NHS Greater Glasgow and Clyde

Trauma Informed Practice Training Needs Assessment

Final report and supporting action plan
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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 frontline staff, 17 focus groups with 96 frontline 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 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 managers 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.
Chapter 1 Introduction and Context

In 2017, Rocket Science in partnership with the University of St Andrews was commissioned to complete a Trauma Informed Practice training needs assessment on a range of services in the West of Scotland. The Glasgow City, East Renfrewshire, Inverclyde and West Dunbartonshire Health and Social Care Partnerships along with Prison and Police Custody Healthcare came together to jointly commission this work. This training needs assessment includes:

- Glasgow City Criminal and Community Justice, Homelessness, and Addictions Services
- Inverclyde Criminal and Community Justice, Homelessness, and Addictions Services
- East Renfrewshire Criminal and Community Justice, Homelessness, and Addictions Services
- West Dunbartonshire Criminal and Community Justice and Homelessness Services
- Prison and Police Custody Health Care Services across the NHS Greater Glasgow and Clyde area.

1.1 Our Review

The purpose of our review was to:

- Assess the extent to which staff understood trauma, the impacts that it can have, and Trauma Informed Practice
- Assess the extent to which staff were currently implementing Trauma Informed Practice
- Identify the gaps in current staff skills for Trauma Informed Practice
- Recommend who needs to be trained, when and in what in order to support the implementation of Trauma Informed Practice across the services
- Identify other activities and changes to support the implementation and remove the barriers of Trauma Informed Practice.

Between August 2017 and June 2018, we have:

- Completed a literature review of Trauma Informed Practice (see Chapter 2 for evidence)
- Conducted an online survey of all frontline staff – completed by 264 staff (see Chapter 3 for survey findings)
- Conducted 17 focus groups with frontline staff – 96 staff participated in a focus group (see Chapter 4 for focus group findings)
- Conducted 22 interviews with service managers across the service (see Chapter 5 for key messages from service managers interviews).
This report contains our findings and a recommended action plan for who to train, when and in what, as well as other action required to implement Trauma Informed Practice.

2.2 The context

Individual trauma results from “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening” (SAMHSA 2014: 7). 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). Traumatic events can include witnessing or directly experiencing emotional, physical or sexual abuse, torture, war or life-threatening illness (NES 2017: 20).

There is a substantially increased likelihood that Type II trauma may lead to PTSD and more serious psychological problems and consequently behavioural outcomes such as homelessness, addiction, and involvement with the Criminal Justice system. It is also more likely that Type II trauma experiences are not only of one form but are combined. The Sanctuary Model proposes that:

“A traumatic experience impacts the entire person – the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world...”

Experience of trauma is thought to be highly prevalent amongst adults across the UK, for example:

- Approximately one in four young adults in the UK report that they have experienced “severe maltreatment in childhood” (Radford et al 2011 cited in Covington 2015a: 1)
- In 2016-17 there were 58,810 incidents of domestic abuse recorded by the police in Scotland (Scottish Government 2017b: 1)
- Childhood sexual abuse is under-reported, but prevalence studies show a range of rates of 7-30% of girls and 3-13% of boys (Henderson, S. and Cosgrove, K. 2009: 3).
- A study in England found that almost 50% of people had suffered at least one form of Adverse Childhood Experience and over 8% reported experiencing 4 or more. It is believed that the prevalence could be even higher in Scotland given higher levels of morbidity and mortality (Couper, P and Mackie, P. 2016).
- A review conducted in 2016 with Glasgow Addiction Services found that “67% (n=37) attended one or more type of trauma training...Mean prevalence rate for trauma in current caseloads was 73% (SD=22.6), and for overall experience was 78% (SD=18.4)...Participants felt that trauma was a contributory factor in 69% (SD=24.3) of cases” (Burns, A, no date). This review also found that the most effective approaches were “Empowerment, Enhancing Self-Esteem and Communication Skills” (Burns, A, no date).

There are clear and demonstrable links between trauma and mental health difficulties. There is also widespread agreement in the psychological and applied services literature that a

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1 Sandra Bloom, M.D.
2 This includes abuse, neglect, parental substance misuse, parental separation or incarceration, parental mental illness and living in care.
recognition of the importance of trauma-focused therapeutic models are an important aspect of service delivery.

Recognition of the incidence and impact of trauma on the lives and health outcomes of individuals has grown in Scotland over the past five years. More broadly, “a diverse and rapidly growing research base is leading to new understanding of trauma” with “major implications for service provision” (Kezelman & Stavropoulos 2012). It is increasingly understood that those who have experience of trauma may face barriers to accessing health and social care services and can risk being re-traumatised if service delivery is not appropriately trauma-informed.

Trauma in childhood is associated with health-harming behaviours and with the social determinants of ill-health. A Welsh study found that people with 4 or more experiences of adversity and abuse in childhood were 4 times more likely to be high risk drinkers; 6 times more likely to smoke; and 20 times more likely to be incarcerated, for example (Public Health Wales cited in NHS Education Scotland, 2018). Trauma experience can have impacts on mental health, physical health, social inclusion, economic inclusion or employment.

The many possible impacts of trauma mean that 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. Issues may include ‘difficulties with trusting staff, difficulties with procedures that involve touch, not feeling understood by services and frequent disengagement for instance difficulties attending appointments.’ (NHS Education Scotland, 2018)

Appropriate training of staff is therefore crucial to ensure that health and social care services, such as Homelessness services or Employability services, can respond adequately to trauma. The Scottish Government identified in its 2012 – 2015 Mental Health Strategy: “While there is a growing recognition of the significance of trauma, clinicians and others may be reluctant to engage with it because of the concern of causing further harm, or of not being able to offer an appropriate response which meets the needs of the person. We need to address that deficit and improve the general service response to trauma.” (Scottish Government, 2012)

The Scottish Government (2017a) has pledged its commitment to supporting those affected by trauma and has supported the launch of NHS Education for Scotland’s (NES) National Trauma Training Framework. Minister for Mental Health, Maureen Watt stated that trauma is a “public health issue and how we deal with it and respond to those affected is everyone’s business – we all have a part to play” (Scottish Government 2017a). This notion of encouraging workers to adopt trauma-informed practices across services underpins the current approach to trauma training in Scotland. This project forms part of the Scottish Government Survivor Scotland Strategic Outcomes and Priorities 2015 – 2017.

The development of this framework is occurring between 2016 and 2019. During the first year they developed a strategic framework. During year two they developed the National Strategy and Training Plan, due to be published Autumn 2018. Between now and early 2019, NHS Education Scotland are working on the delivery of the training plan and its evaluation. The strategic framework includes the multiple facets of trauma, outlined in Figure 1.
Trauma Informed Practice Training Needs Assessment

Figure 1 NHS Education Scotland Definition of Trauma. [Source NHS Education Scotland]

The framework breaks down the various trauma skill levels into four stages:

- **Trauma Informed Practice** is the “knowledge and skills required for all members of the Scottish Workforce”

- **Trauma skilled practice** is required for “workers with direct and frequent contact with people who may be affected by trauma”

- **Trauma enhanced practice** is required for “staff with regular and intense contact with people affected by trauma and who have a specific remit to respond by providing support, advocacy or specific psychological interventions to protocol and/or staff with responsibility for directly managing care and/or services for those affected by trauma”

- **Trauma specialist practice** is for “staff who have a remit to provide evidence-based interventions and treatment for those affected by trauma with complex needs” (NHS Education Scotland, 2017).

The focus of this piece of work is limited to the first tier, Trauma Informed Practice.
Chapter 2 Literature Review

This chapter explores the literature around trauma, and Trauma Informed Practice.

2.1 Impact of trauma on behaviours and health outcomes

An individual’s experience of trauma can impact on their health outcomes, while barriers to accessing health and social care can remain high for several reasons. Compared with people with no Childhood Adverse Experiences (ACEs), those with four or more ACEs are two times more likely to currently binge drink and have a poor diet, six time more likely to have had or caused an unplanned teenage pregnancy and eleven times more likely to have used heroin or crack or been incarcerated (CPH 2014: 2). Childhood trauma exposure is linked to both negative mental health outcomes (including depression and anxiety) and physical health outcomes (including diabetes, heart disease and cancer) (D’Andrea 2011: 379). Evidence which links cardiovascular disease and exposure to psychological trauma is “particularly strong” and has been found “consistently across different populations and stressor events” (Boscarino 2004). Considering these potential health issues, taking steps to enable wide access to health and social care services is vital.

While certain mental health conditions are associated with experience of trauma, these conditions can be harder to treat amongst this group and the effect of trauma on their health can be long-lasting. A meta-analysis on the treatment of depression has demonstrated that childhood maltreatment was related to reduced response or remission during treatment for depression (Nanni, Uher & Danese 2012). The impact of trauma on health outcomes can be lifelong, for example in 2004 it was determined that Vietnam veterans’ chronic PTSD was associated with autoimmune diseases such as rheumatoid arthritis, psoriasis and thyroid disease (Boscarino 2004). Thus, trauma-informed practice considers the often lasting impact of trauma on individuals’ lives.

Barriers to accessing health and social care services can exist for those with experience of trauma in several ways. The use of services has the potential to be re-traumatising for a person who has experienced trauma and elements of clinical settings can act as triggers. Retraumatisation can occur when a “situation, interaction or environmental factor replicates events or dynamics of prior traumas and evokes feelings and reactions associated with the original traumatic experiences” (National Centre on Domestic Violence, Trauma and Mental Health 2015: 1). Triggers are reminders of trauma and often evoke the same “emotional and physiological responses” associated with the original event (Sweeney et al. 2016: 176). Those with experience of trauma can avoid health and social care settings if these are anticipated either consciously or subconsciously to be potentially retraumatising.

Experience of trauma can impact on a person’s willingness or ability to form trusting relationships, and a lack of trust has implications for seeking out often much needed support in health and social care settings. In other words, while those with experience of trauma may be “amongst those most likely to need to engage in effective relationships” to access care and support, “the impact of trauma on relationships means that they may be the least likely to seek or receive this help and support” (NES 2017: 12). What is more, the coping responses that a person may develop to manage trauma can create additional barriers to accessing services. For example, the links between trauma and addiction are “very strong” (Bonner 2017), and trauma is both a “cause and consequence of homelessness” (HCH Clinicians’ Network 1999: 1). Ultimately, if barriers to accessing care are reduced or removed through the implementation of Trauma
Informed Practice, this will result in improved health and social outcomes for those with experience of trauma.

Several behaviours are associated with experience of trauma. When a person affected by trauma experiences psychological and physical distress this can cause the following emotional and/or physical responses (Covington 2015b: 39):

- Retreat - including isolation, dissociation, depression, anxiety
- Harmful behaviour to self - including substance use disorders, eating disorders, deliberate self-harm, suicidal actions
- Harmful behaviour to others – including aggression, violence, rages, threats
- Physical health issues – lung disease, heart disease, autoimmune disorders, obesity.

*Covington 2015b: 39*

The NHS Education Scotland framework looks at the link between trauma and health and social care outcomes. It uses the diagram in Figure 2 to demonstrate these links.

*Figure 2 The links between trauma and health and social care outcomes [Source NHS Education Scotland]*

To provide trauma-informed services, practitioners must have awareness about the above behaviours and be confident in adapting their practice accordingly.

2.2 Trauma Informed Practice

Trauma Informed Practice (TIP) is distinguishable from trauma skilled, trauma enhanced or trauma specialist practice which all go further in assisting a person to process trauma and proactively move forward in their lives. 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 require disclosure or treatment of trauma (BCCEWH 2009: 4).

Rather than treat the symptoms associated with trauma, trauma informed organisations provide services that are “welcoming and appropriate to the special needs of trauma survivors” (Harris & Fallot 2001: 5). In Scotland, it has been recognised that practitioners with access to those affected by trauma across all workplaces should be equipped to adopt a trauma-informed approach. Core elements of TIP include (Kazelman & Stavropoulos 2012: 12):

- Safety: Ensuring physical and emotional safety
- Trustworthiness: Maximise trustworthiness through task clarity, consistency and interpersonal boundaries
- Choice: Maximise consumer choice and control
- Collaboration: Maximise collaboration and sharing of power
- Empowerment: Prioritise empowerment and skill-building

Kazelman & Stavropoulos 2012: 12

As part of their research, NHS Education Scotland spoke with survivors of trauma to understand what was important for them when thinking about the services they engage with. These features are outlined in Figure 3.

Figure 3 Key features important for trauma survivors in the services they engage with [Source: NHS Education Scotland]

The steps that should be taken to guarantee the above elements of TIP can vary from setting to setting. For example, in domestic abuse refuges creating safe environments could mean ensuring that refuge addresses and telephone numbers are confidential, and rules are established around
the use of alcohol and drugs or visitors to protect the safety of residents (Women’s Aid 2018). In clinical settings, choice and empowerment could be enabled through informing patients about various treatment options and allowing them to make decisions about which options they prefer (Menschner & Maul 2016: 3).

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 in service users
- Responding to the impact of trauma by adapting practice to be cognisant of the 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).

Despite these differences in practice, a joined-up approach between services can result from training which provides all workers with shared understanding and skills in various areas of trauma. Workers should understand that trauma is widespread and be able to identify the kinds of scenarios which can bring back “memories of the trauma and associated feelings” (NES 2017: 30). They should have knowledge around the ways in which trauma can have an impact on an individual’s life and be able to listen, be empathetic and enquire about the help a person may need at that time (NES 2017: 32). In addition, they should appreciate the circumstances in which a person is at risk of re-traumatisation and routinely apply “the principles of trauma-informed practice to their work” (NES 2017: 33-4).

Overall, trauma-informed practitioners should feel confident that they are not reinforcing barriers to accessing care for the high proportion of their clients who will have had experience of trauma in their lives. The implementation of TIP across services enables practitioners to feel confident that their clients will not be at risk of re-traumatisation if referred on to another service and collaboration between services can ensure that clients receive appropriate holistic support.

2.3 Self-care, supervision and staff burnout

Beyond ensuring improved health outcomes for individuals with experience of trauma, a core element of TIP involves practitioners knowing how to engage in self-care and seek out relevant support for themselves. This helps to reduce the incidence of staff burnout from vicarious trauma and can reduce costs associated with organisations having to cope with staff turnover, recruitment and the training of new workers.

Vicarious trauma is “process of change resulting from empathetic engagement with trauma survivors” and can include feelings of rage and sadness, loss of hope and experiences of “bystander guilt” (BMA 2015). Many workers in health and social care settings are at risk of vicarious trauma and burnout due to the high prevalence of trauma amongst their care group. Examining job satisfaction and burnout in community Mental Health teams in the UK, Onyett has shown that many studies report high levels of “emotional exhaustion” with lack of resources and workload pressures remaining a source of concern among staff (2011). To address this, the following appear to be “protective factors”: effective team working, good leadership and management, and support and supervision (Onyett 2011).
Growing numbers of social care organisations are recognising the importance of becoming trauma-informed to tackle staff burnout and this can involve reviewing their “supervisory, management and leadership practices to incorporate an awareness of how trauma impacts practitioners” (Shemmings 2017). The culture of an organisation is seen to be important in making sure that staff feel supported, including cultivating an atmosphere where client-related emotions are not left “unprocessed and unregulated” (Shemmings 2017).

Problems in staff retention can have a significant impact on the quality of provided services and the health and social outcomes of clients. Since new practitioners learn through “interaction and peer support”, the loss of experienced workers can reduce the quality of the “community of practice” for those starting out in the profession (Bowyer & Roe 2015: 3). Considering that trauma experience frequently impacts an individual’s willingness and ability to develop trusting relationships, if relationships with practitioners are developed over time, staff continuity is important. Therefore, it can be problematic if continuity of relationships for service-users is “compromised by high staff turnover” as this “instability cuts through the core of relationship-based practice” (Bowyer & Roe 2015: 3).

