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Trauma-informed care: An overview and applications

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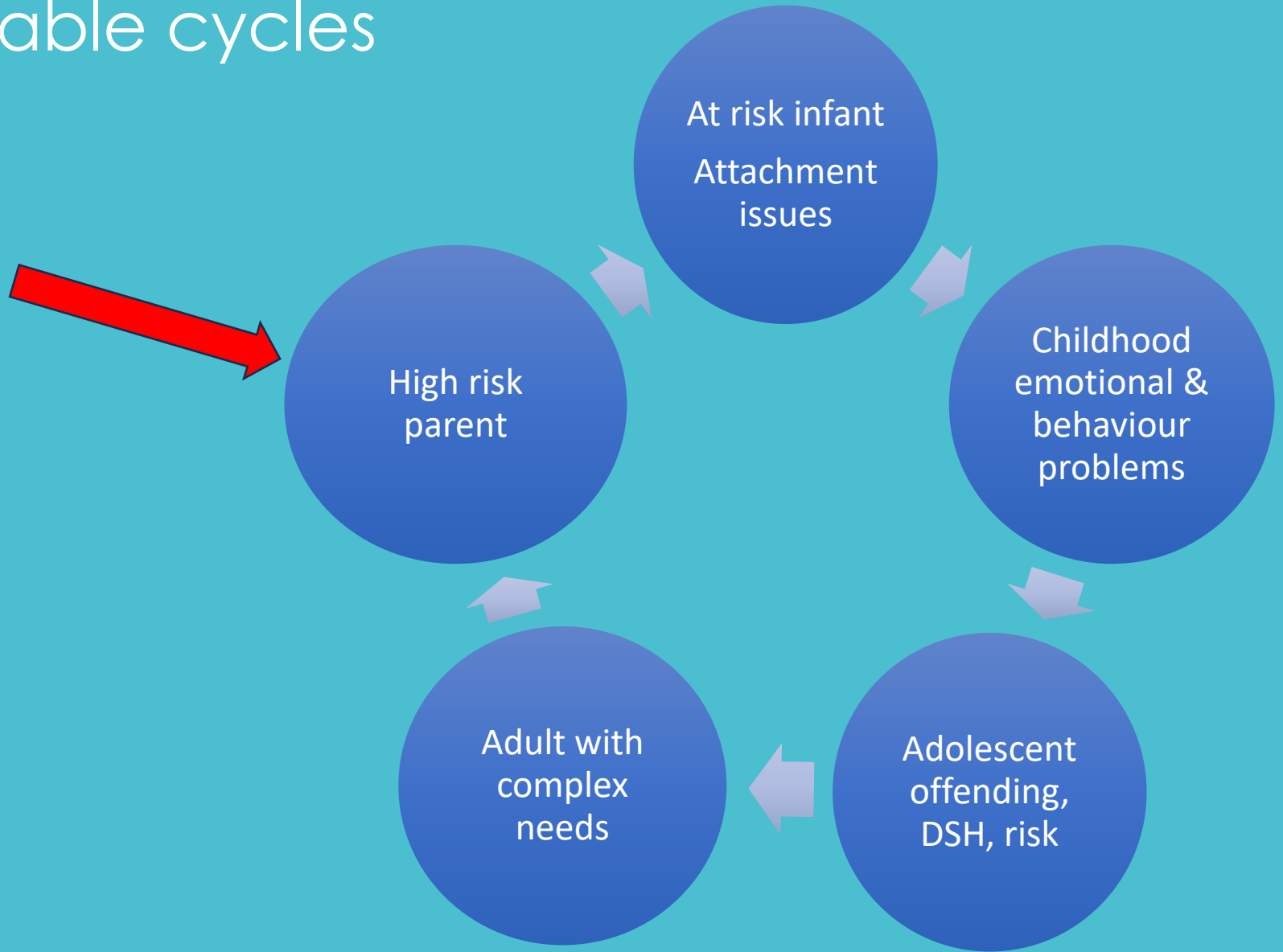
Outline

- Rationale for trauma-informed approaches – what problem are we trying to solve?
- Origins, philosophy and principles of trauma-informed care – how has this evolved?
- What trauma-informed thinking can bring to services – the spectrum of applications from universal precautions to very specific protocols
- Critique

Inescapable cycles



What problem are we trying to solve?

Trauma is prevalent.

Trauma is prevalent across all health and social care sectors

- Inner city **primary care** - 87.8% one type of trauma, 19% child sexual abuse, 17.2% physical abuse (Gillespie et al, 2010).
- Community **mental health** – 91.1% 1 trauma, 45% forced sexual assault, average 4.7 types of trauma(Cusack et al, 2004)
- Prevalence of sexual abuse in **adults with learning disabilities** – 32.9% (Tomsa et al, 2021)
- 58% of people in **inpatient detox** unit had PTSD symptoms within a range requiring treatment, Shora et al (2009)
- 94% of those in **domestic abuse** perpetrator programme reported trauma, average 6.3 types (Maguire et al, 2015)
- ¾ **juvenile offenders** have been exposed to traumatic victimisation and 11-50% have PTSD, Ko et al (2008)
- 41% **adult male prisoners** lifetime poly-victimisation, 22% sexual trauma, Facer-Irwin et al (2021)
- 87.7% **homeless adults** exposed to child maltreatment, 45.8% to sexual abuse, Song et al (2018)

Trauma is relevant.

ACEs UK

- Bellis et al (2014) Household survey –
  - 47% at least one ACE.
  - Those with 4+ vs 0 ACEs were 3.29x more likely to smoke, 7.71x more likely to perpetrate violence, and 5.86x more likely to have teen pregnancy.

- Bellis et al (2014) Retrospective cross-sectional study –
  - Those with 4+ vs 0 ACEs were 9.69x more likely to have used crack or heroin, 8.83x more likely to have spent one or more nights in custody.
  - ACEs also associated with deprivation and educational and employment disadvantage.
  - Within a substance use sample, 64.2% had 4+ ACEs.

The ACE study is not the only evidence that trauma is associated with adverse outcomes

- Childhood exposure to verbal aggression, domestic abuse, physical and sexual abuse associated with anxiety, depression and anger symptoms. (Teicher et al, 2006)
- Meta-analysis - child sex abuse associated with later physical health symptoms (Gastric, pain, obesity, cardio) with small to moderate effect sizes. (Irish et al, 2010)
- PTSD rather than Combat exposure associated with physical health outcomes such as arthritis, musculoskeletal, hypertension. (O'Toole & Catts, 2008)
- Adult Experiences Survey – sample of women, 71% 2+ adversities; all 10 adversities associated with poorer physical and mental health (Mersky et al, 2020)

Diagnosis	Effect of non-consensual sexual intercourse before the age of 16 years expressed as Odds Ratios
Depression	5.07
Phobia	12.12
OCD	7.01
PTSD	8.23
Eating Disorder	6.53
Psychosis	10.14

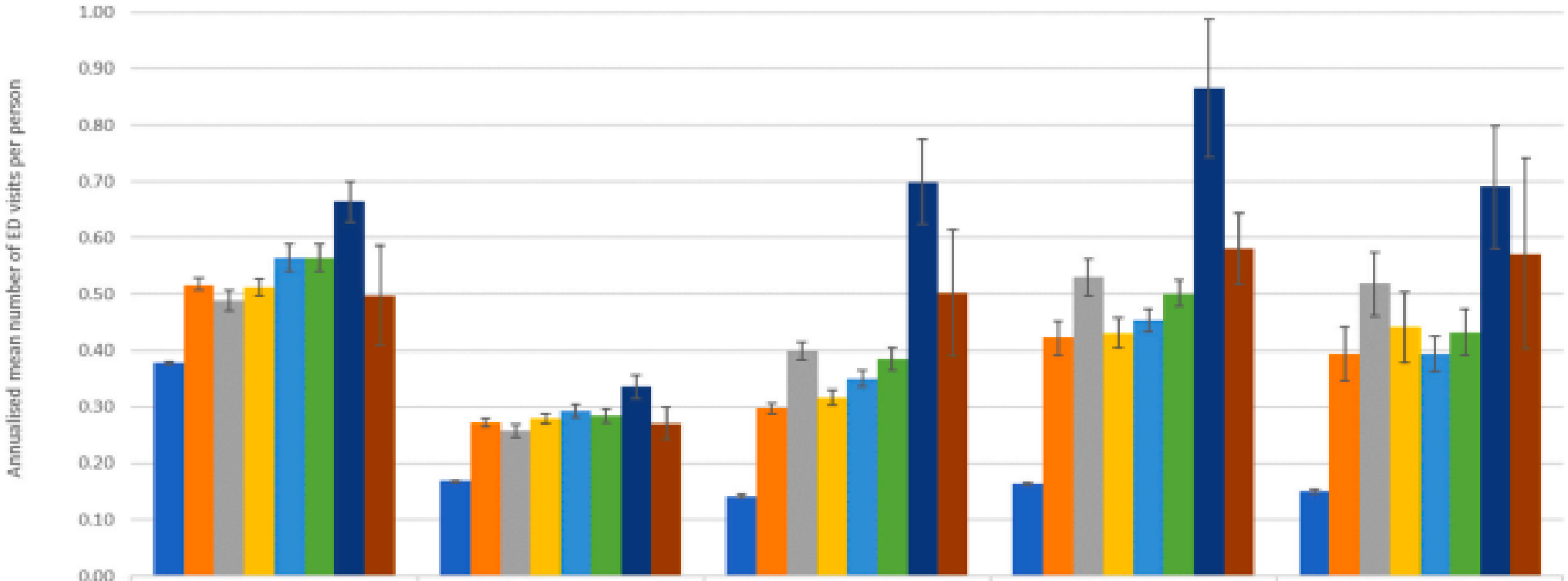
jonas s, et al. (2011) sexual abuse and psychiatric disorder in England: results from the 2007 adult psychiatric morbidity survey. psychological medicine; 41: 709-20.
bebbington et al (2011) childhood sexual abuse and psychosis: data from a cross-sectional national psychiatric survey in England the British journal of psychiatry 199, 29–37.

Cluster B Personality Disorders	No Maltreatment	Childhood Maltreatment & SA	
	%	%	AOR *
Antisocial	3.5%	19.9%	(5.10)
Borderline	3.1%	21.1%.	(5.25)
Narcistic	5.0%	20.3%.	(3.76)
Histrionic	1.0%	6.3%	(4.83)
All	10.2%	42.4%	(5.17)

Turner et al (2017) the relationship between childhood sexual abuse and mental health outcomes among males: results from a nationally representative united states sample Child Abuse & Neglect 66: 64–72

* adjusted for demographics and household dysfunction

Child maltreatment & emergency department visits
Gnanamanickam et al (2022)



	1-5 year olds	6-12 year olds	13-17 year olds	18-24 year olds	25+ year olds
No CP	0.38	0.17	0.14	0.16	0.15
NOC only	0.52	0.27	0.30	0.42	0.39
Other notif.	0.49	0.26	0.40	0.53	0.52
CPM notif.	0.51	0.28	0.32	0.43	0.44
Investig. Only	0.56	0.29	0.35	0.45	0.40
Subst. only	0.56	0.28	0.39	0.50	0.43
OOHC + Subst.	0.66	0.34	0.70	0.87	0.69
OOHC, no Subst.	0.50	0.27	0.50	0.58	0.57

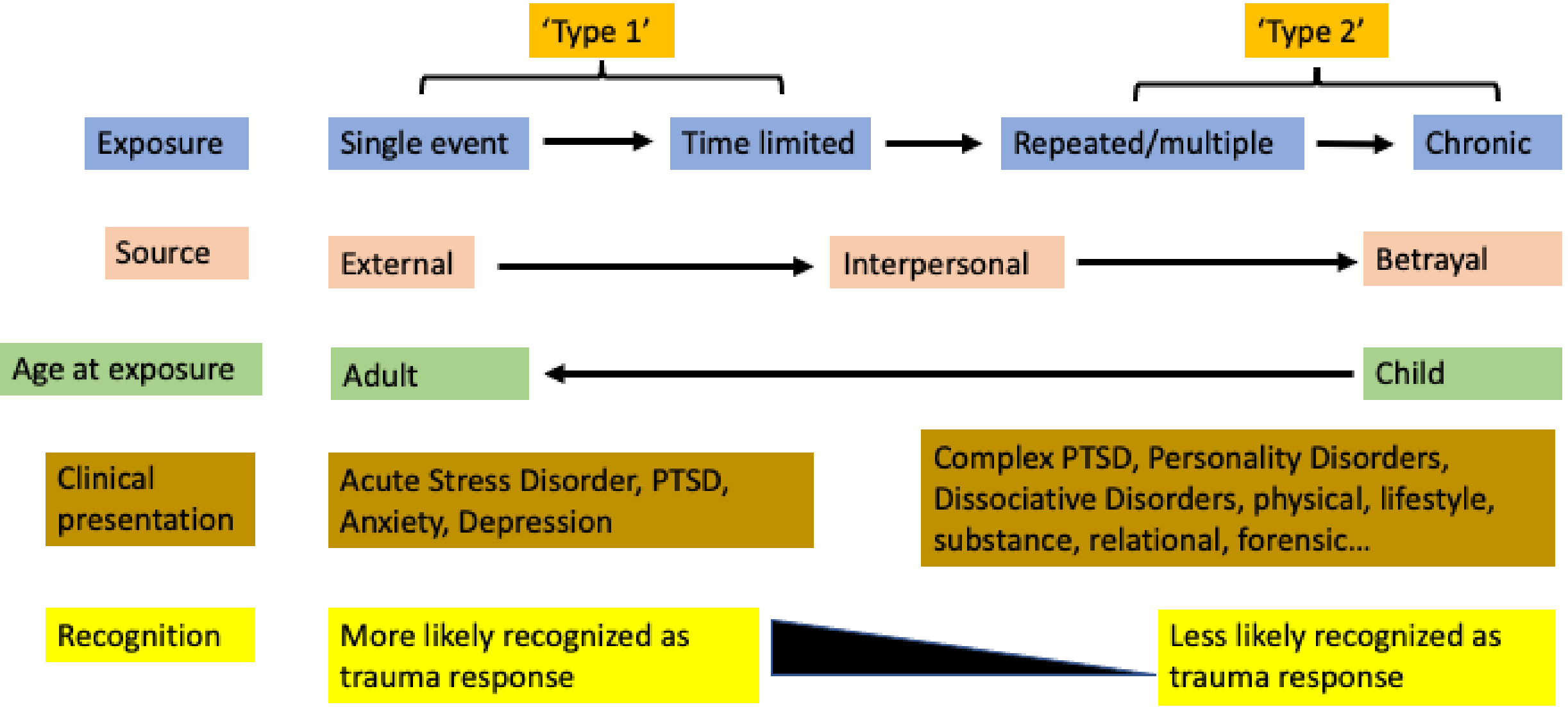
Fig. 2. Annualized mean ED visits (for financial years 2004–2018) by child protection system (CPS) involvement and age groups (full cohort, $N = 443{,}754$).

'Trauma is a tricky customer. It can make the impact of historical events appear to be caused by current events, can hide itself in one place but unleash itself with force in another, and drive those living and working with children affected by it into a new trauma of their own'

Brooks (2020)

Trauma is hidden.

Dimensions of trauma



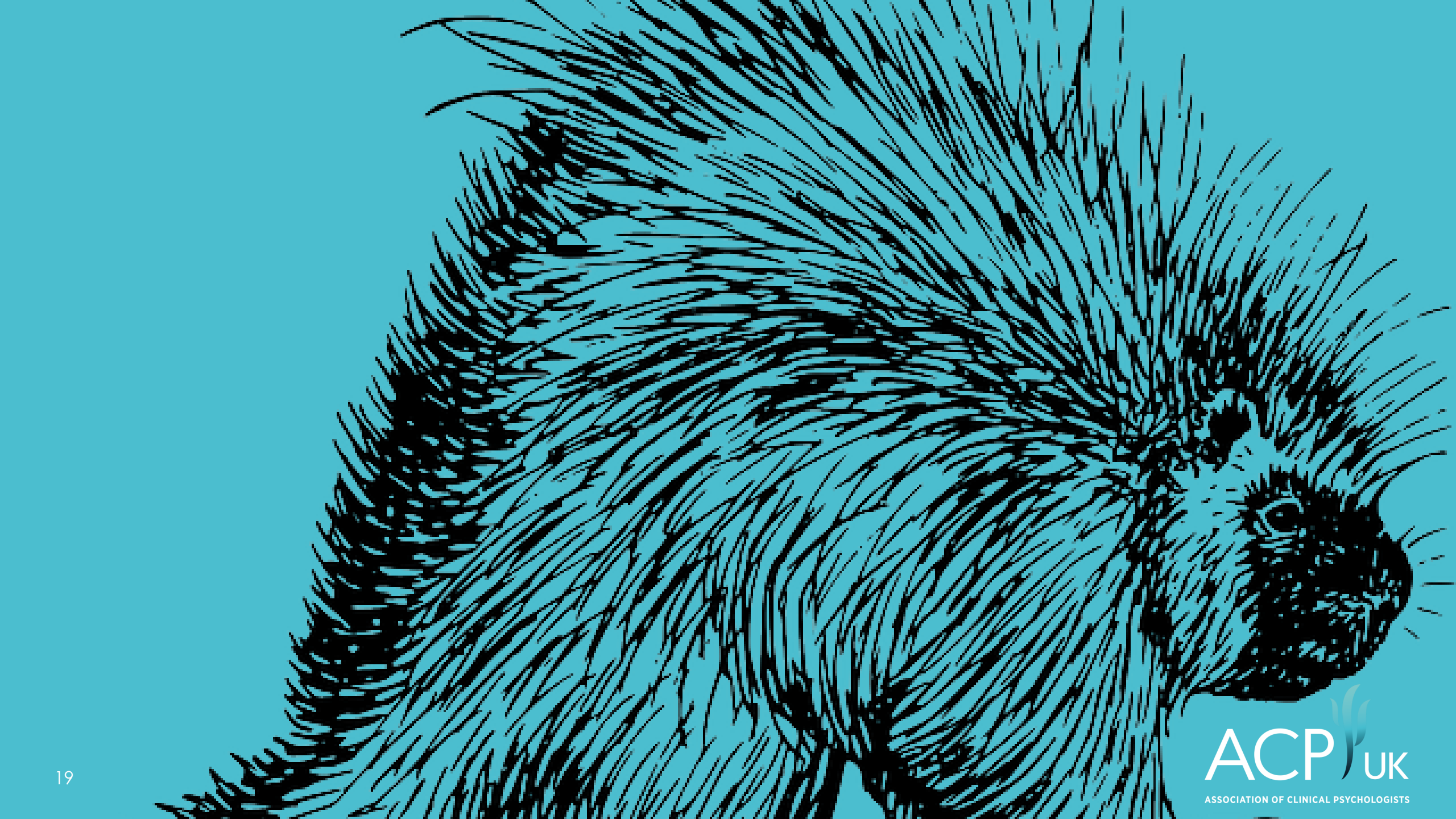
Services have the potential to traumatise.

Is that all?

"Those words in itself…was one of the worst moments in this entire process for me. To have my abuse be minimized and disregarded by the people who were supposed to protect me, just to feel like my abuse was not enough.'

Sept 2021, McKayla Maroney's testimony to the senate regards her treatment by the FBI in the Larry Nassar investigation.

Trauma interferes with engagement.



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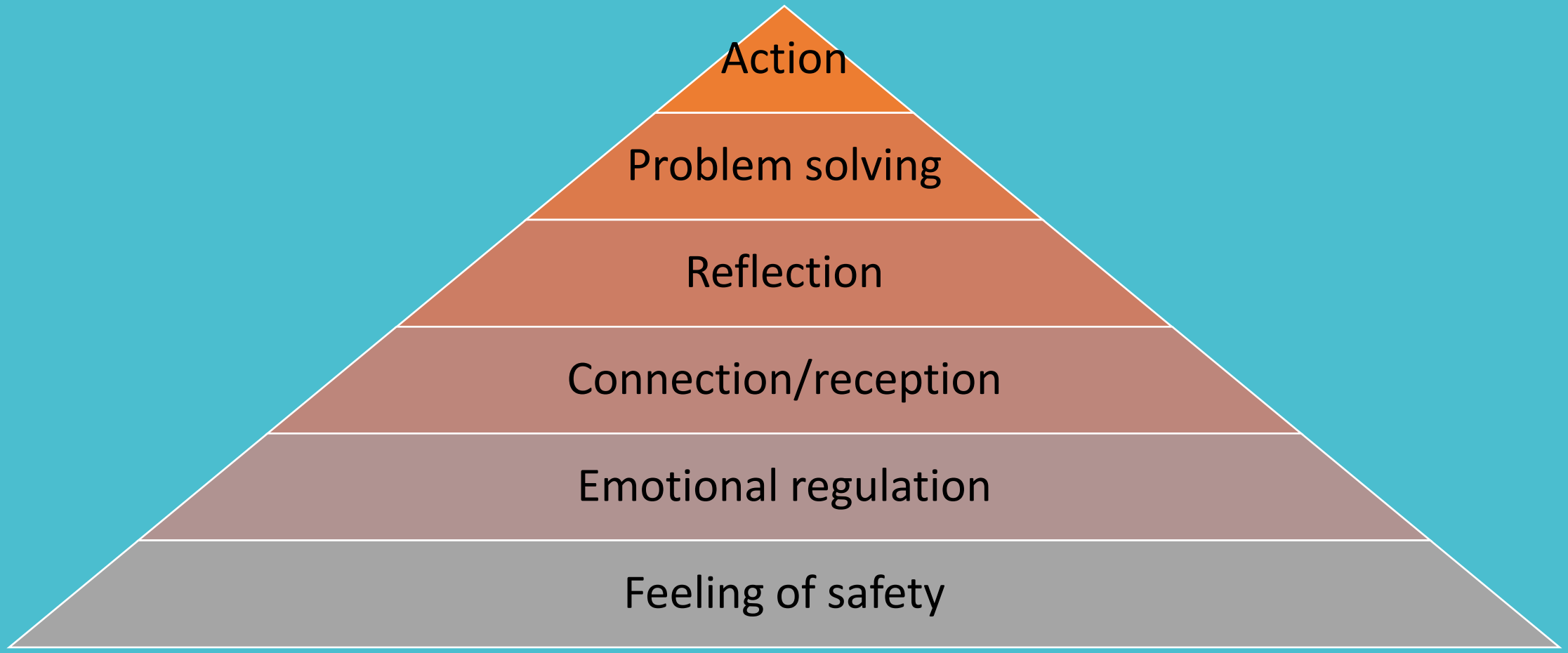
'Strategies that survivors develop for self-protection combined with the post traumatic stress symptoms of hyperarousal and avoidance, make a survivor's entrance into a service setting seem fraught with danger'

Elliot et al (2005) Trauma informed or trauma denied, p.463

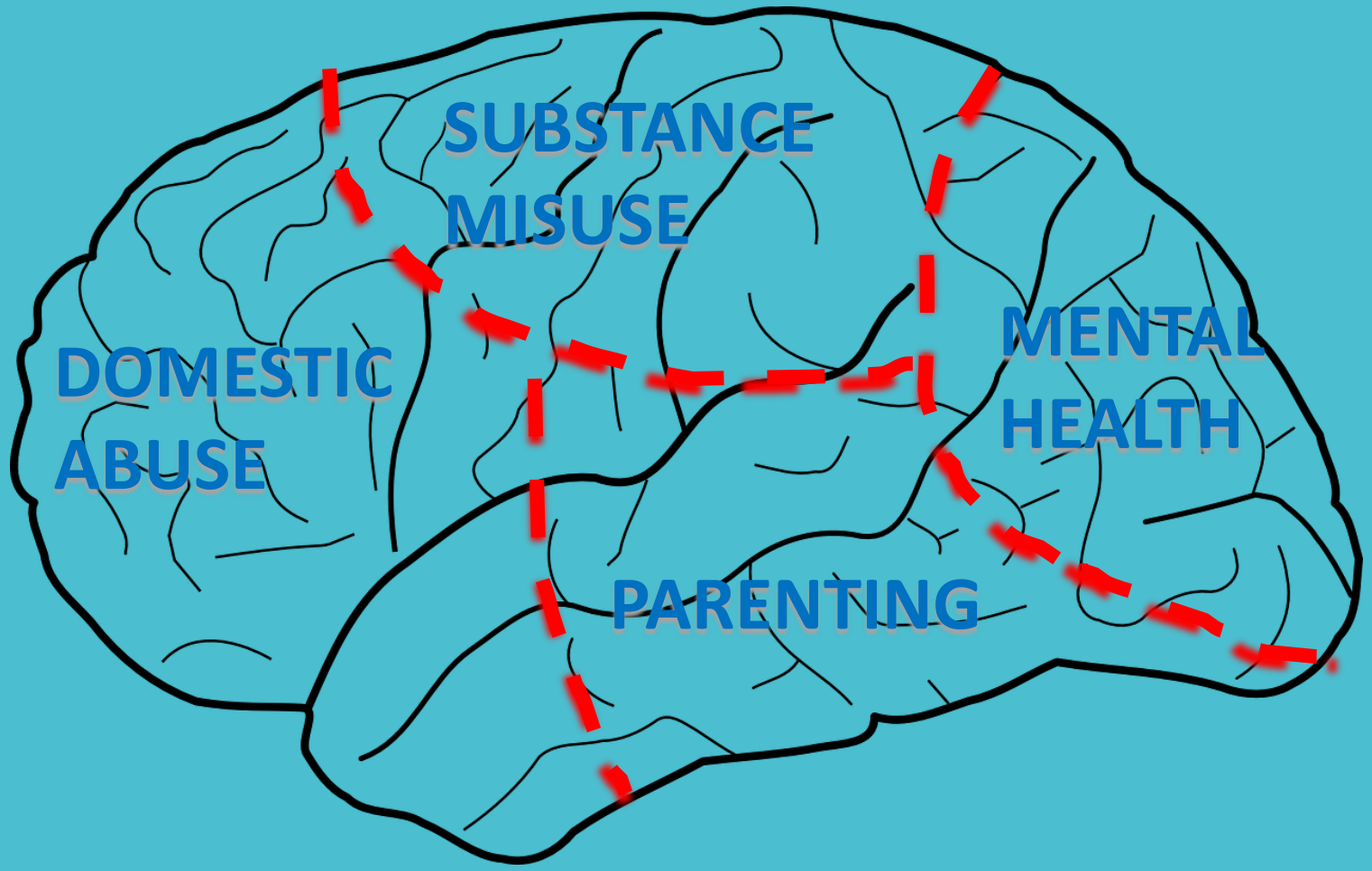

MULTIPLE-DOSE
LIDOCAINE HCl
10 mg/mL

FOUNDATIONS FOR MEANINGFUL ENGAGEMENT



Our service systems are not designed with trauma in mind.


