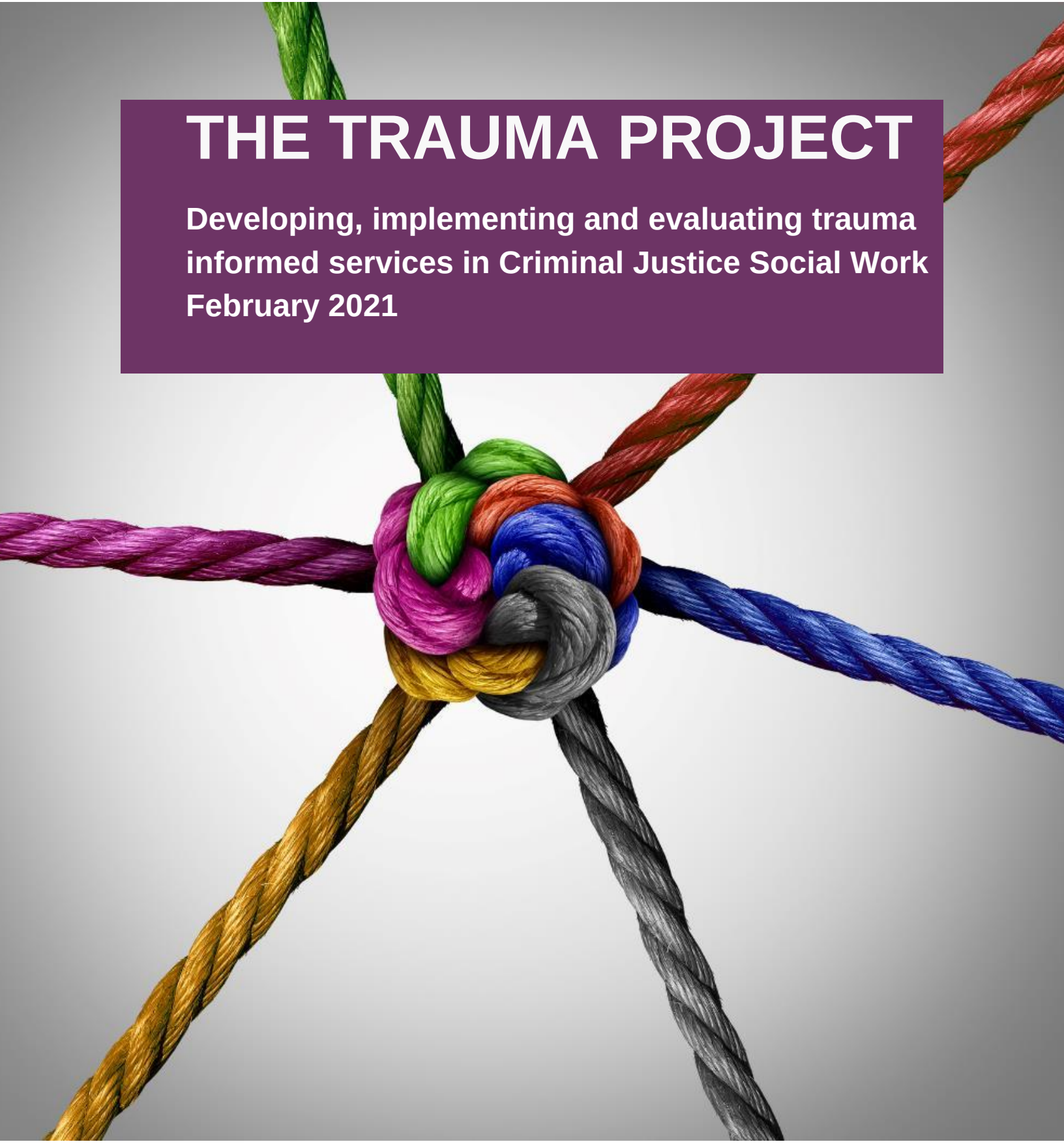

THE TRAUMA PROJECT

Developing, implementing and evaluating trauma informed services in Criminal Justice Social Work

February 2021

Re:d
working **with** people with multiple and complex needs

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Acknowledgements

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The Re:D Collaborative is an innovative community of practice established to promote partnership working to combat negative outcomes for individuals and communities that arise from deep-rooted inequalities. It is supported by Edinburgh Health and Social Care Partnership.