Furthermore, ensuring positive staff health and wellbeing is seen to be of particular importance during periods of limited funding. In a discussion of NHS workers’ health and wellbeing, The Royal College of Physicians has stated “far from being a discretionary luxury at a time of unprecedented financial and clinical pressures, investment in staff health is more crucial than ever to enable value-for-money, sustainable services and high-quality patient care” (2015: 7). Thus, taking steps to promote self-care can ensure both higher quality care and greater cost efficiency.

Public Health England and Leeds Beckett University have reviewed evidence on how to prevent burnout in individuals within organisations (Bagnall et al. 2016). Burnout is related to workload and time pressure, role conflict and role ambiguity, lack of social support and lack of feedback (Bagnall et al. 2016: 4). Working with clients who have experience of trauma can intensify pressures on staff. To tackle burnout combining individual and organisational level approaches involves a “system change that adopts a participatory environment, promotes open communication, manager and peer support, a culture of learning and successful participation of employees in planning and implementation of programmes” (Bagnall et al. 2016: 5).

Hospice UK has developed a framework, drawing on a wide range of evidence, with suggestions to enable staff to provide high quality care whilst being supported in the workplace (2015). It recommends steps such as collecting and using information to monitor staff wellbeing and stress through methods such as regular surveys and informal feedback (2015: 8). Supervision arrangements should be established, and spaces should be created to allow staff to reflect on challenges (2015: 8). Line managers should be trained in people-management and equipped to identify and assess risks from work related stressors (2015: 9). Appropriate support should be offered for distressed and burnt-out individuals and rehabilitation should be provided for people returning to work after absence (2015: 9). This framework can be utilised in health and social care settings to monitor and address workplace stress and vicarious trauma associated with caring for those affected by trauma.
2.4 Current barriers to Trauma Informed Practice

While trauma-informed practice is increasingly recognised as being linked to improved health and social care outcomes for individuals, several barriers to this approach can exist across services.

Traditional separation of related services

Trauma Informed Practice often involves assisting a person to receive rounded support and enabling them to access a variety of services. For this reason, the integration of e.g. Mental Health, Substance Misuse, Homelessness and Housing, and Physical Health services can be beneficial. Blakey and Bowers examine the barriers to providing integrated treatment of substance abuse and trauma and find that “one obvious barrier has been the historical separation between substance abuse treatment and mental health systems” (2014: 252). Turning Point refers to the combination of mental health issues and drug and alcohol misuse as a “dual dilemma” (2016: 1). It recommends that Mental Health and Substance Misuse services should “communicate and share information so individuals get the support they need, when and where they need it” (Turning Point 2016: 7). In addition, Mental Health staff should receive drug and alcohol awareness training and vice versa to “gain confidence in how to refer and how to work together to provide multi-agency support” (Turning Point 2016: 7). If related services can work together to tailor support to individuals this will lead to improved health and social care outcomes for those with experience of trauma.

Fostering an organisational culture of trauma-informed practice

Services must have leadership which supports the implementation of trauma-informed practice and there must be an organisational culture of trauma-awareness, adaptability and practitioner-self-care. The absence of this can be a barrier to trauma-informed practice. Leadership should support and be fully committed to principles of trauma-informed practice such as client safety and choice (Carter et al. 2017: 1). Service leaders should “champion” the transformation of the service and allocate appropriate “resources, including people, time, money and technology” to ensure trauma-informed practice is implemented (Carter et al. 2017: 2). Fallot and Harris have provided a series of suggested steps for the achievement of cultural change towards Trauma Informed Practice (2009: 3-4):

1. **Initial planning** of organisational trauma-informed change including the formation of a trauma initiative workgroup to “lead and oversee the change process” and the identification of “trauma champions” to “keep the initiative alive and on the front burner”

2. **A kick-off training event** attended by “as many of the staff as practical”, which includes presentations on the central ideas of trauma-informed cultures, the importance of staff support and care, and the importance of trauma in the work of the specific organisation or service

3. **Follow up** involving reviewing progress to date and ensuring that momentum is maintained until the “culture change is thoroughgoing”

Fallot & Harris 2009: 3-4
Barriers to relationship-building between practitioners and those who have experience of trauma

Core elements of trauma-informed practice include helping clients to feel emotionally safe and maximising trustworthiness within client-practitioner relationships. This necessarily involves the development of trusting and stable contact with a client over time. However, heavy caseloads can limit the amount of time that practitioners have in which to work with an individual who has experience of trauma. To be trauma-informed, services should “prioritise building trusting, mutual relationships between staff and survivors”, and therefore the practice of time-limited contact can be re-evaluated considering the impact of this on service delivery (Sweeney et al. 2016: 179). Longer or more frequent interactions with clients can help to build trust and break down barriers to accessing health and social care.

In addition, barriers to communication about trauma can persist. Shannon et al. have explored refugees’ perspectives regarding the nature of communication barriers that “impede the exploration of trauma histories” (2012: 47). They found that two-thirds of refugee patients reported that they never shared how they were affected by political conflict with their doctors and that their doctors never asked them about it (2012: 47). Barriers to talking about war trauma with a doctor included that they were not asked about it and felt it would only be appropriate to discuss war trauma if a doctor initiated the conversation, that they did not consider the impact of war on them as a health-related issue or as a relevant topic for clinic visits, and that they did not want to “raise bad memories” (2012: 51). These challenges should be considered, and practice should be adapted to ensure trauma-informed services are successfully delivered.

2.5 Leading trauma informed services

Research to date has sought to illuminate the best ways to implement Trauma Informed Practice in health and social care settings. With a focus on Homelessness services, it has been recommended (Hopper et al. 2010: 93-94).

On a practice level:

- There should be consistency in trauma-informed service implementation across sites
- Services should seek to avoid any practices that may be retraumatising
- Substance Abuse, Mental Health and Trauma services should be integrated
- **Trauma-specific services** should be made available for those who wish to receive targeted treatment
- Programmes should encourage consumers to be involved in activities such as goal-setting and programme design, evaluation and refinement. This will help to build feelings of empowerment amongst clients
On a programme level:

- “Buy-in” should be obtained at multiple levels of the service
- A needs assessment should be conducted to identify areas for change
- Training on trauma should be provided
- Trauma-based consultation and supervision should be offered

_Hopper et al. 2010: 93-94_

The following are examples of organisations or services where trauma-informed practice has been successfully implemented:

**Tomorrow’s Women Glasgow**

Tomorrow’s Women was developed following the Commission on Women Offenders in 2012. The Commission recommended that Women’s Justice Centres should be established, and Tomorrow’s Women was set up as a “one-stop shop” to meet the “complex needs of high risk female offenders” (McKechnie 2016: 23). The design of the service was informed by an approach that recognises the prevalence of trauma exposure and vulnerability to trauma amongst clients, and therefore establishes practice that is “non-judgemental, compassionate and accepting” (McKechnie 2016: 23). Elements of TIP which are implemented in the service include light and airy rooms, welcoming staff, allocation of a key worker who completes a care plan with each woman, prioritisation of staff support and training, and where relevant, provision of referrals for assessment and treatment of mental health problems (McKechnie 2016: 23-24). Outcomes from engagement with Tomorrow’s Women include reduced reoffending, court appearances, A&E attendances and drug and alcohol use (NHS Health Scotland 2017: 6). The rollout of trauma-informed practice in the service provides a model of best-practice for related services in Greater Glasgow and Clyde.

**Survive & Thrive in Scottish Prisons**

Survive and Thrive is a course for survivors of complex trauma. It became an approved intervention in March 2014 and since then has been run successfully in HMP YOI Corton Vale, HMP Greenock and HMP Edinburgh (One Small Thing 2017). Survive and Thrive is a phase one trauma intervention in that it focuses on safety and stabilisation (NES 2018). The course offers those in prison the opportunity to learn about effective strategies to cope with the effects of trauma and abuse (NES 2018). The course is based on evidence which shows that core challenges facing survivors are difficulties with “emotional regulation and interpersonal difficulties” (NES 2018). While evidence supporting the intervention for use with female prisoners has been established, work addressing the needs of male prisoners is currently in progress (NES 2018). The course has been adapted for use across different settings with different client groups.
Willow Service, Edinburgh

Willow Service is a partnership between NHS Lothian, City of Edinburgh Council and Sacro to address the “social, health and welfare needs of women in the Criminal Justice system” (NHS Lothian 2015). Work in Willow is trauma-informed, and services are designed to make sure that women feel “safe and empowered” (McStay 2015: 4). Support includes mental health support, psychological therapies and trauma interventions (City of Edinburgh Council 2018). In 2015, Willow won the COSLA Gold Award for its work in tackling inequalities and improving health (COSLA 2017).

A multi-disciplinary team offers women holistic support. The core Willow team includes Criminal Justice Social Workers, Support Workers, Nurses, Psychologists and an Occupational Therapist, however services are managed by one person to ensure their integrated delivery (COSLA 2017). Women receive a multi-agency assessment and individualised plan, including one-to-one key work and group work (McStay 2015: 4). The service aims to reduce reoffending by providing tailored support to women in the area.

My Body Back Project

My Body Back provides specialist services such as a cervical screening clinic and maternity clinic for women who have experienced sexual violence (My Body Back 2018a). The clinics work with women to ensure that they feel safe and relaxed. The clinics were started in “direct response to requests from women” and give women a space in which they feel “in control” and that “their needs are met” (My Body Back 2018b). The London-based project opened “Scotland’s first clinic for victims of sexual violence” at Sandyford in Glasgow at the end of February 2018 (Glasgow City HSCP 2018). The clinic at Sandyford recognises the barriers that survivors of sexual violence can face when accessing services. Understanding clients’ trauma and adapting services to break down barriers to access ensures that the clinics are trauma-informed.

2.6 Specialised services for men and women

One Small Thing has been a leading organisation in the push for trauma-informed services for women in the Criminal Justice system. Edwina Grosvenor, the founder of One Small Thing has described the focus on women as being due to three main reasons (Grosvenor 2018):

1. There are smaller numbers of female prisoners, so it is a “manageable challenge to get the female estate to embrace the concept of becoming trauma-informed”. Success in the delivery of trauma-informed services for women could productively lead to changes in services for men

2. “Women’s experience of trauma is distinctive” in that they are more likely to “suffer at the hands of the person they love” rather than a stranger

3. Women have historically been a “secondary consideration in the prison system”.

Grosvenor 2018
The focus on providing trauma-informed services for women acknowledges the types of trauma that women most often face and the impact that these types of trauma can have. While in recent years there has been a focus on increasing the availability of trauma-informed services for women, there is now growing interest in ensuring services for men are appropriately trauma-informed (Covington 2017: 3).

It has been argued that there are gender differences in trauma exposure, trauma symptoms and responsiveness to treatment (Cosden et al. 2016). The “co-occurrence” of substance misuse and trauma is apparent in both men and women who are in substance misuse treatment (Danielson et al. 2009 cited in Cosden et al. 2016). In childhood, girls and boys are at equal risk of abuse from family members and people they know; in adolescence young men are at risk from people who dislike them and are at greater risk if they are gay, young men of colour or gang members, while young women are at risk from lovers or partners; and in adulthood men are at risk from combat or being victims of crime, while women are at risk from those they are in intimate relationships with (Covington 2017: 8).

Trauma related behaviours and difficulties are more likely to involve internalising amongst females including self-harm, eating disorders and avoidance, whereas males are more likely to externalise including violence and hyper-arousal (Covington 2017: 9). The reluctance of men to disclose experience of trauma has been linked to factors such as “the stigma associated with male reports of sexual abuse, the tendency of others to underplay the significance of abuse to men and concern that others will think the male victim will become an abuser” (Cosden et al. 2016).

Even though the evidence on these gender-specific differences is currently limited, it suggests that trauma-informed practice needs to be designed in a way that takes these differences into account.
Chapter 3 Survey Findings

There were 264 respondents to the online survey that ran between October and December 2017. Figures 4 and 5 breakdown respondents by service type and position where we were able to determine this. We did not break down the analysis by geographical region as we did not ask this in the survey for concern of low respondent numbers revealing individuals in some HSCP areas.

![Survey respondents by service type](image1)

**Figure 4**

![Respondent type by position](image2)

**Figure 5**

### 3.1 Summary Findings

Overall, the survey findings suggest that respondents have high levels of commitment to trauma-informed practice and are enthusiastic about the prospect of gaining more skills and knowledge in this area.

The survey data highlighted areas where practitioners evidently feel confident and knowledgeable regarding trauma-informed practice. At the same time, areas of training requirement have been highlighted:
Areas of established commitment, experience and knowledge

- 46% of respondents stated that they had received trauma-related training in the past
- 75% of those who had not received trauma-related training felt that training would have been very useful for their work
- Respondents felt that they had high levels of understanding about what trauma is, the kinds of experiences that are traumatic and the effects trauma may have on someone’s life
- A large majority of respondents (84%) either strongly or somewhat agreed that they understand the benefits of TIP for both staff and for those who use health and social care services
- A large majority (77%) strongly agreed that they understand the potential for a person to be distressed or re-traumatised if certain situations remind them of past trauma experience
- A large majority of respondents stated that they always listen carefully when someone speaks about their experiences of trauma and they always respond with empathy and without criticism
- 91% of respondents either strongly or somewhat agreed that they understand the importance of taking good care of themselves when exposed to trauma in the workplace

Areas of potential training need

- 45% of respondents stated that they had not received trauma-related training in the past and a further 10% were not sure whether they had
- The most frequent response to statements around what TIP looks like, how it can be implemented in general, and how it can be implemented in one’s role was ‘somewhat agree’ indicating a level of training need
- Only 28% of respondents strongly agreed that they were confident they could identify behaviours and difficulties that are related to traumatic experiences
- Only 33% of respondents strongly agreed they felt confident in knowing how to help someone who speaks about their experience of trauma feel safe
- Only just over a third of respondents strongly agreed that they are confident deciding at what point and where it is best to refer someone who needs a trauma-specific intervention
- 96% of respondents agreed that they would value gaining more skills and insights into how to better recognise those clients who have been affected by trauma
- 96% of respondents agreed that they would value opportunities to learn more about responding to trauma
Service specific findings

We also analysed responses by service type. We were unable to independently analyse Police Custody and Prison Health Care as the sample size was too small. In addition, a number of respondents were from trauma specialist treatment services – these were also excluded from the explicit comparative analysis as they exhibited high understanding and application of Trauma Informed Practice and trauma treatment.

Addictions service respondents were most likely to feel like they understood trauma and that they were currently implementing various elements of Trauma Informed Practice, are adequately supported to do so, and know where to refer service users for trauma specific interventions. They were also more likely than respondents overall to have received trauma-related training.

Criminal and community justice staff generally valued the training they had received previously highly and expressed a high interest in further training. However, they were also most likely to consider that there were barriers to implementing Trauma Informed Practice and had inadequate support and supervision to be able to implement Trauma Informed Practice and engage in self-care. They also felt least able to make someone feel safe and were unsure when and where to refer for trauma specific training.

Housing and Homelessness services were least likely to have received training in the past and least likely to have found that training very useful or express a desire for further training. They were also least likely to strongly agree that they understood what trauma or complex trauma is, the types of experiences that are traumatic and the effects trauma has on someone’s life. They were also least likely to understand how to implement Trauma Informed Practice and least likely to identify the benefits of trauma informed practice for service users and themselves. They were also least likely to identify barriers to implementing Trauma Informed Practice, which appears to be linked to the lower value they place on the need for Trauma Informed Practice.

3.2 Detailed Findings

Level of training

Most respondents agree that trauma-related training is useful for staff but only around half of them have received training so far

- 46% of respondents stated that they had received trauma-related training and a similar 45% of respondents stated that they had not received training, with the remaining 10% not sure
- Respondents who had not received training felt that trauma-related training would have been useful for their work with 75% stating that this training would be very useful and no respondents stating that it would be not useful. The remaining respondents either would have found training slightly or moderately useful (12%) or felt unable to tell whether training would be useful for their work (12%). These remaining respondents reported lower levels of knowledge and confidence around trauma-informed practice than respondents in general. This suggests that a better understanding of trauma-informed practice and its relevance might increase buy-in from these groups.
• 92% of management staff who had not received trauma-related training believed that training would have been very useful for their work (compared to 75% of respondents overall). This indicates that buy-in from this decision-making group is particularly high.