Drug & alcohol use, offending, self-harm, eating disorder
domestic abuse, violence, homelessness, chronic pain,
Self-protective strategies
Negative beliefs about world & others
Emotional & physical overwhelm
Trauma & attachment



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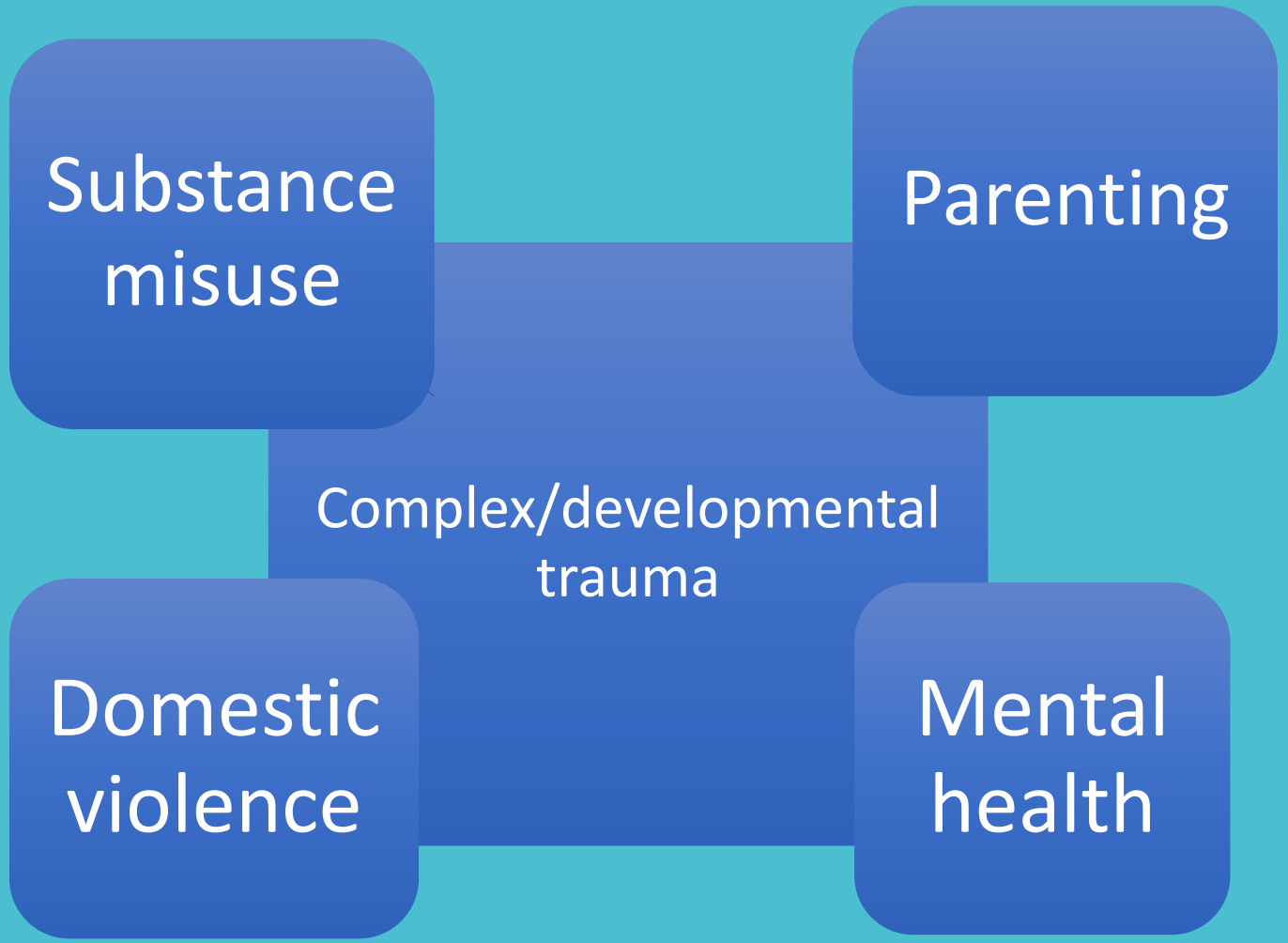
Co-morbidity is the norm not the exception:
Karatizias et al (2019) UK Data

	MDD	GAD	AUD	Suicidality	Chronic illness
PTSD	48.2%	30.4%	60%	57.1%	44.6%
CPTSD	89%	86%	58.8%	56.6%	45.6%

Treating everything but trauma



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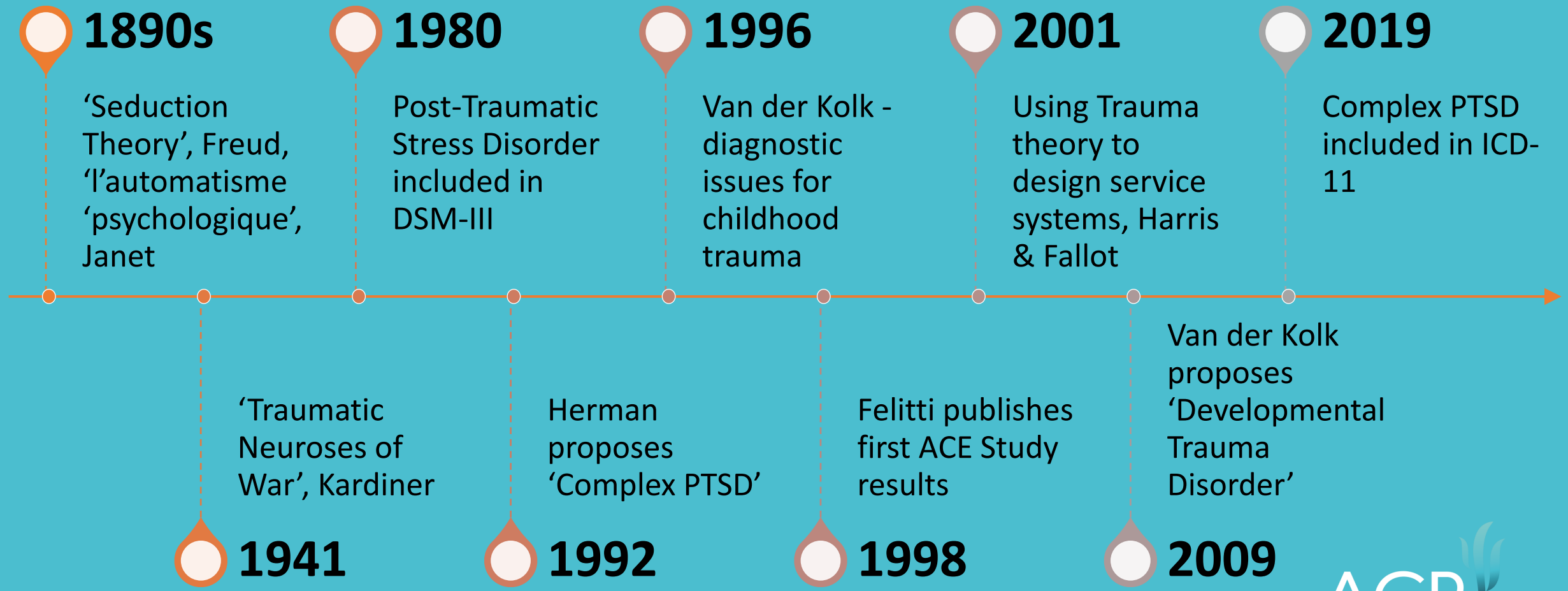
100+ years of trauma



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Trauma affects professionals

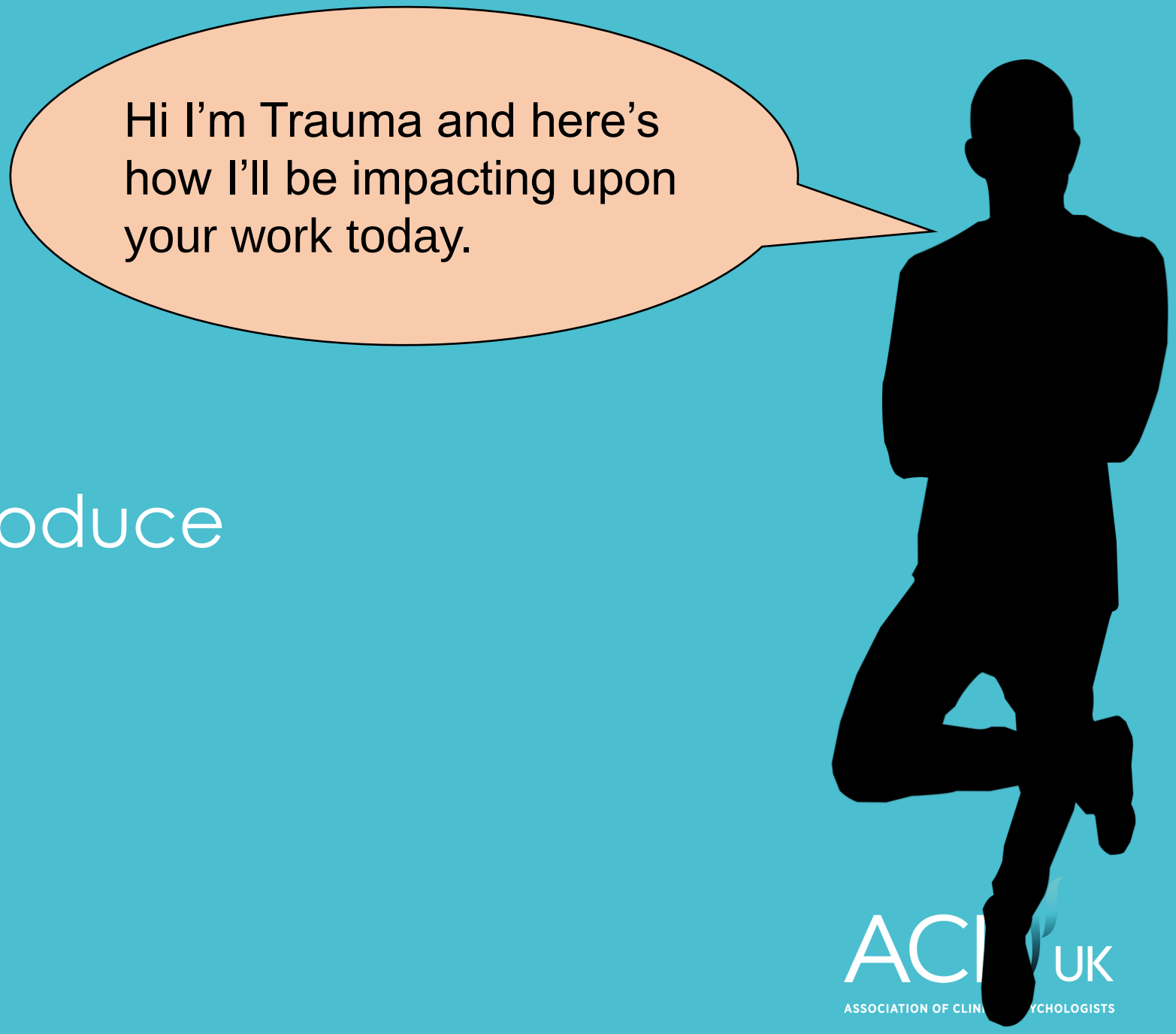
Frequently we think of service delivery in some abstract way, as if human emotions and human experiences play little if any role in that ‘delivery’ of services.

Sandra L. Bloom (2010)

Trauma lens on staff wellbeing

- **Vicarious trauma** – empathic engagement with clients trauma leads to changes emotional, thinking or belief in the worker,
- **Burnout** – Impact of prolonged stress of high work pressures seen general across many sectors, leading to exhaustion, disengagement and disillusionment with job.
- **Compassion fatigue** - Impact of sustained emotional exertion, a specific form of burnout, can lead to cutting off emotionally, even hostility.
- **Secondary Traumatic Stress or PTSD** – via verbal and physical attacks, injury, or symptoms that parallel PTSD that occur with exposure to the shocking details of harm to others.
- **Moral injury** – where staff feel forced to practice in opposition to values and ethics.
- **Betrayal-based moral injury** – where staff feel exposed to risk and harm due to a lack of protection by organizational/leaders

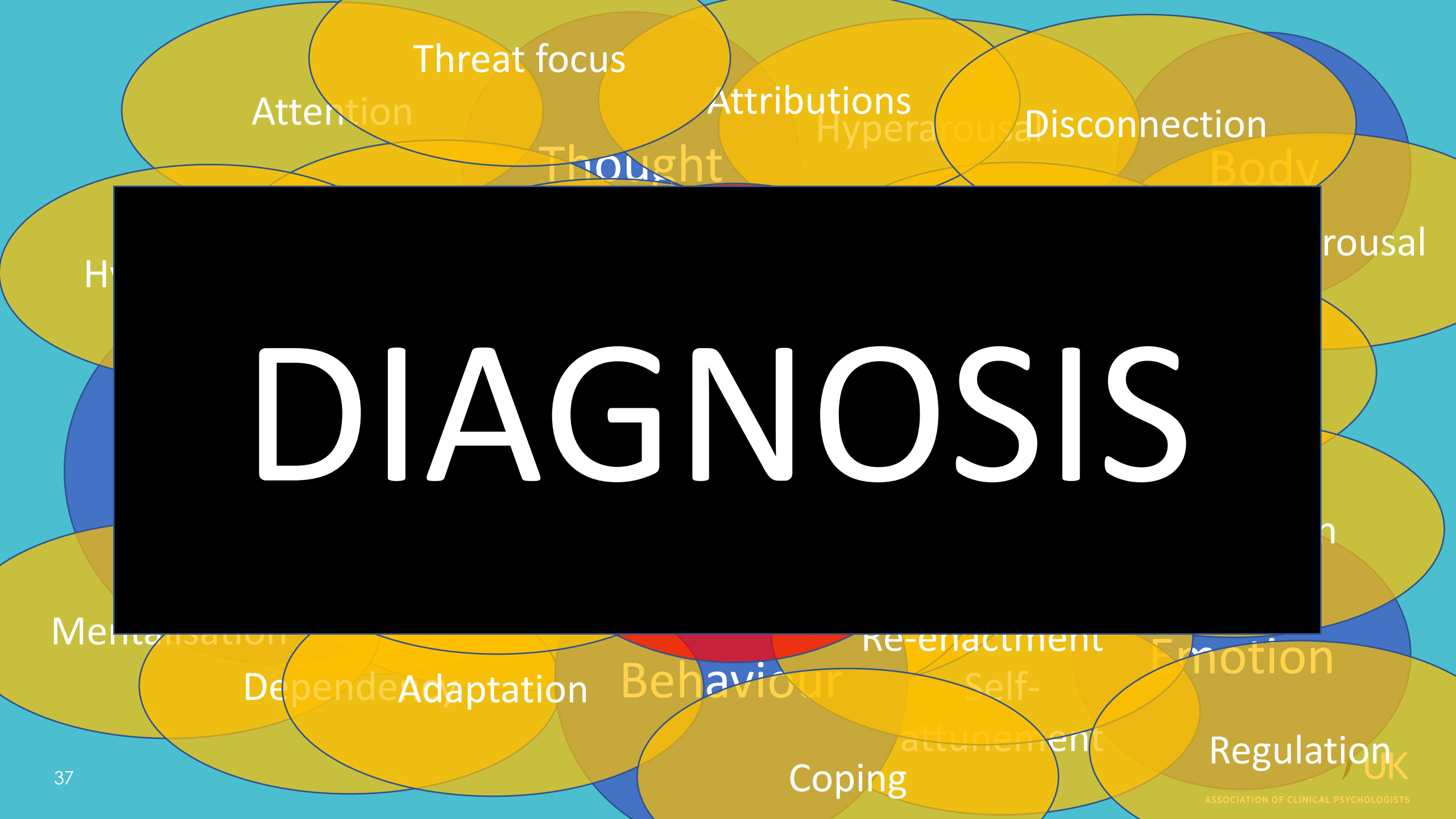
Trauma doesn't introduce itself

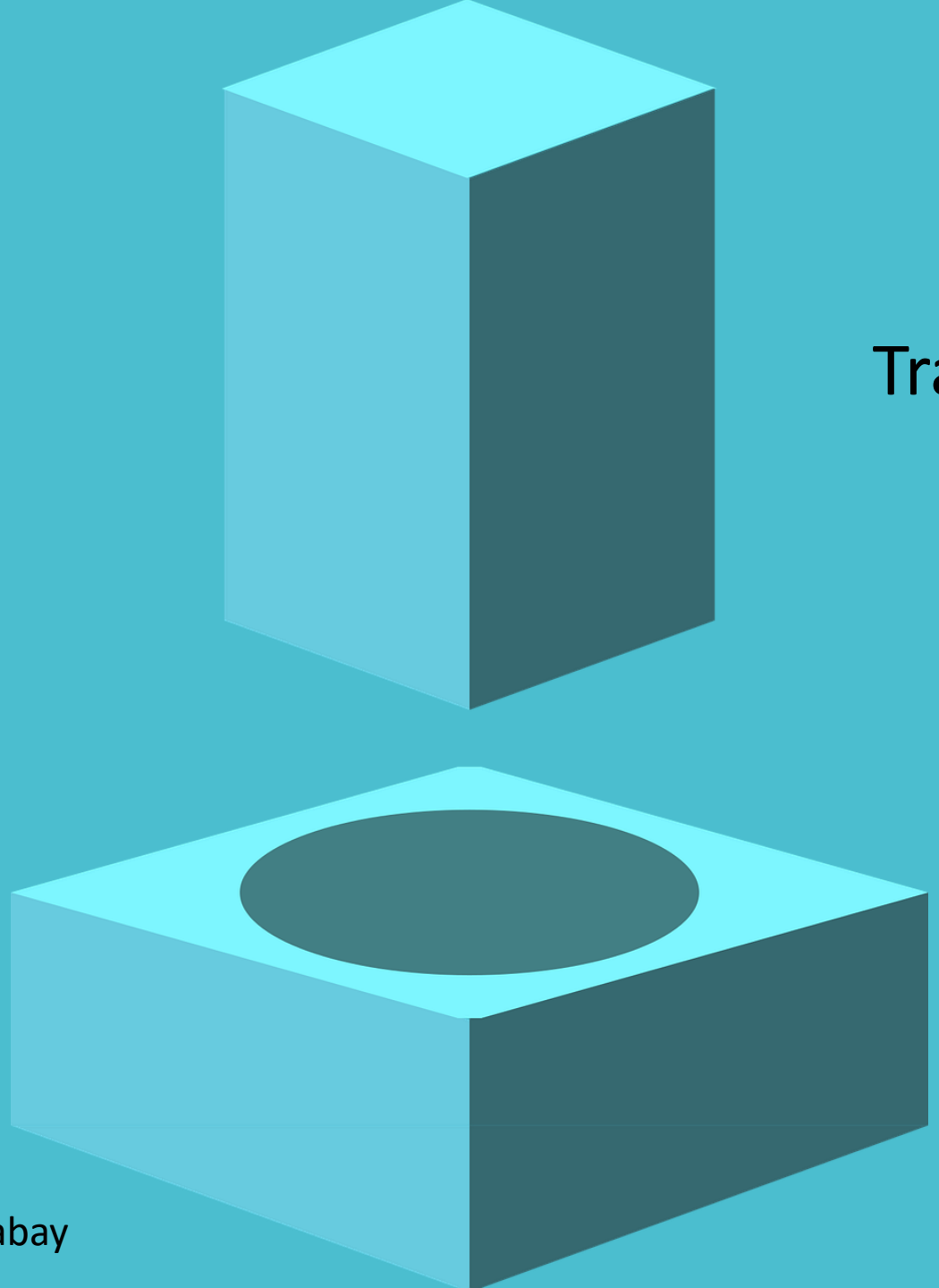


Common reactions from practitioners under pressure

Intellectualising, Lecturing, Fixing	***Struggle: feeling helpless***
Gift giving, Boundary crossing	***Struggle: feeling guilty***
Coercing, pushing	***Struggle: feeling pressure to get an outcome***
Being defensive, Blaming	***Struggle: feeling attacked***
Cutting off, zoning out	***Struggle: feeling overwhelmed***

Trauma is often misunderstood, or missed entirely.





Trauma

Diagnosis

Image credit: maestrosphere1 @pixabay

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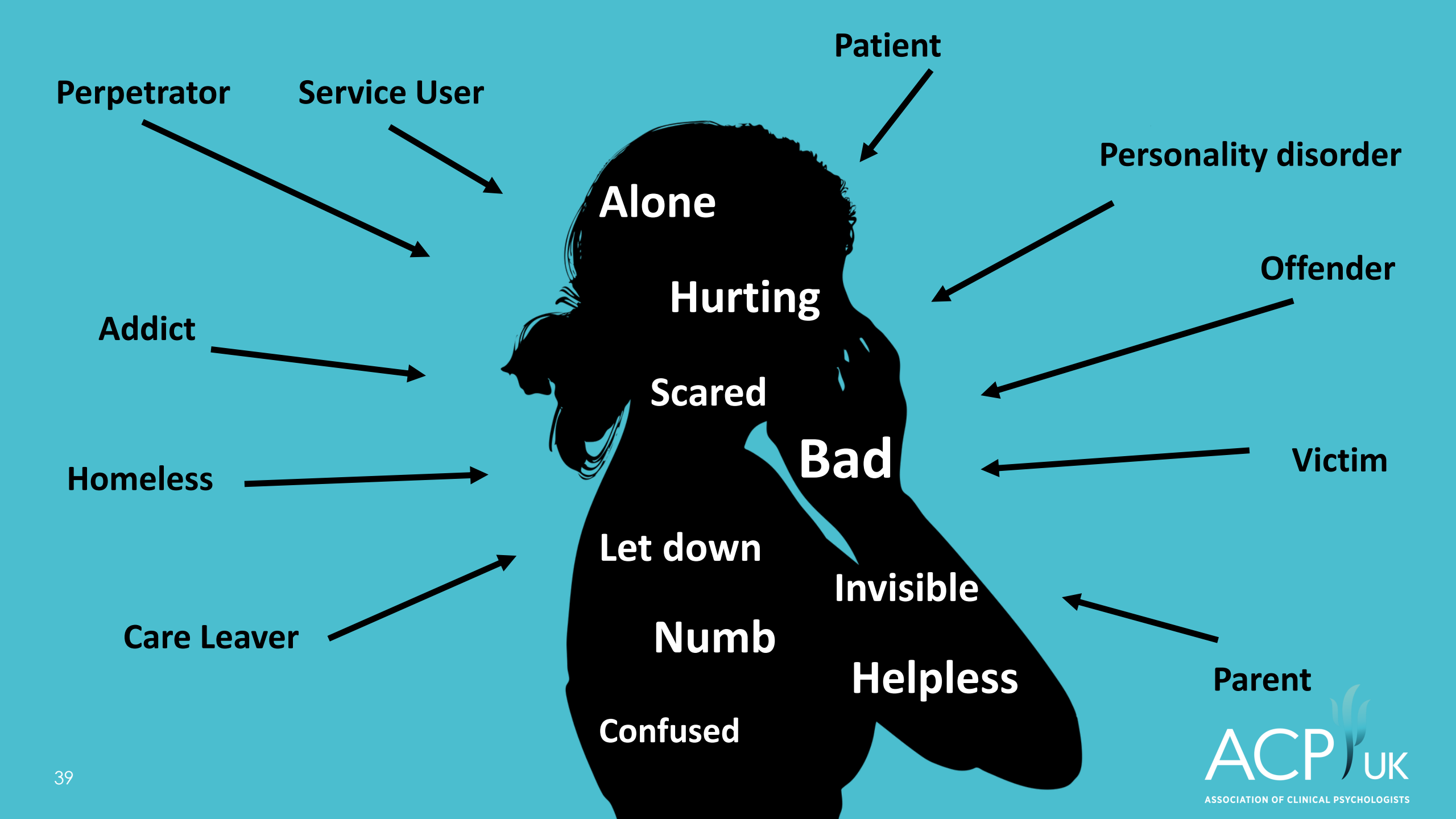

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'I knew that what I was experiencing made sense given what had taken place in my life. Even then I understood my reactions as sane responses to an insane world. I was told, whatever else might be going on with you is not relevant – it's your mental illness that matters. This drove me into a frenzy, for now help was just another perpetrator saying, you liked it, you know you did; that wasn't so bad; it's for your own good'

Beth Filson, 2016, From Sweeney & Taggart (2018)

Evolution of trauma-informed care

‘When, in addition to the strain caused by this analytical situation, we imposed on the patient the further burden of reproducing the original trauma, we created a situation that was unbearable. Small wonder that our effort produced no better results than the original trauma.’

Sandor Ferenczi (1933) The passions of adults and their influence on the sexual and character development of children.

The rationale for trauma-informed care

- Trauma is pervasive.
- The impact of trauma is very broad and touches many life domains.
- The impact of trauma is often deep and life shaping.
- Violent trauma is often self-perpetuating.
- Trauma is insidious and preys particularly on the more vulnerable among us.
- Trauma affects the way in which people approach potentially helpful relationships.
- Trauma has often occurred in the service context itself.
- Trauma affects staff members as well as consumers in human services programs.

Harris & Fallott (2009)

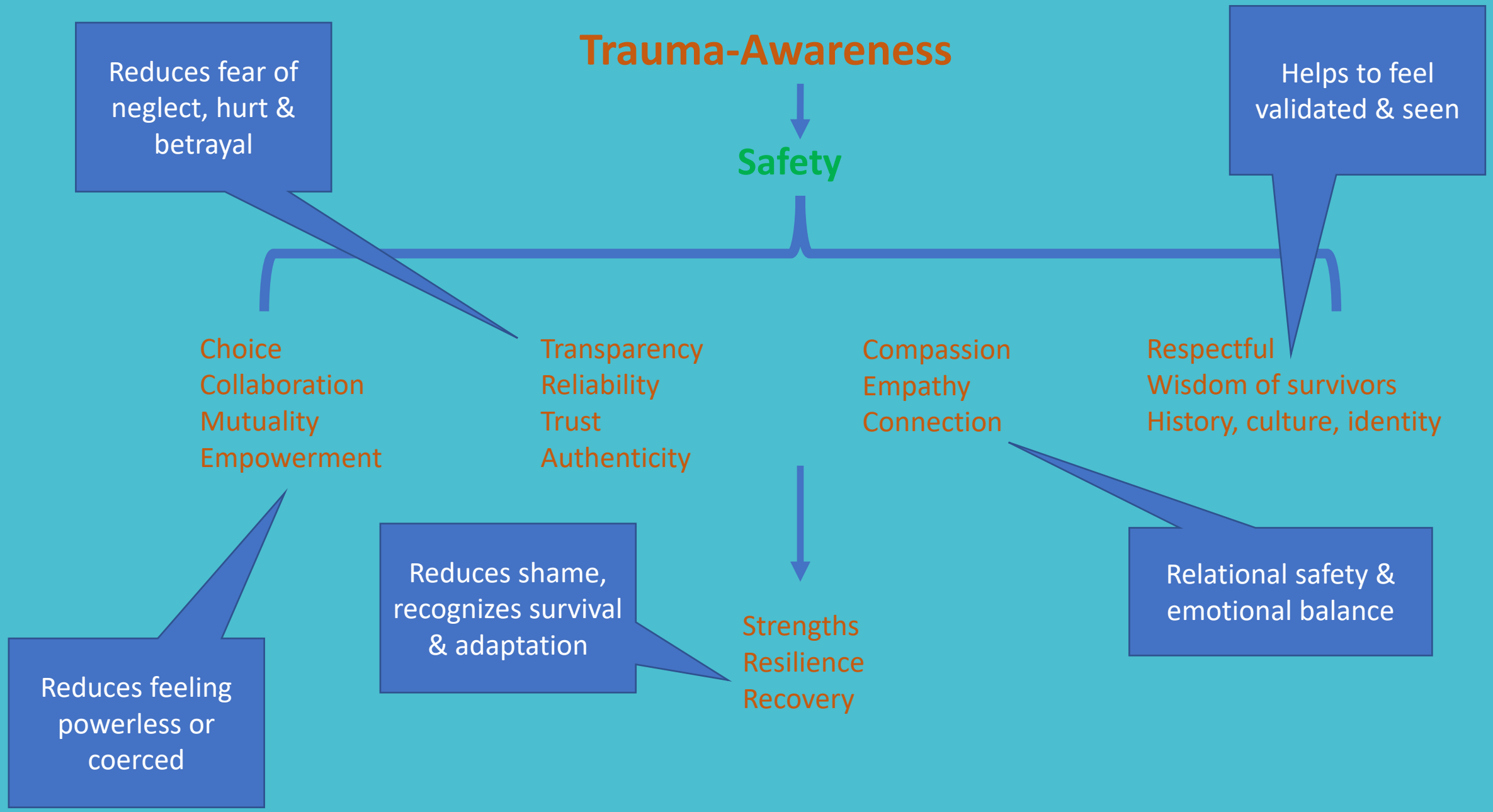
Creating cultures of trauma-informed care: A self-assessment and planning protocol

	Traditional approach	Trauma-informed approach
Understanding trauma	Trauma as a single event with clearly linked and diagnosable impact.	Trauma can be chronic or repeated affecting fundamental aspects of thinking and behaviour. Link between symptoms and trauma not obvious.
Understanding the consumer survivor	Consumer's identity bound by the presenting problem, focus on treating symptoms.	Consumer as a whole individual living in a context, focus on understanding the person, symptoms as survival/coping.
Understanding services	Services are content specific, time limited, outcome focussed.	Services aim to promote growth and resilience, are strengths based, and flex to the need of the consumer survivor.
Understanding the service relationship	Consumer is passive, receives treatment from service which holds power. Trust is assumed. Service is the expert.	Service relationship is open and genuinely collaborative, giving consumer survivors choice. Trust is earned. Both service and consumer have wisdom to bring.

Harris & Fallot, 2001

Principles not procedures

- Culture shift not a manualised model
- A ‘lens’ for reflection on practice
- Core principle of ‘Do No Harm’
- Form of safety governance – like a sharps policy, or infection control
- A re-conceptualisation of ‘pathogenesis’ and recovery
- A way of understanding and working with non-engagement
- Something that is already inherent in many people’s practice
- It is both nothing new and completely revolutionary


Trauma-Awareness
Safety
Reduces fear of neglect, hurt & betrayal
Helps to feel validated & seen
Choice
Collaboration
Mutuality
Empowerment
Transparency
Reliability
Trust
Authenticity
Compassion
Empathy
Connection
Respectful
Wisdom of survivors
History, culture, identity
Reduces feeling powerless or coerced
Reduces shame, recognizes survival & adaptation
Strengths
Resilience
Recovery
Relational safety & emotional balance

Why are we trying to achieve by being trauma informed?