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Contents

Introduction

This report relates to the development, implementation and evaluation of a project the purpose of which was to establish broad based change within one sector of the City of Edinburgh Council's Criminal Justice Social Work (CJSW) services, namely Groupwork Services (GWS). The overarching aim of this project was to promote fundamental cultural change within the service. This was to involve adopting a trauma informed model of service provision that recognises and centres the contribution made by experiences of trauma and its impact on service users' presentations. Trauma and its impacts are positioned as crucial considerations in determining how to work most effectively with service users. This involved taking steps towards creating a trauma informed approach to service delivery. As such, the scope of this project, which we will refer to as the 'Trauma Project', relates, in varying degrees, to all aspects of service delivery and therefore impacts on all members of staff involved in service delivery as well as users of the service.

Groupwork services consists of four teams providing a broad range of activities in relation to the provision of services to people in contact with the criminal justice system. These are

Crossroads: Provided groups for men aged 18 and over, convicted of a range of miscellaneous crimes including dishonesty, drug related crime, crimes of violence and road traffic offending

Community Intervention Service for Sexual Offending (CISSO) Delivers the Moving Forward, Making Changes and other group and individual interventions, for people convicted of sexual offences. Provides treatment and risk assessments for other social work staff

Domestic Abuse Services: Delivers the Caledonian group interventions to men. Prepares Criminal Justice Social Work Reports and supervises Community Payback Orders and post custodial licences. Provides support services to women and children impacted by domestic abuse. Works with individuals on a voluntary basis in relation to domestic abuse and parenting, including the provision of services in Polish to those whose first language is Polish.

The Willow Service is a service for women in contact with the justice system. This is delivered through a variety of groups and treatment interventions. This service had explicitly adopted a trauma informed model of service provision which predates the development of the Trauma Project.

There are two Team Leader, 7 Senior Social Worker and 1 Senior Practitioner posts in GWS. These will be referred to as the frontline managers. Seven of these posts are out with Willow and

are therefore leadership positions in teams that had not, as of the start of the current project, explicitly worked to a model of trauma informed service provision.

This report relates to activity that primarily took place from the formal launch of the Trauma Project in August 2018 until March 2020 when, in response to the Covid19 pandemic and the associated lockdown, there were major changes to the ways in which CJSW services were being delivered. These changes had a significant impact on all aspects of the service, including the Trauma Project. As we will see below, some of the developments that had been implemented proved to be of great value, particularly in relation to staff well-being, when the service was faced with the challenge of adapting to the changes brought about by the Covid19 pandemic lockdown.

Within the Council's CJSW Services, the Willow Service, had for a number of years been successfully delivering a model of service provision that incorporates knowledge and understanding of the impact of trauma on those who use the service. This service was established through a partnership between CJSW and NHS Lothian. Much of the learning from the experience of the Willow Service was used to inform the approach adopted for the current Trauma Project.

To support the implementation of a trauma informed service model in the current project, mental health specific training and clinical supervision were essential. Input from a specialist clinician was required to ensure appropriate governance structures and processes were in place to support staff in delivering trauma informed assessments and interventions which recognise both the impact of trauma and associated mental health difficulties. To this end, a jointly funded post for a Highly Specialist Clinician, appointed as a Senior Clinical Psychologist (SCP), was established. Funding for this post was shared by CJSW and NHS Lothian. The post holder joined the project in April 2019 and was embedded in the project and the teams, with day to day line management of the post from within GWS.

Alongside the CJSW Sector Manager, the specific purpose of the SCP post was to contribute to and/or provide:

- Co-leadership of the Trauma Project
- Governance, expertise and specialist knowledge relating to trauma and its impact on mental health, in all aspects of the Trauma Project
- Additional support to senior social workers and team leaders in the implementation of various components of the trauma informed approach within GWS, including case consultations
- Involvement in a series of specific development and mentoring sessions for senior social workers and team leaders
- Development and delivery of staff training relating to mental health in the context of trauma
- Development of and supporting the implementation of a standardised screening and assessment process for trauma and mental health (Trauma And Mental Health Screening: TAMHS)
- Development of materials to support staff in delivering trauma informed interventions
- Developing and delivering regular trauma informed group supervisions
- Occasional ad hoc availability for in-depth case consultations with front line staff when trauma and/or mental health difficulties were a significant factor in the service user's presentation

- Ensuring suitable governance around the pilot of the Survive and Thrive course and providing supervision for course facilitators
- Reviewing the Survive and Thrive materials in terms of appropriateness for the GWS service user population and to make recommendations to the National Survive and Thrive Reference Group
- Leading on evaluation of the Trauma Project.

The SCP post was established to support the Sector Manager in developing and implementing changes in culture and practice within the service

There were a number of outcomes that this Trauma Project was designed to achieve on various levels, including:

- the systemic level
    - cultural change; adaptation of a trauma informed approach within the service
- the practice level
    - trauma informed assessment and interventions
- the individual worker level
    - increased confidence and competence in working with and responding to trauma and mental health issues
- the service user level
    - improved experience of service, improved outcomes.

