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NHS Greater Glasgow and Clyde

# Trauma Informed Practice Training Needs Assessment

## Executive Summary

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# Executive Summary

Rocket Science, in partnership with the University of St Andrews, was commissioned to complete a staff training needs assessment about Trauma Informed Practice for Addictions, Homelessness, and Criminal and Community Justice services across Glasgow City, Inverclyde, East Renfrewshire and West Dunbartonshire, as well as Police Custody and Prison health care across the NHS Greater Glasgow and Clyde board area.

This work comprised of a literature review of best practice, an online staff survey with 264 front line staff, 17 focus groups with 96 front line staff, and 22 interviews with service managers from across the services. This evidence was analysed to produce an assessment of the staff training needs and other actions required to foster Trauma Informed Practice, and an action plan for the organisations to take forward.

## Trauma

Awareness of the prevalence and impact of traumatic experience on health and social care service users has increased over the last decade. Approximately one in four young adults in the UK report an incidence of childhood trauma (Radford et al 2011 cited in Covington 2015a: 1), and a 2016 Glasgow Addiction Service study found that 78% of their service users had experienced some form of trauma (Burns, A, no date). Type 1 or single incident traumatic events are isolated and unexpected, while Type 2 or complex trauma is characterised by traumatic events that occur over a prolonged period (Terr 1991 cited in NES 2017: 24).

Experience of trauma, and particularly complex trauma, can have impacts on mental health, physical health, social inclusion, economic inclusion or employment. Survivors of trauma are more likely to be in contact with health and social care services than the average population. Yet these people might also face difficulties in accessing services or maintaining access with services.

## Trauma Informed Practice

NHS Education Scotland are currently in year two of a three-year project to develop a National Trauma Training Framework. They identify four levels of practitioner skill level when it comes to working with people with trauma experience, Trauma Informed Practice, trauma skilled practice, trauma enhanced practice and trauma specialist practice. Trauma Informed Practice is the NHS Education Scotland expected minimum level for all members of the Scottish Workforce.

To be trauma informed means to use understanding of the role that “violence and victimisation” play in the lives of individuals accessing services to “design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment” (Harris & Fallot 2001: 4). Importantly, ensuring that service delivery is trauma-informed does not

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require disclosure or treatment of trauma (BCCEWH 2009: 4). Broadly, according to NHS Education Scotland, Trauma Informed Practice needs to include:

- Realising that traumatic experiences and their impact are an important consideration
- Recognising the impact of trauma on service users
- Responding to the impact of trauma by adapting their practice to be cognisant of trauma related difficulties (note that this doesn't include treating the trauma)
- Resisting retraumatisation through focusing on safety, choice, empowerment, collaboration and trust (NHS Education Scotland, 2017).

## Our findings

We found that there was a wide recognition by staff that trauma was highly prevalent amongst their service users, that this may affect the way they engage with the service and that interactions with services can be retraumatising.

The majority of staff expressed a willingness to learn more about trauma, Trauma Informed Practice and ways that they could better engage with their service users. Almost all staff we engaged with recognised the importance of being cognisant of trauma in the way they worked.

Staff generally reported a good understanding of trauma and its affects, however we found that there is more to be done in ensuring that this understanding is comprehensive, up to date with current evidence and consistent across all staff.

Generally, staff reported low levels of confidence in being trauma informed, with many worried that they will say or do the wrong thing. We also observed a low level of understanding of what Trauma Informed Practice is and what it isn't. There was often a misunderstanding between Trauma Informed Practice and treating trauma, where practitioners were concerned that they would be asked to treat and address service users' trauma on top of their other work. This was most commonly brought up by staff saying that they had to deal with the crisis (eg housing, addictions or immediate health needs) before they could *deal* with the trauma.

The largest barriers reported by staff, and reinforced in the literature, were:

- A lack of time staff had with service users – often closely linked to the misunderstanding that Trauma Informed Practice means additional activities that will take more time,
- The structure of services which made it hard to be flexible and response to service users' needs

- Cross referrals between services including being able to find appropriate services for service users and barriers with long wait times for services
- The physical service environments including the buildings, waiting areas, scope for privacy, and formality of service spaces.

The literature and our research emphasises the risk of vicarious trauma amongst staff who regularly work with service users who are survivors of trauma. This includes a combination of well-structured support and supervision in services and empowering and enabling staff to engage in self-care.

Generally, Addictions services were more likely to feel like they understood trauma and were currently implementing various elements of Trauma Informed Practice. They were also the most likely to feel well supported and to know where to refer service users for trauma specific interventions. Part of this pattern is likely to be explained by the fact that psychology are integrated across all Greater Glasgow and Clyde Addictions services and therefore clinical psychologists can provide access to information and peer support on trauma and Trauma Informed Practice.