1) **Avoid causing harm** – *by preventing new harm or triggering past harm*
2) **Encourage engagement** – *by recognising how trauma affects engagement with services*
3) **Be more effective** – *by recognising the role of trauma in presenting issues*
4) **Promote wellbeing** – *by creating a safe context for healing and growth*

A wide spectrum of application

Fast growing literature

High trauma prevalence

- Homelessness services
- Women's services/Intersectional issues
- Substance misuse/addiction services
- Domestic abuse survivors/refuges
- Domestic abuse perpetrators
- Child welfare/safeguarding/
- Residential/out of home care
- Parenting & kinship care/adoption
- Family Drug & Alcohol Courts
- Juvenile justice/youth services
- Adult mental health/inpatient/restraint
- Child and adolescent mental health
- Forensic mental health/prison
- Refugees
- Military

High risk of trauma

- Paediatric acute care
- Hospitalised adolescents
- Neonatal intensive care

Specific conditions

- Youth suicide prevention
- Eating disorders
- Sexual assault
- Bereavement/end of life care

Universal services & disciplines

- Primary care
- Schools
- Older adults
- Learning Disability services
- Children with disabilities
- Nursing
- Social work

Other applications

- Racism
- Animal welfare
- COVID-19
- Career counselling
- Trauma-informed supervision

Trauma-informed culture

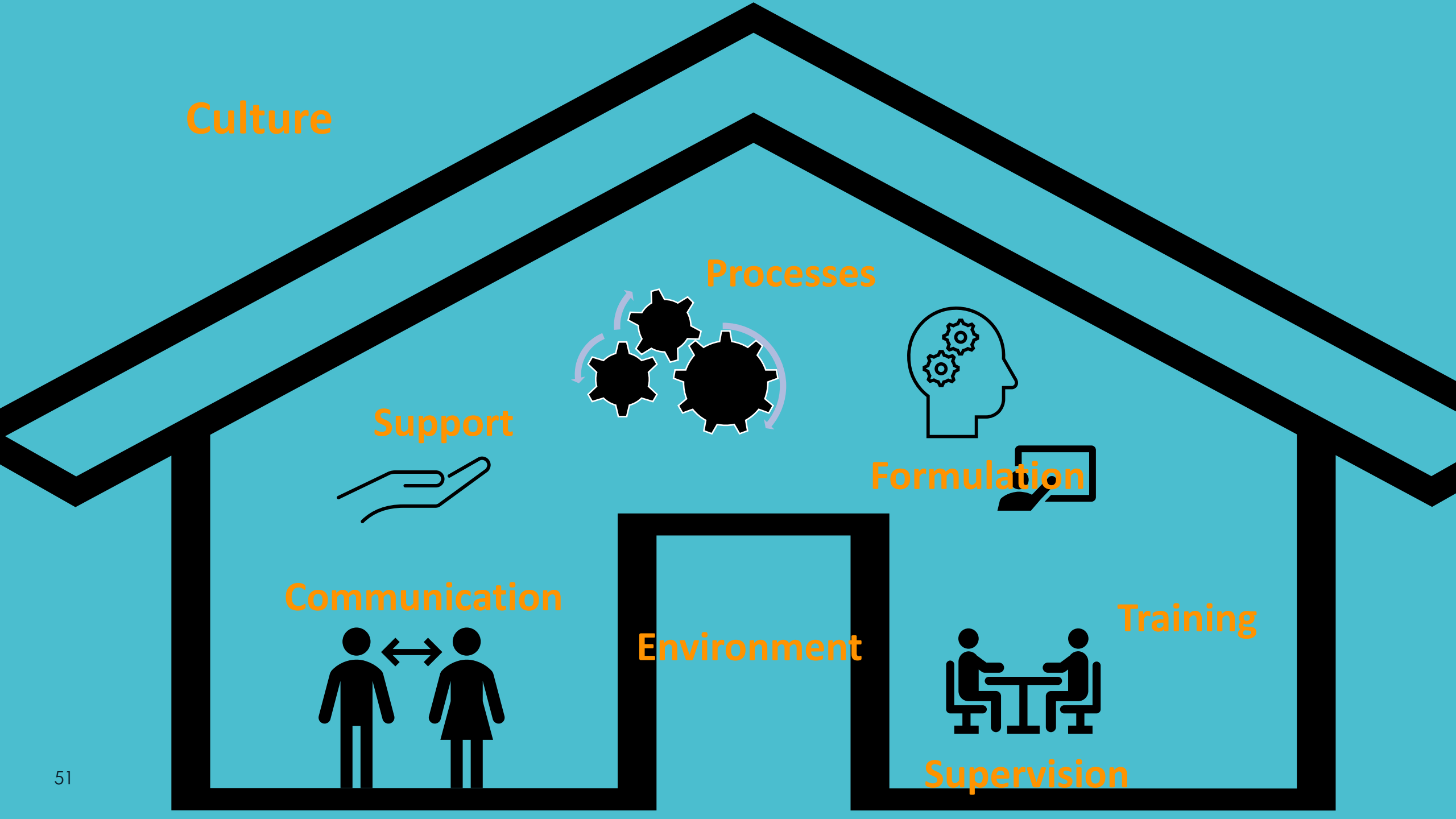
Universal precautions, promotes safety, minimizes harm

Trauma-informed services

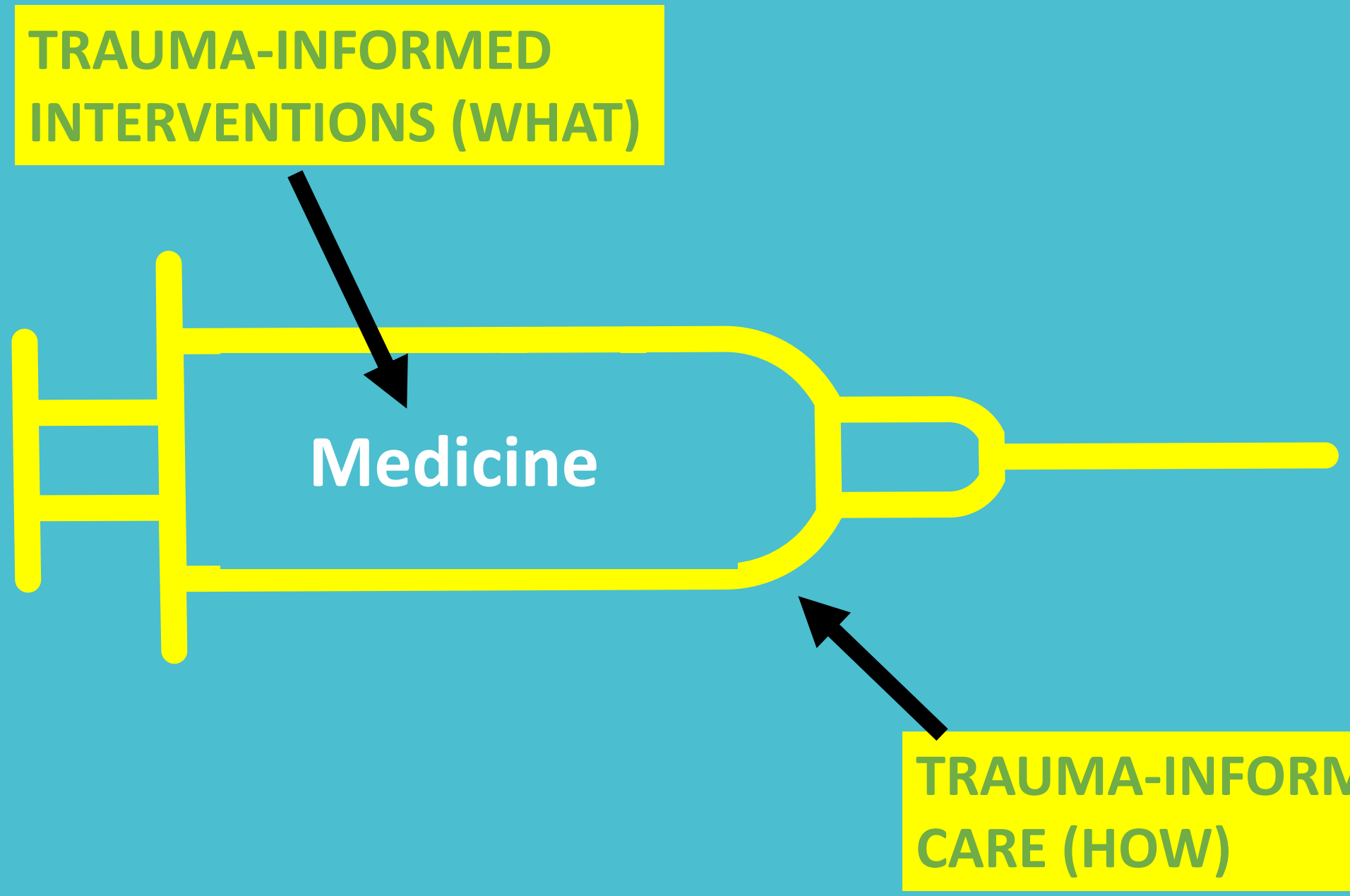
Promote resilience, coping, stabilization, skills self-awareness, relational & engagement capacity

Trauma-specific services

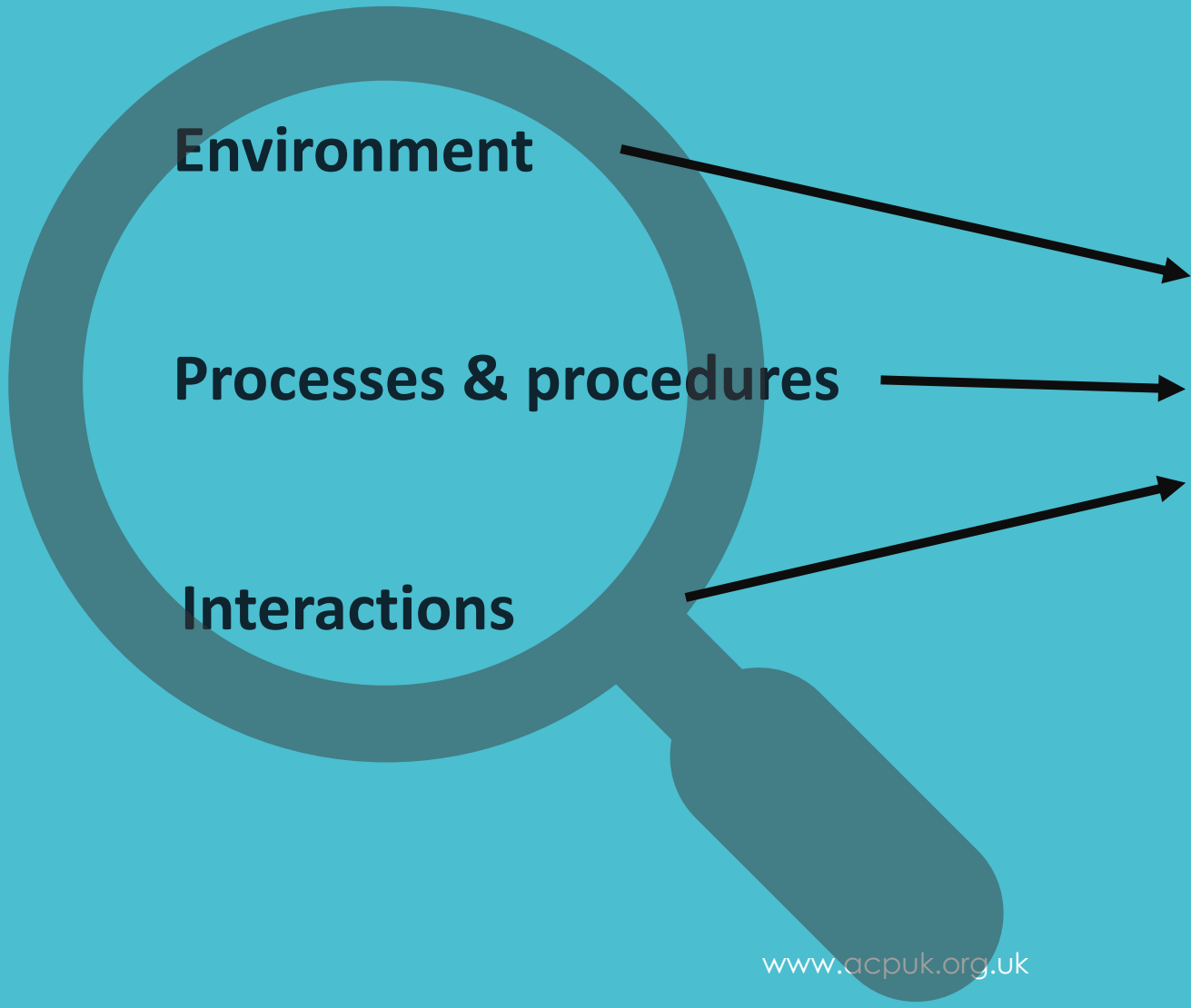
Treatment of trauma-related symptoms


Culture
Processes
Support
Formulation
Communication
Environment
Training
Supervision


Prevent new trauma
Promote engagement
Trauma Specific treatment
Avoid re-traumatising
Promote healing
Prevent secondary traumatisation
PERSON'S JOURNEY THROUGH SERVICES
Create safe environment
Minimise collateral harm
Advocate for trauma treatment
Support organisation to be trauma-informed


TRAUMA-INFORMED INTERVENTIONS (WHAT)
Medicine
TRAUMA-INFORMED CARE (HOW)

HOW
‘Universal precautions’



- ✓ Promote emotional safety
- ✓ Reduce risk of harm
- ✓ Minimise triggers

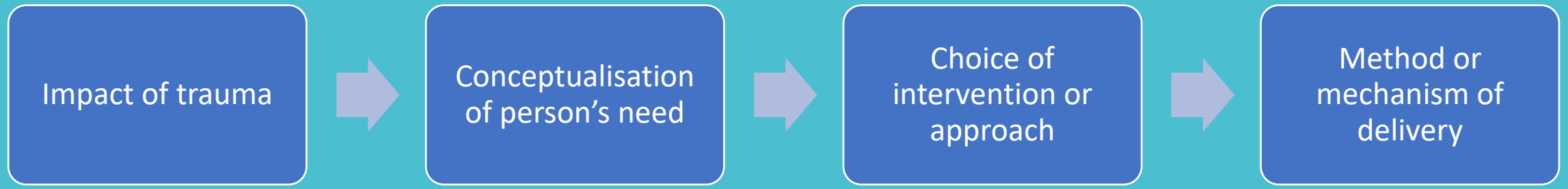
"Humanise the reports as well. I really struggled to read reports that spoke about me like I was a case and not a person. I found it helpful when professionals would talk about me holistically. I appreciate that you are writing a report on my drug use, but make me a person who uses drugs, not just a drug user, if that makes sense."

(Survivor, mother)

"In addition to the perpetrator- (not victim-) orientated dimensions such as intrusive search techniques…we might add many others, including: harsh, unnatural lighting, sterile spaces (literally and metaphorically), desolate holding cells, loud, unexpected noises, personal possessions boxed up into containers, institutional showers in full view of reception staff, sounds of distress from other inmates, and the fear of not knowing what happens next."

Jewkes et al, 2019: Designing 'healthy' prisons for women: Incorporating trauma-informed care and practice (TICP) into prison planning and design.

WHAT
‘Trauma-informed intervention’



'A trauma-informed approach 'connects a person's behaviour to their trauma response rather than isolating their actions to the current circumstances and assuming a character flaw.'

Sandra Bloom, Why Philadelphia should become a trauma-informed city

Childhood experience	Frustrating behaviour
Being coerced, forced, frightened into doing things	Avoidance, not engaging, withdrawing
Being neglected, dismissed, unheard, unseen	Not seeking or accepting help, not talking
Being lied to, told to lie, not being believed	Lying, withholding information
Being betrayed by trusted adults	Not trusting anyone, being hostile and angry
Being made to feel inferior, powerless, disempowered	Not taking responsibility for own actions
Being hurt, harmed, wounded, put at risk	Engaging in dangerous and harmful behaviours

Meeting people where they are

Unable to connect or regulate, high risk lifestyle, no engagement

One safe relationship, windows of regulation, distress, symptoms

Connections routine, motivated to work on trauma, up & down

Mostly regulated, engaged reclaiming life, making connections

Establish one working relationship, start to build a daily routine, attend some appointments

Weekly attendance, add new relationships, may be ready for emotional regulation or coping skills

May be ready for therapy, memory processing

Start to explore learning, creativity, relationships, community, career

Recovery from Complex Trauma in children (and adults!)

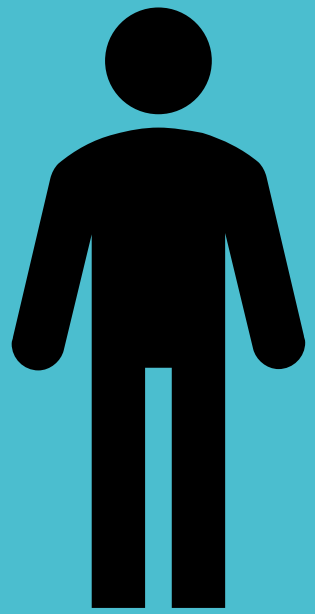
- Feeling safe in my body and my mind
- Learning how to respond to difficult feelings in my mind and body and stay in balance
- Learning to step back and reflect on myself, my actions and my goals
- Processing and making meaning of my traumatic memories
- Learning how to relate to others
- Learning to live in and enjoy the present, and being myself

Heavily paraphrased from: Cook et al (2017)

Thinking, learning, memory, behaviour (CBT)

Dissociation, fragmentation, parts (Fisher, Schwartz)

Neurobiology, survival, emotional regulation (Siegel, Porges)

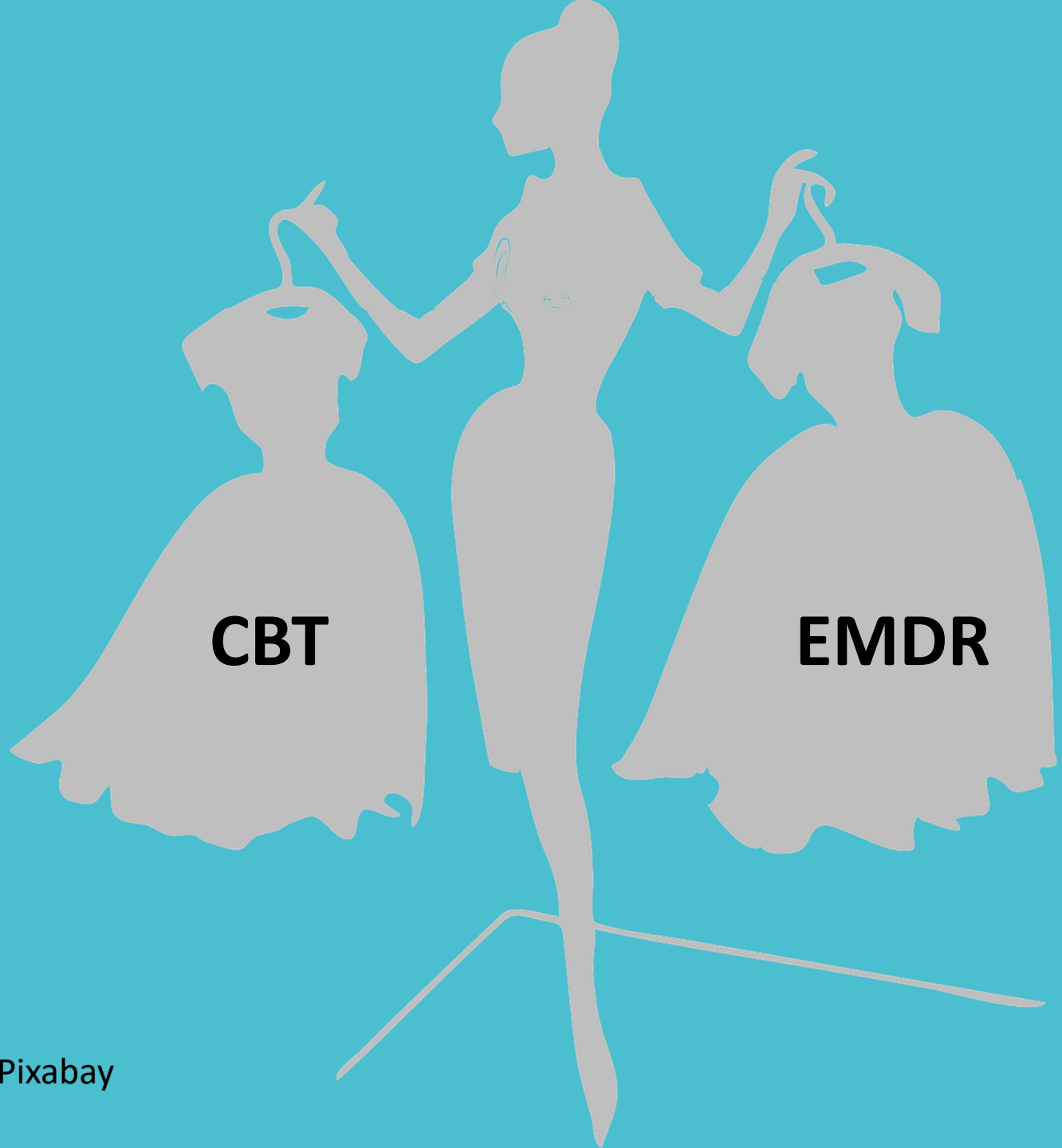


Somatic, implicit conditioning, embodied (Ogden, Levine)

Developmental, adaptive, environmental (McCrory)

Relational, attachment, connection, psychodynamic

Resilience, recovery, strengths (Bonnano, Seligman)



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Trauma & adversity

Emotional dysegulation

Threat-focused thinking

Traumatic memories

Fight/flight responses

Distress tolerance

Relational disconnection

Self-protective behaviours

Limited coping resources

Dissociation

Self-alienation

DRUG & ALCOHOL USE

DOMESTIC ABUSE

MENTAL HEALTH

OFFENDING

Teaching

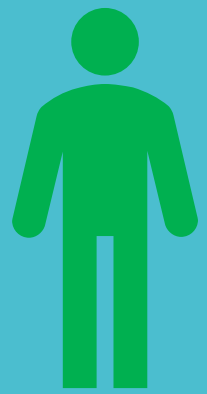
Sanctions

Risk management

Medication

Mainstream therapies

NEGOTIATING WITH the bodyguards



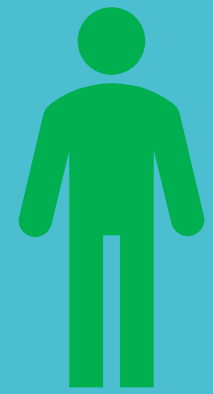
ME

Defending

Hiding

Hypervigilant

Placating



YOU

Trauma-Informed treatment and prevention of intimate partner violence (Taft et al, 2016)

- Recognition of role of trauma in affecting social information processing.
- Therapeutic interview, motivational interviewing, client-control over disclosure, strategies to manage extreme emotions.
- Safety planning for partners.
- Awareness of impact of trauma and shame on therapeutic alliance, avoid reinforcing power and control.
- Psychoeducation re trauma responses, option for trauma-specific.

Trauma Informed Schools (e.g. Brooks, 2020)

- Reframing behaviours in context of trauma
- Recognising the importance of relationships
- Setting up the environment
- Supporting around hotspots like transitions & free-time
- Attending to aspects of the curriculum that may be challenging or triggering
- Modification of rewards and consequences systems
- Alternative responses to challenging behaviours

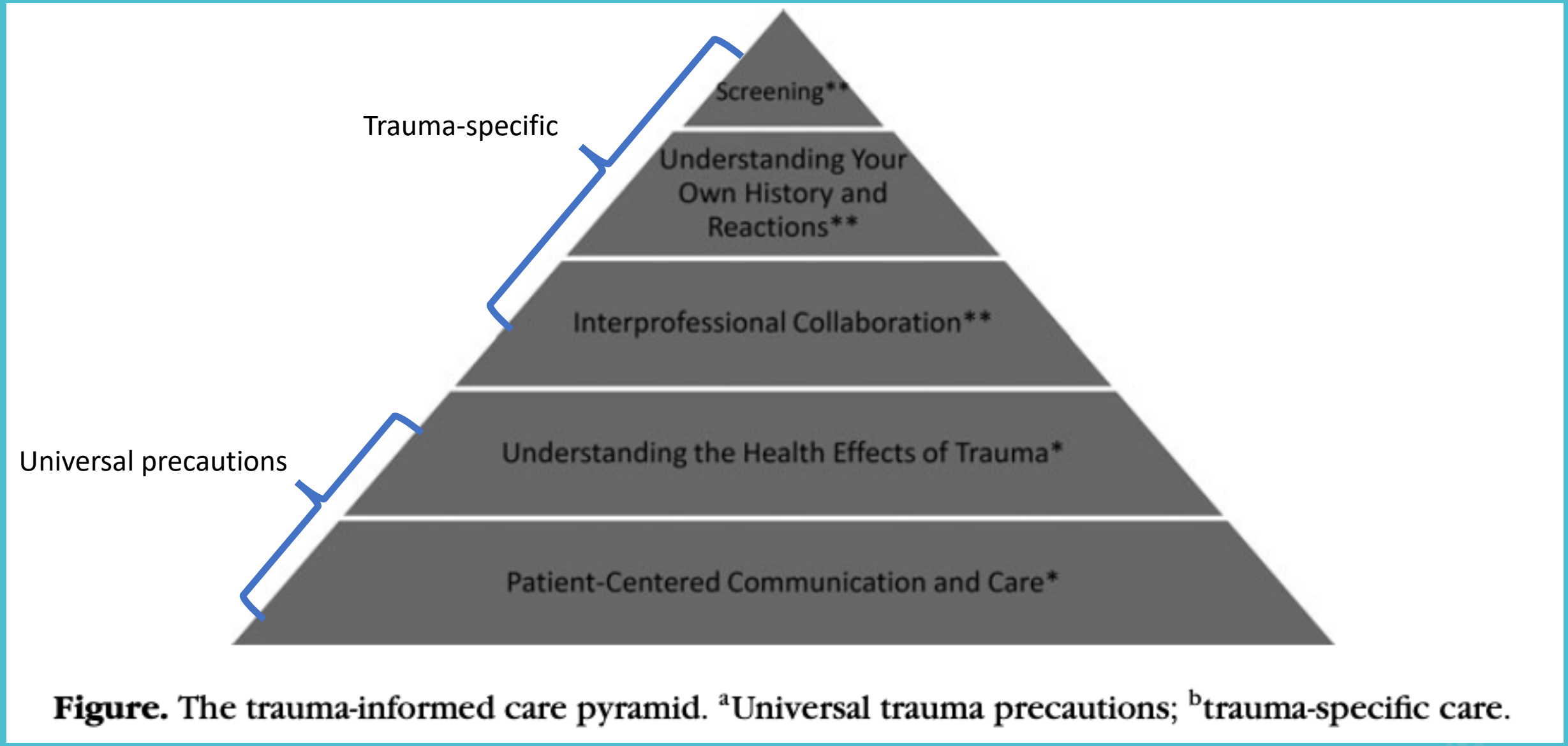


Figure. The trauma-informed care pyramid. [a]Universal trauma precautions; [b]trauma-specific care.

Adapted from: Raja, S et al (2015). Trauma informed Care in medicine: current knowledge and future directions. Family & community health, July 2015.

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What’s the catch?

Critiques of trauma-informed care

(e.g. Berliner & Kolko, 2016; Birnbaum, 2020; Asmussen et al, 2020; Smith & Monteaux, 2023)

- NOTHING NEW
- TOO VAGUE
- INCONSISTENT
- NARROWED FOCUS ON TRAUMA
- PATHOLOGISING
- DETERMINISTIC
- SELF-SERVING
- NO EVIDENCE

Problems with organisational implementation

Brandon et al (2017) Review of 10 articles on TIC in Youth Justice - 71 recommendations - only 8 were common to most.

Fernandez et al (2023) Review of 15 articles evaluating implementation - 49 components identified, with an average of 3.26 applied per agency.

- Defined leadership 18.4%
- Procedures to reduce traumatization 16.3%
- Provision of services 14.3%
- Collaboration with other agencies 14.3%
- Policies 12.2%
- Procedures for client input 12.2%
- Provision of a safe physical environment 6.1%
- Collaboration within agency 6.1%

Cultural responsiveness is missed

- Bias and stereotypes mean trauma may be under-recognised or not responded to in some groups
- Intersectional identities – disproportionate exposure to trauma & reduced access to resources
- Race bias and inequalities in treatment & interventions
- Historical & cultural trauma, racial trauma, discrimination, microaggression
- Trauma seen through a western-centric lens
- Ultimately - health inequalities from multi-level impacts

Misconceptions (Sweeney & Taggart, 2018)

1. *Trauma informed approaches claim that all mental health service users have experienced trauma*
2. *Trauma informed approaches treat people who have experienced trauma*
3. *The shift from asking what's wrong with you, to asking what happened to you, is a literal one*
4. *Trauma informed approaches are purely conceptual*
5. *Trauma informed approaches are implemented by individual practitioners*
6. *This happens already*

Considerations

- Trauma not the answer to every question
- Choice means not imposing trauma on survivors
- TIC is not just about being ‘nicer’ to survivors
- TIC is not just about ACEs, or about the past, but can be about preventing new harm
- TIC is not about ignoring risk, but understanding the drivers of risk
- TIC is not just for service users but for the staff also
- Needs to happen within an organizational change framework
- Need to be realistic about wider context – foundation training, commissioning, government… this is a long haul.

Having said that…

- Little things go a long way.
- Message of empowerment for all staff.
- Outcomes emerging are positive.
- Huge appetite for change.
- Growing evidence and knowledge around trauma to draw upon.
- There is an important role for clinical psychology.