Within the time frames of this project, it has been possible to look at evaluation for some of these anticipated outcomes, although others (for example, outcomes for service users) require a longer time frame for specific evaluation.

Background and context

The importance of trauma

One of the most significant developments in health and social care services over the past 20 to 30 years has been the growing recognition that traumatic experiences, including adverse childhood experiences (ACEs), make an important contribution to increased risk of a wide range of physical and mental health conditions and social problems. These include obesity, substance misuse and a range of life-limiting health conditions (see Bellis et al, 2019 for an overview) and anxiety, depression, post traumatic stress (see Kessler et al, 2010) and psychosis (Varese et al, 2012). There is also growing evidence that ACEs are associated with increased risk of involvement with criminal justice services (Scottish Government, 2018), although at the time of writing there was little local research in this area.

The evidence-base that experiences of trauma can have a broad range of long-lasting impacts is now very robust. Alongside the growing body of evidence there has been the growing recognition that services which work with people who have a trauma history need to take this into account in their services delivery. Failure to do so has been shown to impact negatively on outcomes for service users. Indeed, there is a strong body of research that demonstrates that overlooking the role of trauma can mean that services inadvertently 're-traumatise' individuals leading to a range of negative outcomes for service users (Sweeney et al, 2018). That is, services which fail to acknowledge and take into consideration the fact that significant numbers of their client base have a trauma history, run the risk of causing harm to their service users.

Recent years have witnessed an exponential growth in the evidence base that demonstrates the widespread prevalence and significance of traumatic experiences in the general population. Further, there is growing evidence that for a range of services, including mental health services, the rates of traumatic experience among users of these services are significantly higher than in the general population (for example, see Lewis et al, 2019). There is less specific research highlighting prevalence of trauma and its impact within the particular population of men who find themselves in the criminal justice system, although this too is growing at pace (see Ashton et al, 2016; Levenson, 2016; Taft et al, 2016).

Despite the widespread prevalence of traumatic experiences, for a variety of reasons, service providers may not know which of their service users have a significant trauma history. This has led to the recognition that individual and group interventions (such as Trauma-informed Cognitive Behaviour Therapy, Eye Movement Desensitisation and Reprocessing (EMDR),

Safety and Stabilisation approaches etc) for those known to have been impacted by trauma can only ever be one component of the way in which services respond. There has been growing recognition that while individual interventions are effective in supporting some individuals concerned, a broader, systemic approach is required. This approach requires health and social care services to be delivered in a manner that recognises that a significant number of their service users will have a trauma history, which they may or may not choose to disclose, but which will nonetheless impact on their experience of the service concerned.

Trauma informed services

This has led to the development of what has come to be referred to as 'trauma informed care' as a model of service delivery. This approach has, at its core, the recognition of both the prevalence and the impact of trauma. A trauma informed care (TiC) model of service delivery would, ideally, incorporate understandings of the impact of trauma into all aspects of the service including, for example, the experience of the service user as he/she arrives for his/her first appointment in reporting to reception. The essential argument in favour of organisations adopting a TiC approach is that this will be of benefit to all users of the service, not only those with a significant trauma history. People who have been impacted by trauma may be adversely affected by a service which is not trauma informed, whereas there will be no such negative impact on those with no significant trauma history who engage with a trauma informed service.

NHS Education for Scotland (NES) has recently produced two documents (Transforming Psychological Trauma: Knowledge and Skills framework for the Scottish Workforce, 2017 and the Scottish Psychological Trauma Training Plan, 2019) which provide an overview of the rationale and evidence for TiC. These documents also give some helpful guidance on the range of factors that organisations which aim to work in a trauma informed way need to take into consideration. These documents and the principles they enshrine have the support of the Scottish Government which has made a strong commitment to the development of trauma informed organisations and a trauma informed workforce in Scottish public services. Recent years have witnessed the development of trauma informed policing approaches in Scotland and trauma informed training provided by the Law Society of Scotland for solicitors, to give but two examples of work places where the principles and practice of trauma informed approaches are being adopted.

The figures below, taken from the NES Trauma publications, illustrate important elements of what is required for an organisation to move towards being trauma informed and describe different levels of expertise required for different members of the workforce. The first figure, "trauma informed principles, values and leadership", conveys the breadth of the issues that organisations need to take into account in working towards being trauma informed, while also – in the central flower section – identifying key values that services should adopt and nurture in their relationships with service users (and these values should, of course, also inform how the service relates to its own staff), namely: Choice, Empowerment, Safety, Trust and Collaboration.