• Of those who had experienced training, 94% felt that it had been either moderately or very useful for their work

• “The effects trauma can have and trauma-related difficulties” was the aspect of received training identified by the highest number of respondents (112 out of 120). On the other hand, “How health and social care services can better support someone with trauma-related difficulties” was the aspect of received training identified by the fewest number of respondents (90 out of 120).

**Understanding trauma and trauma-informed practice**

Respondents believe that they have high levels of understanding about various aspects of what trauma is and what its impacts are

• Respondents demonstrated that they believe they have a high level of understanding about what trauma is (54% strongly agreed), the kinds of experiences that are traumatic (53% strongly agreed) and the effects trauma can have on someone’s life (57% strongly agreed). Perceived understanding about the term “complex trauma” was slightly lower (39% strongly agreed).

• Respondents perceive the benefits of trauma-informed practice however are not completely confident in their knowledge of what trauma-informed practice looks like or how it can be implemented

• The most frequent response to statements about understanding what trauma-informed practice looks like and how it can be implemented was somewhat agree. This indicated that while respondents do have knowledge in this area, some level of further training could be beneficial

• Respondents felt that they have a high level of understanding about the benefits of trauma-informed practice for both staff and for those who use services. However, 65% either strongly or somewhat agreed that barriers exist to implementing trauma-informed practice in their role and/or service.

**Trauma-related skills**

The survey asked respondents the extent to which they agreed with a range of statements that indicated their ability to identify appropriate trauma-related behaviours. This is used as a proxy to assess the extent to which respondents possessed trauma-related skills. This proxy was used as it wasn’t possible to test individuals more directly on their current skill level through this survey. We tested skills further in our focus groups and interviews and our conclusions on current skill level are based on a combination of surveys, focus groups and interviews in order to provide the most accurate picture of current skill level possible.
Taking trauma into account

Respondents are mindful of circumstances which can cause distress for those affected by trauma, and consider that a person’s behaviour can be linked to trauma-related difficulties

- Responses demonstrated a very high level of appreciation that a person may experience distress or even be re-traumatised in certain situations if these remind them of past trauma
- A majority of respondents strongly agreed that they always keep in mind that a person’s behaviour or reactions could be linked to trauma-related difficulties
- However, less than a third of respondents were confident that they could identify behaviours and difficulties that are related to traumatic experiences.

Responding to trauma

Respondents feel that they are empathetic and listen carefully when someone speaks about their experience of trauma, but a smaller proportion feel confident that they know how to make the person feel safe

- A large majority of respondents (75%) strongly agreed that they always listen carefully and respond with empathy when someone speaks about their experience of trauma
- A much smaller proportion of respondents felt confident that they know how to help someone speaking about experiences of trauma feel safe (33% strongly agreed they knew how to do this)
- Regarding asking service users with experience of trauma about the help they may need, 71% strongly agreed that they understand the importance of doing so and 64% were confident that asking was part of their routine practice
- When supporting someone who has experienced trauma, respondents were much more likely to consider ‘What has happened to you?’, the question recommended as part of trauma-informed practice, than consider the less appropriate question ‘What is wrong with you?’. 97% of those who answered this question consider the former question, whereas only 17% consider the latter.

Referrals for trauma-specific intervention

Around two thirds of respondents were not entirely confident about their ability to decide when and where to refer those who need a trauma-specific intervention

- Around two thirds of respondents did not feel entirely confident about their ability to both decide when referral is necessary (65%) and where someone should be referred to (66%)
- Respondents showed that they felt more able to determine at what point a person should be referred on, and less able to decide where the person should be referred on to.
Professional self-care and support

Respondents are aware of the importance of taking good care of themselves when exposed to trauma in the workplace but do not feel entirely confident that they are equipped to do so

- A majority of respondents (60%) **strongly agreed** that they are aware of the importance of taking good care of themselves when exposed to trauma in the workplace
- However, only 42% were confident in their **ability** to take good care of themselves
- A similar proportion of respondents (43%) **strongly agreed** that they have ready access to formal or informal support.

Professional learning and development

A majority of respondents strongly agree that they would value opportunities to learn more about responding to trauma

- 96% of respondents agreed that they would value gaining more skills and insights into how to better **recognise** those clients who have been affected by trauma
- The same proportion agreed that they would value **opportunities** to learn more about how to identify and respond to those affected by trauma as part of their role
- Over a third of respondents feel confident that they have a range of insights and experience of working with those affected by trauma which would be valuable to other staff and a further 42% **somewhat agreed**.
Chapter 4 Focus Group Findings

4.1 Introduction

Rocket Science facilitated 17 focus groups with practitioners from February to April 2018. Frontline practitioners working in Addictions, Homelessness, Criminal Justice, Police Custody and Prison services participated from Glasgow, East Renfrewshire, Inverclyde and West Dunbartonshire. A total of 96 workers participated in focus groups.

Focus groups facilitated a closer examination of the trends which had emerged from the analysis of the large-scale practitioner survey (see Chapter 3 and Appendix 1). Practitioners reflected on their level of previous trauma-related training, the frequency with which they felt they worked with clients who had experienced trauma, their understanding about Trauma Informed Practice and its implementation, and potential barriers that can exist to the provision of trauma informed services.

This stage of the research encouraged participants to reflect on Trauma Informed Practice as an approach taken by staff to ensure that the service they provide is cognisant of the trauma that their clients may have experienced in the past. Practitioners were reminded that implementing Trauma Informed Practice does not necessitate the treatment of trauma.

Focus group findings are structured as follows:

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4.2 Trauma-related training and experience

Previous training

The level of training which had been undertaken by practitioners varied widely, with some having had extensive training and development in the area, and others having never previously received any trauma-related training. Some described that they had attended training in the past, but this was many years ago. The most experienced staff had attended university to pursue training in the area, and one Addictions practitioner in Glasgow described that they had previously been personally delivering trauma related training and one-to-one sessions with colleagues.
Participants mentioned a variety of training providers including:

- Good Shepherd
- Turning Point Scotland
- Safe to Say
- NHS Education Scotland
- The Anchor Centre
- Glasgow Council on Alcohol
- Tomorrow’s Women

It was expressed that the extent to which practitioners had received training sometimes depended on their own drive to learn more in the area. For example, one Addictions Nurse in Glasgow stated that she had completed a master’s degree and Cognitive Behavioural Therapy (CBT) training to develop her practice but that this additional learning resulted from her seeking out training herself rather than it being offered to her through her role. Furthermore, an Addictions and Mental Health Nurse explained that nurses are often not offered sufficient training and therefore need to seek it out themselves:

“Social Workers get more training than nurses, Mental Health Nurses are expected to have a level of understanding, knowledge or experience from their training [to qualify] but are not provided with training [on the job]”.

Mental Health and Addictions Practitioner, Glasgow

In this case, the worker sought out one-to-one training with psychologists within their service to develop trauma-related skills. This indicates a level of commitment to professional development in Trauma Informed Practice.

While some practitioners felt that they had received training which was beneficial for the implementation of Trauma Informed Practice, this was not necessarily “trauma-specific”. Participants discussed related training which had increased their feelings of awareness about trauma and its impacts, for example on domestic abuse, self-harm, suicide, Adverse Childhood Experiences (ACEs) and trafficking. Others had undertaken training on trauma within a specific field or relating to a particular issue such as the impact of trauma on children, the impact of trauma on mental health and homelessness, vicarious trauma, and trauma and substance misuse.

Problems with accessing training

Participants recognised some barriers to accessing training. One Police Custody worker described that they had tried to access NES training but had been required to give a justification for why training was needed so “gave up” on the process. A Homelessness worker in Glasgow described that staff were cautious in their service to engage in training due to high caseloads. Going away to take part in a training day was seen to lead to a need to “catch up” on their return to the workplace. Others felt that trauma-related training had never been on offer:
Furthermore, it was felt that while there was training “out there” it was oversubscribed (Supported Accommodation Practitioner, Glasgow). One Criminal Justice Social Worker in Glasgow described gaps in understanding about trauma amongst workers as due to “training only having certain capacity, there might be five spaces on a training course, you have to apply and if you are lucky you get on”.

Limits to previous training

Focus group participants identified several problems or shortcomings of the training which they had received:

- **Limited scope to implement practice recommended during training** - A Criminal Justice Social Worker in Glasgow expressed that they had received training which focused on creating trauma-informed environments but as a worker felt there was only a limited scope to make changes in this area

- **Need for a broader or alternative training focus** - A community justice worker in Inverclyde stated that while training on the impact of trauma on children was useful for providing context to their work with adults, the training was primarily tailored around supporting children. In addition, a homelessness worker in Glasgow described that they had completed training about self-harm amongst women which was of limited use as their role mainly involved supporting men

- **Need for more in-depth or extensive training** - A Criminal Justice Social Worker in Glasgow stated that the trauma training they had undertaken only lasted a day and thus it was felt that information was “crammed in”. In this case the training would have benefited from being longer

- **Too much emphasis on referrals** – A Homelessness worker in Glasgow described that received training had focused primarily on how to refer a person with experience of trauma on to another service and should have included more information about how practitioners can themselves support a client

- **Need for spaces and support to implement learning from training** – An Addictions worker in Glasgow praised a three-day training course they had taken with Dr Deborah Lee. However, it was felt that within their role, this learning could not be put into practice because of the need for appropriate supervision by a clinical psychologist. In addition, a Criminal Justice Social Worker in Glasgow stated that it is “all well and good” to offer training but felt that frontline workers are often under too much pressure to implement learning.
Prevalence of trauma amongst clients

There was consensus across workers from all services in all locations that experience of trauma was highly prevalent amongst clients. Many participants suggested that all or most clients have experience of trauma, for example one Homelessness practitioner in Inverclyde estimated that 90% of people using Homelessness services have experience of trauma and a worker from Tomorrow’s Women Glasgow stated that all their clients have experience of trauma. Furthermore, it was recognised that clients were likely to have had repeated experiences of trauma or have experienced trauma over the course of their lifetime:

“There is a lot of trauma involved in being involved in the criminal justice system”. 

Drug Court Practitioner, Glasgow

“People will have experienced trauma throughout their lives. Women are on constant high alert”. 

Tomorrow’s Women Practitioner, Glasgow

“The people who social workers engage with as children grow up to be the people social workers work with as adults, for example due to offending”.

Social Work Practitioner, Inverclyde

Experience of trauma was conceptualised as a ‘cycle’ for some clients, for example women who repeatedly come in and out of contact with the Criminal Justice system. Practitioners recognised that clients are likely to have experience of many different types of trauma and that these experiences are linked to present problems relating to substance misuse, homelessness or offending. While it was seen to be “well recognised” that women’s offending is often associated with experience of trauma, it was felt that men’s behaviour could simply be labelled as aggressive without recognition that trauma may be the cause of aggression (Tomorrow’s Women Practitioner, Glasgow).

Despite the prevalence of trauma, it was noted that clients themselves would not generally use the word ‘trauma’ to describe their experiences. A Criminal Justice Social Worker in Glasgow described that clients would associate the word ‘trauma’ with, for example, being involved in the Manchester bombing.

The following were identified by practitioners as traumatic experiences:

- Bereavement
- Assault
- Domestic abuse
- Sexual and physical abuse
- Childhood abuse
- Experience of war

Recognition of the prevalence of trauma for clients led to the view that “it is important to have a trauma strategy across services and raise awareness about trauma” (Addictions Practitioner, Inverclyde).
Training and skills development on the job

Practitioners were asked to reflect on the extent to which their trauma-related skills and knowledge had been gained on the job. It was felt that practical experience was instrumental in the development of skills around Trauma Informed Practice, for example an Addictions worker in Glasgow stated that her experience had given her insight about the best ways of working with substance misuse clients such as “being accepting of people not wanting to talk about trauma”. Even having not had undertaken formal training, one Youth Homelessness worker in Glasgow stated that they would “like to think” that their practice was trauma-informed due to having experience on the job.

Despite the recognised benefits of experience, formal training was seen to be necessary to ensure a consistent and effective approach. Practitioners described a fear of making someone feel worse and not knowing whether they had done the “right thing” in interactions with clients:

“You reflect back and see opportunities where you could have been better equipped to help a person. It could be useful to have mandatory training”.

Addictions Practitioner, Glasgow

“There is a need for training, I might be getting it wrong”.

Criminal Justice Social Work Practitioner, Glasgow

Training was seen as essential for making sure that workers across roles and services implement similar approaches regarding trauma:

“We all learn through experience, but training makes sure that all workers are on the same page regarding trauma”.

Addictions Practitioner, Glasgow

“We would all approach [Trauma Informed Practice] in a different way so we need training”.

Homelessness Commissioning Practitioner, Glasgow

Overall, it was generally recognised that learning on the job was important for the development of skills and familiarity with clients who have experience of trauma, however some level of formal training was seen to be necessary to refine practitioner approaches. In this way, experience and formal learning were seen to be essential for the successful implementation of Trauma Informed Practice:
4.3 Understanding about trauma

Basic understanding across practitioners

Practitioners across groups generally felt that they had a good level of basic knowledge about what trauma is, the types of experiences which would be considered traumatic and the effects trauma can have on individuals. Furthermore, it was felt by some that a level of understanding about trauma was necessary for effective practice: there was agreement across one group of Criminal Justice and Addictions workers in Glasgow that “as professionals, we should understand about trauma or leave the profession”. Elsewhere a supported accommodation services worker in Glasgow stated that “people working in our environments need to have skills and certain principles”.

While most practitioners described a broad level of basic understanding about trauma, one practitioner who was involved in the overseeing of unpaid work placements in Glasgow described a lack of awareness about trauma amongst workers interacting with this client group. This worker stated that their team would be “starting from scratch” with learning about trauma as their work to date had been primarily about “getting people to do placements”.

There was recognition that the level of understanding about trauma was not uniform across all members of staff within their services. Understanding about trauma was evidently high amongst those working in Tomorrow’s Women, where services had been designed according to trauma informed approaches. The level of trauma experience amongst client groups was seen to have an impact on staff knowledge around trauma:

“There are a range of different experience/knowledge levels relating to trauma across services. In addictions and homelessness, the threshold is very high [experience of trauma amongst clients is highly prevalent], and workers deal with the impact of trauma on clients on a day-to-day basis”.

Homelessness Commissioning Practitioner, Glasgow
In addition, understanding was seen to be higher amongst those who had been working in services for a longer duration of time:

“There is a general understanding amongst some members of staff about the impact of trauma, however do new members of staff have the same level of knowledge?”

Additions Practitioner, Inverclyde

Practitioners in East Renfrewshire felt that there were different levels of training and knowledge throughout staff teams. The most experienced staff members tended to have the most in-depth knowledge and expertise.

Conversely, one Homelessness Commissioning worker in Glasgow stated that “there is a huge mix in workers’ levels of understanding, Trauma Informed Practice is more to do with a worker’s attitude than their role”. In this case it was felt that understanding was not solely dependent on seniority, experience or previous training.

Gaining clarity about clients’ experiences of trauma

While trauma experience was seen to be prevalent amongst clients, practitioners discussed difficulties in gaining clarity about clients’ pasts. Often it was seen to take time to develop relationships where a client would feel comfortable to open up about traumatic experiences. This lack of clarity was felt to create difficulties in understanding the types of impacts that trauma experience might be having in the present:

“Clients have complex needs. It is often difficult to pull out what has happened. Those accessing homelessness services have the full range of problems”.