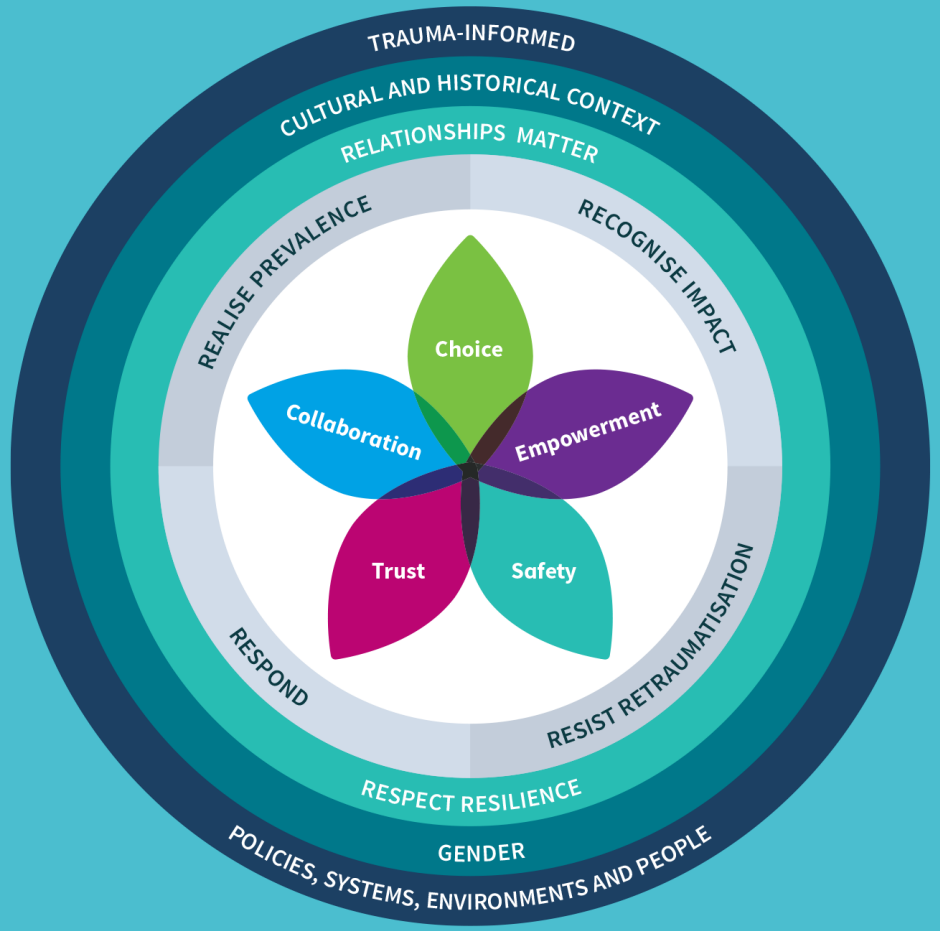
"I wouldn't even be sitting here, they showed me understanding they taught me about the trauma, and also they made me be kinder towards myself and love myself which I didn't have and accept me for me and understand that everything's ok, that my trauma doesn't have to define me or my future."

(Survivor, mother)

Thank you for listening!

@swebbpsychology

Scotland's
National Trauma Training Programme



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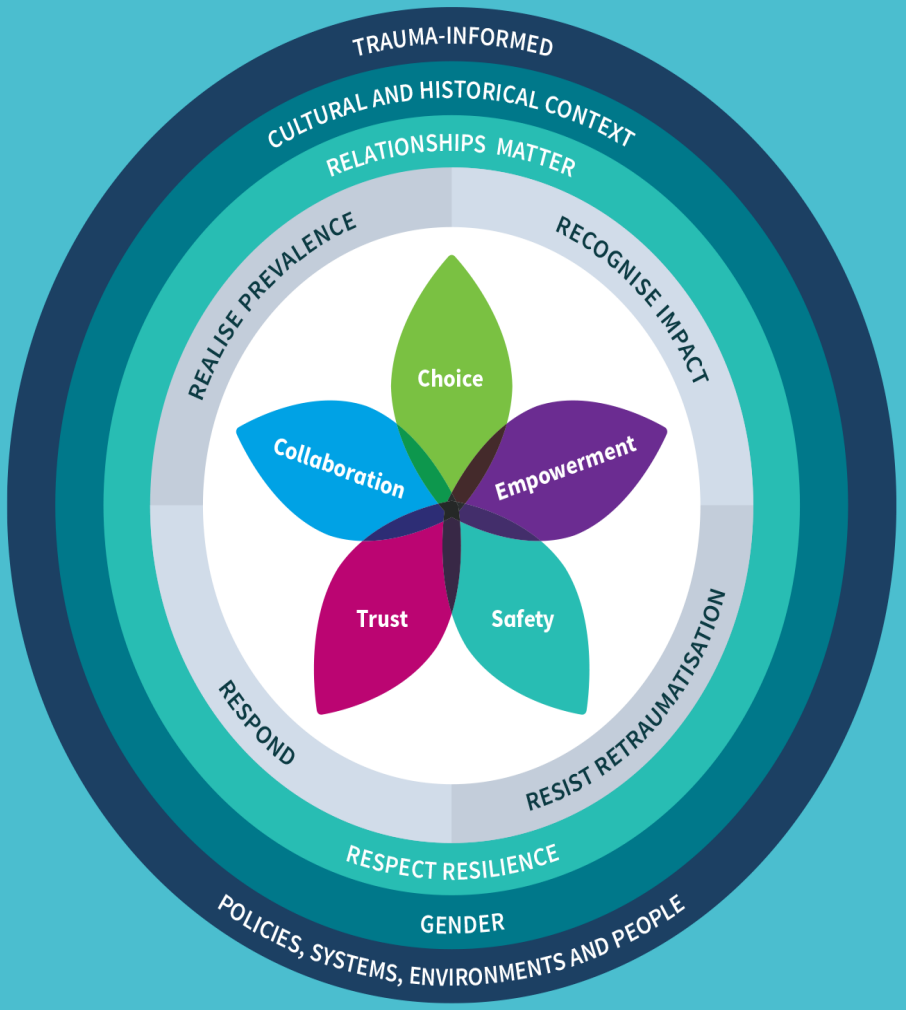
Twitter hashtag: #TransformingPsychologicalTrauma

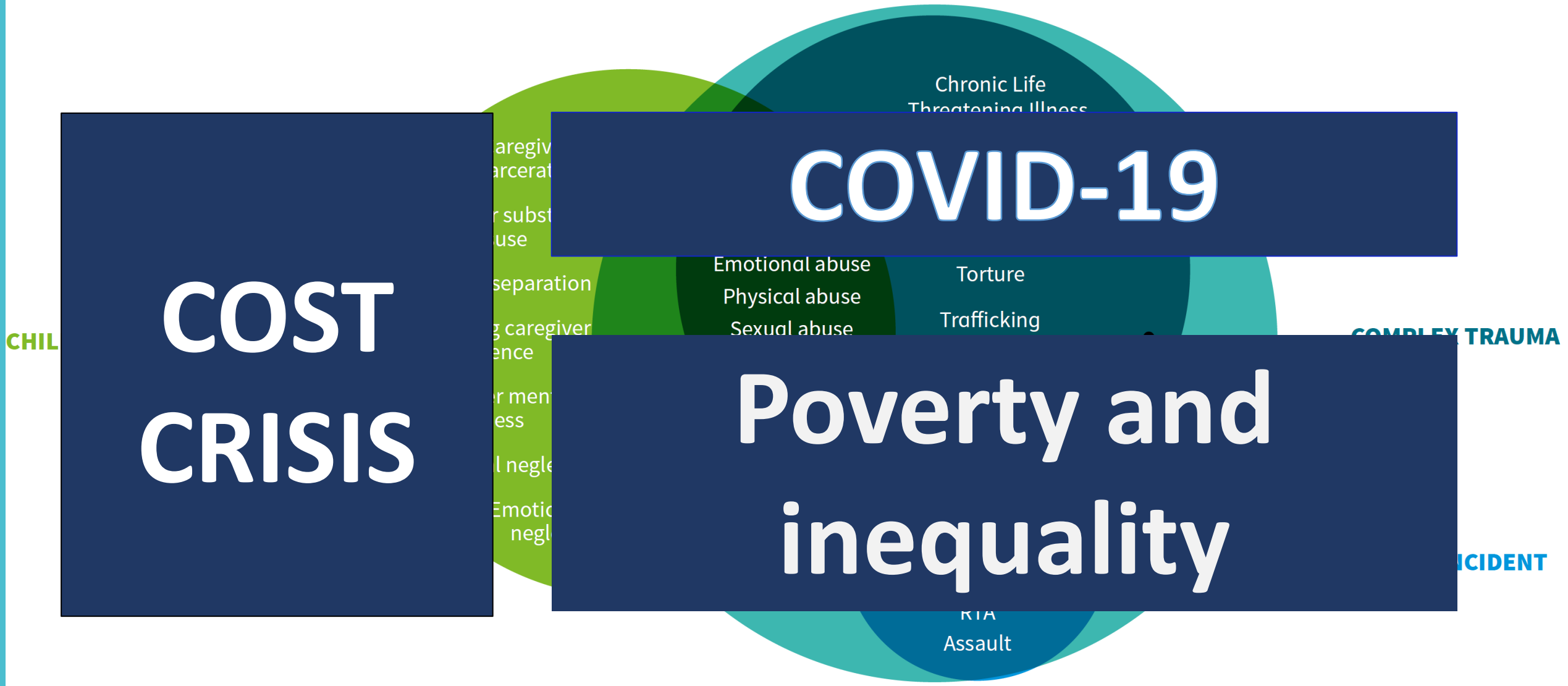
Trauma is common

We won't talk about traumatic experiences in detail today but encourage you to do whatever helps you to feel ok.

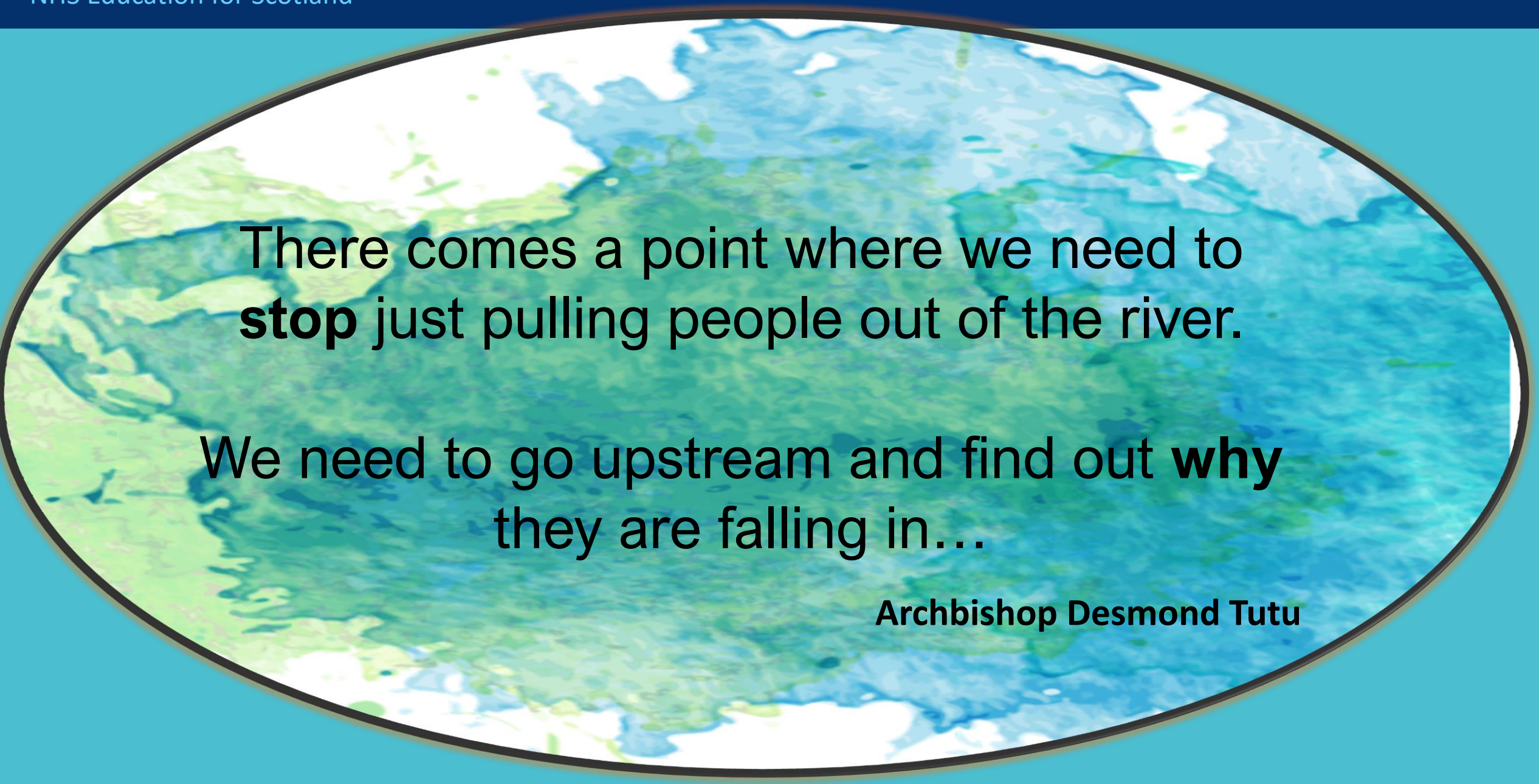
Overview

- **Why** consider Trauma informed and responsive approaches in mental health?
- **How** are we doing this in Scotland – Introducing the National Trauma Training Programme (NTTP)
- **What** is the National Trauma Training Programme? Why training isn't enough
- **So what?** How will we know if this is working?
- **What next?**




COST CRISIS
COVID-19
Poverty and inequality
Chronic Life
Emotional abuse
Physical abuse
Sexual abuse
Torture
Trafficking
Assault
RTA
CHIL
TRAUMA
CIDENT
separation

Adversity is NOT destiny



There comes a point where we need to **stop** just pulling people out of the river.

We need to go upstream and find out **why** they are falling in…

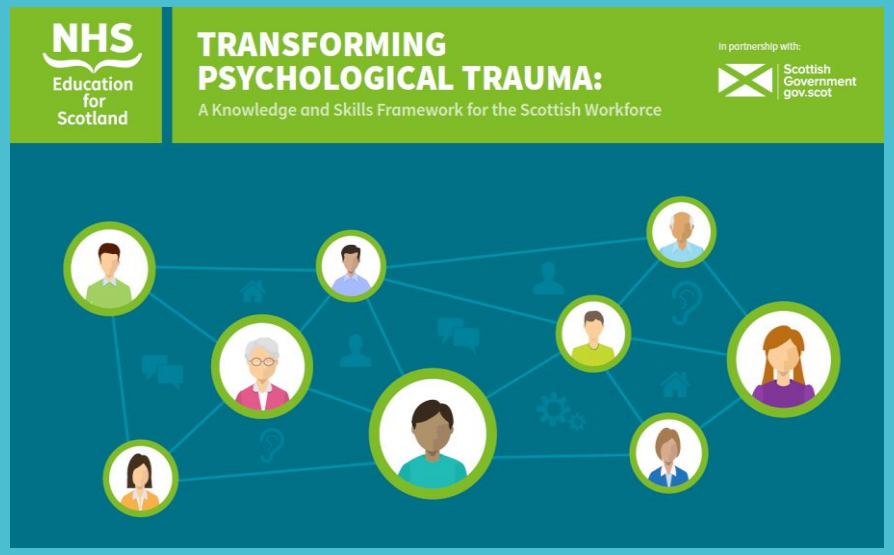
Archbishop Desmond Tutu

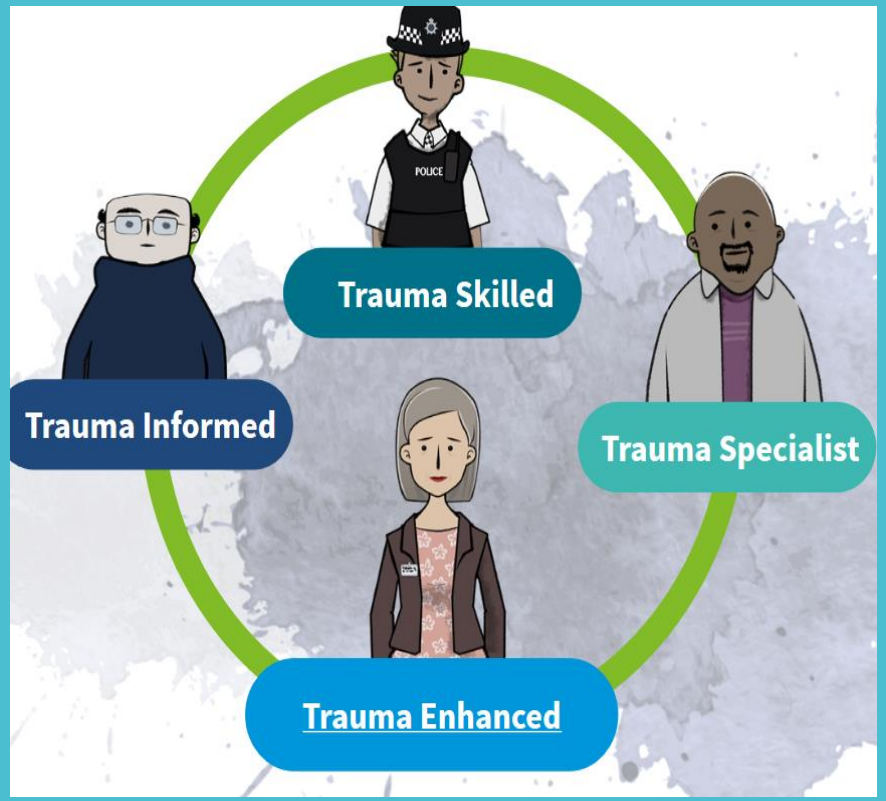
The big vision

"A trauma informed and responsive nation and workforce, that is capable of recognising where people are affected by trauma and adversity, that is able to respond in ways that prevent further harm and support recovery, and can address inequalities and improve life chances."

Ambition into policy

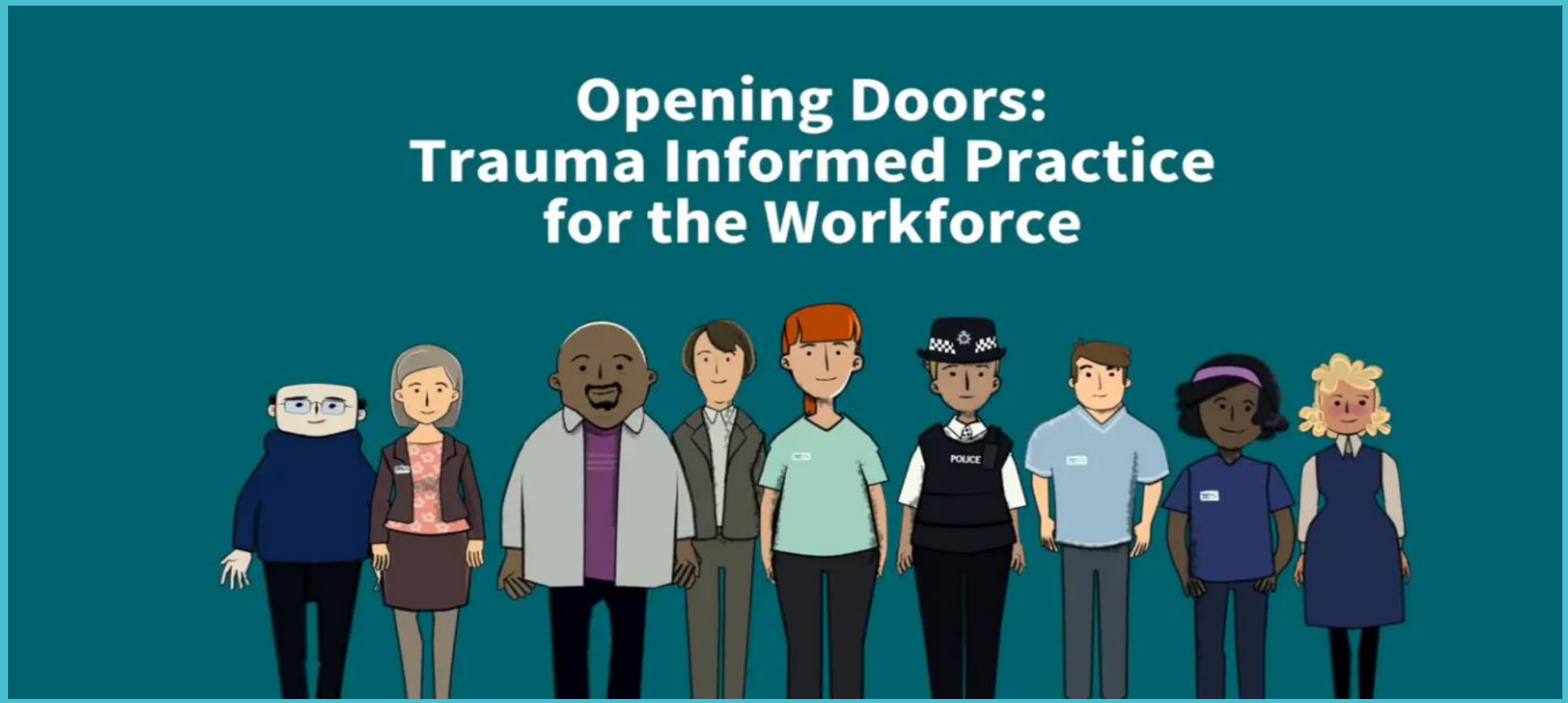
The Knowledge & Skills Framework





Example of a universal trauma informed resource

https://vimeo.com/274703693



Trauma Skilled Learning Resources: Four e-Modules to develop your practice

Trauma is everyone's business:

- What is trauma and how common is it?
- Human survival responses to trauma
- Surviving the survival - the impact of trauma
- Taking a trauma informed approach to your work
- Ways to recognise the mental health impact of trauma & pathways to recovery
- Trauma in children & young people
- Understanding the use of substances to cope with the impact of trauma

NES Trauma Skilled eModule – User Feedback

‘A really thought-provoking course’

‘Very informative & well presented. Covered a lot of important information & I feel it was a great refresher…I feel I have more tools & confidence working with trauma.’

‘Absolutely excellent. Everyone from all professions should be asked to complete this’

‘Comprehensive and thorough. I will be recommending this to lots of my colleagues’

‘Brilliant e-learning course. Interactive made it easier to learn. Hand-outs/ attachments/ additional links were helpful.’

‘Thank you for giving me the opportunity to learn about trauma skilled practice. You have no idea how many dots I have joined in my head in the past couple of hours. I've had to stop a number of times as I needed time to process all of the memories I have of past interactions with students and people around me. Having this knowledge will allow me be a more sensitive, more effective and impactful professional. And probably, in some ways, I will be a nicer human being too…’

‘An excellent learning package - I will definitely cascade this to my case handlers’

‘Superb course, really well done & was delivered in a way that captivated me. This is such a powerful message & I will be sure to roll this out to my staff to make them trauma aware. Really tough subject but one which more people should be aware of & know how to deal with better both with themselves & others’

‘A brilliant insight about trauma & how to work with people who have experienced it.’

‘Loved this module. Gave me an insight to how people are able to be expected to cope with the type of trauma they have experienced. I feel this module …will help within my work practices as a Community Early Years Practitioner in the future. Love the colourful images!’

‘Brilliant course which offered a vast range of resources for further reading. I really enjoyed the different learning methods and the inclusion of videos which further developed my knowledge.’

‘Very accessible training resource, good use of mixed media! learning materials. Videos were excellently produced & relevant’

‘The information was delivered well, understandable & educational. I feel more informed about what trauma is, how it affects people & how to deal with it.’

‘This eLearning resource was excellent. It was informative, thought-provoking & engaging. I particularly enjoyed the animations & content overall. Well done NES’

Excellent
Superb
Engaging
Relevant
Informative
Valuable
Great
Interesting
Clear
Helpful
Effective
Interactive

Trauma enhanced and specialist training for mental health staff

Enhanced examples

NHS Education for Scotland

survive & thrive

moving forward from interpersonal trauma

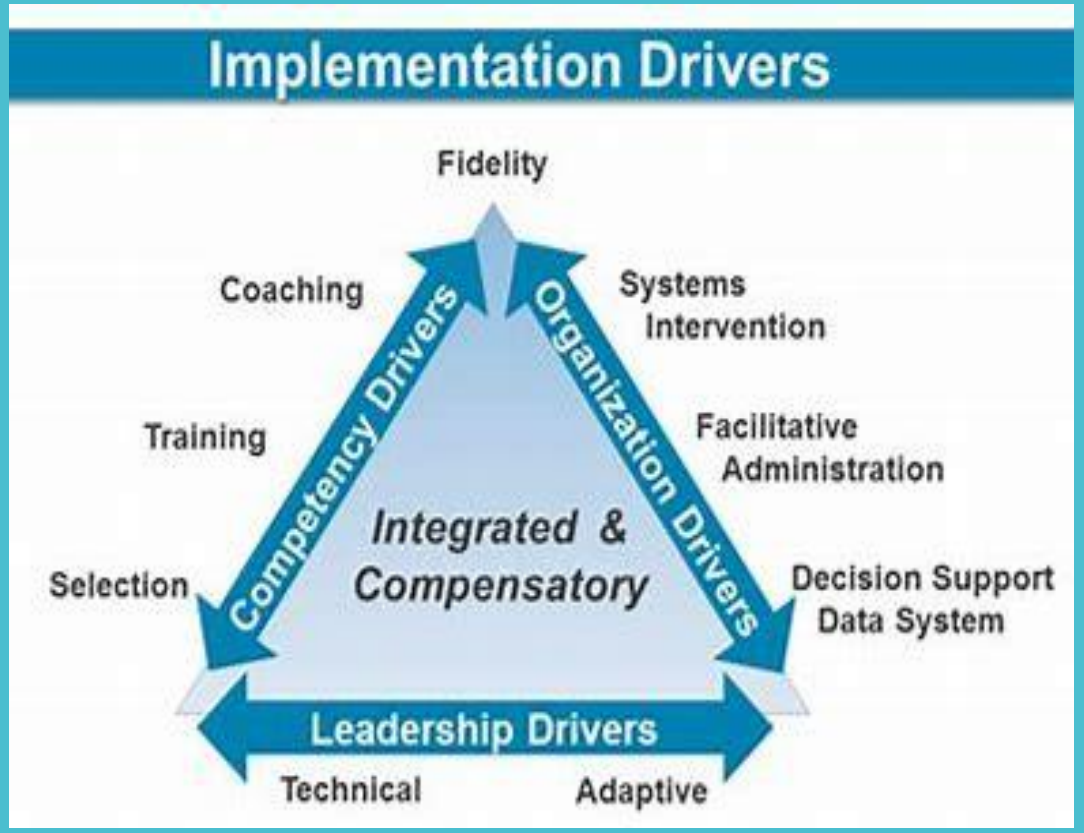
Specialist examples

How to access these learning resources & more:

https://transformingpsychologicaltrauma.scot/media/w3hpiif4/nes-national-trauma-training-programme-training-resources.pdf

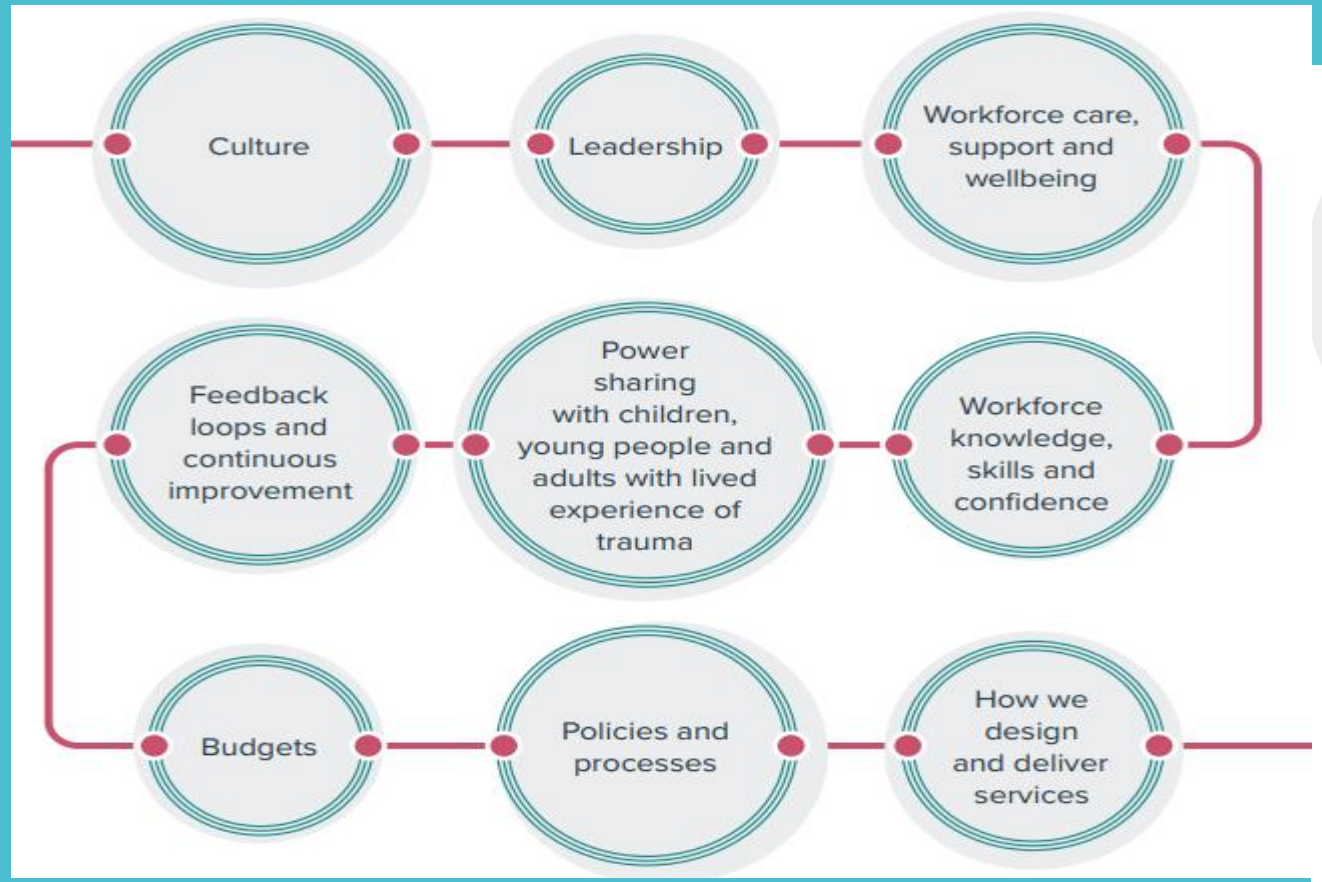
Implementation Science: Training is necessary but not sufficient

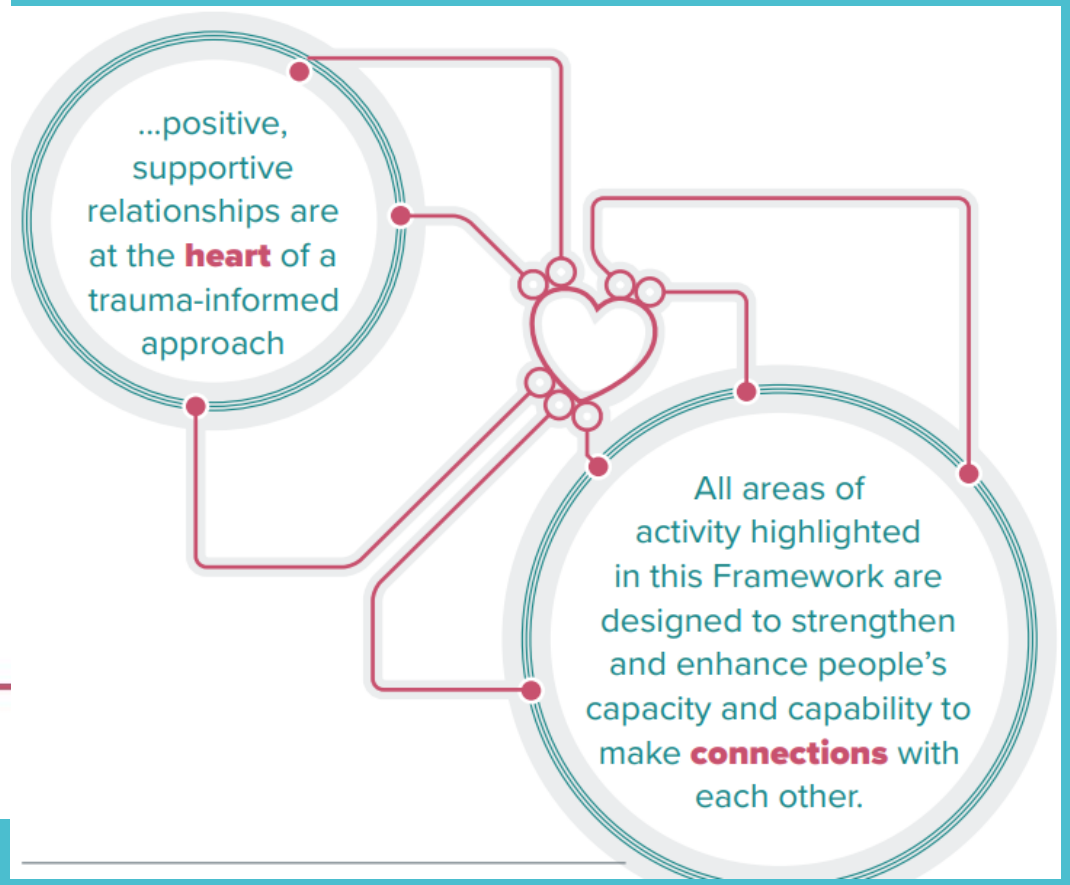
- The right staff getting the right, targeted training and crucially the right support.
- Planning for leaders to enable skills and knowledge to be put in place
- Thinking about organisational supports that need to be considered e.g. environment, policies and ways of evidencing impact/data collection



NIRN e.g. Blasé and Fixen (2011)

Draft Quality Improvement Framework





Trauma Informed Leadership Training

Scottish Trauma Informed Leaders Training (STILT)

Scottish Trauma Informed Leaders Training (STILT)

Contributes to:

- Improving understanding and awareness
- Increasing confidence to act
- Focusing on areas for service and system improvements
- Making leaders more workforce aware
- Exploring challenges, barriers, and mitigating measures

Led to changes in:

- Leaders' own practice
- Staff working conditions
- Staff knowledge, skills, training and practice
- Organisation policies and practices
- People with lived experience of trauma's experience
- Monitoring and evaluation of trauma informed practice
- People with lived experience of trauma's involvement in design

Examples of Trauma Informed Practice in Scotland

Leadership Pledge of Support For Trauma-Informed Practice

What next?