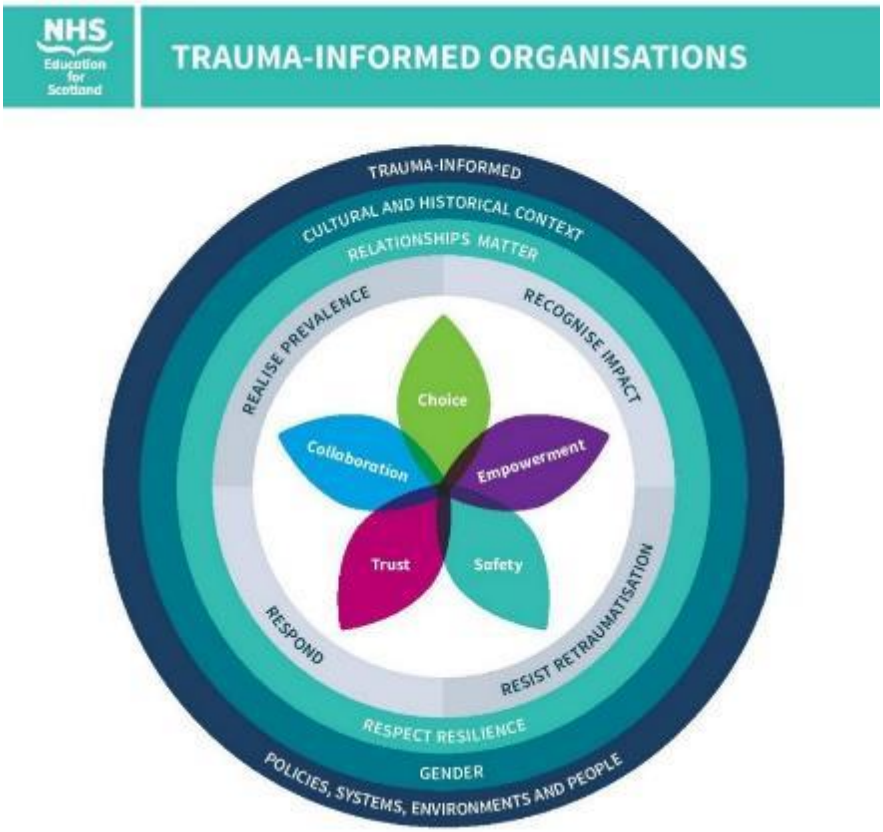


Figure 1: NES Trauma Informed Principles, Values and Leadership

The discussion about 'trauma informed organisations' helpfully broadens out the relevance and applicability of trauma informed approaches beyond that of services which provide 'care'. Providing 'care' is not an explicit aim of CJSW practice in Scotland and as such the term seems misaligned with service aims and objectives. Experience of implementing trauma informed approaches to service delivery at Willow identified some of the difficulties associated with the language of trauma informed 'care', particularly within statutory justice services. Discussions with some leaders and colleagues within wider justice services highlighted some scepticism that TiC was relevant to, or achievable within, the provision of CJSW services.

The implication was that a focus on trauma and its impact on those who have committed a crime somehow negated our primary focus on the assessment and management of risk within our public protection functions. Some had concerns that by attending to the trauma experiences of those who have committed crimes, TiC approaches in CJSW re-prioritise a focus away from victims of crime and is therefore unwarranted in the administration of justice through statutory supervision. However, experiences at the Willow Service found that acknowledging and attending to the impact of trauma within a population of individuals who have committed crimes is not only compatible with the administration of social and criminal justice, but evidence suggests this enables interventions to be more effective. Evaluation at Willow indicated that service users' experiences and outcomes improved when the service adopted a trauma informed model of service delivery. Taking account of these challenges and our Project's aim to develop trauma informed services in one part of our wider organisation (Council) we refer here to 'trauma informed service (TiS) delivery', rather than 'trauma informed care'.

A trauma informed justice workforce

The NES Trauma Framework helpfully acknowledges the different levels of expertise required by different members of staff involved in an organisation dependent on the nature of their involvement with service users.