Homelessness Commissioning Practitioner, Glasgow

In seeking to gain clarity about trauma experience, practitioners discussed difficulties in encouraging certain groups of clients to talk about their pasts, for example men and those with negative childhood experiences of Social Work. One Housing Support Worker in Glasgow described that workers are frequently “cautious” to bring up trauma with male clients because they can react “negatively” to this. A worker from Tomorrow’s Women Glasgow elaborated on this and stated that there was a problem with men feeling that they must be “hard and tough”. It was described that people can have a negative view of Social Workers from previous experiences and that this can create barriers to the development of trusting relationships between clients and practitioners.
Areas where understanding should be developed further

**Complex trauma**

It was noted amongst those working in Prison and Police Custody that while basic understanding about trauma was good, further training about complex trauma was necessary. One Mental Health Nurse working in Police Custody noted the prevalence of complex trauma as the service deals with those who have experienced “many types of trauma such as prostitution, domestic violence and witnessing violence”.

**Trauma experience of refugees and asylum seekers**

Practitioners recognised that knowledge around the types of trauma experienced by refugee and asylum seeker client groups could be improved. A Homelessness worker in Glasgow who was working with asylum seekers and refugees recognised the “different types of trauma” experienced by this group of clients. This point was also raised in West Dunbartonshire where practitioners stated that:

> “The refugees we work with have experienced traumatic events that are not typically seen throughout our services such as war. The display of problematic behaviours is evident in different ways and time frames than we are typically used to”.

**Practitioners, West Dunbartonshire**

In a different group, a Homelessness worker in Glasgow described trafficking and torture as distinct, “new” types of trauma. In these cases, it was felt that “even if you listen and understand, you cannot fully appreciate what they have gone through”.

In Glasgow, a Homelessness worker described a process of gaining understanding about types of trauma and resulting difficulties over time:

> “You get to know people, you start working things out the more you deal with people. In working with refugees and asylum seekers there can be language barriers and they don’t want to tell you about trauma”.

**Homelessness Practitioner, Glasgow**

A lack of familiarity with the types of trauma typically experienced by refugee and asylum seeker client groups had been addressed through training for Homelessness workers in Glasgow which offered them an indication of “what a person might have been through based on the country that they had come from”.


Despite this, experience of trauma was seen to be hard to detect at times due to differences in trauma-related behaviour and difficulties for refugees and asylum seekers. The need to use an interpreter was seen to have implications for disclosure about trauma as “it is a different kind of interview, it is not one-to-one, there is someone else in the room” (Homelessness Practitioner, Glasgow). Another practitioner discussed that in cases where clients rely on translators to describe their experience of trauma, this will often be their own child. This process of translation was seen to be potentially traumatic for clients.

**Gaps between the language of trauma and Trauma Informed Practice**

Practitioners expressed concern that there can be a gap between the widespread use of the term ‘trauma’ and the implementation of Trauma Informed Practice. While workers broadly claimed to understand what trauma is, there was some scepticism that this was reflective of the implementation of trauma informed approaches.

An Addictions worker in Glasgow explained that there is “a problem, particularly amongst Social Workers, of using the language of trauma but not adopting Trauma Informed Practices”. Similarly, a practitioner working in commissioning for Addictions and Homelessness in Glasgow stated:

> “Trauma Informed Practice is used to evaluate bids when commissioning alcohol and drugs services. Providing a “trauma informed” environment has become a buzzword but is it evidenced? Do services actually provide Trauma Informed Practice or just say they do?”.

**Addictions and Homelessness Commissioning Practitioner, Glasgow**

Furthermore, when discussing the level of understanding about trauma across services, some workers mentioned a “risk” that the term trauma is being used frequently without full understanding of its meaning. One Criminal Justice Social Worker in Glasgow discussed that other terms such as “on the spectrum” have been similarly widespread without full consideration of their meaning.

Elsewhere, it was explained that while a broad range of workers might say that they understand the term trauma, they might all have different interpretations of its meaning and in this way, there is a lack of consistent understanding (Criminal Justice Social Worker, Glasgow).
4.4 Implementation of Trauma Informed Practice

Strengths and weaknesses in implementation

Practitioners across services and locations voiced varying levels of confidence in the current implementation of Trauma Informed Practice.

Criminal Justice

Criminal Justice practitioners demonstrated an awareness about the impact of trauma on the lives of their clients, however it was expressed that knowledge of Trauma Informed Practice is “patchy” (Criminal Justice Social Care and Social Work Manager, Glasgow). It was felt that practitioners who worked in women-specific teams had access to more training on Trauma Informed Practice. The emphasis of Criminal Justice services was seen to be on “keeping a person stable”, and it was felt that expertise could be further developed in how not to retraumatise clients.

A Criminal Justice Social Worker in Glasgow described that there can be problems in ensuring continuity in trauma-related discussions and support if workers are only seeing clients every four weeks. Criminal Justice practitioners across groups brought up the problem that a level of control is a feature of their work and that this can be a barrier to Trauma Informed Practice.

Tomorrow’s Women

Practitioners from Tomorrow’s Women recognised that trauma informed approaches were a central feature of their service delivery. Across focus groups, Tomorrow’s Women practitioners were confident in discussing trauma informed interactions with clients, and steps to improve service environments. One practitioner stated:

>“Tomorrow’s Women is a welcoming, safe place, it is modelled around what women want. Women continue to be involved in the design and running of the centre. They came up with the rules for the centre and were harsher than workers about what should be allowed. Women have choice about their care plan”.

Tomorrow’s Women Practitioner, Glasgow

Despite this emphasis on Trauma Informed Practice, one Tomorrow’s Women worker expressed “Tomorrow’s Women implement Trauma Informed Practice, but you also forget and have to remind yourself of a person’s past trauma. We are only human” i.e. it can be easy to forget that a client’s behaviour or difficulties might be related to trauma experience. In addition, when asked about any limits to Trauma Informed Practice in Tomorrow’s Women, one worker in Glasgow stated, “there is always room for improvement, a client might not take to you regardless of what you have done”.

Tomorrow’s Women Practitioner, Glasgow
Homelessness services

Several limits to the implementation of Trauma Informed Practice in Homelessness services were identified by practitioners. A Housing Support Officer in Glasgow described that residential services were built for short client stays (between 7-10 days). The idea was that a client would come in, be linked to other services and then moved on. However, at present clients ended up staying in residential homelessness accommodation for many weeks. This practitioner discussed situations where a person would disclose experience of sexual abuse while loud noises were coming from elsewhere in the building such as someone shouting or the operation of the lift. While residential services used to be mixed, increased support for sex offenders meant this was no longer the case. The importance of information sharing about a client’s trauma history was stressed in the context of an example where somebody had come across their attacker in a service setting.

Pressures on housing stock were seen to lead to difficulties in implementing Trauma Informed Practice. A Homelessness case worker in Glasgow described that temporary accommodation is “non-existent and we often cannot get people into housing on the day that they need it”. This shortage resulted in families with children and suitcases waiting all day and then being put in a bed and breakfast. Elsewhere a practitioner in Homelessness Commissioning in Glasgow described “you might not get a bed for the night and have to sleep rough”.

Women’s Aid

Focus group participants from Women’s Aid demonstrated confidence that aspects of their services were currently trauma informed. In East Renfrewshire, Women’s Aid practitioners discussed workers’ access to an in-house psychologist who could provide advice on complex cases. In Glasgow, a worker described that Women’s Aid have historically focused on a “woman-centred approach” where clients are provided with choices. In addition, this practitioner detailed that the organisation has “robust recruitment strategies in place to ensure hired practitioners have an understanding of domestic abuse”. In East Renfrewshire, the following approach to service delivery was described:

“Women’s Aid do implement Trauma Informed Practice to an extent. We help women to understand what abuse actually is, explain the effects, and help women to feel safe within our service. We sign-post for counselling and have an open-door policy to try to create a harmonious environment. We also provide practical and emotional support, for example, we can help women manage their medication if they are struggling and we conduct need and risk assessments”.

Women’s Aid Practitioner, East Renfrewshire
The provision of safe environments was seen to be a considerable strength of Women’s Aid services (see Section 4.7). While elements of practice were evidently trauma informed, Women’s Aid workers in East Renfrewshire described that they had not to-date received trauma-specific training. These workers felt that trauma training would be “extremely useful for outreach staff as they worked with high risk clients e.g. those with historic abuse and mental health problems”.

Addictions services

Participants with knowledge of Addictions service delivery described variation in the extent to which Trauma Informed Practice was implemented across workers and services. Practitioners explained that the level of implementation of Trauma Informed Practice depended to some extent on the level of previous training and experience:

“In Addictions, the level of implementation [of Trauma Informed Practice] varies between services. Some have received national funding to implement Trauma Informed Practice through training. Others are less trauma informed”.

Addictions Commissioning Practitioner, Glasgow

“It is difficult to comment on overall knowledge or confidence in implementation as there are different levels of knowledge. Many workers are scared of disclosure. The difference between staff members is due to differences in training and experience. In the current team about half are experienced workers and half are not. Training is not being implemented as much as it should be, awareness about trauma is slowly filtering through”.

Addictions Practitioner, Glasgow

Addictions workers highlighted strengths and weaknesses in the implementation of Trauma Informed Practice. For example, a senior Addictions worker in Glasgow stated when reflecting on elements of Trauma Informed Practice, “this explains what we do, we are pragmatic, and person centred, we don’t set out with a particular approach”. This highlights a perception of valuable flexibility in working with clients who have experience of trauma.

On the other hand, an Addictions Nurse described the process of allocating clients to workers as an area which could be improved. Effective allocation would allow for more tailored interventions:
“In the Community Addiction Team (CAT) there is such a high volume of clients, you get allocated someone to work with. However, I want to work with clients with experience of trauma, whereas other workers don’t want this. It would work to match clients with suitable workers at the beginning of their engagement... There are pressures in the service, but it would be more effective if engagement with clients was planned in a more individualised and long-term way and this could lead to building relationships”.

Addictions Practitioner, Glasgow

Police Custody and Prison services

Amongst those working in Police Custody and Prison services, it was felt that while Trauma Informed Practice was not “formally implemented”, staff learnt about strategies for working with clients with experience of trauma through peer learning (Police Custody Practitioner).

In Police Custody, it was described that clients have access to Mental Health services, general health services and Addictions-specific services and that therefore care is holistic. Despite this, due to the time-limited nature of a client’s experience in Police Custody, the extent to which trauma could be discussed was limited and it was “not necessarily appropriate” to get into discussions about trauma with a client.

The need for skills to contain discussions about trauma was deliberated by Police Custody and Prison workers:

“The process of being taken into custody is traumatic. Staff need to know how to deal with it. Sometimes being able to put the lid on the box (to stop disclosure) is a useful skill. Practitioners should acknowledge trauma, but a person might not necessarily be ready to talk. Staff need to have a toolkit”.

Mental Health Nurse, Police Custody

“Often we wouldn’t encourage clients to disclose any experience of trauma because it is not appropriate”.

Healthcare Practitioner, Police Custody

A Mental Health Nurse in Police Custody described that as workers were not able to see people alone because of security risks, this had implications for the development of relationships or trust with clients.
Trauma informed approaches are part of current day-to-day practice

When asked about the implementation of Trauma Informed Practice, some practitioners felt there was a lack of clarity about what this approach would entail. However, when presented with aspects of Trauma Informed Practice, for example listening, building trust, working collaboratively and referring a person to appropriate services, it was expressed that these elements were already in place. While the label ‘Trauma Informed Practice’ was seen to be new, elements of this approach were seen as already being implemented:

“Right now, there is a focus on ‘trauma’, the approach is the same as it always had been but has been relabelled. Practitioners always recognised the benefit of a trauma-informed approach, it just wasn’t called that”.

Women’s Aid Practitioner, Glasgow

“Nurses have always been good listeners, before ‘trauma’ became in vogue. People using services seem anxious because they are talking to strangers and nurses know how to adapt to this”.

Practitioner, Police Custody

“Elements of Trauma Informed Practice are part of everyone’s skillset”.

Social Work Practitioner, Inverclyde

Dealing with chaos or crisis

Practitioners described the need to deal with chaos or crisis before trauma could be considered. This demonstrated a view of Trauma Informed Practice as an additional commitment on top of their current practice, rather than a shift to their existing approach. One Criminal Justice Social Worker in Glasgow described that clients have “ordered priorities”:

- **Crisis**: Practitioners must help clients to deal with any immediate crises that they are facing when engaging with a service.
- **Stability**: After dealing with crisis, practitioners can help clients to gain stability.
- **Trauma**: Only then can practitioners work with clients to understand experiences of trauma and tailor support.
These ordered priorities reflect a misconception of Trauma Informed Practice as trauma treatment. Trauma Informed Practice entails considering the barriers that clients can face to accessing services and includes (NHS Education Scotland, 2017, p.12-13):

- Providing those with experience of trauma with a “different experience of relationships” where they are offered “safety rather than threat, choice rather than control, collaboration rather than coercion and trust rather than betrayal”
- Minimising barriers to “receiving care, support and interventions that those affected by trauma can experience when memories of trauma are triggered by aspects of the service or interactions with staff”.

A consideration of client-practitioner relationships and avoiding retraumatisation can happen prior to and alongside dealing with crisis. Despite this, time pressures and chaotic service environments can have an impact on the implementation of particular elements of Trauma Informed Practice such as listening when a person speaks about their experiences of trauma, building trust and helping a person to feel safe (NHS Education Scotland, 2017, p.32-34). If workers only have a very short time with each client (e.g. between 5 and 10 minutes in community methadone clinics), it can be difficult to have the space to listen carefully, build trust or ensure a person feels safe. In addition, busy service environments can make it difficult to consider trauma experience:

“We are only human, when people are being difficult, for example shouting, it is difficult to consider their trauma experience there and then”.

**Tomorrow’s Women Practitioner, Glasgow**

“We some workers would say “are you kidding me?!” if they were asked whether they implement TIP when they are dealing with chaos”.

**Addictions and Homelessness Commissioning, Glasgow**

**Trauma Informed Practice as a mindset or lens**

While some practitioners expressed that Trauma Informed Practice was an additional commitment on top of their usual workload, others understood Trauma Informed Practice to be a “mindset” or “lens”. By this it was meant that client behaviours and difficulties could be better understood if trauma experience was consistently considered by practitioners.

Across focus groups, concern about the ‘labelling’ of clients was voiced because this was seen to facilitate an avoidance of the consideration of trauma experience and its relationship to behaviours. For example, it was felt by one Mental Health and Addictions Nurse in Glasgow that a personality disorder diagnosis changed the way clients were viewed or treated. With this group of clients there was seen to be a focus on behaviours rather than trauma experience. In these cases, “if you break down behaviour you understand [the relationship between their trauma experience and behaviour]”. Elsewhere, an Addictions worker in Glasgow found that women with a history of domestic violence were often given a personality disorder diagnosis which could be
“problematic as their history can be overlooked”. Thus, viewing behaviours with a trauma ‘lens’ assists in understanding behaviours and improving client outcomes.

Caution about the use labels was evident across groups. A Criminal Justice Social Worker in Glasgow stated that there was a “trend for labelling” as an answer for trauma-related behaviours, for example “personality disorder”, “drug-induced behaviour” and “schizophrenia”. Clients could be labelled as “not engaging” for missing an appointment but it was recognised by this worker that “it is not as black and white as this”. Practitioners in West Dunbartonshire described that:

“There is an issue with ‘labels’ when providing care for an individual. Managing complex behaviours often leads to service users being labelled as ‘difficult’ or ‘problematic’. This then leads to services not being willing to take on that service user because of that label. Their behaviours are most likely due to underlying traumas, but they are not able to get the help they need because services feel they would be especially difficult to work with”.

Practitioners, West Dunbartonshire

When clients had been diagnosed, there was concern about this not being a robust or thorough assessment. A supported accommodation worker in Glasgow described that mental health teams often would not work with someone who has a personality disorder diagnosis, but questioned: “Who has diagnosed them? Was this after a ten-minute test?”.

Overall, Trauma Informed Practice was seen to involve a level of compassion and understanding. It was felt that practitioners should be equipped to look past labels and presenting behaviours to consider trauma experience.