Criminal Justice staff across the four Health and Social Care Partnership areas generally valued the training they had and expressed the highest interest in receiving future training. They were also most likely to feel like there were barriers to their ability to implement Trauma Informed Practice – with the penal nature of the service limiting flexibility in their support and tolerance for service users' behaviour. They generally felt able to make someone feel safe (one of the first elements of Trauma Informed Practice) but felt less sure about where to send someone who needed a trauma specific intervention. They also reported lower levels of adequate support and supervision and felt limited in their ability to engage in self-care. Community Justice understanding around trauma and the implementation of Trauma Informed Practice was somewhat lower than Criminal and Community Justice services.

Housing and Homelessness services in the four Health and Social Care Partnership areas were the least likely to have received training in the past. They were also the most likely to report that time with clients was a barrier for them to be able to do more – as their engagements with service users were usually one-off short interactions very focused on addressing immediate housing crises. Residential Homelessness services felt better able to implement Trauma Informed Practice and reported that they had more time with their residents. Generally Non-residential Homelessness services were more hesitant about the importance of Trauma Informed Practice as part of their job and were worried about their ability to do this. This appears to be largely driven by a misunderstanding that Trauma Informed Practice requires them to *'deal'* with the trauma and do *'more'* work and activities rather than adapt their approach. Once practical examples of Trauma Informed Practice were discussed with staff through our focus groups, staff expressed a more positive view about the usefulness of Trauma Informed Practice and their ability to do some of these in their practice.

Police Custody and Prison Healthcare reported high levels of interest in Trauma Informed Practice and all recognised the importance of being cognisant of trauma in their practice. They also highlighted that service users are at a high risk of retraumatisation through the custody and incarceration processes. They generally felt restricted in their ability to be trauma informed by the processes in place within their host services. Police Custody Healthcare staff also reported feeling restricted by the time they had with the service user.

Service managers across all of the services generally had received training in the past that had some element of trauma covered. Many also noted that they have picked up knowledge through their work and the groups and meetings they participated in. They recognised that as managers they have a role to play in setting the agenda and supporting its implementation. While managers recognised that heavy caseloads can create pressures on frontline workers, it was expressed that workers should be able to understand trauma and adapt their practice regardless of the time they have with clients.

## Our recommendations and action plan

There are three elements to making a service trauma informed.

- The **physical environment** needs to be focused on reducing retraumatisation and removing barriers for people engaging with the service.
- How **staff behave and respond** to service users is an important element and the focus of this training needs assessment.
- How the **service is designed** has a large impact on the extent to which it can be trauma informed. This includes service criteria and eligibility, the paperwork required, waiting processes, the availability of female staff, and the degree to which there is flexibility around the services processes.

There is a high degree of enthusiasm to do more about trauma from service staff. We consider that the services are in a good place to build off their understanding and buy in. However, there is a risk that this buy in will reduce if staff cannot see progress occurring against all three elements of Trauma Informed Practice (physical environment, staff behaviours and service design). We recommend that the Health and Social Care Partnerships and Prison and Police Custody Health Care Services openly consider how to improve the physical environments and service design and discuss this with all staff.

There are four drivers of staff behaviour

- Gaining buy in to the importance and relevance of Trauma Informed Practice amongst staff
- Ensuring that staff have the required knowledge
- Building staff confidence to use their skills

- Providing realistic actions for staff that are possible within service constraints.

We recommend that service managers are trained first – including all those with staff supervisory responsibility. This training should include understanding Trauma Informed Practice and breaking down myths such as low security service environments being higher risk for staff or clients. Managers and supervisors should be encouraged to see the benefit of Trauma Informed Practice – it is important that they see this as intrinsically important to their service and not a 'nice to have add in'. Knowledge around the practical ways to do Trauma Informed Practice and what it should look like in their service should be developed including areas they will need to action – such as the physical environment and service design. In addition, training should facilitate their exploration of service delivery and governance implications for implementing Trauma Informed Practice in their service.

The primary objective of this training should be to ensure that managers develop their commitment to Trauma Informed Practice and begin to identify practical changes to be made that will facilitate the implementation of Trauma Informed Practice. For this reason, we recommend that part of this training be in the form of a workshop where the various layers of service mangers for each service are able to discuss and plan how to implement Trauma Informed Practice in their service.

Following this, we recommend that frontline staff receive training in:

- Awareness and understanding about trauma
- Managing conversations and disclosures
- Identifying triggers and avoiding traumatisation
- Body language and effective communication
- Referral processes – when and where to refer
- Effects of trauma on practitioners and vicarious trauma
- Recognising and understanding trauma related behaviours
- Managing crises in a trauma informed way
- Making clients feel safe
- Self-care.

Consideration should be given to whether specific training is provided for staff with supervisory responsibilities following the manager training. This training would focus on how to provide appropriate support and supervision for staff. Insight from the manager training will be needed to develop the content for this.