- 3 year delivery plan
- Refreshed Mental Health Strategy- TIP as a proposed core element
- New website
- Roadmap: Quality Improvement Framework due soon
- Knowledge and Skills Framework for Victims and witnesses in the Justice system implementation
- EVALUATION
  - Evidence review recently published
  - Follow up of Pilot delivery trials
  - Publication of process evaluation for substance use, maternity and social care settings

- Working with partners

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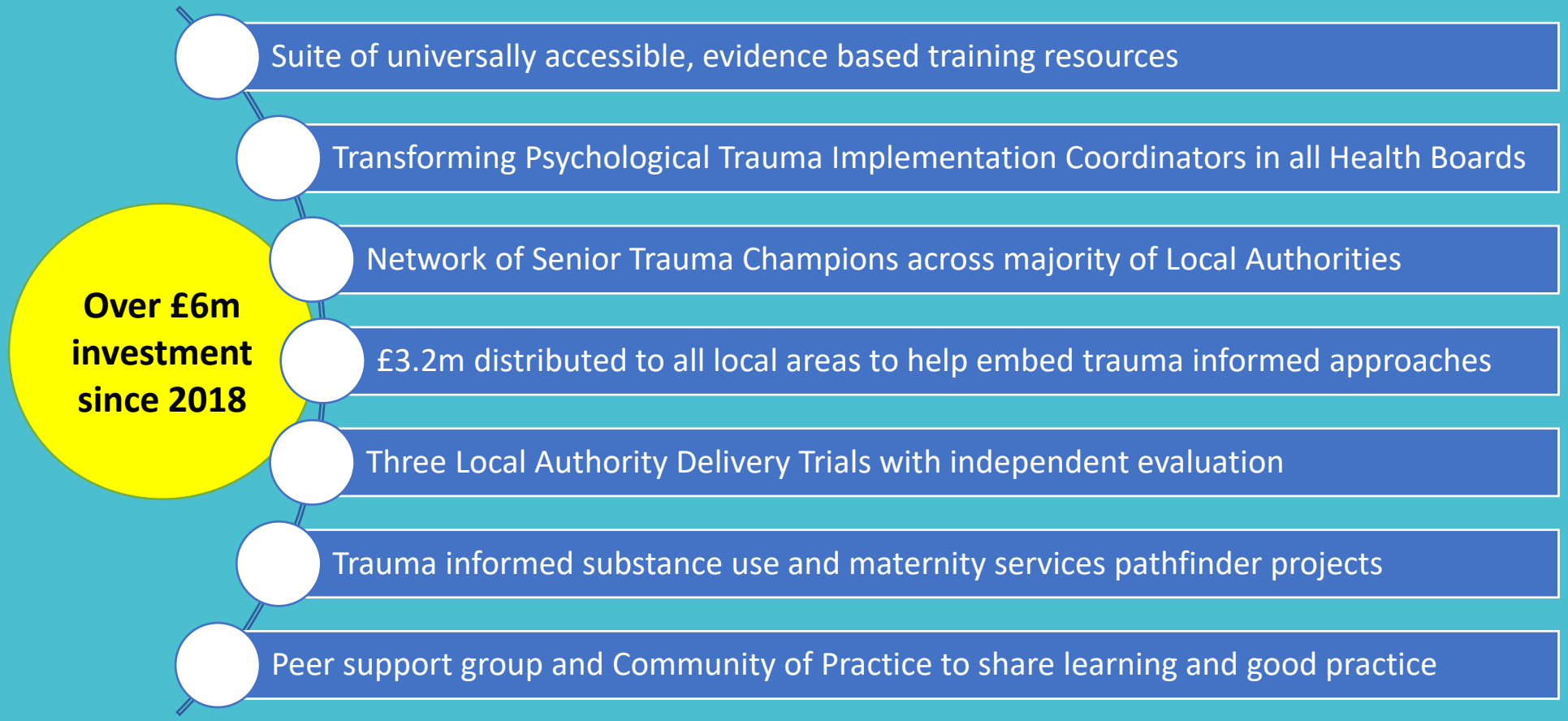
Overview of the NTTP Implementation support



Developments in Trauma informed care in Wales

Dr. Nick Horn

Straen Trawmatig Cymru | Traumatic Stress Wales

Traumatic Stress Wales is funded by Welsh Government and aims to improve the health and wellbeing of people of all ages living in Wales at risk of developing or with post-traumatic stress disorder (PTSD) or complex post-traumatic stress disorder (CPTSD).

Hyb ACE Cymru
ACE Hub Wales

The ACE Hub Wales was set up (in 2017) to support Welsh society to help create an ACE Aware Wales and make Wales a leader in tackling, preventing and mitigating ACEs.

Straen Trawmatig Cymru | Traumatic Stress Wales

https://traumaticstress.nhs.wales/

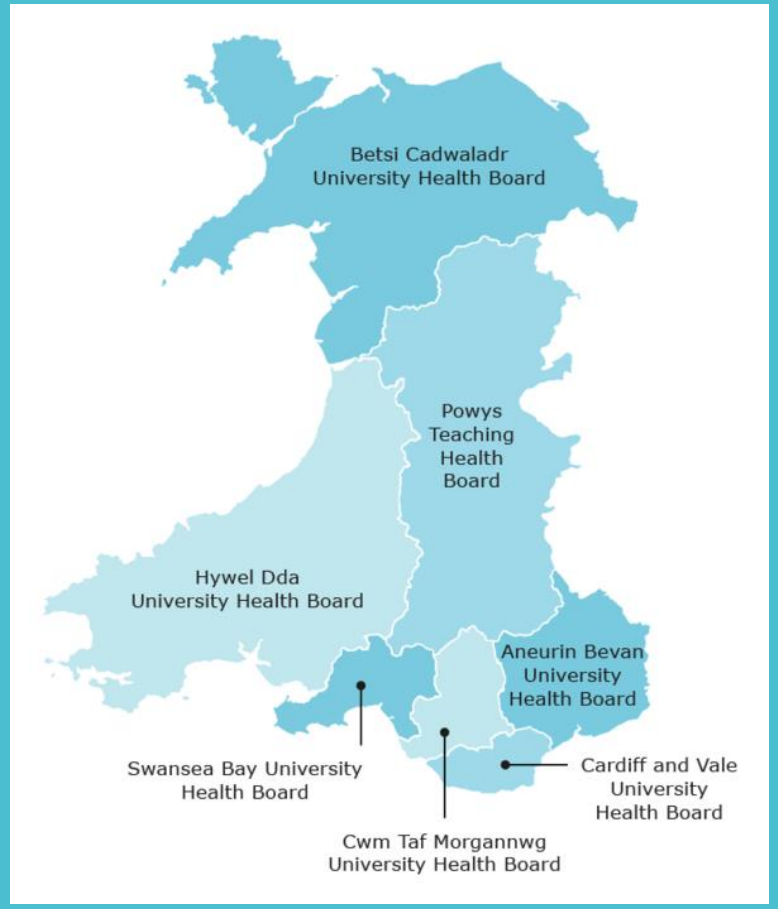
- National initiative funded by Welsh Government
- Aims to:
  - Improve the health and wellbeing of people of all ages living in Wales who have been affected by traumatic events
  - Raise trauma-informed awareness and practice across Wales
- Focus on those at risk of developing or with post-traumatic stress disorder (PTSD) or complex PTSD
- Aspires to be co-produced, co-owned and co-delivered by all relevant stakeholders, including people with lived experience of being affected by traumatic events

Straen Trawmatig Cymru | Traumatic Stress Wales

- Equitable access to evidence-based services
- Nationally agreed model of care and practice framework
- Functions and outcomes consistent, form of services may differ
- Continuously improving national approach
- National dataset to monitor and facilitate improvement

Straen Trawmatig Cymru | **Traumatic Stress** Wales

- Hub and Spoke model
- Leads in all seven Health Boards
- Network of easily accessible, locally based services centred around the people they are trying to help
- Streamlined, cross-sector care pathways that avoid unnecessary repeated referral and assessment



Workstreams

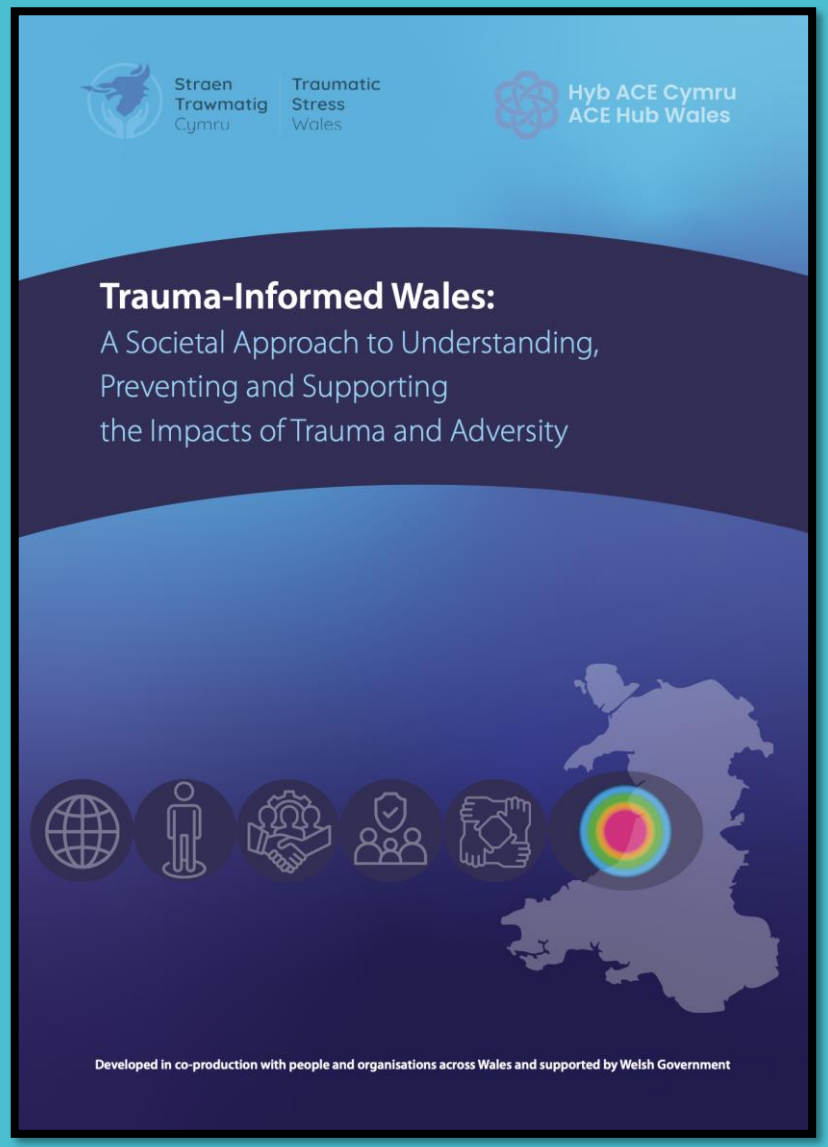
- Children and Young People
- Perinatal
- Criminal Justice and Prisons
- Refugees and Asylum Seekers
- Sexual Assault
- Assessment and Outcomes
- Prescribing

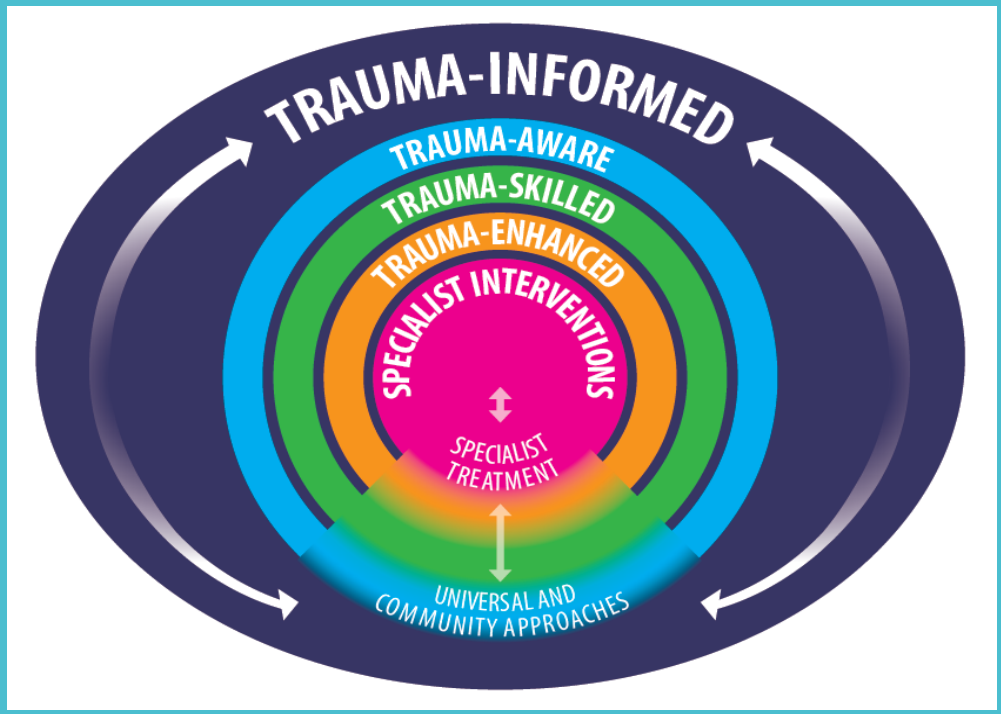
What's been done so far….

- Leads in each Health Board
- Providing training in specific evidence based therapies – including CT-PTSD; CBT; Narrative Exposure Therapy; SPRING Guided Self-help
- Developing Training standards for Trauma informed care
- Resources from specific workstreams – e.g. Refugees and Asylum Seekers
- Core dataset and App for therapists to use
- Prescribing Algorithm
- Development of Trauma informed Wales Framework

Straen Trawmatig Cymru | Traumatic Stress Wales

Hyb ACE Cymru
ACE Hub Wales





Trauma informed wales

- **Trauma-aware** is a universal approach that emphasises the role that we all have as members of Welsh society, personally and professionally, and seeks to raise awareness and understanding. It challenges perceptions that maintain oppression and inequality, and highlights that people in all communities have a role to play in preventing ACEs, adversity and traumatic events, providing community-led responses to the impact of ACEs and trauma, and supporting resilience through connection, inclusion and compassion.
- A **trauma-skilled** approach is embedded within the practice of everyone who provides care or support to people who may have experienced trauma, whether or not the trauma is known about. This applies to most organisations and services in Wales, and many working in and with the community.
- A **trauma-enhanced** approach is used by frontline workers who are providing direct or intensive support to people who are known to have experienced traumatic events within their role, and encompasses ways of working to help people to cope with the impact of their trauma.
- **Specialist interventions** may be formal personalised and co-produced interventions that are offered within a range of settings, or specialist input to support organisations and systems to be trauma-informed.

A societal ambition

In practice, a Wales trauma-informed approach recognises that we all may at some point in our lives experience adversity, trauma or distress. To be trauma-informed, all individuals, communities, organisations and systems in Welsh society will understand behaviour as communication, recognise and understand the impact of cultural, gender and historic inequalities, and social injustice and their causal link with experiences of trauma. Collectively, we will seek to be non-judgemental, kind and compassionate, promoting resilience and strength as collective rather than individual resources. We will understand the importance of safety and trust in addressing adversity, trauma and distress.

We will seek to create healthy psychosocial environments in which people can thrive but where adversity, trauma or distress occurs there is peer support embedded in local communities and clear pathways to more specialist involvement at the appropriate level, as set out in the Wales Trauma-Informed Practice

What is yet to be done….

- Continue to develop resources, training, guidance and ‘pathways’
- Further develop support structures around evidence based therapies
- ‘Implementation’ of the Trauma Informed Wales framework
- Development of a social movement

Challenges for TSW and ‘Implementation’ of Trauma informed Wales framework

- Top down vs Bottom up
- Focus on PTSD/c-PTSD vs all manifestations of trauma
- Systemic/societal vs Specialist/clinical
- Consistency vs Variation
- Psychological vs Medical paradigm?
- Reinventing the wheel?? Or possibly re-painting the wheel?
- Meaningful co-production

Trauma Informed Care on Wards

- A new training day for Bristol Inpatient Staff

Dr Laura Baxendale
Bristol Inpatient Psychology Service
Laurabaxendale@nhs.net

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Avon and Wiltshire Mental Health Partnership NHS Trust

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Aims

- The context – Trust and local
- Our response – an overview of the training package
- Focus on experiential exercise
- Feedback and evaluation
- Future plans

Context

AWP context:

Longstanding Bristol Inpatient Psychology Service ambition

- Dovetailing with Working Therapeutically on Wards Training

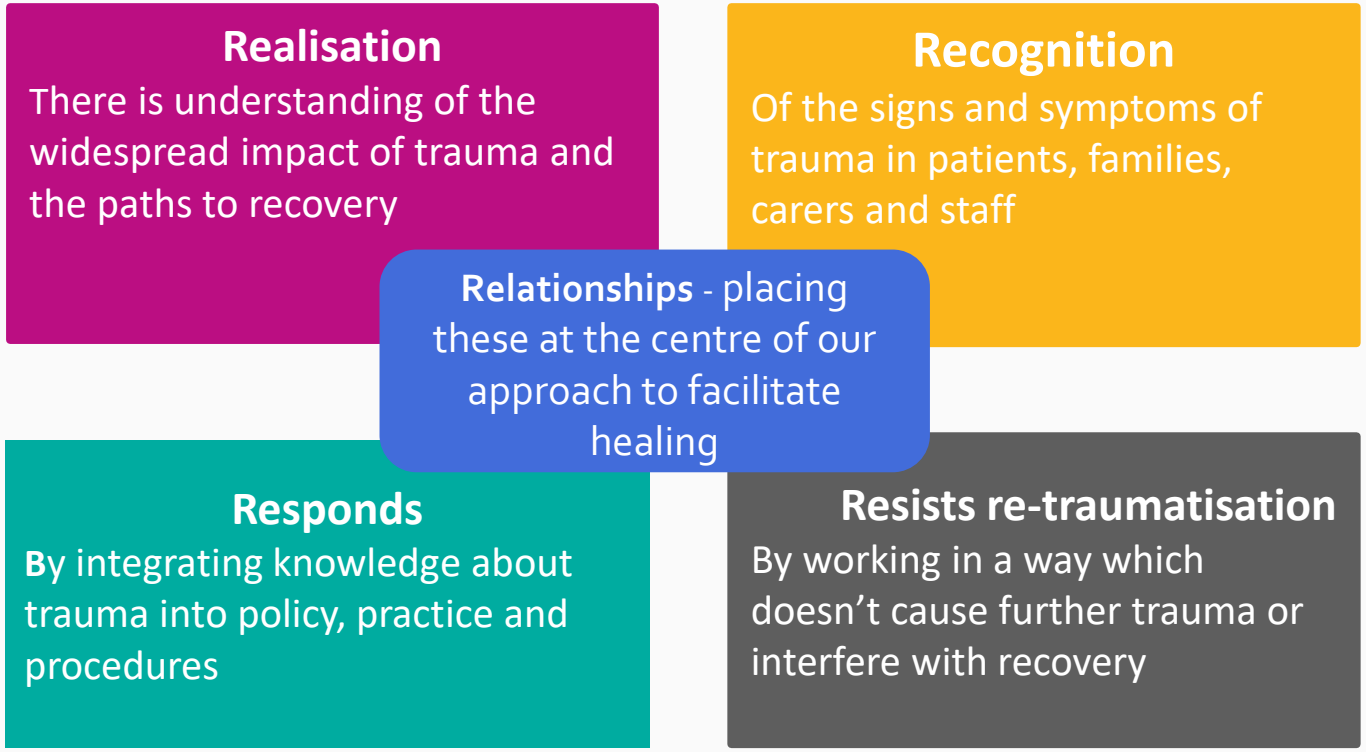
Other TiC packages being launched within the trust, reflecting local context

- Currently developing an introductory e-learning package

Our response

- Development of a training day ‘Trauma Informed Care on Wards’
- Open to all inpatient staff
- A full day incorporating information, group exercises and experiential practises of stabilisation skills
- Covers all aspects of the 4 R’s
- Aims of training day:
  - Increase awareness and understanding of trauma
  - Admissions and their role in trauma
  - Stabilisation - How to support a trauma survivor
  - Secondary trauma – our experiences and wellbeing

4 R's of Trauma Informed Care



(SAMHSA, 2014)

Responds: It's a cultural shift from…

"What's wrong with you?"

"What's happened to you?"

Course outline

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Part 1 Introduction to trauma (Realise, recognise, respond)	Part 2 Resisting Retraumatisation (Resist and Respond)	Part 3 – Trauma and Staff Wellbeing (Realise, Recognise, Respond, Resist)
▪ Introduction to trauma Spotting trauma Types of trauma Different cultural responses or expressions of trauma ▪ Prevalence of trauma ▪ Psycho-education of trauma ▪ Fictional case vignette ▪ Group exercise – Comprehend, Cope Connect formulation (CCC, Isabel Clarke) ▪ Dissociation ▪ Grounding (examples and practises throughout the training).		

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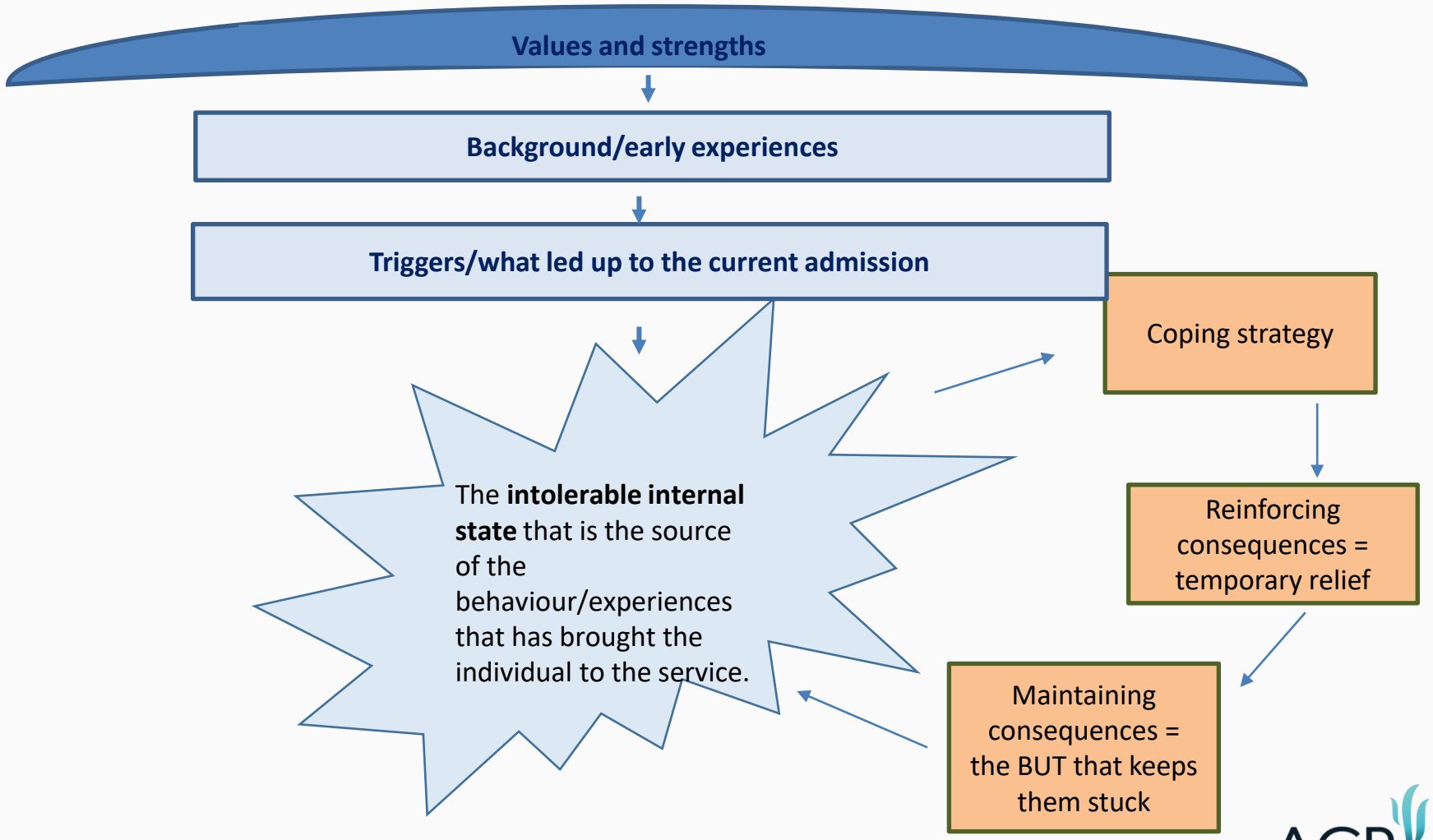
ionate care

Model from Comprehend, Cope, Connect (CCC, Isabel Clarke)



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	▪ Facilitated jointly with AWP Safewards lead) ▪ Introduction to topic – Revisit earlier fictional vignette and formulation developed ▪ Group exercise – different aspects of an admission ▪ Supporting service users (use of TIC core values) ▪ Post incident relationship repair	

Resisting retraumatisation group exercise

Small groups consider different aspects of admission to hospital:

1. Assessment and transport to hospital
2. Admission onto ward/initial experience
3. First night being on the ward
4. Ward round/meeting/CPA
5. Restraint/seclusion

Resisting retraumatisation group exercise

Avon and Wiltshire Mental Health Partnership NHS Trust

A (Antecedent) Triggers	B (Beliefs)	C (Consequences)
Think about triggers for distress Consider the senses (sights, sounds, smells) Links between past experiences and current experiences? **Eg: Being in room at night, knowing that there are others on the ward (staff and SUs,)…**	What might she be thinking? What might be going through her mind? **Eg: I don't know these people, they may hurt me……**	How might she be feeling? What might she do/ not do? **Eg: Scared, worried, May not sleep…….**

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What could we do?