Barriers to the implementation of Trauma Informed Practice

| Time constraints | Practitioners felt that only having access to a client for a short duration could limit elements of Trauma Informed Practice such as building relationships or trust. In addition, it was felt that services should be given adequate time to implement aspects of Trauma Informed Practice before a new area of practice comes onto the agenda. |
| Supervision and support | It was felt that limited support or supervision could act as a barrier to Trauma Informed Practice. Managers were viewed to be important in influencing the implementation of Trauma Informed Practice (see Section 4.10). |
| Need for training | Training was felt to be useful for ensuring that all staff and managers are on the same page in terms of knowing how to implement Trauma Informed Practice. |
| Resources limitations | Service staffing issues related to funding were discussed as a barrier to Trauma Informed Practice. Issues with funding could limit the variety of services available to clients. In addition, measures such as having |
available accommodation for clients in case need arises was seen to be unfeasible due to cost.

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<thead>
<tr>
<th>Demand and pressure on services</th>
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<tbody>
<tr>
<td>Workers described being under pressure or “firefighting”. An Addictions worker in Glasgow saw the putting out of Addictions services to tender as a cause for increased pressure on workers as organisations ended up making overambitious promises about what they could offer. Pressure on workers was seen to limit their ability to recognise trauma experience amongst clients.</td>
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<tr>
<th>Client engagement and disclosure</th>
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<tr>
<td>The provision of trauma informed support was seen to be dependent on a client’s level of engagement. If a client stopped engaging with a service, it was felt to be impossible to look out for their safety. It was described as sometimes difficult to engage a client in continuous, long-term support. It was also felt that client disclosure about trauma was necessary for the referral of trauma-specific support.</td>
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<tr>
<th>Client behaviour</th>
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<tr>
<td>Client behaviour was viewed by practitioners as a barrier to implementation. In cases where clients were behaving aggressively, it was felt that worker safety had to be prioritised over trauma informed approaches – “you deal with what is in front of you”. It was described that if a client was shouting, it could be difficult to consider their trauma experience in that moment.</td>
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<tr>
<th>Legal requirements and court-ordered engagement</th>
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<tr>
<td>Those working in Criminal Justice services felt that an element of “control” limited Trauma Informed Practice. Workers’ roles were felt to be at times “punitive” and this was seen to limit possibilities for implementing therapeutic approaches. As a feature of Social Workers’ roles was to “challenge behaviour” this was seen to not be entirely compatible with making someone feel safe.</td>
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### 4.5 Managing disclosures

Across services and locations workers described a need to develop skills in being able to manage disclosures about trauma.

#### Dealing with unexpected disclosures

Participants discussed the occurrence of unexpected disclosures about trauma experience across services and the need to be able to react appropriately in these situations. Trauma disclosure was seen to be difficult to predict:
Workers were concerned that they were not necessarily equipped or trained to deal with disclosures but nevertheless felt a responsibility to support clients. There was a fear that when disclosures about trauma come unexpectedly that workers can be left not knowing whether they have done the right thing and worrying that they have made things worse:

“Recently a young man came to me and started to disclose about his experiences, I felt that I wasn’t trained but still sat and listened to him even though I didn’t have very much time”.

Prison Healthcare Practitioner

“Many are scared they will react wrongly to trauma – there are time limits to engagement with a client and workers are scared to say the wrong thing”.

Addictions Practitioner, Glasgow

“You only have a certain time slot with a person, you can be doing something simple like dressing a wound and suddenly they will disclose but you don’t have time to deal with what they have said”.

Police Custody and Prison Healthcare Practitioner

Practitioners could feel pressure to be able to personally support a client in the event of disclosure about trauma if it was understood that the client would not necessarily disclose to anyone else. For example, one Homelessness worker in Glasgow described:

“Physical and sexual abuse is prevalent amongst supported men. Even when services do exist e.g. Open Doors, men will not use them. They will disclose to me but will not want to go elsewhere to talk”.

Homelessness Practitioner, Glasgow
Disclosures in unsupportive settings

Practitioners were cognisant of the risks associated with clients disclosing experience of trauma in situations where adequate support could not be provided. An Addictions Nurse in Glasgow described that clients can disclose accounts of trauma in peer support settings and where “trained workers aren’t there to support them and no referral pathways are in place”. This could compromise client safety and leave individuals without appropriate follow-up support. This concern was echoed by a Tomorrow’s Women worker in Glasgow who described that in her previous role in a prison, people would be encouraged to disclose through group work and then be “left to deal with it”. In addition, prisons were seen as potentially unsuitable settings for disclosure due to the limited support which can be accessed by individuals:

“People disclose in prisons, but the system isn’t set up to deal with this. There are 800 people in Barlinnie with a limited MH team. Workers can feel helpless in these situations”.

Supported Accommodation Practitioner, Glasgow

Those working in Police Custody explained the process of questioning when an individual enters custody which often results in disclosures in a non-private setting:

“When people are taken into custody they are asked if they are an ex-veteran and about their mental health, but this is not a private area”.

Police Custody Practitioner

[In continuation of previous comment] “The person stands at the bar and is asked a series of questions with one member of police staff on each side of them. People disclose about for example alcohol problems and being suicidal there and then”.

Police Custody Practitioner

In settings where adequate support is not in place, the importance of referral pathways and links to other services was stressed. For example, a Police Custody worker explained:

“Referrals are important because there are time restraints and if a police officer is there it might not be appropriate or comfortable for someone to disclose experience of trauma. If service options are provided for the person to access after they leave prison or custody this can be useful”.

Police Custody Practitioner
Avoiding clients having to repeat accounts of trauma experience and the need for information sharing

It was recognised that clients are often asked to repeat descriptions of traumatic experiences to multiple practitioners, particularly if they are engaged with various services or referred on from one service to another. This was seen to be potentially “retraumatising” and “exhausting” for individuals:

There is a problem of clients having to tell their stories multiple times and this can be retraumatising – the service is aware of how that can be traumatic”.

**Tomorrow’s Women Practitioner, Glasgow**

“We are asking people to bare their soul every time they engage with a service, it is understandable that people wouldn’t want to tell their story each time”.

**Criminal Justice Support Worker, Inverclyde**

To limit the need for individuals to continually recount their trauma experience, practitioners emphasised the importance of:

- A continuity of relationships and sustained support by one practitioner

“Continuity [of relationships] is key. Someone can be asked about their experience of trauma and then assessed and moved on and then asked again. No wonder people don’t want to disclose experience of trauma”.

**Addictions Practitioner, Glasgow**

- Information sharing between services and members of staff
Limiting disclosures and setting boundaries

There was an awareness amongst practitioners that it is sometimes necessary to try and limit what clients will disclose in a service setting. Skills in limiting disclosure were described as being able to “put the lid on the box” or prevent the “opening of a can of worms”. Containing disclosures was seen as necessary due to limited resources and skills to support an individual:

“As a system there is a need to look at relationships with clients. If a practitioner has already developed a relationship with a client, this should be maintained through continued support by that person. Services should work together to make sure this happens”.

**Community Justice Practitioner, Inverclyde**

“When treating a client, practitioners will receive a form with a patient’s history from their GP, there will be just one or two lines at the bottom of the page detailing child abuse. As a practitioner you have to look out for the information rather than have it clearly available to you”.

**Police Custody Practitioner**

It was felt to be particularly important that practitioners were equipped to limit disclosures in Prison or Police Custody settings because “at the end of the day that person has to go to a cell so if they disclose they will have to be thinking about that in a cell”.

Practitioners expressed that clients would talk about trauma experience when they were ready to do so and should not be pushed into disclosure. Addictions workers in East Renfrewshire described a “fine balance between supporting and prying”. They felt that workers should not push people to speak about issues and should instead deal with disclosures once a person is ready to talk.
4.6 Adapting practice to accommodate those with experience of trauma

Throughout focus groups practitioners described a wide variety of ways in which they adapt their practice to accommodate those with experience of trauma. This highlights the motivation of workers to remove barriers to accessing services, a core component of the implementation of Trauma Informed Practice. Practitioners were concerned about instances where they felt they had to exclude an individual from a service due to potential risks to other clients and seemed keen to avoid this outcome. Workers in Addictions services seemed to be particularly flexible in their approaches. Examples of the adaptation of practice included:

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<tr>
<th>Seeing clients outside of typical service settings e.g. going to their homes or meeting in a café</th>
<th>This was viewed as beneficial where clients were hesitant to come into clinics or offices due to territorial issues or being worried they would see someone they know. One Addictions Nurse in Glasgow stated, “if someone cannot come in, we wouldn’t give up on them, we would do a home visit”.</th>
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<tbody>
<tr>
<td>Allowing clients to access services outside of peak hours</td>
<td>An Addictions worker in Glasgow offered the example of a man with anxiety who was facilitated to come into the service earlier in the day when it was quieter.</td>
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<tr>
<td>Seeking guidance from specialist practitioners to be able to provide more tailored support to clients</td>
<td>A Mental Health and Addictions practitioner in Glasgow described working with a psychologist to develop client-centred support for an individual in their care.</td>
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<tr>
<td>Minimising the time spent by clients in busy waiting rooms or queues</td>
<td>An Addictions worker in Glasgow described allowing clients to wait in a separate room rather than busy queue where appropriate. A Criminal Justice Social Worker in Glasgow stated “I make sure to go and get clients quickly, so they are not waiting a long time”.</td>
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<tr>
<td>Keeping a first-time offender separate in a custodial setting</td>
<td>A Police Custody Healthcare practitioner described this example as a “good intervention”.</td>
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<tr>
<td>Asking a client to go away for half an hour and then come back to the service if they are agitated (“going off”)</td>
<td>An Addictions worker described that benefit sanctions mean that clients can go without money or food and therefore their disruptive behaviour is unsurprising. Asking someone to go away and come back was a way of avoiding the exclusion of clients.</td>
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4.7 Trauma Informed Environments and making clients feel safe

Possibilities for altering service environments

Practitioners generally felt limited in their ability to make meaningful change to the environments in which they were working, and settings seemed to vary across locations and services. Many described that buildings, waiting areas and offices would not be considered as trauma informed due to being run down, overly busy or unwelcoming. On the other hand, those working for Women’s Aid or Tomorrow’s Women felt more confident that their environments assisted in making clients feel safe.

“Environments really vary across the city. Most of the time you have your head down and cannot think about the environment”.

**Criminal Justice Social Care and Social Work Practitioner, Glasgow**

“We have caged windows, toilets in the waiting room, no dignity, shoving multiple services in one building. People don’t feel safe”.

**Criminal Justice Social Work Practitioner, Glasgow**

“Safety is Women’s Aid’s number one outcome. Refuges ensure safety for women through: being warm, comfortable and having an occupancy (including agreeing to ‘no men’ and ‘no drug use’).”

**Women’s Aid Practitioner, Glasgow**

The cost of altering environments was seen to be a barrier to change. For example, while Women’s Aid practitioners were confident they could help women to feel safe, one worker commented that “we do what we can” in terms of environments with the resources we have. In addition, limited space was seen as a barrier to ensuring trauma informed environments. It was expressed that “there is a lack of private spaces throughout the services where you can speak confidently with a service user” (Practitioners, West Dunbartonshire). Those working in healthcare in Police Custody described that they had “no control” over the service setting as it is a Police Scotland environment – “cells are a certain way and we cannot do anything about that”.

Some environments experienced by clients outside of service settings were identified as not being trauma informed. Homelessness practitioners expressed that steps to avoid a person entering temporary accommodation would be beneficial considering that these environments could make clients feel unsafe. For asylum seekers and refugees, it was felt that if workers were told earlier that a person would be homeless they could arrange suitable accommodation while avoiding temporary accommodation. It was described that temporary accommodation and B&Bs could be “frightening”.

It was seen as unsurprising that frontline workers would not be able to consider transforming physical environments. A practitioner working in commissioning for
Homelessness and Addictions services in Glasgow felt that changes to environments can depend on leadership because in many cases frontline workers are “low paid staff who have to deal with extremely challenging day-to-day situations and thinking about the environment is low down on the list of priorities”. Furthermore, this practitioner felt that commissioning practices had a role to play in the development of trauma informed environments. It was stated that “through a line in the contract” Trauma Informed Practice and environments could be expected from services.

The importance of leadership was reiterated by a worker who described that under the leadership of a new member of staff, a Youth Homelessness service environment in Glasgow had been transformed with around a 90% drop in violent incidents. Before this manager had taken up their post the environment was described as a “hard place to work” and “oppressive and dark” where there was “lots of fighting”.

Despite limits to what workers felt they could change about environments, they demonstrated awareness about the types of environments which could make a person feel safe. For example, an Addictions worker in Glasgow described the importance of:

- Working in a room with two doors
- Appropriate lighting
- Clean spaces
- Clients feeling sure that nobody will come into the room during an appointment (privacy)

**The importance of workers’ practice in creating safe spaces**

Considering the limits faced by practitioners in changing physical service environments, their own practice was felt to be important for helping clients to feel safe:

> “[Safety] depends on what workers bring to the table – relationship building, honesty, being genuine”.

**Criminal Justice Social Work Practitioner, Glasgow**

“It’s difficult to say you are able to make someone feel safe. Often we are talking about their whole life safety not just in the service. We can help someone feel safe by doing our job well but as soon as a person leaves we have no idea about their personal safety”.

**Practitioner, East Renfrewshire**
Providing clients with a place to go

There was recognition that the provision of spaces and services which individuals could go to when in need was useful for encouraging feelings of safety. A practitioner provided an example where a case was made for allowing a “particularly vulnerable young person” to “come and go” in a Youth Homelessness service (i.e. not stay there every night but keep a bed). This was described as a useful way of keeping the young person safe. Elsewhere, an Addictions worker in Inverclyde explained the importance of “open-door policies” where clients could walk into services without previously arranged appointments – “services need to be people-friendly, and open-door policies help with this”.

The importance of flexible and open support was also discussed for individuals accessing Homelessness services. A Homelessness practitioner in Inverclyde described that the hostel is a “safe place” and that individuals could go to Homelessness services even if they are not looking for a tenancy – “people can present if they are in crisis and there is immediate access”.

Making clients aware that they can come back to services after the end of a period of engagement was also seen to be beneficial for clients’ feelings of safety. In East Renfrewshire, Women’s Aid practitioners described “our service users are made aware that they can always return to Women’s Aid in the future should they require the service; this provides the women with a constant place of safety”.

High and low security environments

The concept of a spectrum between high security and risk averse settings on one hand, and low security and welcoming settings on the other hand was discussed:

<table>
<thead>
<tr>
<th>Low security</th>
<th>High security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tea and coffee facilities</td>
<td>CCTV</td>
</tr>
<tr>
<td>Relaxation spaces</td>
<td>Locked doors</td>
</tr>
<tr>
<td>Warm and comfortable</td>
<td>Security checks</td>
</tr>
</tbody>
</table>
High security settings were seen as necessary to mitigate risks and some practitioners suggested that these settings helped to make clients feel safe. For example:

“In one youth centre, young people were checked using a metal detector before they came in. Apparently young people were canvassed and said this process made them feel safer, however it is not welcoming”.

Homelessness Commissioning Practitioner, Glasgow

“There are cameras in communal areas but not in rooms. Service users seem happy with this. They can leave their belongings in communal areas and feel safe doing this”.

Housing Support Officer, Glasgow

“All services have good security such as secure entry... The cameras make people feel safe”.

Homelessness Practitioner, Glasgow

However, workers from Tomorrow’s Women challenged the idea that lower security environments were associated with higher risk. One practitioner described that while there were initially concerns about the lack of security in Tomorrow’s Women, since the service’s inception there had only been one violent incident. Tomorrow’s Women was designed to be a trauma informed environment and practitioners noted several benefits associated with this type of setting:

“There is a café, a creche, men sit outside because it is a centre for women, the service is inviting and personal”.