Trauma Informed Practice	Trauma Skilled Practice	Trauma Enhanced Practice	Trauma Specialist Practice
All workers	Workers who are likely to be coming into contact with people who may have been affected by trauma	Workers who have a specific remit to respond to people known to be affected by trauma AND are required to provide advocacy support or interventions OR are required to adapt the way they work to take into account trauma reactions to their job well and reduce risk of re-traumatisation OR are required to manage these services	Workers who have a specialist interventions or therapies for people known to be affected by trauma with complex needs
Examples could include shop workers, taxi drivers, recreation workers and office workers,	Examples could include some lawyers, GPs, teachers, support for learning staff, police officers, nursery staff, sports-club coaches, receptionists, dentists, judges, A&E workers, lecturers, housing workers, care workers, service managers, youth development workers, health visitors and counsellors.	Examples could include some lawyers, mental health nurses and workers, specialist domestic abuse support and advocacy workers, educational support teachers, some specialist police officers, some psychiatrists, forensic medical examiners, social workers, prison staff, secure unit workers, drug and alcohol workers and specialist counsellors.	Examples could include social workers with specialist roles / training, major incident workers, some psychiatrists, managers of highly specialist services, psychologists and other therapists.

Figure 2: NES Workforce Practice Levels

The Framework identifies 4 workforce practice levels (Trauma Informed, Trauma Skilled, Trauma Enhanced and Trauma Specialist) and proposes that organisations use this structure to determine the level of expertise required for different members of staff working in an organisation. For example, while a psychological therapist delivering specialist trauma interventions may be required to be operating at the 'trauma specialist' level, reception staff in the same organisation may be required to be 'trauma skilled' in their level of expertise.

The NES Framework provides extensive information to support organisations in determining appropriate levels of trauma expertise required for their staff. The graphic below provides a summary in flow chart form of the decision making process in establishing levels of knowledge (and therefore training) required:

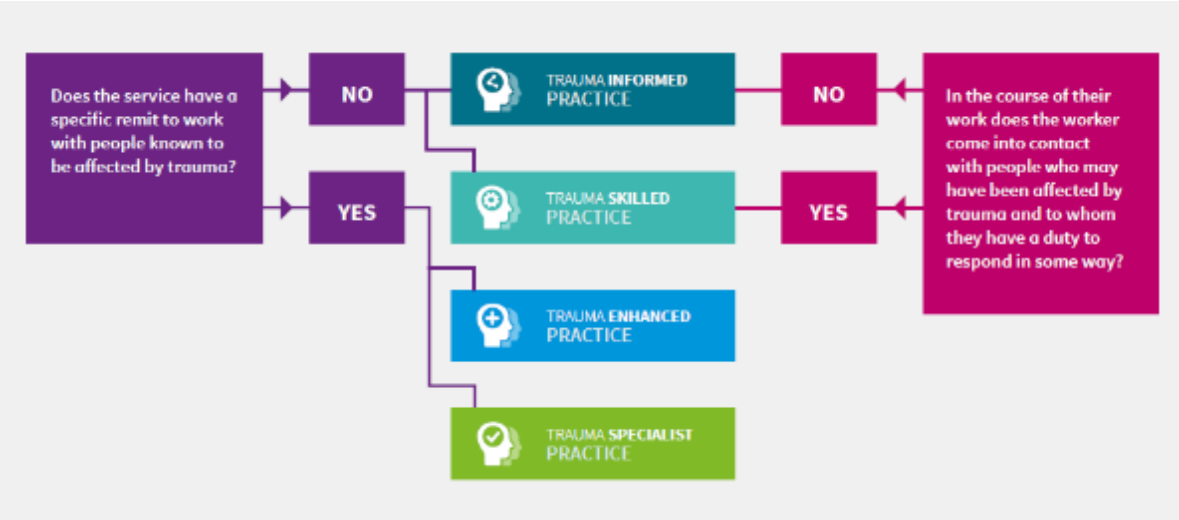


Figure 3: NES Identifying Workers' Practice Levels

The NES documents provide details on the specific activities that organisations should be taking into account in evaluating the level of expertise required by different workers within the organisation. Trauma enhanced practice level is required for those workers who have

> **"specific remit to respond to people known to be affected by trauma and are required to provide advocacy support or interventions or are required to adapt the way they work to take into account trauma reactions to do their job well and reduce risk of re-traumatisation or are required to manage these services."**

Examples of workers expected to practice at this level include social workers' (NES, 2019, p8). Social workers within a criminal justice service need to be operating at this level if the organisation aims to adopt a trauma informed approach to service delivery. The training and other supports delivered as part of this Trauma Project were therefore aligned with and benchmarked against the specifications required to support workers in acquiring the knowledge and skills required to practice at this 'trauma enhanced' level.