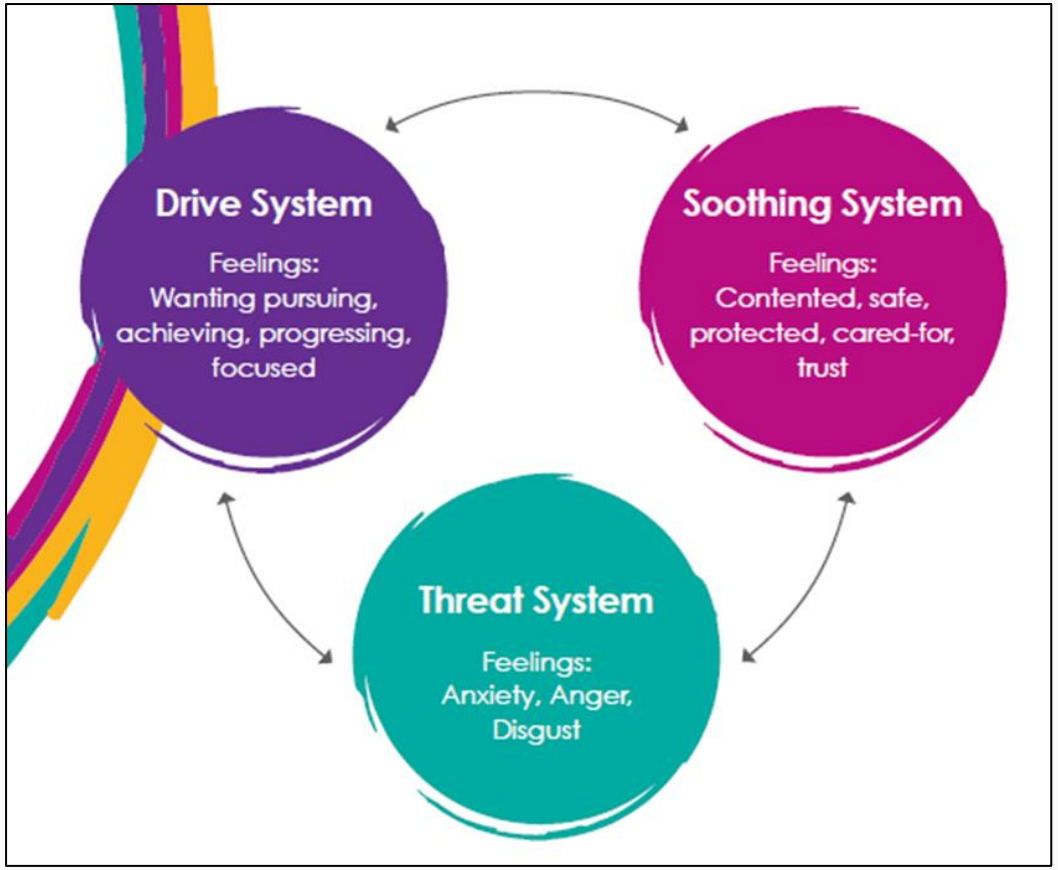
Using Safewards approaches, TIC Core values and the other skills we have developed through our work, what do we think would be helpful at each stage of the admission?

Safewards Interventions

- Bad News Mitigation
- Calm Down Methods
- Clear Mutual Expectations
- Discharge Messages
- Know Each Other
- Mutual Help Meeting
- Positive Words
- Reassurance
- Soft Words
- Talk Down

Part 1 Introduction to trauma (Realise, recognise, respond)	Part 2 Resisting Retraumatisation (Resist and Respond)	Part 3 – Trauma and Staff Wellbeing (Realise, Recognise, Respond, Resist)
		▪ Definitions of threats to wellbeing (burnout, secondary traumatic stress, Empathy Distress fatigue) ▪ Group exercise – noticing what happens in our body when we're feeling impacted by our work ▪ Compassionate Mind Theory

Part 3 – Trauma and Staff Wellbeing (Realise, Recognise, Respond, Resist)



Part 3 cont– Trauma and Staff Wellbeing (Realise, Recognise, Respond, Resist)

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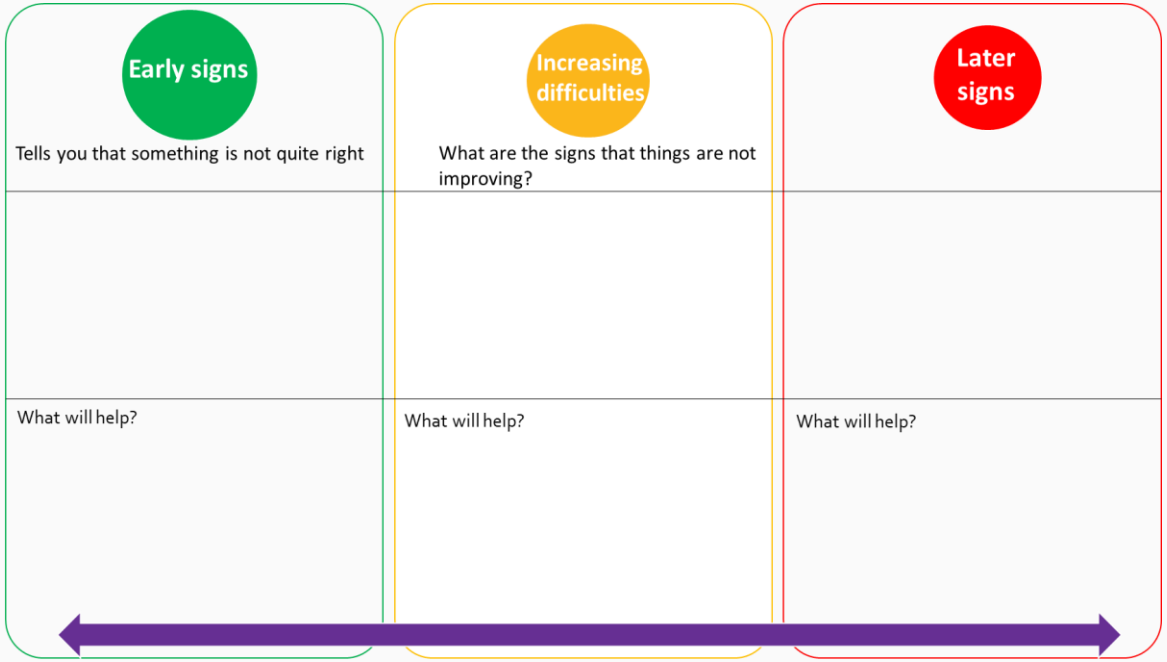
- Recognising warning signs
- Responding to warning signs
- Systems and processes in place to support staff

•Supervision
•Debriefs
•Self help resources

•Wellbeing services
•AWP Staff Traumatic Stress Service



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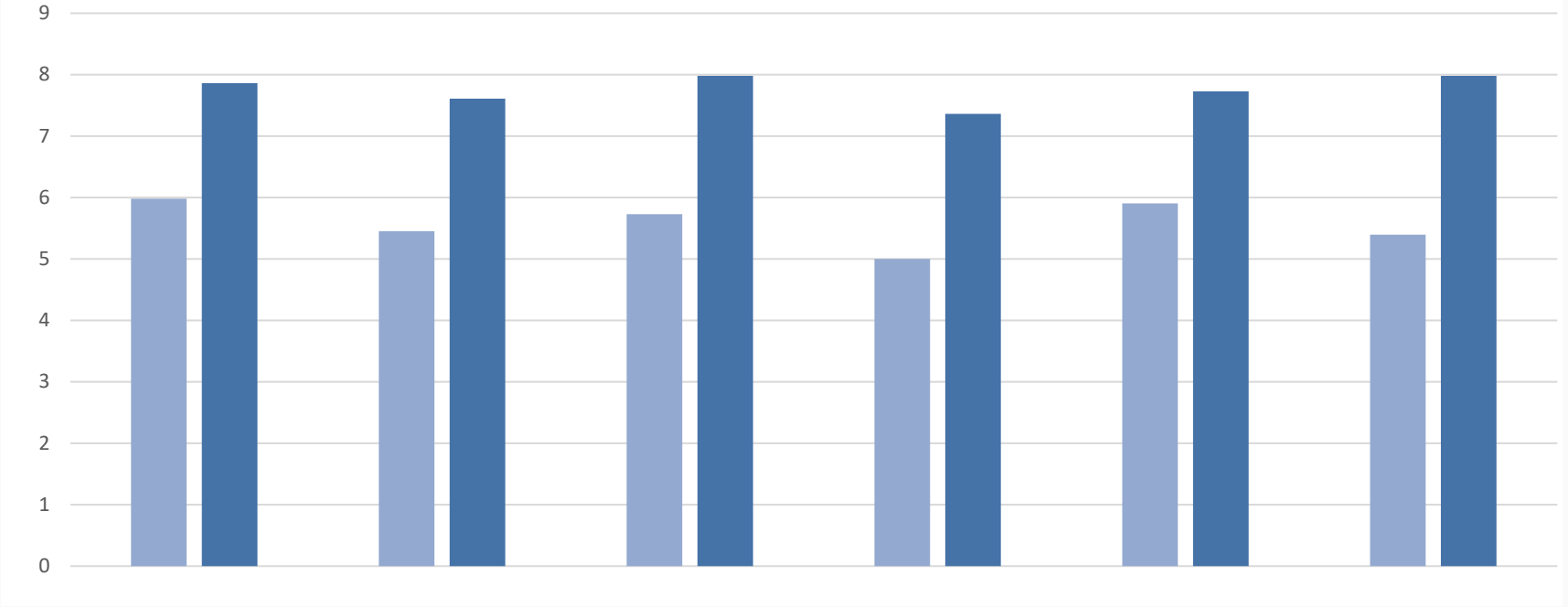
Feedback


It was all good, especially having a space to reflect and hear other colleagues' perspectives
I will use the grounding technique and take a few minutes for myself when feeling tired/stressed
I found it helpful to discuss the case study with people from other wards
Better awareness will improve my confidence and ability to support service users
I will be more reflective and remember that every detail of my interactions with service users is meaningful
I will be more aware of how the environment can affect trauma responses

Evaluation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I have a good **awareness of the prevalence** of trauma and the **type of trauma** that service users may have experienced
I can **recognise signs** that somebody may have experienced trauma
I understand different ways in which somebody may be **retraumatised** during an admission
I have the **skills and confidence** to support individuals who have experienced trauma
I can recognise different signs that I may need support for my **wellbeing** as a staff member
I feel confident in knowing the different **types of support** that are available to me as a staff member
Beginning
End

Reflections

- Usefulness of shared experiences and discussions
- Balance of information and practise/exercises
- Range of MDT members and from across different wards (acute, PICU, rehab, later life) give different perspectives
- Appetite for learning about Trauma Informed Care
- Noticing increase in people considering trauma on the wards and considering psychology input (direct or indirect)
- Imbedded within wider context of programmes (CCC model, Working Therapeutically on Wards, managerial support, Team Formulation)

Future Plans

- Co-creation with individuals with lived experience
- Continued evaluation of training
- Contribution to wider trust strategy for trauma informed care training

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Mental Health Partnership
NHS Trust

Thank you for listening.

Any questions?

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Applying a Racialised Lens to Trauma Informed Care in Inpatient Services

DR LORRAINE GORDON

CONSULTANT COUNSELLING PSYCHOLOGIST

HEAD OF PSYCHOLOGY AND PSYCHOTHERAPY SOUTHWARK

SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST

Implementing Trauma Informed Care in Acute Settings

Psychological Safety Agreement

- Talking about race can be difficult, for some it brings up hurt from the past, or some people might feel guilt and shame
- I will not be asking anyone to re-live their own hurt and pain
- However, I would encourage you to sit with any discomfort that comes up and reflect on how you can use it to facilitate change in the environments where you are based
- If required, take a few slow deep breathes to help you stay connected

Outline

- This presentation highlights the urgent problem of racial inequity in mental health service provision
- It exposes systemic disparities experienced by people of African and Caribbean descent, who have been racialised as Black
- It asserts that organisational antiracism work must include attention to anti-Blackness, also known as anti-Black racism

Racial Trauma

- Racial trauma is a mental and emotional injury resulting from racism
- It can affect anyone who experiences direct or in-direct racism
- It can elicit a response similar to post-traumatic stress disorder
- Studies show that for people racialised as Black, racism in society, can lead them to internalise hateful messages relating to people of colour

Institutional racism

"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people."…. "It persists because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation. It is a corrosive disease."

Stephen Lawrence Enquiry in the MacPherson Report (1999: para.6.34)


WANDSWORTH
Socialist Worker
Black Lives Matter
Smash racism by any means necessary
STAND UP TO RACISM
BLACK LIVES MATTER
ACP UK
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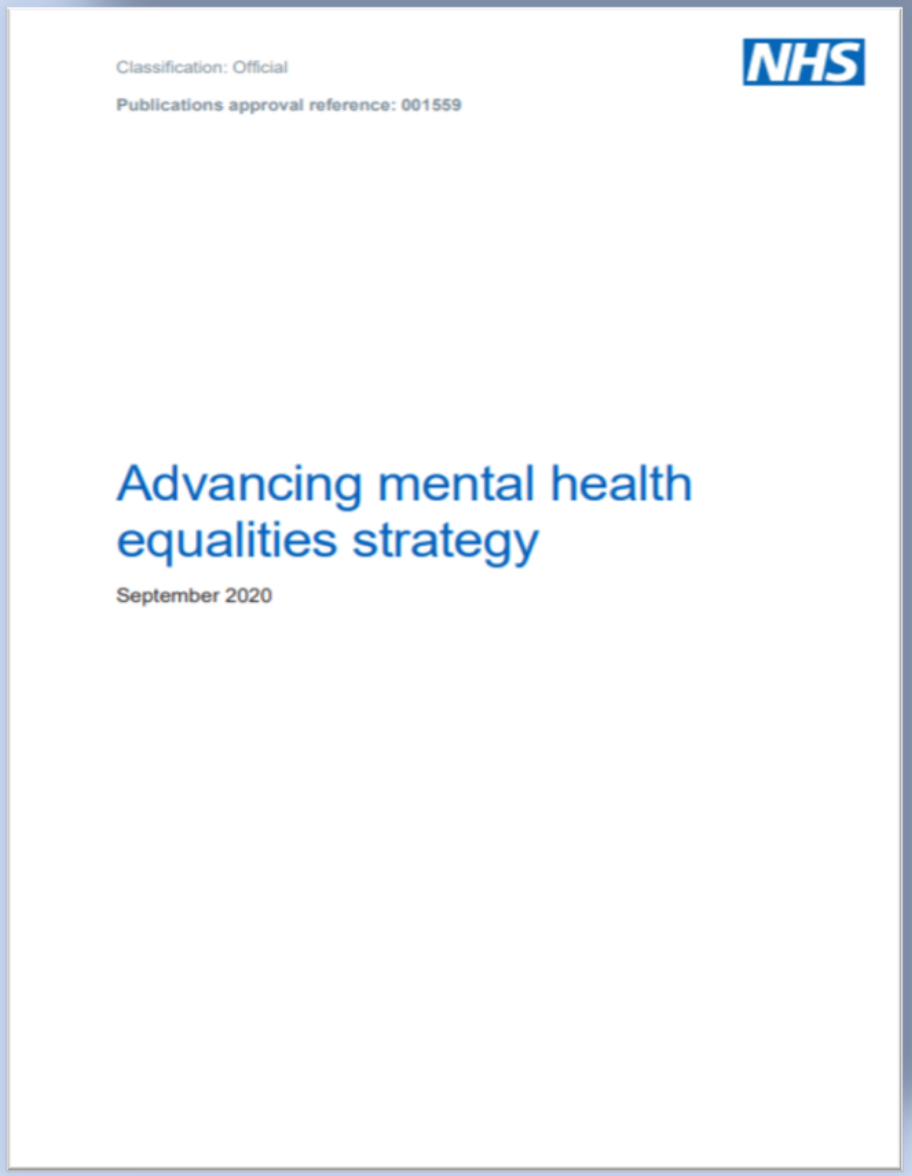
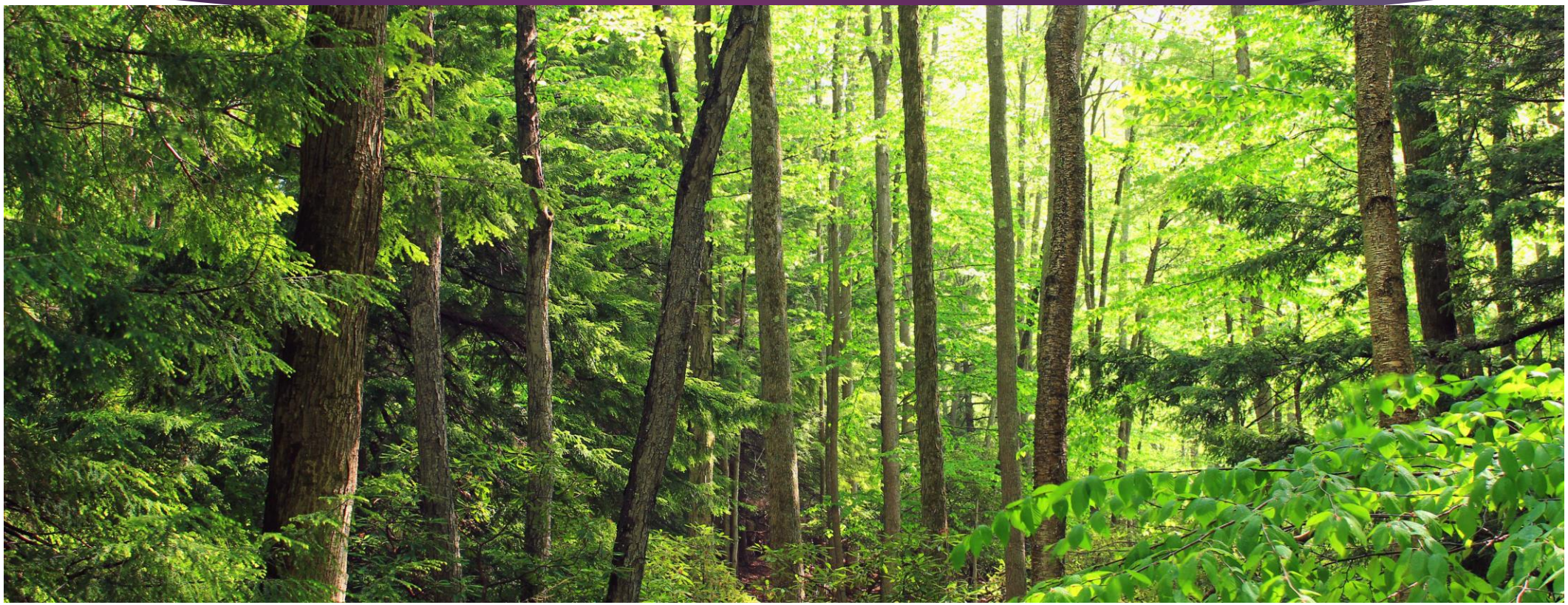
South London and Maudsley
A partnership to achieve anti-racism and equity
Black Thrive


Classification: Official
Publications approval reference: 001559
NHS
Advancing mental health equalities strategy
September 2020

Video Olaseni Lewis' Mother Ajibola Lewis, speaking in 2020

Space for Reflection

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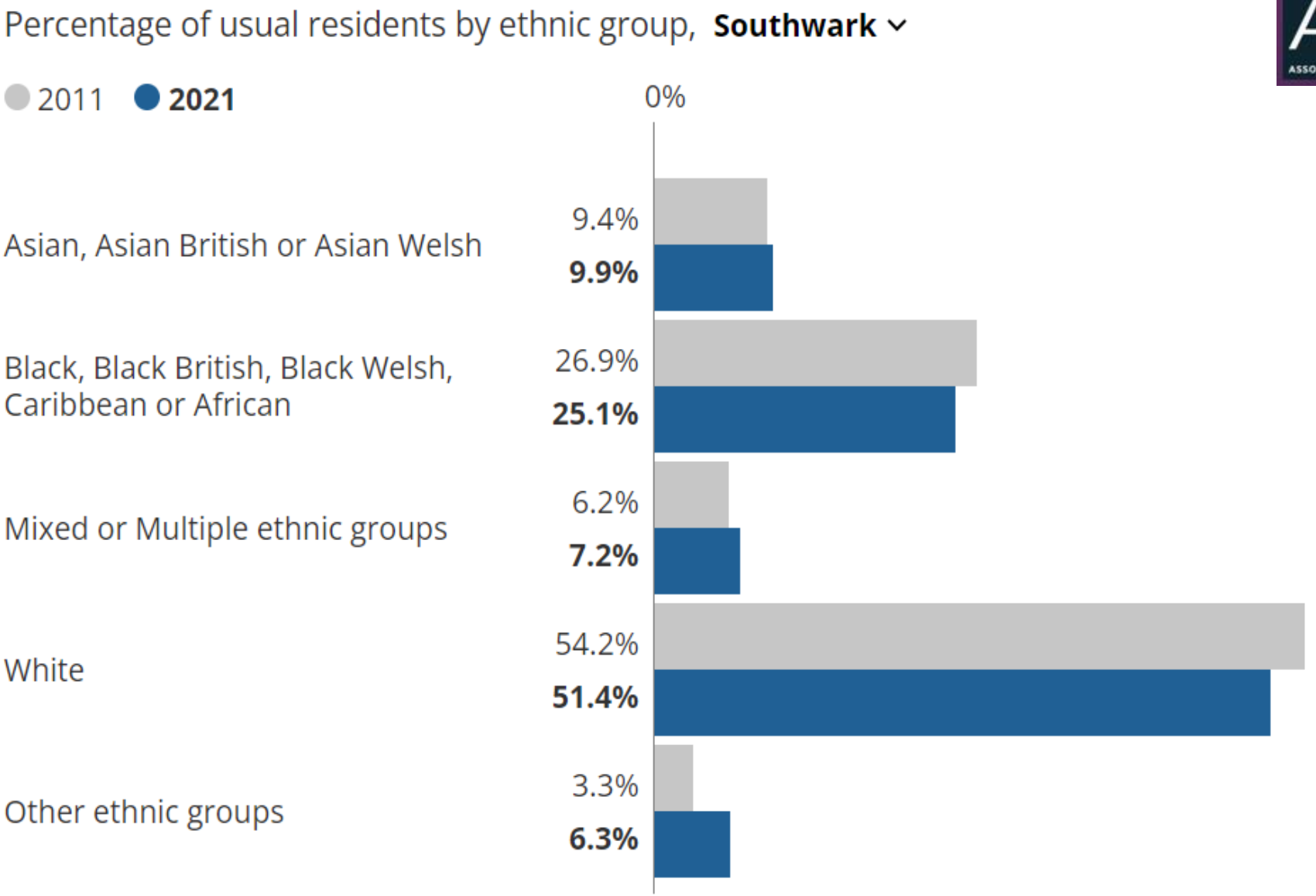
Lambeth
Black Thrive

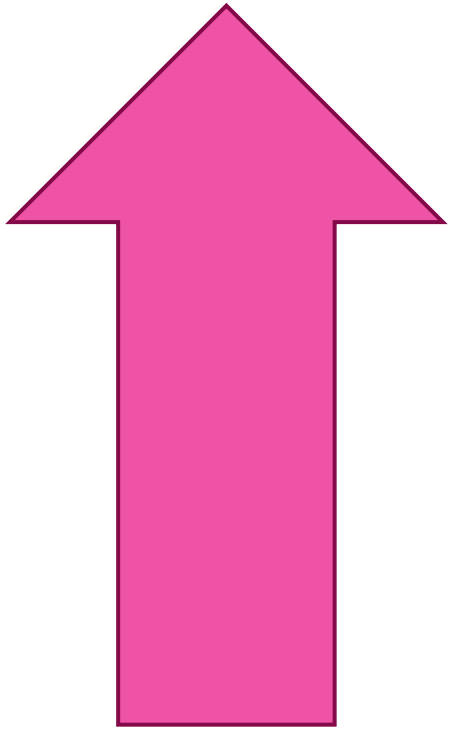


Source: Office for National Statistics – 2011 Census and Census 2021

2011 & 2021 Census 18+ years old

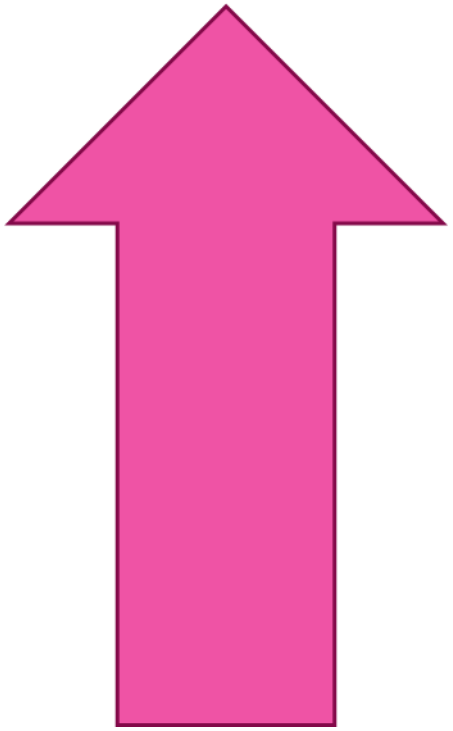
Seclusion by Ethnicity

In 2021 - Feb. 22 Black people were 3 times more likely to be secluded than white people



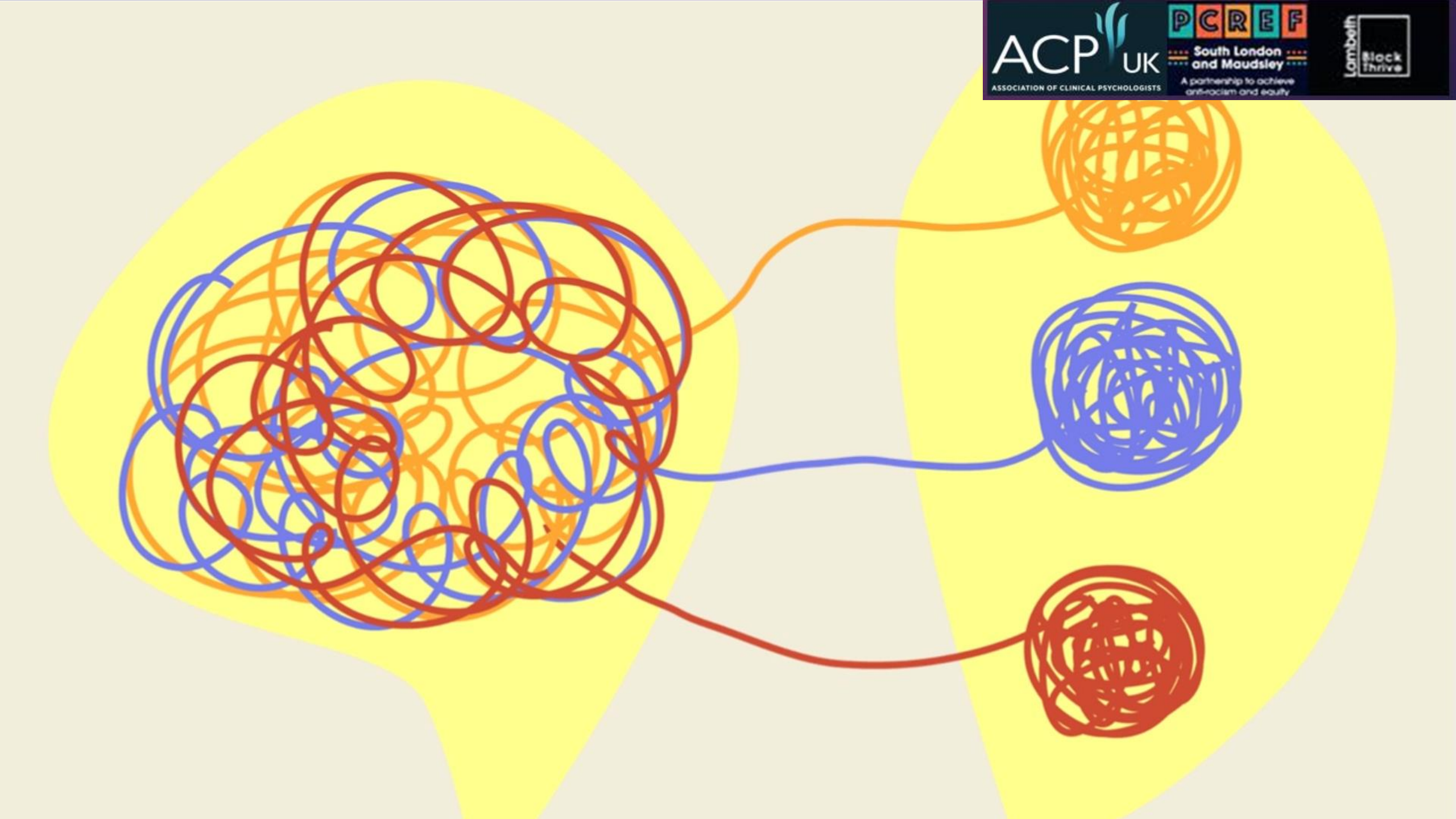
Restraint by Ethnicity

In 2021 - Feb. 22 Black people were 8 times more likely to be restrained than white people



What is antiracism?