“When people come to Tomorrow’s Women, the service isn’t what they expect, and they feel at ease”.

“Tomorrow’s Women is very different to residential homeless services. There are no cameras, it was designed to be different from prison. All women wear lanyards and they like this. It feels calm, safe, relaxed. There is a place to wash clothes. It doesn’t resemble other Social Work environments”.

Tomorrow’s Women Practitioners, Glasgow

The creation of welcoming environments was felt to have benefits for those who would likely face barriers to engagement with services that reminded them of Social Work settings. A Homelessness and Addictions commissioning practitioner in Glasgow explained “some clients may have a fear of Social Work settings due to their experience of care services when they were younger”. To address this, services could provide “a kitchen, sofa, warm lighting, shower and towels or washing machine”. Furthermore, a
residential Homelessness practitioner in Glasgow felt that there would be benefits of having a tea machine for clients in the service, however noted that this would likely not be possible because the perceived risk would be too high.

Recognition of triggers and avoiding retraumatisation

Risks of retraumatisation were recognised to have implications for clients’ feelings of safety when accessing services. In this context, the development of understanding about triggers was deemed necessary. Throughout focus groups, practitioners raised examples of aspects of services which they knew or suspected would be retraumatising for clients.

It was felt to be important that workers could anticipate what might act as a trigger for a client, however there was variation in how easy this would be. Workers recognised that the selling of drugs in Homelessness or Addictions waiting rooms would understandably be retraumatising for individuals. However, a Homelessness worker in Glasgow noted that “even the colour of your hair could be a trigger”. Therefore, while some steps to reduce the potential for retraumatisation seem clear, in other areas triggers would be harder to avoid. In the latter cases, workers could be mindful that behaviours and difficulties might be the result of a person being reminded of past trauma.

A Tomorrow’s Women worker in Glasgow described a time where the service provided costumes for a photobooth resulting in one client becoming distressed. A support worker later realised that this was due to one of the clothing items reminding the client of previous abuse. This worker explained that previous training by the Anchor Centre had demonstrated that what might be good for one client might be bad for another, for example hugging.

Waiting rooms and reception areas were identified as potentially retraumatising for several reasons:

“There is a long way to go in terms of ensuring trauma informed environments. The service is losing its building which means that high risk offenders, children and families and homeless clients are all in one building. There are also territorial issues which means people won’t attend clinics in some parts of the city. People worry about bumping into people”.

Criminal Justice Social Work Practitioner, Glasgow

“People will sell drugs in the office, the office is very busy, it can take a lot to get a person through the door and then the waiting room is retraumatising... Waiting rooms can smell of alcohol and this can be a trigger”.

Addictions Practitioner, Glasgow

In addition to service environments being potentially retraumatising, practitioners recognised that clients could trigger each other. A Tomorrow’s Women practitioner stated that while workers are “bound by confidentiality”, women in the service are not.
Worker safety

In discussions of safety, practitioners raised issues relating to their own safety in interactions with clients. A Homelessness commissioning practitioner described a service which was previously Third Sector-provided becoming Social Work-provided and this change had resulted in a discussion about the need to install screens to protect workers. It was felt that in Homelessness “we have never moved away from the idea that you need to be protected from clients”. This worker felt that there were ways of “balancing protecting workers and clients”. For example, in the Hamish Allan Centre, workers could choose whether they wanted to have screens opened or closed when engaging with clients.

An Addictions worker described that when working with the 218 Project (for women offenders), safety for practitioners when engaging in one-to-one sessions was ensured through the client being assessed three times before being alone with a worker. If there were concerns about safety, two workers could engage with the client together.

Managerial support in instances where practitioners had been in unsafe situations was viewed as essential. One Homelessness worker in Glasgow described being assaulted by a client and in this event had felt “scrutinised” about whether they had done the right thing. The worker was offered counselling, but this had “made things worse”, resulting in their supervisor taking the attitude of “oh well, you tried” without the provision of further support.

4.8 Identifying trauma-related behaviours and difficulties

Identification of behaviours

Practitioners identified a wide-range of behaviours and difficulties which they associated with trauma experience including:

<table>
<thead>
<tr>
<th>Addiction</th>
<th>Risk-taking</th>
<th>Crying or shaking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-harm</td>
<td>Aggression</td>
<td>Lack of responsibility</td>
</tr>
<tr>
<td>Chaotic behaviour or instability</td>
<td>Feelings of hopelessness</td>
<td>Non-compliance (in criminal justice settings)</td>
</tr>
</tbody>
</table>

Variation in trauma-related behaviours and difficulties

While a broad range of trauma-related behaviours and difficulties were identified, practitioners acknowledged a level of variation in how these were presented depending on the individual. For example, in a Youth Homelessness setting in Glasgow, it was described that “trauma-related difficulties can be really different amongst different young people – from one extreme to another”.
Those working with refugees and asylum seekers noted differences in trauma-related behaviours and difficulties for this group. This group was seen to be less chaotic and readier to get settled:

“It is difficult to recognise trauma-related behaviour amongst refugees, because unlike other clients they do not use alcohol or drugs” [where alcohol and drug use was recognised as trauma-related behaviour].

**Homelessness Practitioner, Glasgow**

“Refugees and asylum seekers go through the system quicker, they want to get settled, they are not chaotic. In my old role [general homelessness support] I couldn’t house people because there were addiction issues and instability. Obviously, there are [trauma] issues with current client group but we don’t get to know”.

**Homelessness Practitioner, Glasgow**

A youth homelessness worker described that while trauma-related behaviours and difficulties were harder to recognise for refugees and asylum seekers, practitioners also received less information about the person’s history at the beginning of their engagement with a service. It was explained that if a client had been in care or was known to social services, practitioners would receive “fairly detailed information” about the person, however with refugee clients “you don’t get any background information”, so it is harder to find out about any history of trauma in that way.

**Identification of trauma-related behaviours and difficulties through the development of trusting relationships**

Workers explained that often the link between trauma experience and current behaviours or difficulties would only become clear through the development of a trusting practitioner-client relationship. Addictions and Criminal Justice practitioners in East Renfrewshire expressed that “identifying behaviours linked to traumatic experiences is all down to the therapeutic relationship between staff and the service user”. A homelessness commissioning practitioner in Glasgow described that it can take a year for young people to open up to a staff member about their experiences. It was observed that often young people are “moved on” before they have had the time to develop trusting relationships which allow workers to “get to the heart of issues”.

**Continuity of contact with one worker was seen to be important for the recognition of trauma-related behaviours or difficulties.** A Social Worker in Inverclyde described that there is a “need to know a person well before it is clear that their behaviour is linked to trauma”. If one practitioner is the main contact for a client over a period of time, it is possible to understand their behaviours or difficulties, “but if you pick up the case from someone else, this can be difficult”.
Dealing with behaviours on ‘face value’ without addressing underlying issues

Where behaviours were described as needing de-escalation or immediate attention, it was felt that it could be difficult to consider “underlying trauma”. Practitioner roles were considered to involve “managing immediate risks”. A homelessness and Women’s Aid worker in Glasgow described that clients are “passed from service to service” such as Homelessness and Addictions to manage urgent presenting issues without consideration of a person’s trauma experience. In Addictions, there was a view that some workers would say “we are dealing with addictions not trauma”, however it was felt that there should be a realisation that these two things are linked. Overall, behaviours were seen to often require being dealt with on “face value” without a full understanding of the link between behaviours and trauma experience. In Homelessness services in Inverclyde, the delivery model was described as “linear” in that people come into the service and the goal is to move them on into a tenancy without addressing their experience of trauma.

Practitioners felt that it could be difficult to identify trauma-related behaviours in cases where a client was using alcohol or drugs. Some behaviours were felt to be “drug-induced”. A Police Custody practitioner explained that it can be difficult to know what is causing a person’s behaviour when they come in, most are “intoxicated” and it can be hard to tell whether their behaviour is caused by one of the many difficult aspects of being in custody, for example police being outside their door, or whether behaviour is related to trauma experience.

Tolerance and understanding about trauma-related behaviours and difficulties

There was recognition that the level of tolerance or understanding around trauma-related behaviours would depend on individual workers and the services in which they are working. A practitioner who was working in both Criminal Justice and Drugs services in Inverclyde, stated that there was a “clear difference in terms of acceptance of behaviour” between these two teams:

“In drugs services, trauma is at the forefront, they ask the question of why the client has an addiction and they tolerate trauma-related behaviours. However, in criminal justice trauma is not necessarily considered. For example, if a person has a driving offence – trauma is not at the forefront of practitioners’ minds. Different services have different levels of acceptance of certain behaviour, in criminal justice it is accepted that ‘if you are in this building you will behave yourself’. Managers reinforce this, support workers are told, ‘we do not tolerate certain behaviours’”.

Criminal Justice and Drugs Services Practitioner, Inverclyde

A Criminal Justice worker in Inverclyde supported the notion that the level of understanding about behaviour would depend on which service a client was accessing. This worker gave the example of a doctor’s surgery as a setting where a client would be asked to leave if they exhibited disruptive behaviours.
In addition to varying levels of understanding of behaviours in different services, the attitudes of individual workers were also considered to be important. For example, a Homelessness Commissioning worker in Glasgow described that how workers consider behaviours would depend on the “attitude of the worker” where some would say “this behaviour is unacceptable” and others would be more understanding.

A Homelessness Commissioning practitioner identified three factors which impact on recognition and understanding around trauma-related behaviours and difficulties:

- **Service model**: This determines the amount of time a practitioner can spend with a client
- **Goals of service**: Types of available practitioners depend on what the service aims to achieve
- **Staff burnout**: The extent of staff burnout determines the level of experience in a team

**Risks associated with not being able to identify that behaviours or difficulties are related to trauma**

Practitioners were asked to reflect on whether they felt there were risks associated with instances where client behaviours or difficulties were not recognised as being related to trauma. The following risks were identified:

- A client “ending up back on the street” and not getting help due to being excluded from a service because of their behaviour
- A risk of self-harm or harm to others
- Poorer client outcomes due to a failure to identify appropriate referral pathways. If behaviour is not identified as being related to trauma, clients cannot be directed to suitable services
- Practitioners failing to provide essential support. An Addictions worker in Glasgow described a situation where an individual came into the service “like a bag of bones” and was about to be put in a taxi by another worker, when it was recognised that the client needed more support, in this situation it was seen that the client was “vulnerable” and letting her go could be dangerous”. Without the appropriate support, clients could “fall through the gaps”.
4.9 Referral processes

Practitioners recognised the importance of referral processes in circumstances where the provision of adequate support for clients was beyond the scope of their role or skillset. There was generally a greater level of clarity about **when** a client would need to be referred on to another service than **where** they should be referred to.

**Need for clarity about referral criteria**

It was expressed that there was sometimes a lack of clarity around which clients would be accepted into other services. Practitioners identified a need for more information around the circumstances in which referrals would or would not be accepted. There was also a view that different services might assess one client’s needs differently and thus disagree about what appropriate support would look like. It was explained that often when referring a client on, their needs would be assessed as either “too high” or “too low”. Aside from level of need, a client’s age, the complexity of their needs or how “chaotic” they were, were all seen as factors which could lead to a person being deemed ineligible for access to a service.

There was a level of frustration that “organisations are quick to tell you what they cannot provide, clients are passed around like footballs from one service to another” (Police Custody and Prisons Practitioner). Despite this, there was recognition that services need to prioritise based on need due to **limited resources**.

**Continuously changing range of services**

There was recognition that referral processes were complicated by a continuously changing variety of available services. One Police Custody and Prisons worker identified problems with both **statutory** and **voluntary** organisations:

- **Statutory organisations**
  - Long waiting lists e.g. 12 weeks for psychological support

- **Voluntary organisations**
  - Can have their funding cut at any point, a service will stop operating from one day to the next

Continuous change to available services was seen to have implications for staff awareness about referral routes. The development of a ‘go-to’ list or directory of services was seen to be challenging as it would need constant updating. To address this challenge, a Criminal Justice Social Worker in Glasgow felt that there should be an “online portal of relevant services”, where individual services would have the responsibility to upload information about:

- Which services they provide
- Referral processes
- The criteria for acceptance into the service.
An online portal was seen to be more conducive to reflecting continuous change, in contrast to a book or directory of services.

Problems with communication about available services was illustrated by an Addictions worker who described the setting up of a Survive and Thrive group which was undersubscribed because “people don’t know about it”.

**Relationship between Addictions and Mental Health services**

The relationship and referral processes between Addictions and Mental Health services was an area of concern for practitioners. It was felt that often those with substance misuse issues could not access appropriate mental health services. A mental health nurse in Police Custody stated that community mental health teams and psychology services would not “touch anyone with addictions”. A Criminal Justice Social Worker in Glasgow described this as “passing the buck between Addictions and Mental Health services”.

The lack of clarity in the relationship between Mental Health and Addictions was seen as a barrier to the provision of holistic or meaningful support. It was recognised that substance misuse issues were often linked to mental health issues and that therefore these two areas should be addressed simultaneously through practitioner support. A Police Custody healthcare practitioner described that young people would use cannabis to cope with trauma experience and as a result be excluded from receiving support. This was viewed to be particularly problematic as intervention while a person was young was felt to be crucial in limiting the continued impact of trauma on a person’s life as they get older.

In some cases, those working in Addictions described having access to intensive support from their own nurses, psychologist and psychiatrist. The “in-house” referral for assessments and treatments within a multi-disciplinary team was viewed as beneficial for being able to provide tailored support within a shorter timeframe.

**Importance of peer learning about referral pathways**

Peer learning and learning from team management was seen to be crucial for understanding around referral pathways. Workers described asking other members of their teams about where a client should be referred on to and this was useful for “navigating” available services. Women’s Aid workers in East Renfrewshire, felt that working in a small team facilitated the sharing of advice between colleagues and more experienced staff.

**Balancing a need for relationship continuity and tailored support**

While the provision of tailored support through a referral was often seen as necessary, this had to be balanced against the benefits of preserving continuity in client-practitioner relationships. A Criminal Justice Social Worker in Glasgow, explained that they arrange referrals through “negotiation with a client”. The practitioner would assess whether a person would want to be referred and would ask the client how they would feel about being referred on to another service. This negotiation was seen as important: “there is a need to be gentle about referrals because people can feel vulnerable once they have disclosed so you don’t want to rush them onto another service”.


It was seen to be important that clients “set the pace” in terms of referrals. They need to be willing and ready to be referred on. If a person is felt to be not ready or not interested in specific treatment, then there was seen to be no benefit of initiating a referral. Workers realised that joining other services could be daunting and that clients may end up not attending because of this.

Waiting times and limited variety of services

Waiting times and a limited variety of available services were identified as barriers to smooth and beneficial referral processes. Mental health support services for adults and young people were identified as being oversubscribed with long waiting lists. Within a prison setting, “a gap in provision for psychological support” was identified, where current provision was seen to be “a drop in the ocean”.

A Criminal Justice Social Worker in Glasgow felt that were not many trauma-specific services and that there were fewer services available for men with experience of trauma. In Inverclyde it was felt that there were fewer organisations to refer to, whereas in Glasgow there was a greater variety of third sector organisations. Referrals to services in Glasgow from Inverclyde were inhibited by “geographical barriers”. Similarly, in West Dunbartonshire, practitioners noted the lack of local mental health services and the need to often have to “travel a long distance to receive help”.

4.10 Self-care, support and supervision

Current models of supervision and support

There was evidence of successful systems of support for workers across services. In Women’s Aid, it was described that small working teams, employee counselling, team meetings, individual support and continuous access to managers all helped to ensure that workers were adequately supported. Women’s Aid workers described being able to use ‘time off in lieu’ where this was felt to be necessary. Successful supervision was described by a Criminal Justice Social Worker in Glasgow who stated that these meetings encouraged discussions about wellbeing and self-care. Addictions workers in East Renfrewshire described having regular supervision and feeling comfortable to approach managers or supervisors with any issues.