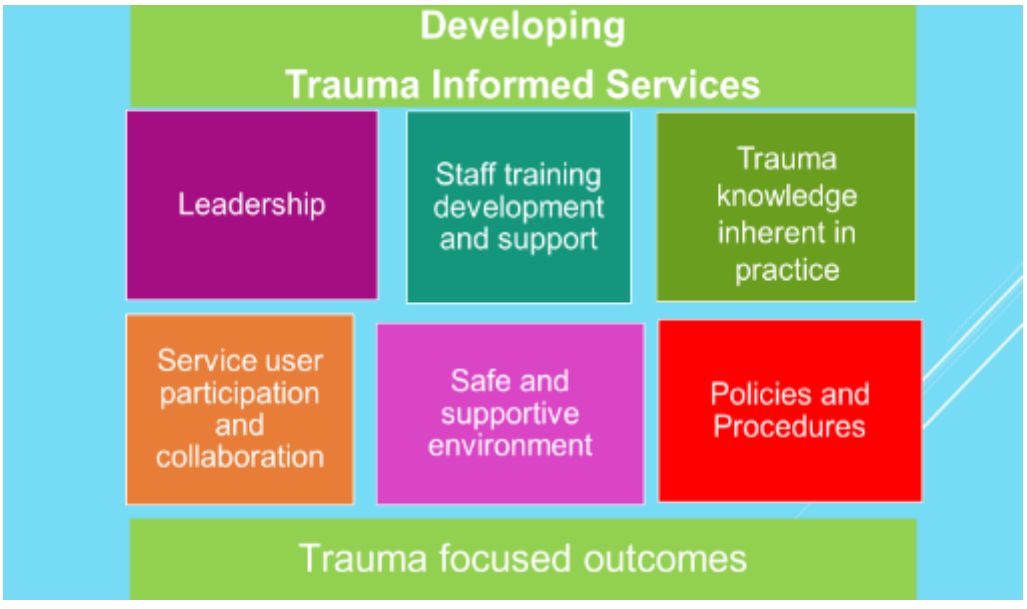
Whilst the NES Trauma documents provide guidance on many aspects of the principles of TiC they are not designed to provide a step-by-step guide on how to develop TiS provision within a particular service. Great diversity exists between different organisations and services and there is recognition of the need for those with expertise within these services to determine how best,

on a practical level, to develop and implement trauma informed approaches within their service area. For the current Project, we drew on learning from the experience from the Willow Service where trauma informed service provision and practice that could later be defined as trauma enhanced level, were well established.

The Scottish government recently funded the research and publication of Trauma Informed Practice: A Toolkit for Scotland (Homes and Grandison; 2021). This toolkit draws on best practice in Scotland and provides practical tools for use by organisations to begin to move towards more trauma informed models of service delivery. However, work to become a Trauma Informed Service at Willow predated the publication of both NES Trauma documents, and the Toolkit for Scotland. Whilst the Toolkit for Scotland now has a helpful 10 domain checklist, at the time of starting our Trauma Project there was no specific UK TiS guidance available.

Drawing on the wider research literature in existence at the time and having identified 2 specific documents (Guarino et al, 2009; Fallot & Harris, 2009) that were particularly helpful, a practical framework was drafted drawing on the experiences of implementing TiS provision at Willow. This framework helped identify and define seven domains of activity that had taken place at Willow. By defining these domains, project leads were able to readily share information about the areas of activity that required attention to move towards being a TiS.

These domains of activity (see below) were used during development sessions and training. They included a checklist with which participants could assess their teams' current provision in relation to TiS delivery, consider readiness for change and identify priority areas to focus on to support the move towards working in a trauma informed way. Subsumed under each of the domains of activity headings there are a range of activities identified as 'indicators' and summarised in a table of 'domain indicators'[1]. In practice there is considerable overlap and interplay between these domains and the activities they entail. The domains are shown in figure 4 below:



[1] Available on request from authors.

Figure 4: Trauma Informed Services: Domains of Activity

These domains relate to and include the following areas of activity:

- Leadership
    - Leadership and management commitment to trauma informed service provision is evident throughout all levels of the organisation
- Staff training, development and support
    - The prevalence of trauma and understanding of its impact is recognised from the point of recruitment, induction and through trainings made available routinely to all staff, with a wide range of staff supports available, and a particular focus on staff well-being.
- Trauma knowledge inherent to all practice
    - Staff understanding of trauma becomes inherent in all decision making and practice; over time it becomes routine and habitual practice which is integral to trauma informed service provision. This is demonstrated in relationships, assessments, interventions and activities
- Service user participation and collaboration
    - Expertise by lived experience is recognised and power sharing maximised through service user involvement in service design, planning, delivery and evaluation. Opportunities are created that invest trust in and provide opportunities for greater responsibility taking by service users
- Safe and supportive environment
    - A proactive approach is taken to create environments that support physical and emotional safety and actively work to avoid re-traumatisation.
- Policies and Procedures
    - Local policies and procedures explicitly reflect the need for particular actions and approaches being required to be a trauma informed organisation; the application of national policy reflects the role of trauma and its impact, including in the interaction between service users, staff and the organisation.
- Trauma focused outcomes
    - Common trauma impacts are understood across the organisation, with progress towards trauma informed service provision assessed at organisational, team and individual levels.