- Antiracism is a process of actively identifying and opposing racism
- It includes ideologies and practices that affirm and seek to enable the equality of races and ethnic groups
- It is the active, on-going process of dismantling systems of racial inequity and creating new systems of racial equity
- It demands that this work be done at the individual, community, organisational/institutional, and cultural levels in order to effectively address systemic racism
- The goal of antiracism is to challenge racism and actively change the policies, behaviours, and beliefs that perpetuate racist ideas and actions. It is rooted in action; taking steps to eliminate racism at the individual, institutional, and structural levels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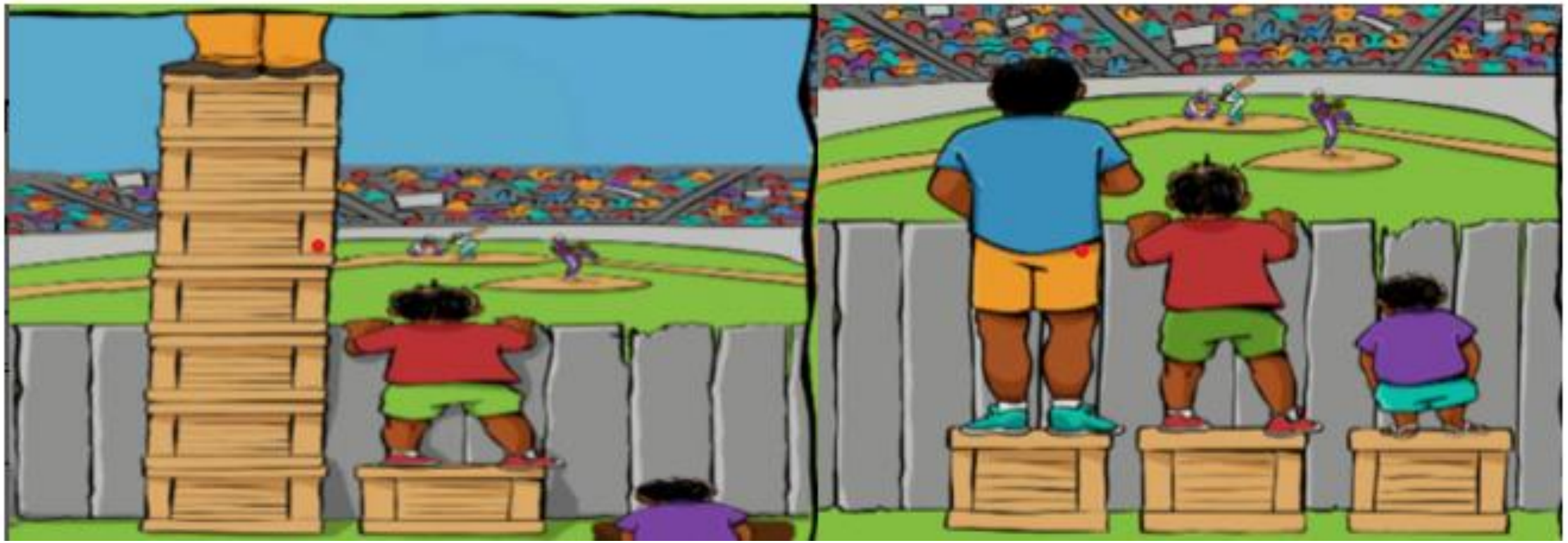
Reality vs. Equality



Equity vs. Liberation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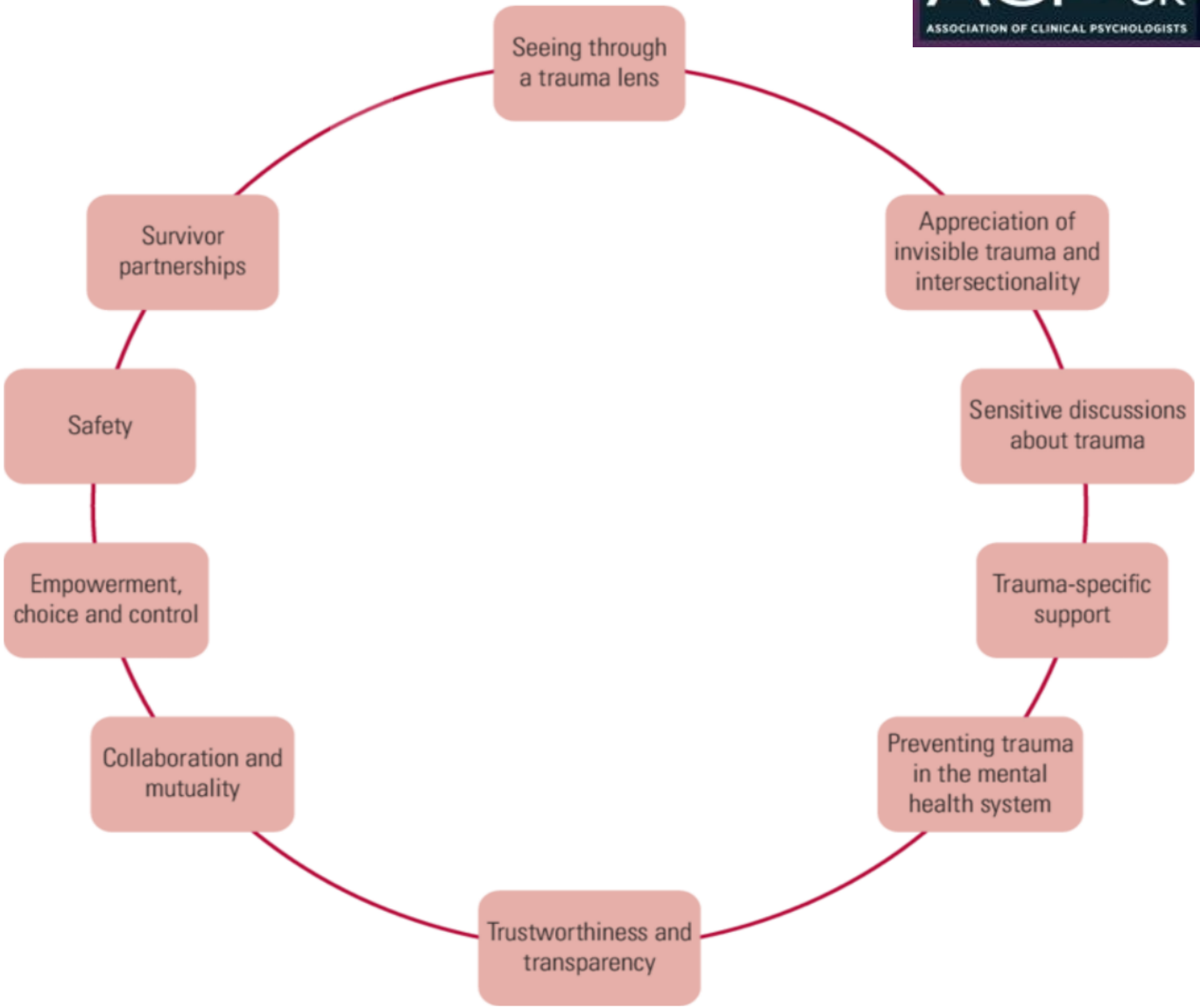
Black Thrive

Seni Lewis Training Programme

- Launched in January 2023, it is a training course designed to improve experiences of and safety in mental healthcare, including providing care in a culturally sensitive manner
- It has been developed in partnership with service users, carers, Black Thrive community members, Trust staff, and the family of Olaseni Lewis, who the course is named after
- The course advocates a system-wide approach to improving patient safety, including reducing the use of forceful or restrictive practices
- It directly replaces previous disengagement training in the Trust

Trauma Informed Care



Ten key principles of trauma-informed approaches (adapted from Elliot 2005; Bloom 2006; Substance Abuse and Mental Health Services Administration 2014).

Cultural Humility

- Cultural humility is a life-long commitment to self-evaluation and self-critique (Tervalon and Murray-Garcia, 1998)
- Another feature of cultural humility involves taking action to address power-imbalances
- This approach includes developing partnerships with people and groups who advocate for others (Tervalon and Murray-Garcia, 1998)
- The training we have received, is key to enable us to implement our change ideas

Summary

- This presentation discussed the urgent need to disrupt systems and processes that maintain racial inequity in mental health services
- It exposed systemic disparities experienced by people of African and Caribbean descent, who have been racialised as Black
- It asserted that organisational antiracism work must include attention to anti-Blackness, also known as anti-Black racism

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ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Trauma-Informed Practice in an Intensive Psychiatric Care Unit (IPCU): A Scottish Perspective

Dr David Carmichael: Clinical Psychologist
Ward 1 (IPCU) & Ward 17: St. John's Hospital
NHS Lothian Psychosis & Complex Mental Health Psychology Team

Ward 1 (IPCU): St. John's Hospital

- 10-bedded, mixed sex, Intensive Psychiatric Care Unit
- 24-hour intensive psychiatric, psychological and nursing care
- Locked Ward & Increase Nursing-Patient Ratio
- All patients detained under Mental Health Care and Treatment (Scotland) Act 2003 or Criminal Procedure (Scotland) Act 1995
- Admitted due to risk of absconsion, self-harm/suicide, violence and aggression /risk to others, court ordered assessment, chaotic behaviour or risk to dignity that can not be safely managed on an open ward
- Multi-Disciplinary Team: Psychiatry, Clinical Psychology, Nursing, O/T, Pharmacy, Art & Music Psychotherapy, Addictions Liaison Nurse
- Typical Presentations: Acute Psychosis, Acute Mania, Severe Depression (Suicidality/Catatonia), Puerperal Psychosis (when not safe on Mother and Baby Unit)

Setting the Scene

- People experiencing a mental health crisis requiring admission to inpatient mental health services report tell us that, while they recognise the role of psychiatric/medical treatment, what they most value is the opportunity to talk to someone, to be listened to, for people to help them feel safe and for someone to help them to make sense of and to help them understand their experiences (Mind, 2011).

- Despite this, adult inpatient mental health services have previously been heavily criticised for their lack of therapeutic activity and input (Schizophrenia Commission, 2012).

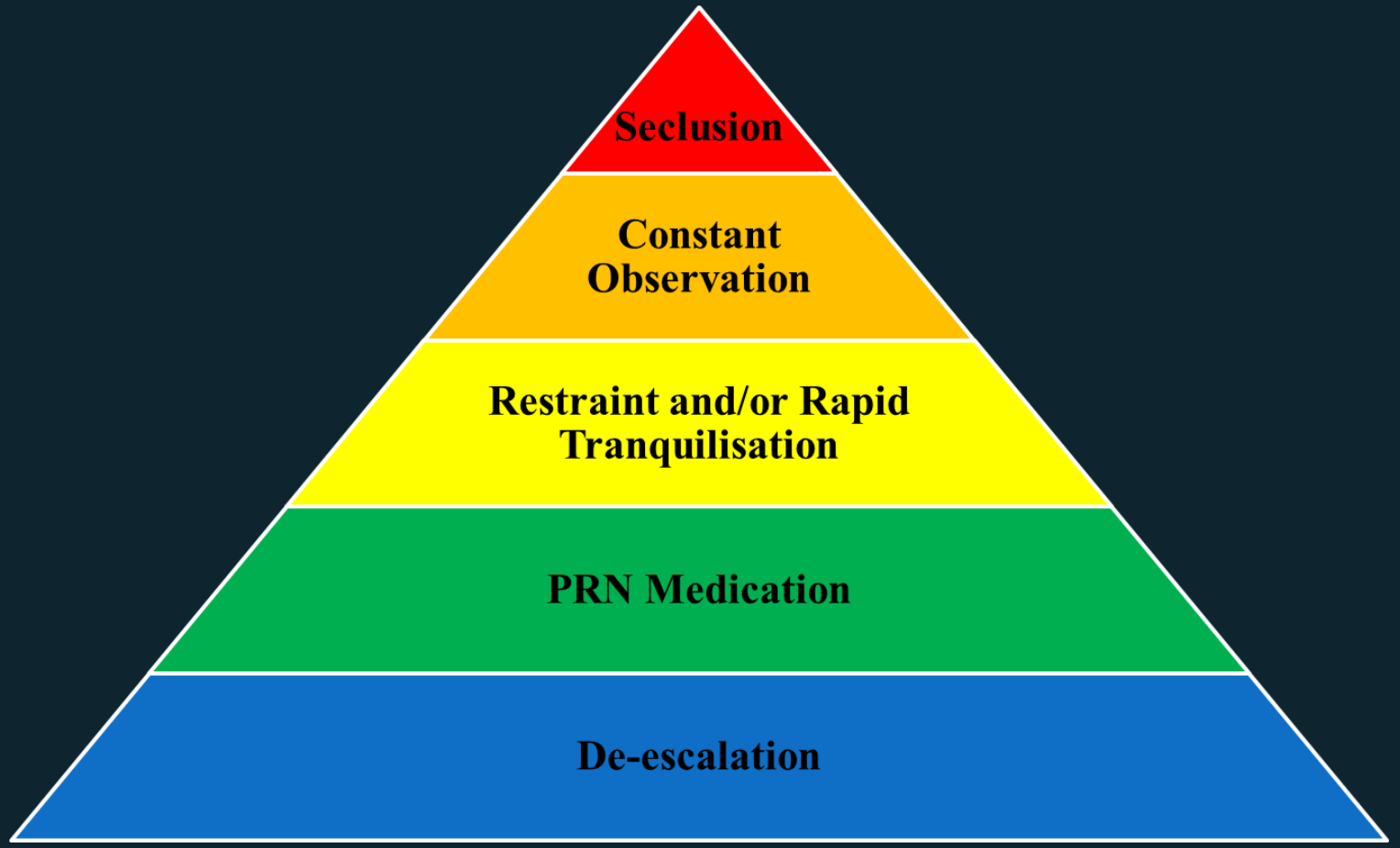
- It has been suggested this may account for the high rates of re-admission often experienced by these services (Information Services Division Scotland, 2019; Paterson et al, 2019).

Access to psychological therapies and the clinical psychology service was considered to be one of the most important resources available in the hospital. Patients expressed that psychology offered unique benefits to their recovery and wellbeing not afforded by a purely medical model of treatment, and the meaning-making process of psychology was of vital importance.

Many patients throughout the hospital reported a lack of access to psychological therapies and the clinical psychology service despite believing it would be helpful. Inadequate access was particularly prevalent in the Adult Acute and Older Persons wards.

Patients identified several aspects of being in hospital which caused significant distress and had the potential of causing trauma or re-traumatisation. Excessive restrictions, seclusion, non-consensual or coercive treatment, poor treatment from staff, and the use of restraint were issues identified by patients as having severe consequences for their wellbeing and inhibiting recovery.

Traditional Management of Distress & Associated Risk in IPCU



Trauma & Re-Traumatisation

- There are high prevalence rates of both childhood and adult trauma in people requiring inpatient mental health treatment (Read et al, 2005)
- Trauma plays a significant role in the development of many of the presenting problems we look after in inpatient settings (Aas et al, 2016; Agnes-Blias & Danese, 2016; Beck et al, 1979; Cattane et al, 2017; Courtois, 2008; Garety et al, 2001; Green et al, 2010; Herman et al, 1989; Kessler et al, 2010; Mansell et al, 2007; McLaughlin et al, 2010; Read et al, 2001; Varese et al, 2012).
- Any interventions that reminds people of, or 'repeats patterns' similar to, previous abuse can be re-traumatising (HIS, 2019; NES, 2017; Sweeney et al, 2018)
- Patients report that restraint, IM medication, constants and seclusion are re-traumatising (Cusack et al, 2018; Strout, 2010; Sweeney et al, 2018)

The Challenge

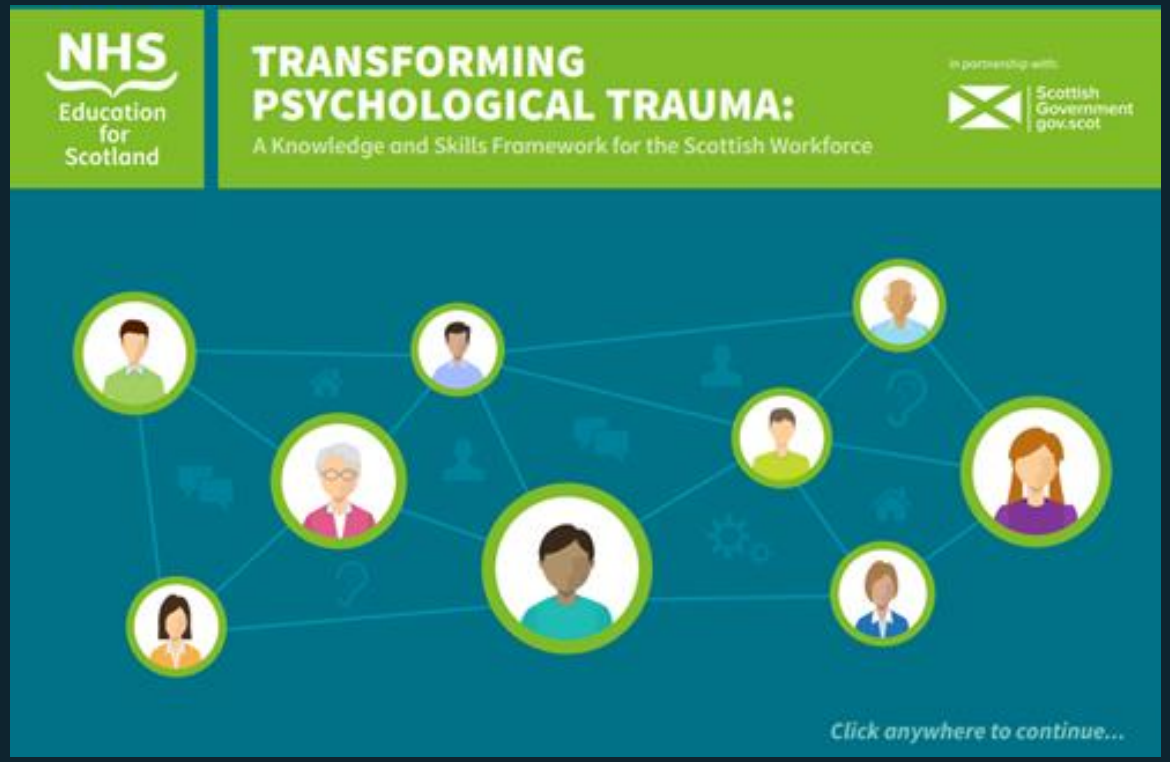
- Even when delivering the highest standard of care, there are often occasions where restrictive interventions such as restraint, rapid tranquilisation, constant observation and seclusion are/appear to be the only option to safely manage risk

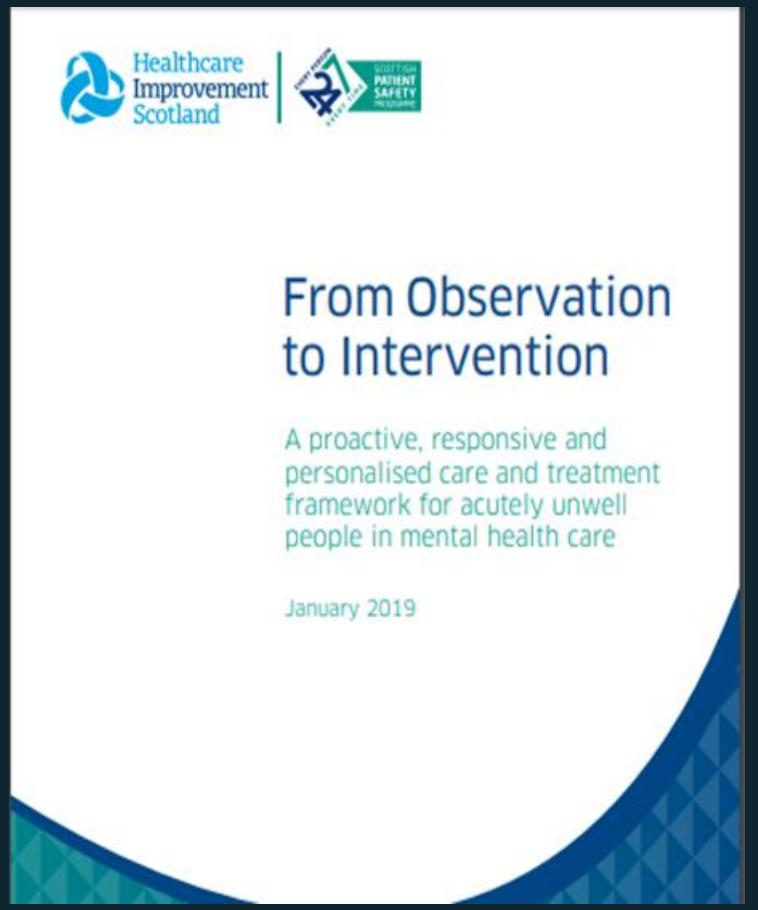
BUT

- If our patient's experience these interventions as re-traumatisating, they may actually serve to increase emotional distress and associated risk

- How to we address this challenge?

Scottish Policy Context





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From Observation to Intervention

1. Involving Carers & Families
2. A continuum-based approach
3. Early Recognition & Response
4. Improved Communication
5. Least Restrictive Practice
6. Continuous Intervention
7. A Trauma-Informed Workforce
8. Personalised Care & Treatment
9. Learning & Quality Improvement

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promoting excellence in psychology

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BRIEFING PAPER

Psychological services within the Acute Adult Mental Health Care Pathway

Guidelines for service providers, policy makers and decision makers.

FING PAPER

Role of an Inpatient Clinical Psychologist

- Direct Clinical Work: Assessment, Formulation & Inpatient Psychological Therapy
- Indirect Clinical Work: Consultation, Advice, Team Formulation, Ward Rounds, Professional Concerns Meetings
- Consultation, Advice & Clinical Supervision
- Staff Support: Reflective Practice Groups & Serious Adverse Event Debriefs
- Teaching & Training
- Service Development, Audit, Research

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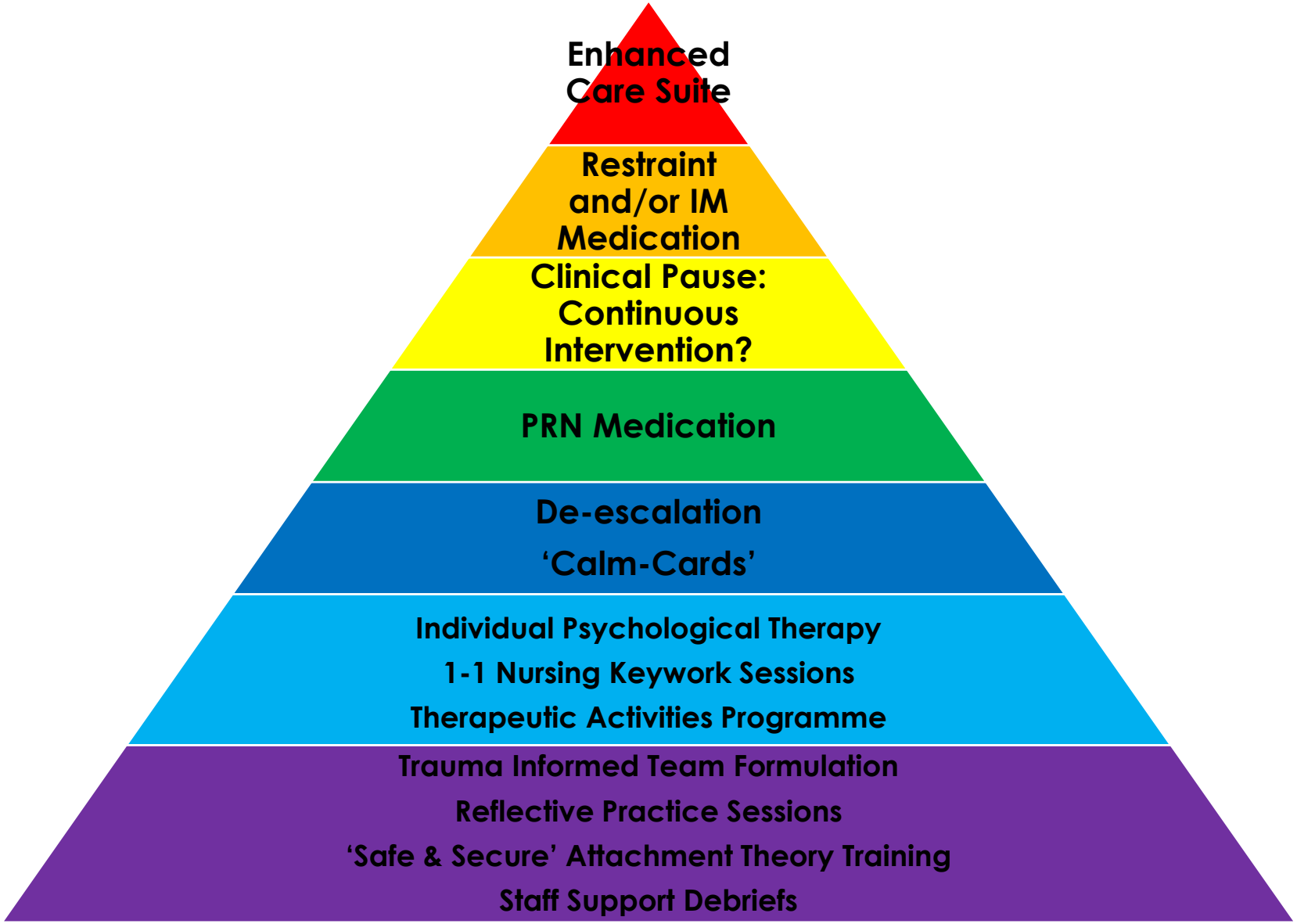
A Trauma-Informed Model of IPCU Care



Continuous Intervention: Role of Clinical Psychology

- When a patient's distress and associated risk is escalating, the team will call for a clinical pause
- A Clinical Pause is a 2 hour window for the MDT to gather and trial a range of interventions in order to consider whether restrictive interventions are required and proportionate
- Inpatient Clinical Psychology prioritise Clinical Pauses above all other clinical demands to provide a formulation based perspective and recommendations for psychosocial interventions
- Patients on restrictive interventions are prioritised for the next Team Formulation Meeting where we consider the risk of re-traumatisation and strategies to reduce this in detail
- Clinical Psychology attend MDT daily reviews of restrictive interventions

‘Go-To’ Strategies

- No longer seclude in bedrooms
- All female/all male restraints if required
- Reduce number of potential restraints/IM’s: Consider clopxiol acuphase?
- Admission to IPCU rather than restrictive management on acute ward? Formulation-driven admission?
- Depots in deltoid rather than gluteal muscle?
- Choices in care (may be limited)
- Considered approach to continuous intervention: could this increase risk?
- Seclusion sometimes less re-traumatising than continuous intervention?
- Culture Change: Pause & Reflect rather than ‘manage now’

Case Examples

1. Impact of Direct Psychological Interventions

2. When CI (and potentially restraint) may be less re-traumatising than seclusion

3. When seclusion may be less re-traumatising than CI

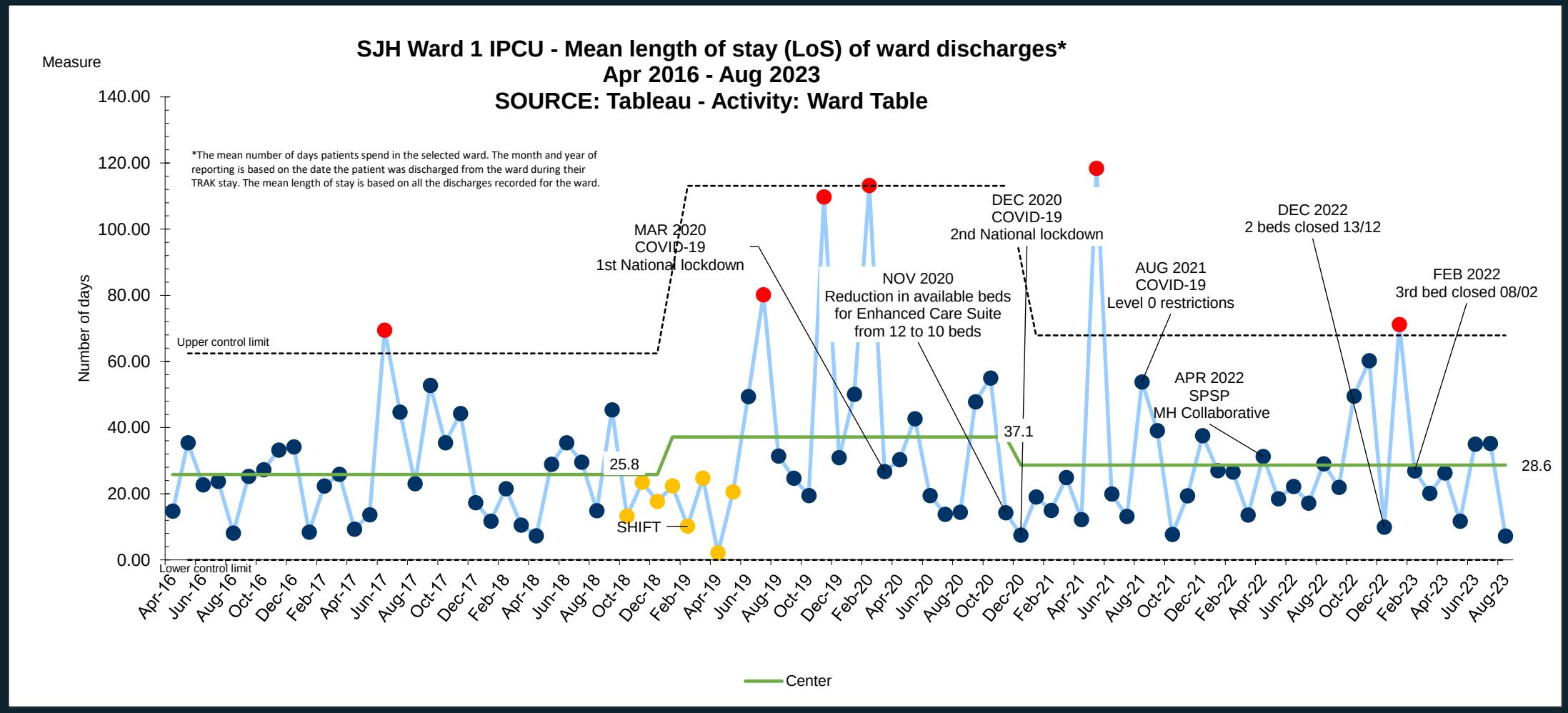
Trauma-Informed Practice: The Evidence Base