Despite these examples of beneficial support, there was recognition that the level of support provided through supervision depended on individual managers. In addition, practitioners across services and locations voiced concerns about current supervision and support practices. Supervision was described by multiple workers across services as a ‘tick-box exercise’ which focused primarily on case load management rather than on how well a worker is coping. Within current systems of supervision, there was felt to be scope for the provision of more “therapeutic” support.

In addition to a caseload management element of supervisions, workers in a Youth Homelessness service in Glasgow felt that supervisions were used to check work against National Care Standards “like an exam” without space to discuss any difficulties.

Workers described occasions where further support for workers was necessary. Those working in Police Custody or Prison settings raised the need for additional support around having to attend court. Attending court was felt to be “traumatic” and “awful”
and involved having “all aspects of you and your work” scrutinised. In these cases, it was felt that workers would use their peers for support. Furthermore, various workers discussed the often significant impacts of client deaths on workers.

**Barriers to debrief and staff burnout**

Busy services and high caseloads were identified as limiting opportunities for debrief or discussion:

- Within Psychology in Police Custody and Prison services, it was felt that despite an emphasis on the importance of supervision, this could be hindered by people being too busy
- An Addictions worker explained that the level of self-care depends on a practitioner’s workload
- A Homelessness worker in Glasgow stated “we are all so busy, we have to run through the motions and say ‘yeah I’m fine’ in supervision. There is not the time to discuss properly”. The volume of “paperwork, bureaucracy and health and safety requirements” was seen to create time pressure
- A Criminal Justice Social Worker described that Social Workers do not want to be seen as “struggling”. Workers are often “spinning plates” and do not have space to think about how they are affected.

Practitioners reflected on problems associated with staff burnout and high turnover. In Homelessness services in Glasgow, a commissioning practitioner described high turnover where most staff work for between two and three years. This was seen as related to the challenging nature of the work rather than primarily a lack of support or supervision. An Addictions worker in Inverclyde stated that “there is burnout with all frontline workers”. Long to-do lists and heavy caseloads were observed to be linked to staff burnout, even with the provision of supervision.

**The development of individual coping or self-care strategies**

The development of strategies to individually cope with challenging aspects of their work was described by practitioners. Experienced workers were seen to know their own personal limitations and understand how to look after themselves, while those with less experience were seen to be less knowledgeable about where to get support from.

Practitioners in Inverclyde felt that there was a feeling that dealing with trauma went with the territory of their jobs. This sentiment was echoed by an Addictions worker in Glasgow who stated that there can be a culture where you are expected to “suck it up and deal with it”. Furthermore, a Tomorrow’s Women practitioner expressed that services can have cultures where workers are seen as “weak” and not able to “handle the work” if they say they need support.

A process of “de-sensitisation” to extreme behaviours was described due to the regularity of their occurrence in service environments. To protect themselves from the impact of serious issues, practitioners described the building up of a “force field” or
“barrier”. Workers across groups explained that they would to use humour or going into a “flippant mode” as a coping mechanism to manage difficult situations.

**Importance of peer support**

There was a strong emphasis on the importance of peer support and collaboration within teams across services and locations. Workers felt able to engage in successful peer support in smaller teams or teams with a fixed base. If a team was permanently operating from one building, this was seen to be conducive to the provision of ad hoc support. Conversely, those who were mobile working described difficulties in establishing successful peer support practices. For example:

> “In my present role, getting support is difficult, it is myself covering different areas in prisons, homes, schools. There are no opportunities for informal debrief”.

**Third Sector Criminal and Social Justice Practitioner, Glasgow**

> “Due to the sharing of offices and agile working, criminal justice staff have less access to managers and colleagues at the moment, which means less support in their day-to-day roles”.

**Criminal Justice Practitioners, East Renfrewshire**

Engaging in peer support was seen as useful in several situations:

- Where unexpected incidents affected workers e.g. a colleague being attacked
- Where workers had different skills and experience and could therefore benefit from drawing on each other’s expertise
- To benefit from more relaxed and less judgemental discussions with peers as opposed to managers.

**4.11 Appetite for training**

There was consensus amongst practitioners that trauma-related training would be useful for their work. Both management staff and frontline staff were identified as likely to benefit from training. Practitioners stressed the importance of training being tailored or adaptable to their specific area of practice. While training was recognised as beneficial for the wider implementation of Trauma Informed Practice, practitioners noted the need for a continued emphasis on trauma and regular reflection on practice beyond a one-off training event.
When asked to reflect on what training should cover, workers identified the following areas:

- **Awareness and understanding about trauma**
- **Effects of trauma on practitioners and vicarious trauma**
- **Managing conversations and disclosures**
- **Recognising and understanding trauma-related behaviours**
- **Identifying triggers and avoiding retraumatisation**
- **Managing crises**
- **Body language and effective communication**
- **Making clients feel safe**
- **Referral processes**
- **Trauma and brain development**

Practitioners felt that there was some scope for peer learning around Trauma Informed Practice within and between services and in many cases, it was felt that peer learning was already taking place successfully. A benefit of having one or few staff who had undertaken more in-depth training was seen to be workers gaining access to someone who would be continually available to ask for advice on cases through peer support. Within Health and Social Care Partnerships, it was recognised that extensive areas of expertise already exist and that these could fruitfully be shared across teams.

While the benefits of peer learning were recognised, there was concern that this would lead to pressure on one person to provide training and support. For a peer learning model to work well, it was felt that time would need to be allocated for a person to share their learning with other members of staff. Various practitioners identified that all members of staff should receive some level of training and therefore it would be important that a peer learning approach would not compromise broad access to training. Training delivered by an expert or someone who “knows that they are talking about” was seen to be required. In addition, there were seen to be benefits of workers gaining access to the same training so that trauma informed approaches would be consistent across teams and services.
Chapter 5 Service Manager Interview Findings

Introduction

Rocket Science conducted interviews with 22 service managers from:

- East Renfrewshire – Criminal Justice, Supported Housing, Addictions, Homelessness and Mental Health
- Glasgow – Homelessness, Addictions, Criminal Justice and Supported Housing
- Inverclyde – Criminal Justice
- West Dunbartonshire – Criminal Justice, Community Justice and Homelessness
- Prison and Police Custody.

Managers were asked to provide information about:

- The scope of their role and whether they felt that they had previously received any trauma-related training
- Their understanding of Trauma Informed Practice in the context of their services
- Current levels of skill amongst staff in the implementation of trauma informed approaches
- Risks associated with staff not being able to identify trauma-related behaviours or difficulties
- The extent to which they feel it is within the scope of their role to ensure their service implements Trauma Informed Practice
- Barriers they face in enabling the implementation of Trauma Informed Practice
- Self-care amongst staff and how this can be supported
- Whether training should be mandatory or tiered
- The types of information it would be useful for training to provide to members of staff.
Findings

5.1 Prior training

Managers most frequently had received some training that covered some elements of trauma, for example psychoanalytic training at university or training on domestic abuse, addictions or mental health. Several described that they had never received any type of training on trauma.

Amongst those who described that they had received trauma-specific training this included half or one day sessions on trauma-awareness or vicarious trauma.

5.2 Relevance of Trauma Informed Practice for services

A large majority of managers felt that trauma informed practice was either relevant or highly relevant for their services.

![Figure 6]

5.3 Understanding of Trauma Informed Practice

Managers provided a description of their understanding of Trauma Informed Practice in the context of their services. Across service settings and locations, managers were somewhat confident in their description of Trauma Informed Practice, with a large majority providing an account of some elements of Trauma Informed Practice. Accounts included the following elements of Trauma Informed Practice:

- Recognising behaviours associated with trauma
- Signposting clients to specialised services
- Acknowledging trauma and being non-judgemental
- Understanding that responsibility for client welfare does not fall on one individual worker
- Working at the client’s pace and building relationships
- Making services accessible to those with experience of trauma
- Being aware of your environment and avoiding retraumatisation
- Allocating clients to the most appropriate worker.
5.4 Current skill level amongst staff

East Renfrewshire

It was felt that Addictions teams were better informed about Trauma Informed Practice as they manage “complex cases”. Addictions staff were described as offering a Recovery Oriented Systems of Care approach which incorporates empowerment, safety and strength. While staff were seen to be skilled, they were not necessarily confident and could be quick to refer on in cases of disclosure about trauma.

On the other hand, Housing staff were seen to be potentially less informed about trauma as they may not have had opportunities to receive training. In Supported Housing, it was felt that while staff were experienced, would listen carefully and can refer on, trauma disclosures were an “exception” due to the “low level” nature of support.

In Criminal Justice services, it was expressed that staff had become skilled through gaining experience on the job. Workers were seen to need to balance the “control” elements of their work with the “caring” elements.

Glasgow

Staff across services were broadly described as “not confident” in implementing Trauma Informed Practice, where only Tomorrow’s Women was recognised as having a clearly defined approach to trauma.

Despite this, it was described that a broad range of Addictions staff have had access to at least some form of trauma-related training and “talk about [Trauma Informed Practice] a lot”. Addictions staff were seen to be good at adapting their practice, for example meeting people outwith the building.

In Criminal Justice, it was felt that while workers were good at building relationships and being mindful of how someone is feeling, there could be issues with individuals being asked to retell their stories multiple times.

Prison and Police Custody

It was described that Police Custody services employ “highly trained nurses” because they know how demanding the work can be. Workers learn trauma-related skills throughout their career through various types of training. Both Prison and Police Custody workers were described as working in environments which were not controlled by them which could limit the implementation of Trauma Informed Practice.

Working effectively in a prison context was seen to require skill in being able to have an open mind when interacting with clients who might have committed offences.

West Dunbartonshire

There was observed to be “varied knowledge” around trauma throughout Criminal Justice services, with Social Workers having a more in-depth knowledge around child protection and domestic abuse.
In Homelessness services, it was expressed that workers had a good understanding that trauma experience could lead to homelessness. Staff were seen to consider clients’ previous experiences and assess their requirements for support.

Inverclyde

In a prison context, it was described that while workers were aware of trauma as an issue and cautious not to retraumatise individuals, there were concerns around staff lacking confidence when clients discussed trauma experience. Staff were maybe fearful that they would not have the skills to discuss trauma and that there would be a lack of services to refer clients onto. Access to counselling services and clinical psychology was described as “very limited”.

The successful implementation of Trauma Informed Practice in Criminal Justice settings was seen to be related to the work culture in services. Support for staff was described as important, where organisations should consider the impact of trauma on their staff members.

5.5 Risk in not identifying trauma-related behaviours and difficulties

Managers identified risks associated with workers being unable to identify trauma-related behaviours and difficulties including:

- Alienating clients or discouraging continued engagement
- Retraumatisation – e.g. in a prison setting, behaviour could lead to control and restraint procedures which could “make things worse”
- Risk of distress to the client and harm to themselves or others
- “Giving up” on clients
- Workers becoming overwhelmed by behaviour
- Limitations to undertaking effective care planning
- Seeing behaviour as non-compliance (in Criminal Justice settings).

5.6 Role of managers in enabling Trauma Informed Practice

There was consensus across managers that leadership was important in ensuring the implementation of Trauma Informed Practice. It was acknowledged that more senior managers have a crucial role in setting the pace, agenda or direction in terms of Trauma Informed Practice, while team leaders should be responsible for working one-to-one with frontline staff to ensure that Trauma Informed Practice is driven forward. It was described that managers should be “as trauma-informed” as frontline staff. Interviewed managers identified several areas where managers should play a role in enabling Trauma Informed Practice:

- Ensuring ongoing discussions about Trauma Informed Practice at team meetings
- Encouraging staff to take part in training
- Challenging staff to think about their practice
- Ensuring consistency in the language and approaches employed by staff
• Creating a trauma informed culture
• Making sure Trauma Informed Practice is discussed in staff supervision
• Supporting staff and being mindful of vicarious trauma
• Planning trauma informed environments.

More senior managers were seen to have a wider overview of services and an ability to roll out training across services.

5.7 Restrictions to improving Trauma Informed Practice in services

Managers felt that improving Trauma Informed Practice in their services was within the scope of their role but would be most effective if this was part of a joined-up effort across services.

The extent to which managers felt that frontline practitioners were impacted upon by heavy caseloads varied across services. In cases where it was felt that heavy caseloads limited the successful implementation of Trauma Informed Practice, managers described personally taking on more work to alleviate pressure on staff and improving the allocation and prioritisation of work. Elsewhere it was felt that managers could do little to reduce pressure on staff as “all public-sector organisations are being asked to do more with less”.

The following restrictions to improving Trauma Informed Practice were discussed:

• Lack of funds to improve the quality of services
• Limited duration of contact time with clients which could restrict the scope for relationship building. However, other managers noted that regardless of the duration of a typical engagement with a client, workers should be trauma informed in their approach e.g. “if you only have ten minutes, what would make those ten minutes better?”
• Lack of trauma informed service environments and limited scope to make changes
• Limits to the rollout of training including limited funding for training and needing to free up staff to attend.

5.8 Self-care and support

The degree to which workers were seen to engage in self-care varied. It was felt that experienced workers knew how to take care of themselves and in cases had become “hardened” over time. Managers demonstrated an awareness about the importance of self-care and identified several actions which could help to ensure adequate support for staff including:

• Managers having an “open door” policy
• One-to-one sessions between managers and frontline staff
• Regular team meetings which can be used to share best practice and reflect on challenges
• Access to independent counselling services
• Training and development days
• Allowing staff to work from home and blocking out time for “breathing” space
• Monitoring whether staff are overworked or stressed.
The importance of peer support was stressed by interviewees, and it was felt that mobile working or teams being split across office locations could be a challenge to this. Fixed, open-plan offices were seen to be conducive to effective peer support. Managers felt that they could play a role in creating environments where staff would feel comfortable coming together to discuss their work. Peer support could be formalised through time devoted to sessions where workers could discuss specific issues. The importance of adapting the support offered to different workers depending on their individual needs was noted. This was seen to only be possible through managers getting to know members of staff.

5.9 Staff enthusiasm and responsibility for training

Managers across all services in all locations felt that staff would be enthusiastic to receive training on Trauma Informed Practice. It was felt that training should be relevant to workers’ roles and be rolled out over an extended period rather than through a one-off session.

While managers recognised that workers should take responsibility for their own personal development and training needs, it was felt that managers should offer opportunities and free up staff for training. It was expressed that while managers can offer training, frontline workers must engage and reflect on what the training means for their practice. It was noted that as trauma informed approaches are not currently embedded in practice, managers need to lead and push for awareness through arranging training. It was stated that “workers might not know what they do not know unless they are offered training” and it was hence felt that they could not be expected to have sole responsibility for seeking out training.

5.10 Tiered training and trauma champions

While some managers felt that having a trauma ‘champion’ would be beneficial, others were more cautious about this model. Identified benefits of having a champion included:

- Their development of a trauma informed ethos in teams and the keeping up of momentum in implementation of new approaches
- Limited disruption associated with losing all staff to training
- Making the most of someone with interest in the area developing their skills and knowledge to be able to lead on trauma informed approaches
- Having expertise to draw on in complex cases.

Despite these outlined benefits, it was expressed that this model could lead to staff passing on responsibility for cases to the champion. Therefore, it was explained that strict procedures should be in place around how staff can make use of the champion.

Managers were generally supportive of the idea of tiered training whereby all members of staff would get a basic level of training, with some receiving more in-depth training depending on their role. Workers with complex cases and those whose role involved building relationships with clients were identified as needing more extensive training.
5.11 What training should cover

Managers reflected on what training should cover to improve the level of Trauma Informed Practice in their services. This included:

- Asking the right questions and knowing how to enquire sensitively
- Recognising behaviours
- Referral processes
- Understanding what is meant by ‘trauma’
- Managing boundaries
- Trauma informed environments
- Impact of trauma on individuals
- Toolkit of skills to deal with trauma disclosures
- Self-care for staff.
Chapter 6 Findings and Action Plan

This chapter outlines our key findings and action plan.