Due to resources and time constraints of the current Trauma Project, it was necessary to identify and focus upon those domains of activity that were considered achievable within the timeframes of the Project. While each domain is important in its own right, if we assume that trauma informed service provision sits on a continuum, then it is reasonable to think of service change as a process that takes time and that happens in a graduated manner and that this may not be even across all of the domains of activity. This is particularly important when considering implementing trauma informed approaches within a service that will continue to operate during the change, as opposed to a situation where a new service in being established, where it would be possible to establish and incorporate the service model prior to being required to deliver the service.

The focus of activity in this Trauma Project was on the following domains:

- leadership
- staff training, development and support
- trauma knowledge inherent in practice

These domains were selected as those where activity was likely to have the most immediate impact on a range of aspects of the service within the parameters of the Project, although this is not to suggest that the other domains of activity were completely overlooked in the Project.

For example, although the domain of ‘Service User Participation and Collaboration’ was not a primary focus of this project, there were a number of activities that involved input and feedback from service users, including seeking and acting upon their experience of the Survive and Thrive group intervention.

In addition, service users were consulted on how the environment of the building impacted on their well-being and what changes they would like to see to the building.

This resulted in service users engaging in an arts project with staff and artists to redefine the space in the waiting area.

Photos of the opening of the new waiting area incorporating a ‘Wall of Knowledge’.

e

Evaluation

In evaluating the Trauma Project, we drew from a range of sources and approaches, including:

- Descriptive data/statistics: for some aspects of the Project, we will simply provide summary statistics (for example, number of Trauma and Mental Health Screenings completed, number of training sessions delivered, etc)
- Psychometric Data (a range of measures used as part of routine assessment, including:
    - ACE (Adverse Childhood Experiences)
    - BCE (Benevolent Childhood Experiences)
    - CORE 10 (General mental well-being)
    - ITQ (International Trauma Questionnaire; a measure of trauma related symptoms including PTSD and Complex PTSD)
    - PHQ9 (A standardised measure of level of low mood/depression)
    - GAD7 (A standardised measure of level of anxiety)
- Staff Questionnaires: in February 2020 staff were asked to complete a questionnaire that covered a range of issues pertaining to their experience of the Trauma Project
- Focus Groups: Staff were invited to participate in focus groups to discuss their experience of involvement in the Trauma Project. To make it easier for staff to speak openly and frankly about their experience, these groups were run by an external facilitator (from within Community Justice Scotland who was independent from the Project). Two groups were run, one for front line managers and one for front line social work staff (referred to below as 'practitioners').
- Training Evaluation Forms: for each training session delivered, a pre and post measure was completed by participants.

It is important to acknowledge limitations regarding this evaluation. Firstly, completed psychometrics were available for only 28 service users. The Covid19 lockdown from March 2020 had a significant impact on capacity for completing routine screening, including psychometrics, and this impacted on the size of the data set. Secondly, we are aware there was only limited involvement from service users. This is something we would hope to remedy as future work develops, as reflected in our recommendations.

Leadership: Domain 1

Commitment from leaders and managers is recognised as being a key consideration in any process that involves significant organisational change particularly when, as with the current project, this involves attempts to bring about fundamental changes in the underpinning philosophy and practice of the service. Not surprisingly, this is also true in the area of trauma informed service provision where the literature is clear and consistent in identifying the importance of leadership and management commitment to bring about the range of changes required.

Various trauma informed frameworks include specific sections on the requirements from leaders and managers in bringing about the kinds of service changes they recommend, including the need for training that leaders and managers may need to be suitably prepared to support the organisation through the process of change (Fallot & Harris, 2009; Guarani et al 2009; Mental Health Coordinating Council, 2018; NES 2017 & 2019). In the Scottish context this commitment can be traced at a National level to leadership commitments from the Scottish Government.

> **"The Scottish Government is fully committed to developing a trauma-informed workforce across Scotland."**
>
> **John Swinney, MSP, Deputy First Minister, Scottish Psychological Trauma Training Plan, NES, 2019**

Within our Trauma Project it was considered crucial to ensure that front line managers within the services were on-board with the project as active participants to ensure they were in a position to support staff in their teams to develop the skills and knowledge required to practice at a trauma enhanced level of expertise.