Patients	Staff
Psychological distress ↓	V&A toward staff ↓
Symptom Severity ↓	Staff burnout ↓
Number of restraints/rapid tranq ↓	Staff splitting ↓
Days in seclusion ↓	Staff sickness rates ↓
Length of admission ↓	Team morale ↑
Rates of re-admission ↓	Staff retention ↑
↑ Ward atmosphere ↑	

Araci & Clark, 2016; Berry et al, 2016; ; Heneghan et al, 2014; McLaughlin et al, 2016; Nicopaschos et al, 2023; Sweeney et al, 2016; Thomas & Isobel, 2019

Outcomes

Length of Stay



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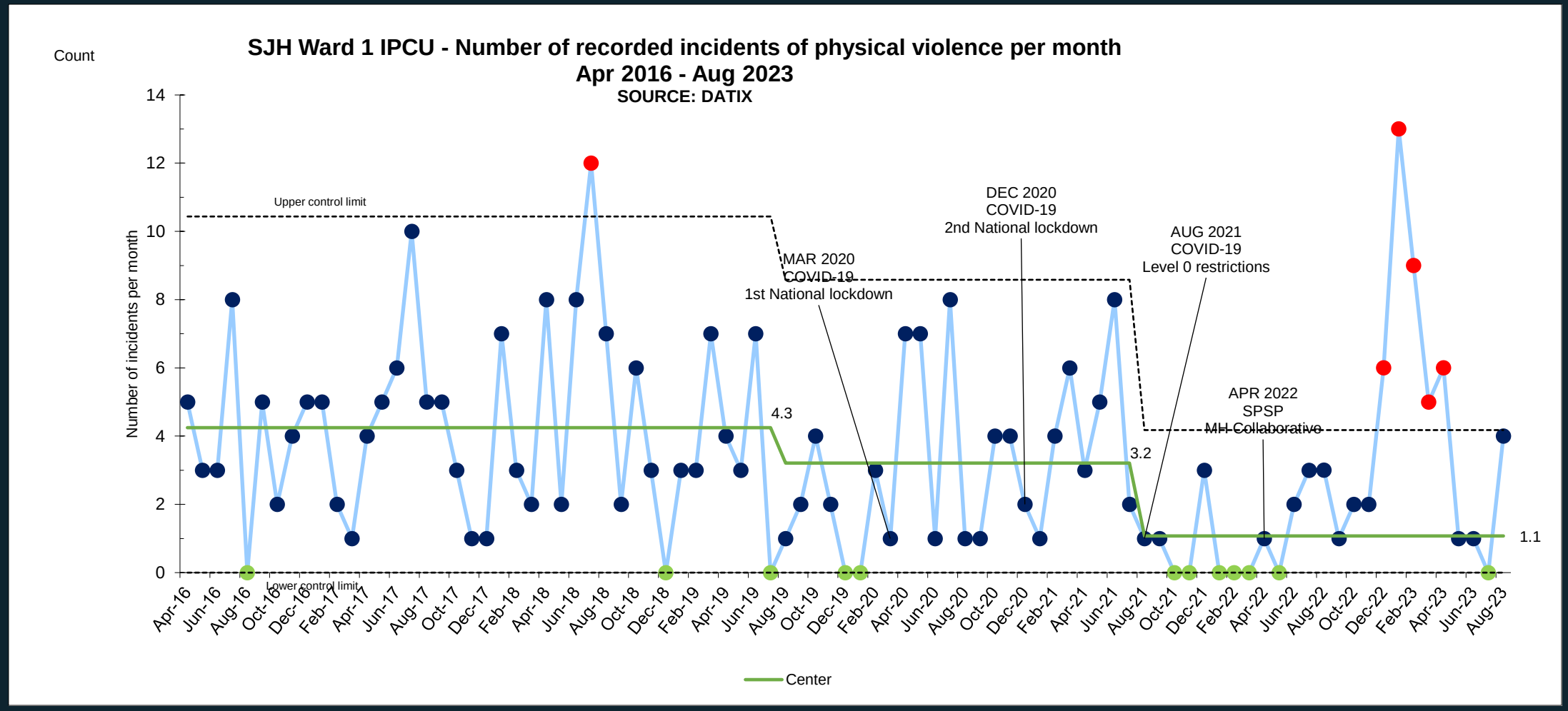
Physical Violence & Aggression



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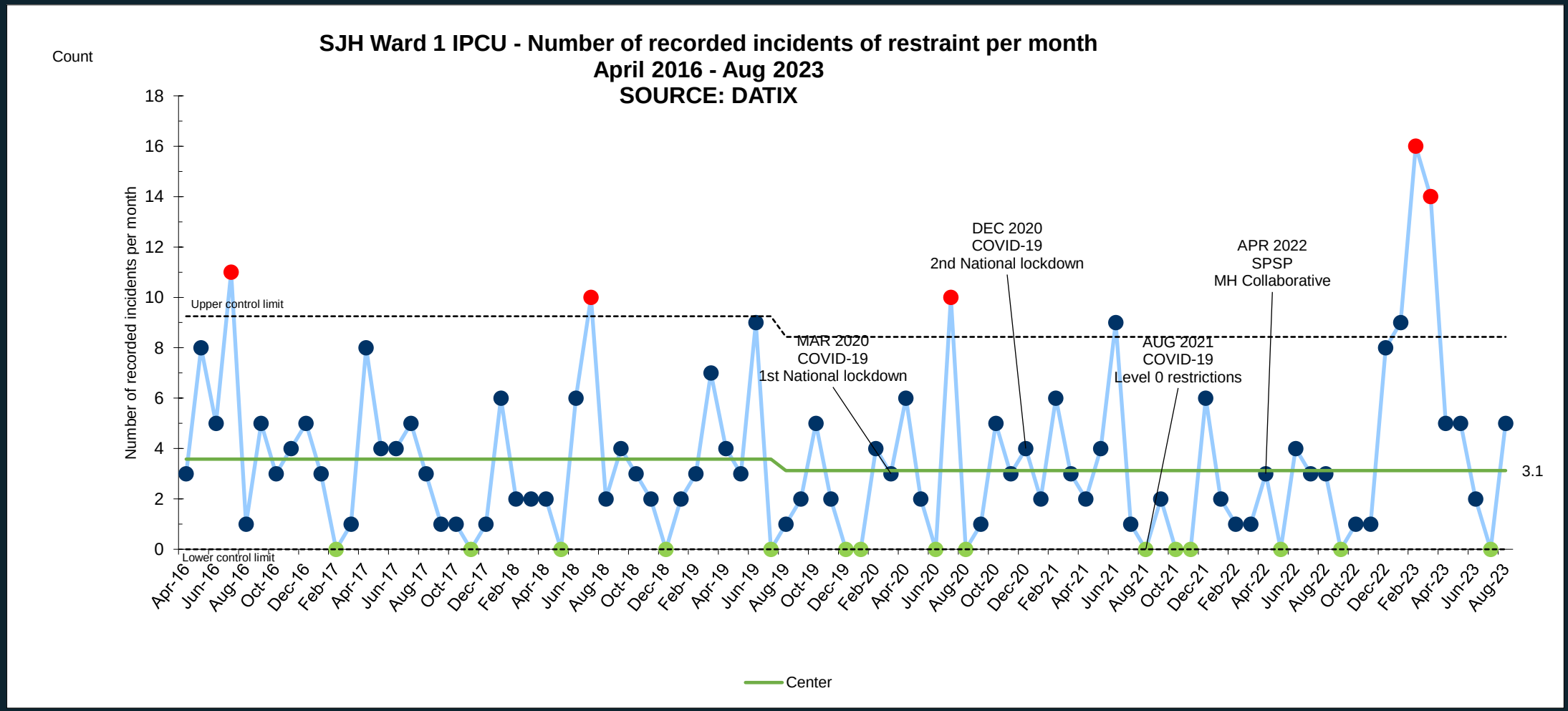
Restraint



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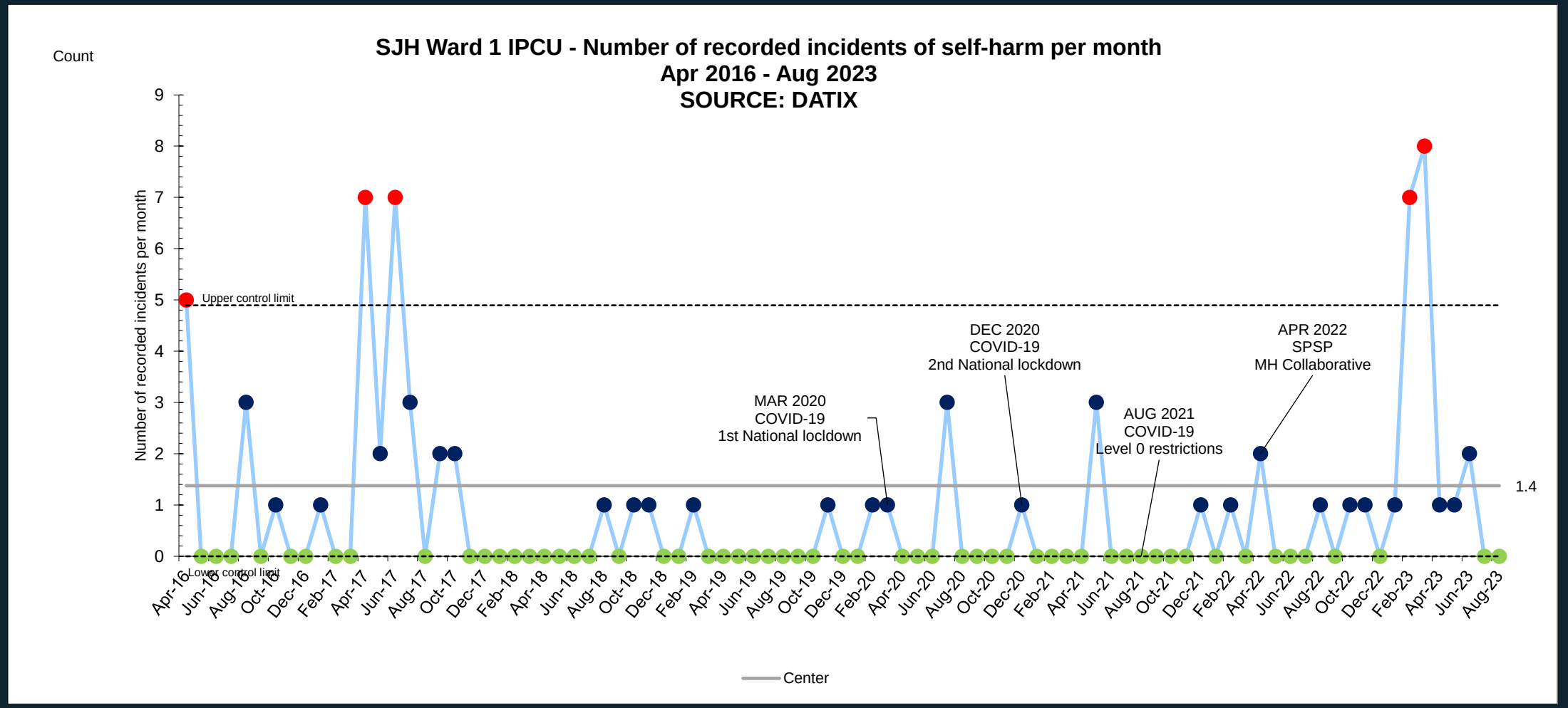
Self-Harm



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Mental Welfare Commission: Unannounced Visit March 2023

- We recognised that some patients were experiencing significant mental ill health issues at the time of our visit however, we felt it was important to gather their views about their care and treatment in Ward 1. We heard from patients that their experiences were positive; they told us "staff are always there if you need them", "staff really care, they are amazing, attentive and active". As visitors to this ward, we witnessed an intensive psychiatric care unit that was calm, and where staff were confident and caring during their interactions with patients.

- It was apparent the clinical team, including nurses and allied health professionals who updated care records, knew their patients very well. With daily detailed accounts for each patient held in their electronic care record, it was easy to identify where there had been steps towards recovery and times where patients had required higher levels of support and outcomes from supportive interventions. In the records, there was a subjective view from patients, a note of interventions that had been helpful and strategies agreed to aid recovery

- We found the approach used in Ward 1, where team formulation, based on a psychological framework, lent itself well to working with patients who by virtue of their early childhood experiences, mental Ill-health and substance use, required staff to be trauma-informed and willing to be flexible to meet the needs of this patient population. We heard from patients that they have felt safe in this environment and secure with staff in the knowledge they were at the centre of the ward's model of care. We were told by patients this was important to them, as they have often felt it difficult to trust professionals, however in Ward 1 they have felt listened too and provided with opportunities to recover from their episode of mental ill health.

Next Steps

1. Level 3 'Trauma-Enhanced' Practice Training: Bespoke training focusing specifically on links between psychological trauma and psychosis and complex mental health problems and risk of re-traumatisation in inpatient settings

2. Formalising recent developments in Staff Support following SAEs into a SOP

3. Understanding and evaluating data: DClinPsychol Thesis or Audits?

4. Further teaching and supervision of psychosocial interventions for MDT colleagues

5. Supporting Implementation of wider service developments: West Lothian AMH EUPD & cPTSD Integrated Care Pathway

NHS
Central and North West London
NHS Foundation Trust

Using the Power Threat Meaning Framework to Inform Team Formulation within Acute Settings

Dr Gina Harwood
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Harrow Crisis Mental Health Services
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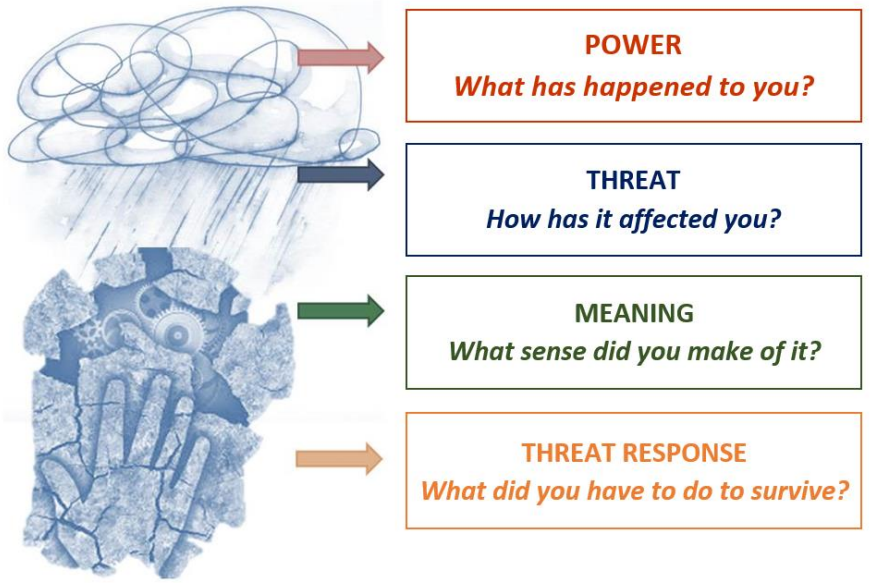
Overview

- Brief TIA and PTMF Introduction
- TIA in CNWL Harrow
- Approach
- Meeting structure
- Stabilisation Manual
- Evaluation

TIA & PTMF

Instead of asking "What is wrong with you?"
Ask "What has happened to you?"

- OUTSIDE IN
- Trauma – broadest context
- Mental health difficulties – trauma response
- Establishing safety – healing trauma
- NHS 10 Year Plan (2019)



TIA in CNWL Harrow

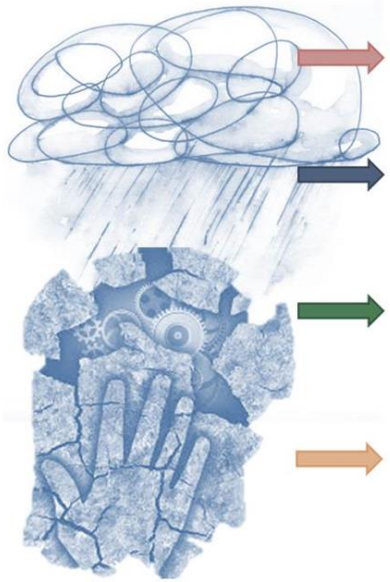
- Shifting culture and practice within the Mental Health Unit at Northwick Park Hospital
- MDT approach

- TIA core practices

1. **PTMF Team Formulation (2018)**
2. Stabilisation Manual (2019)
3. Weekly TIA Training (2019)

Team Formulation Approach

- Fortnightly meeting, one hour
- Open
- Containment of space
- MDT
- Adapted from Johnstone (2013)



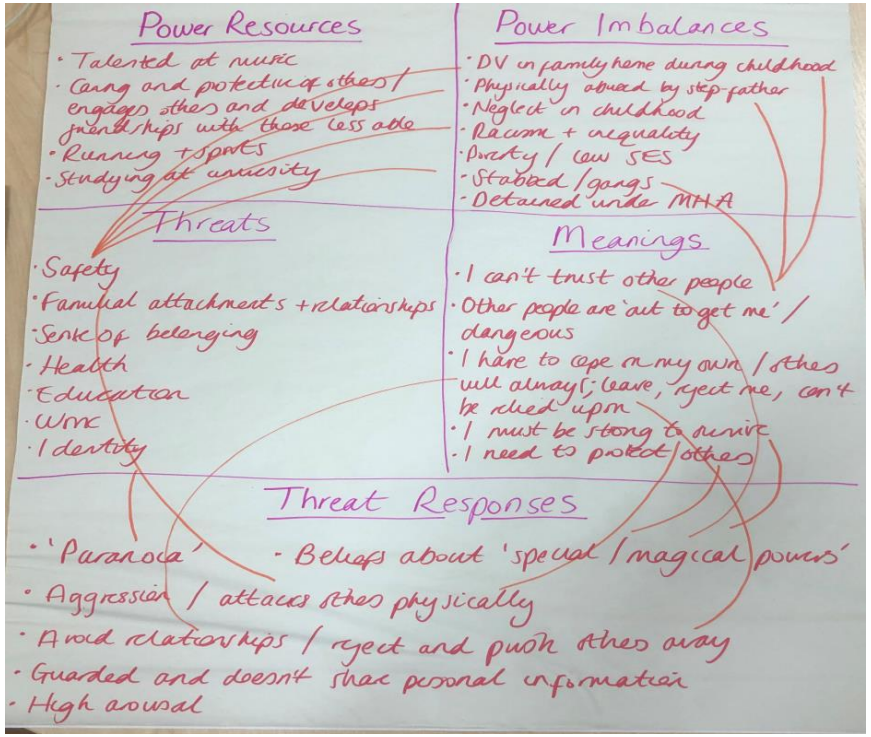
POWER
What has happened to you?

THREAT
How has it affected you?

MEANING
What sense did you make of it?

THREAT RESPONSE
What did you have to do to survive?

Meeting Structure



- Review background
- Feelings
- Stuck/ questions
- **Power resources**
- **Power imbalances**
- **Threats**
- **Meanings**
- **Threat responses**
- Feelings
- Ways forward

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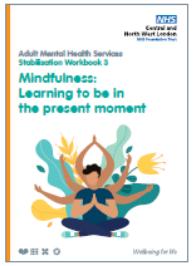
The Stabilisation Manual: Supporting internal safety

Introductory information pack plus 10 stabilisation skills workbooks

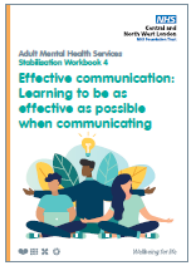
- Self-Compassion
- Soothing & Safety
- Mindfulness
- Effective Communication
- Breathing & Relaxation
- Food & Sleep
- Valued Activity
- Distraction & Distancing
- Grounding
- Maintaining Wellbeing

1. Developing self-compassion

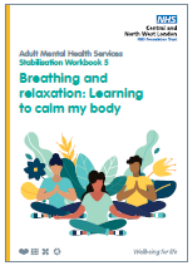
2. Soothing and safety



3. Mindfulness



4. Effective communication

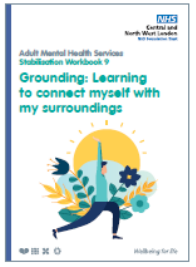


5. Breathing and relaxation

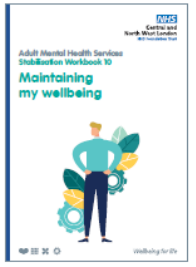
6. Food and sleep

7. Distraction and distancing

8. Valued activity



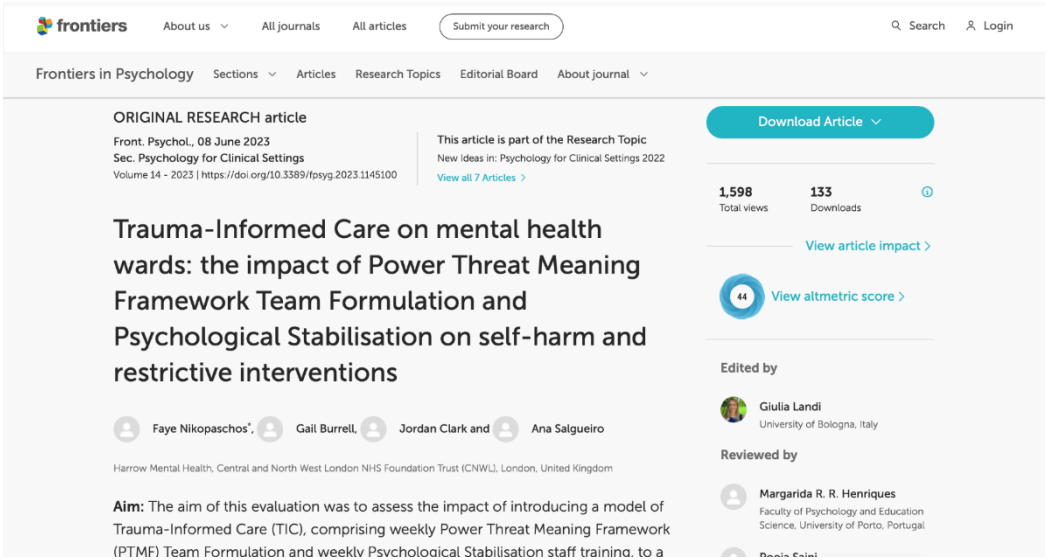
9. Grounding



10. Maintaining my wellbeing

https://www.cnwl.nhs.uk/services/mental-health-services/cnwl-trauma-informed-approaches-tia

Nikopaschos et al. (2023)



Nikopaschos F, Burrell G, Clark J, and Salgueiro A (2023). Trauma-Informed Care on mental health wards: the impact of Power Threat Meaning Framework Team Formulation and Psychological Stabilisation on self-harm and restrictive interventions. Front. Psychol. 14:1145100. doi: 10.3389/fpsyg.2023.1145100

HTT Staff Evaluation

- **What has been the impact of introducing TIA (specifically PTMF-informed Team Formulation and Stabilisation Interventions) for the Harrow Home Treatment Team?**

Theme 1: Understanding

- Empathy

"to make you realise, to remind you that there's always a story behind the presentation." (P.10).

- Improved Relationship

"it's almost a tool that you carry to make that interaction a little bit more personal or a bit more gelled together." (P.12).

- Values

"it kind of reminds you why you're doing what you do. This is why people are coming in to get help." (P.8)

HTT Staff Evaluation

- **What has been the impact of introducing TIA (specifically PTMF-informed Team Formulation and Stabilisation Interventions) for the Harrow Home Treatment Team?**

Theme 3: Systems Change

- Collaborative TI decision making/ care planning

"Regardless of your role and what discipline you're from, the MDT still comes together to this space and reflect and think together." (P.3).

- Team discussions more 'holistic' and psychosocial

"it almost felt like it gave you a new lens on working with our patients." (P.12).

- TIA integrated into standard practice

"we talk to the patients about the formulations as well." (P.6.).

HTT Staff Evaluation

- **What has been the impact of introducing TIA (specifically PTMF-informed Team Formulation and Stabilisation Interventions) for the Harrow Home Treatment Team?**

Theme 5: Hope

- Provides ways forward

"people do feel a little bit helpless or hopeless, I think it give us more tools […], we are formulating which kind of helps us to find a way forward, we don't know if it will work, but we have a way of trying." (P.11).

"I feel that that's where the 'fix' can happen. Especially seeing some of the people who are coming here, who cannot move on." (P.3).

- Patients: confidence in using skills independently – decrease in admissions/presentations

"they might be holding a different perspective as well, or they might come to realise that this is what I was missing." (P.6).

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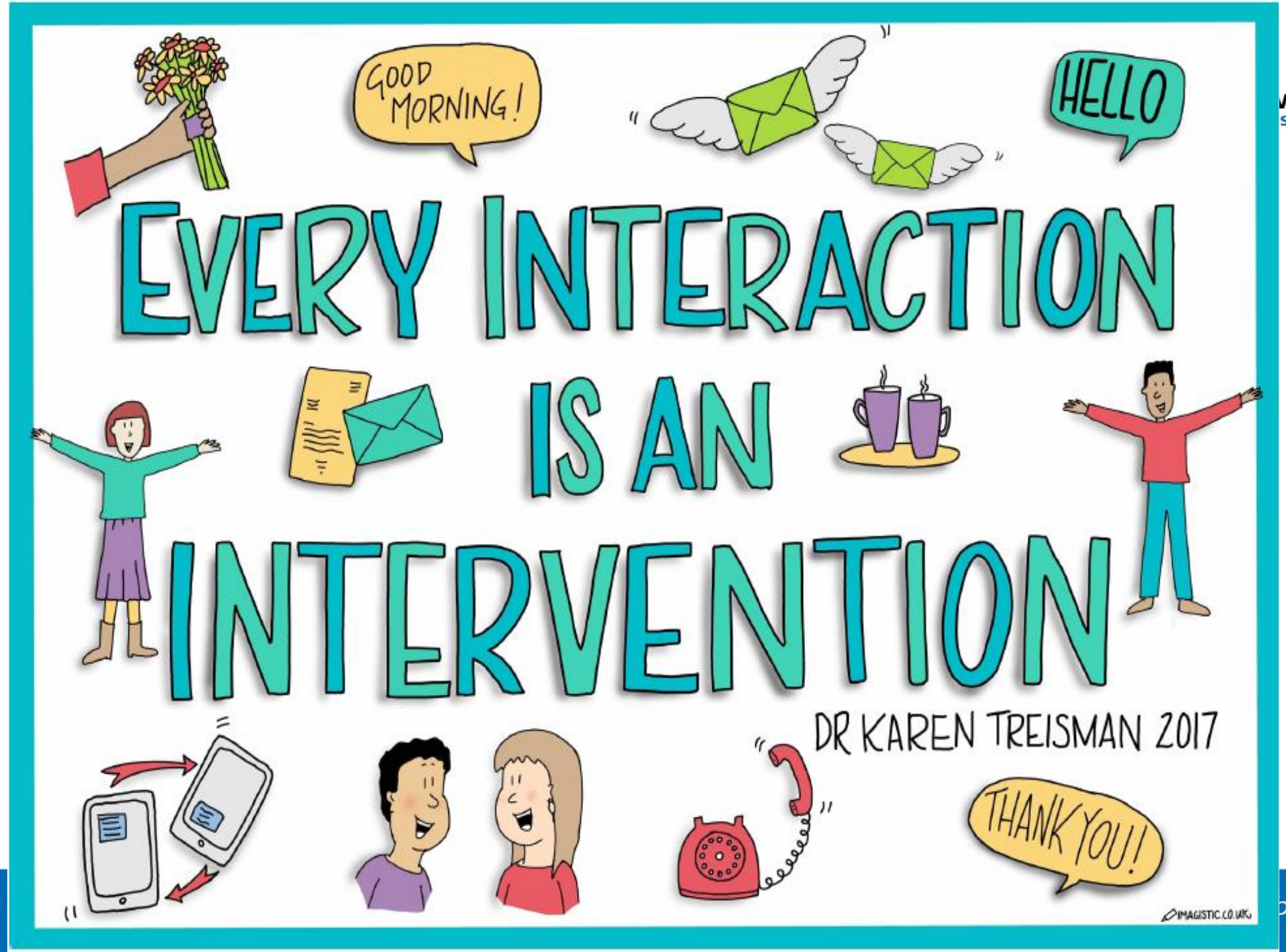
CNWL Harrow Psychology are recruiting!

Contact: fayenikopaschos@nhs.net 07395 283 626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DR KAREN TREISMAN 2017
THANK YOU!
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