6.1 Findings

Overall, we found that:

- Staff across all services stated that a vast majority of their service users have experienced trauma and that engagements with services can be retraumatising.

- Staff reported a good understanding of what trauma was and the impacts it can have on someone’s lives. However, we found that this understanding was not always a consistent and comprehensive understanding of trauma.

- Around half of staff reported that they had received some form of trauma training, but that most training they had received they had to proactively seek out themselves. Therefore, most people receiving training will have already identified that it was important for them.

- Staff reported less confidence in responding to trauma and implementing trauma information. Staff were particularly concerned that they may ‘do the wrong thing’ or ‘make things worse’, in particular around how to handle disclosures of trauma by service users.

- There was a broad misunderstanding between Trauma Informed Practice and trauma treatment. Staff generally viewed that it wasn’t their job to treat trauma, but often conflated Trauma Informed Practice with treating trauma. This was often demonstrated by staff across all services stating that it was their job to ‘deal with the crisis first’.

- More needs to be done to ensure that staff see Trauma Informed Practice as a vital approach to their usual jobs, rather than an additional task or burden.

- Staff understood the importance of self-care when exposed to trauma in the workplace, however the extent to which they had access to formal and informal support varied.

- The largest barriers to implementing Trauma Informed Practice reported by staff were the time they had available with service users, the way services were structured (including how services work together to ensure people don’t fall between the gaps) and the physical environment of the services.

Addiction services across the Health and Social Care Partnership areas were most likely to report that they understood trauma and were most likely to be implementing various elements of Trauma Informed Practice. They also tended to report that they felt adequately supported to implement trauma and to know where to refer services to. We note that where psychologists are embedded within services, they may be providing informal support and training for other service staff.
Criminal and Community Justice expressed a high interest in further training and were most likely to report that there were barriers to implementing Trauma Informed Practice within their service. The most reported barrier unique to Criminal and Community Justice was the penal nature of the service which limited their ability to be flexible and accept some of the behaviours exhibited by those who have had traumatic events. They were also most likely to report that they didn’t receive enough support and supervision to help them implement Trauma Informed Practice and engage in self-care. Community Justice reported slightly lower understanding around trauma and Trauma Informed Practice than Criminal Justice.

Homelessness services tended to have received the least training in the past, found it the least useful, and expressed the least interest in receiving training in the future. This generally was linked to a higher proportion of staff who didn’t feel like Trauma Informed Practice was relevant for their service. They were also the most likely to report time with service users as a barrier to implementing Trauma Informed Practice. Most of these views appear to be driven by a misconception that Trauma Informed Practice was treating trauma and required additional actions and services – rather than it being a lens and an approach to their usual work. We generally found that during focus groups, once we discussed individual elements of Trauma Informed Practice that staff became more interested in it and tended to express that it would be helpful for their role.

Police Custody and Prison Healthcare services expressed a high degree of interest in Trauma Informed Practice and saw it as a vital part of their service. The largest barrier to implementing Trauma Informed Practice reported by frontline staff in these two services was the service structure of their host service – Police and Prison services. They identified that a number of elements of these services processes are likely to be triggers for people who have experienced trauma and expect that many will be retraumatised as a result. They also reported that they faced restrictions in the duration of access to service users, particularly in Police Custody and therefore highly valued anything that could be done to improve throughcare and referrals to other services. They also identified an opportunity to access service users who would not usually engage with other services such as Homelessness, Addictions or Trauma Treatment services as service users were not voluntarily participating in their services.

Service managers we spoke to generally appreciated the importance of Trauma Informed Practice, though there were a few who were less sure of its relevance to their service. They also recognised that service managers generally have different responsibilities in relation to enabling and supporting the implementation of Trauma Informed Practice. These various roles are outlined in the table overleaf:
<table>
<thead>
<tr>
<th>ROLE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Head of Services</strong></td>
<td>Setting the agenda</td>
</tr>
<tr>
<td></td>
<td>Getting ‘behind’ TIP</td>
</tr>
<tr>
<td></td>
<td>Devoting resource to training and implementation</td>
</tr>
<tr>
<td></td>
<td>Governance – facilitating collaborative service delivery and information sharing</td>
</tr>
<tr>
<td><strong>Service Managers and Clinical Leads</strong></td>
<td>Operationalising Trauma Informed Practice in service settings</td>
</tr>
<tr>
<td></td>
<td>Monitoring day-to-day implementation</td>
</tr>
<tr>
<td></td>
<td>Releasing and supporting staff to attend training and developing peer-to-peer support and learning</td>
</tr>
<tr>
<td></td>
<td>Supervising staff and promoting self-care</td>
</tr>
<tr>
<td></td>
<td>Leading by example – including promoting collaborative working and information sharing</td>
</tr>
<tr>
<td><strong>Team Leaders</strong></td>
<td>Identifying trauma-related behaviours</td>
</tr>
<tr>
<td></td>
<td>Making clients feel safe – including sensitively sharing information to reduce retraumatisation</td>
</tr>
<tr>
<td></td>
<td>Recognising prevalence and impact of trauma</td>
</tr>
<tr>
<td></td>
<td>Working collaboratively within and across teams</td>
</tr>
<tr>
<td></td>
<td>Listening carefully</td>
</tr>
<tr>
<td><strong>Frontline Practitioners</strong></td>
<td>Considering potential for retraumatisation</td>
</tr>
<tr>
<td></td>
<td>Identifying and addressing barriers to service access</td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Figure 7 The role of different types of staff in implementing Trauma Informed Practice.*
6.2 Action Plan

6.2.1 Context for the action plan

There are three elements that make up a trauma informed service.

- The **physical environment** has to be focused on reducing retraumatisation and removing barriers to service engagement for those who have had trauma in their past. These range from small to large infrastructure and building changes.

- **How staff behave and respond** to service users is an important element of Trauma Informed Practice. This is the focus of this training needs assessment and action plan

- **How the service is designed** is crucial for Trauma Informed Practice. The processes that service users have to go through can act as a barrier to engaging and potentially retraumatise service users. This includes:
  - Service criteria
  - Paperwork required
  - Waiting time process and environment
  - Availability of female and male staff so that service users have a choice
  - Flexibility in the processes – to tailor the appointment time, location and process for the service users

Interservice referrals is also an important element of the broader design of service. A number of factors can affect those with trauma including:

- Service users that ‘bounce’ between services – where a referral is made but the service refuses to take on the referral due to a variety of reasons such as suitability of the service user for the service

- Wait times for services – where referrals are made to services with long wait times that leave the service user in ‘limbo’ while they wait

- How closely the services work together to minimise the amount the service user has to repeat their story, repeat needs assessments or other actions.

Finally, in relation to service design is the support and supervision structures in place within a service, and the extent to which they are implemented appropriately and sufficiently by service managers and those with supervisory responsibilities. Without adequate support to implement Trauma Informed Practice and to help staff engage in sufficient self-care then Trauma Informed Practice is unlikely to be implemented consistently and sustainably.
Focusing on the staff behaviours element of Trauma Informed Practice, we have found there to be four key drivers of staff behaviour.

- **Changing the hearts and minds of staff** - ensuring there is buy in to the importance and relevance of Trauma Informed Practice amongst staff
- **Staff knowledge** – ensuring that staff have the required knowledge about trauma, the impact of trauma, the barriers to service engagement for those with trauma, likely triggers for retraumatisation, how to respond to service users and how to tailor their behaviour appropriately
- **Staff confidence** – ensuring that staff feel confident to use Trauma Informed Practice, removing some of the uncertainty and concern that they might ‘get it wrong’
- **Providing realistic actions for staff** – ensuring that staff can see that there are things they can do within the current constraints and barriers in their service.

6.2.2 Who to train, in what, and when?

From our research we recommend that all staff across all services receive some form of training in respect to Trauma Informed Practice.

- We recommend that **service managers are trained first** – including those with staff supervisory responsibility. We recommend that **frontline staff are trained following this**. This will ensure that there is sufficient buy in to put in place Trauma Informed Practice consistently and sustainably and the ongoing maintenance of staff support and supervision arrangements.
• Service managers – including service heads, service managers, clinical leads and team leaders – should receive training to ensure that they:
  
  - Understand Trauma Informed Practice – and breaking down myths such as low security not necessarily being higher risk
  
  - Buy in and 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’
  
  - See the practical ways to implement Trauma Informed Practice and what it should look like in their service – including what service design changes can facilitate the implementation of Trauma Informed Practice
  
  - Explore the service delivery and governance implications for implementing Trauma Informed Practice in their service e.g. information sharing and collaborative working
  
  - Start to explore the other areas they will need to action – such as the physical environment and service design.

The primary objective of this training should be to ensure that managers leave with a commitment to Trauma Informed Practice and a clear idea of how to apply it to their service. For this reason, we recommend that part of this training be in the form of a workshop where the various layers of service managers for each service are able to discuss and plan how to do Trauma Informed Practice in their service. For example, managers could complete an NHS Education Scotland online course on trauma and Trauma Informed Practice prior to the training so that more time can be focused on getting service managers to buy into its importance and plan for its implementation

• We think that frontline staff should 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 – how to deal with vicarious trauma, what your supervisor should be providing and how to provide peer support to colleagues
We recommend that all staff with interactions with service users attend this training. This includes practitioners and support staff such as receptionists. It should be noted that this means that staff such as team leaders or senior practitioners with supervisory responsibilities may attend both practitioner and service manager training sessions.

- 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.

Training needs are relatively consistent across service types, but variations by service are outlined in the table below.

<table>
<thead>
<tr>
<th>To enable change, services need to:</th>
<th>Addictions</th>
<th>Criminal, Community Justice</th>
<th>Housing and Homelessness</th>
<th>Prison, Police Custody</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build staff knowledge of how to be TI</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Build staff confidence to implement TIP</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide realistic actions for implementing TIP in current service environments</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Change the hearts and minds to get buy in for the importance of TIP</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Build partnerships with the organisations they work with to enable TIP</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Figure 10 Training needs by service

6.2.3 Other activities to support Trauma Informed Practice

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 this understanding and buy in. However, there is a risk that 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 with staff groups how to improve the physical environments and service design.

While a number of changes are large and may require infrastructural responses that are not possible in the short or medium term, there are a number which require small changes with no or limited resourcing requirements. We recommend that an action plan for short, medium and long-term objectives and actions be developed so that staff can see support for Trauma Informed Practice being planned for and implemented across the organisations.
For Prison and Police Custody Health Care services, this will require strong partnership with Police and Prison services to develop joint commitment and support for Trauma Informed Practice. This will enable the broader services to make changes to be more trauma informed.

We also recommend that the Health and Social Care Partnerships and Prison and Police Custody Health Care services consider options for:

- Reducing the need for clients to repeat themselves to each individual service (information sharing)
- Increasing staff knowledge about where to refer service users (client pathways).
Appendix 1 Bibliography


National Centre on Domestic Violence, Trauma and Mental Health (2015) *Handout Module 2 Impact of Trauma: Defining Triggering, Retraumatisation & Revictimisation*.


NHS Health Scotland (2017) *Community Justice Practice Spotlight Summary 4: Tomorrow’s Women Glasgow*.


Turning Point (2016) *Dual Dilemma: The Impact of Living with Mental Health Issues Combined with Drug and Alcohol Misuse*.

Appendix 2 Staff Survey Questions

About you

- Which type of service do you work for?
- What is your job title?
- Please describe your role briefly:
- How long have you worked within the health and social care sector overall?
- Have you received any trauma-related training while working within the health and social care sector?
- Would you have found trauma-related training useful for your work in health and social care? (Rating from Not Useful to Very Useful)
- Which service did you work for when you received trauma-related training?
- Where did you receive trauma-related training?
- How useful has the training been for your work in health and social care? (Rating from Not Useful to Very Useful)
- Did the trauma related training cover (please select all that apply):
  - Types of trauma
  - The effects trauma can have and trauma-related difficulties
  - How trauma can affect someone’s ability to engage with health and social care services
  - How health and social care services can better support someone with trauma-related difficulties
  - Other (please specify):

Understanding trauma

- Please indicate to what extent you agree or disagree with the following statements (Rating from Strongly Agree to Strongly Disagree):
  - I understand what trauma is
  - I understand the term “complex trauma”
  - I know the kinds of experiences that are traumatic
  - I understand the effects trauma may have on someone’s life including potential consequences for health and social outcomes
Trauma Informed Practice

Respondents were provided with the following information:

**Trauma-informed practice:** A service’s practice is trauma-informed if all aspects – its organisational structure, its management systems and its service delivery – are designed to include a basic understanding of how trauma affects the life of an individual seeking services. The principles of trauma-informed practice are routinely applied to ensure that those affected by trauma are able to effectively access care and support and to reduce the risk of re-traumatisation and trauma-related distress.

**Note that trauma-informed services do not necessarily treat trauma per se; services that do this are called trauma-specific services.**

- Please indicate to what extent you agree or disagree with the following statements (Rating from Strongly Agree to Strongly Disagree):
  - I know what trauma-informed practice looks like in health and social care
  - I understand how trauma-informed practice can be implemented in health and social care in general
  - I understand how trauma-informed practice can be implemented in my role
  - I understand the benefits of trauma informed practice for those who use health and social care services
  - I understand the benefits of trauma informed practice for staff in health and social care
  - There are barriers to implementing trauma-informed practice in my role and/or in the service

**Trauma-related skills**

**Taking trauma into account**

- Please indicate to what extent you agree or disagree with the following statements (Rating from Strongly Agree to Strongly Disagree):
  - I appreciate that a person might feel distressed or even re-traumatised in certain situations if they remind them in some way of past trauma
  - I always keep in mind that a person’s behaviour or reactions - in general and in response to my support – could be linked to trauma-related difficulties
  - I am confident that I can identify behaviours and difficulties that are related to traumatic experiences
I am confident that I can identify areas of my own practice and procedures that may be experienced as distressing by those affected by trauma

I know how to adapt my own practice and procedures to reduce trauma-related distress

I always do adapt my own practice and procedures to reduce trauma-related distress when needed

Responding to trauma

- Please indicate to what extent you agree or disagree with the following statements (Rating from Strongly Agree to Strongly Disagree):
  
  - I know how to help someone who speaks about their experiences of trauma feel safe within the context of our working relationship
  
  - I always listen carefully when someone speaks about their experiences of trauma
  
  - I always respond with empathy and without criticism or blame when someone speaks about their experiences of trauma
  
  - I am aware of the importance of asking someone who speaks about their experience of trauma what help (if any) they need and want at this time
  
  - It is part of my routine practice to ask someone who speaks about their experience of trauma what help (if any) they need and want at this time
  
  - I always ensure not to put any sort of pressure on someone who chooses not to speak about their experience of trauma

- When supporting someone who has experience of trauma, it is part of my routine practice to consider (select all that apply):
  
  - What’s wrong with you?
  
  - What happened to you?

Referrals for trauma-specific intervention

- Please indicate to what extent you agree or disagree with the following statements (Rating from Strongly Agree to Strongly Disagree):
  
  - I am confident in my ability to decide at what point it is best to refer someone who has experienced trauma to another service for trauma-specific intervention
  
  - I know where to refer people who need a trauma-specific intervention
Professional self-care and support

- Please indicate to what extent you agree or disagree with the following statements (Rating from Strongly Agree to Strongly Disagree):
  
  - I am aware of the importance of taking good care of myself when exposed to trauma in the workplace
  
  - I feel able to take good care of myself when exposed to trauma in the workplace
  
  - I have ready access to formal or informal support/supervision to help me manage the impact of trauma exposure in the workplace

Professional learning and development

- Please indicate to what extent you agree or disagree with the following statements (Rating from Strongly Agree to Strongly Disagree):
  
  - I would value gaining more skills and insights into how to better recognise those clients who have been affected by trauma
  
  - I would value opportunities to learn more about how to identify and respond to those affected by trauma as part of my role in health and social care
  
  - I feel that I have a range of insights and experience of working with those affected by trauma which would be valuable to other staff