our interdependencies ensures that trauma and its impact is not seen in silo, or something “other” and not connected to other areas and agendas. Embedding an understanding of trauma and compassion as the foundations to all areas of the work is imperative. The continued work with our Positive and Safe Violence Reduction leads within the trust is especially important because of their influence “setting the tone” for all staff and training and developing them to work with and support our service users before, during, and after crisis. In recent years, Violence Reduction training has broadened its focus to include preventative strategies as well as management strategies. Therefore, prioritising “primary strategies” to avoid conflict in the first place, having effective “secondary strategies” to intervene and de-escalate risk-indicating situations, and being able to deliver safe “tertiary strategies” to manage crisis continues to be influenced by the trauma agenda. However, equally important in this area is the consideration we must give to our staff in relation to the impact those crises can have on them.

From a global, national, and local level, research, papers, other Trusts, evaluations, and trauma-informed pilots all demonstrate the necessity of a trauma-informed agenda which should be built on. The NHS long-term plan (NHS, 2019) is clear with regards to trauma-informed services and it is likely that organisations will need to demonstrate a robust and working trauma-informed agenda in the future. TIC and its place within healthcare is growing and there is a spotlight on those organisations with this agenda at the heart of its work. Becoming a trauma-informed service does not only relate to the work that we do with our service users but transcends this to an all systems approach, where all have a shared language of compassion and understanding. It is the development of a service which understands that we all react and respond in different ways when under duress, when the nature of our work is difficult, stressful, and traumatising at times. That TI service responds to our staff and service users with the understanding – we are all doing the best that we can with what we have.

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Further Reading


Kurtz, A. (2020). How to run reflective practice groups: A guide for healthcare professionals. Routledge. For readers wanting to develop reflective practice within their service, this is very relevant as a step by guide.

References


LeBel, J., & Goldstein, R. (2005). Special section on seclusion and restraint: The economic cost of using restraint and the value added by restraint reduction or elimination. Psychiatric Services, 56(9), 1109–1114. doi:10.1176/appi.ps.56.9.1109


NHS. (2019). The NHS long term plan. NHS.