There are a number of reasons why leaders in any organisation are central to the successful implementation of organisation change. Leaders and managers are identified as "culture bearers" and as such are "key to the success of trauma-informed systems and approaches" (NES 2019, p15). The Training Plan also points out that leaders and managers will have their own training needs and these must be taken into account in supporting and preparing managers to engage effectively in the process of organisational change. As a trauma informed approach may be unfamiliar to some frontline staff, leaders in a service have a crucial role in communicating the vision of service development, including the rationale for the proposed

changes, to staff under their supervision. As such, leaders themselves need to be well prepared to do execute these tasks effectively.

In additional to attitudinal change, a trauma informed approach requires staff to make modifications to their ways of working as they develop and put into practice newly acquired skills. Again, leaders have a crucial role to play in supporting and embedding practice changes through modelling appropriate behaviours in their own practice and reinforcing practice changes through 1:1 supervision and the coaching and mentoring of staff within their teams.

One further consideration is that a central aspect of working in a trauma informed service is the recognition that this kind of work can and does have an impact on front line staff working in the service. Therefore, the support needs of staff must be attended to on both systemic and individual levels. Leaders within the service have an important role to play in both of these levels. On the systemic level, the Training plan (NES, 2019, p36) comments:

> **"Trauma-informed leaders also recognise the potential for working with people affected by trauma to impact at a systemic level and work to establish trauma-informed cultures and system to counter-balance this."**

In addition, supervisors of front line staff have a critical role to play to ensure that this supervision is provided in manner consistent with the principles of trauma informed approaches both to support practice development and to "establish appropriate professional support structures and supervision to mitigate against exposure to the trauma histories of others in the course of one's professional duties (NES 2017, p48).

It was deemed essential to the success of the Trauma Project to work closely with and involve front line managers in all aspects of the project to ensure that they were able to provide direction, support and training to other members of their teams.

Leadership: Activities

Trauma leadership sessions for front line managers

An important consideration in the development of the Project was the preparatory groundwork required. In addition to individual support through supervision and coaching, a number of trauma leadership sessions took place over the course of the project. This allowed the Sector Manager and leaders in each team to assess readiness for change across the service, to allow for reservations and concerns to be highlighted and discussed and ultimately to garner commitment and support from managers who would later be key in the implementation of change. Managers came with varying levels of knowledge about, and commitment to a trauma informed model of service delivery.

Four leadership sessions took place, facilitated by the Sector Manager and the Clinical Psychologist; over the duration of the Project there was increasing input from seniors into both the content and the facilitation of these meetings. They were generally of half a day's duration and some took place off-site.

Topics included:

- Introducing models of TiS delivery

- Assessing service readiness
- Concerns and barriers to TiS provision in community justice services
- The role of leaders in TiS delivery
- How to introduce and support routine assessment of service users' trauma experiences and impacts, into pre-existing community justice processes.

These leadership sessions served a number of different functions including:

- Gaining a shared understanding of existing trauma knowledge and practices in teams
- Nurturing and developing a sense of collective involvement in and commitment to the changes the service was undertaking
- Proving opportunities for front line managers to explore areas of trauma informed care in greater depth
- Sharing information about developments to ensure managers were included in shaping these at an early stage
- Ensuring managers were familiar enough with changes to allow them to support their teams through implementing change.

It was vital to make clear to participants that these meetings were also opportunities to express any reservations they felt about any aspect of the Trauma Project. Engaging managers in this process was considered critical to the success of the Project

Building leadership capacity for active involvement

To support leaders to take up active roles in the project, it was important to draw on existing knowledge, skills and experience, recognising the role leaders play as trauma champions who can visibly "champion" and support change. Leader were asked to identify their own training and development needs, develop knowledge and skills through shadowing (i.e. observing trauma group interventions being facilitated by highly specialist practitioners within specialist trauma services) or by participating in specific training (i.e. stage 1 trauma intervention course for facilitators).

The role of all leaders in a coaching role was viewed as key to establishing culture change and embedding knowledge and skills. This included coaching across the leadership team to support others into new activities and to support leaders to be able to modify practice, to align with trauma principles and approaches.

If we remind ourselves that the key principles of trauma-informed organisations (see figure 1 above, page 7) include choice and collaboration, it is clear that these must be reflected in the way in which the project itself is conducted. It was considered essential to foster these within the leadership team (along with the other key principles of safety, trust and empowerment).

All key developments were discussed with front line managers, who were invited to contribute to these developments at an early stage. For example, it was apparent that operating at a trauma enhanced level of practice required workers to have knowledge of and be competent in routinely screening for trauma and mental health related difficulties. Training packages were developed to support this, with managers taking an active role in delivery of training.

Putting this training into practice required changes in how assessments were carried out. A semi-structured interview template and associated guidance on completing this were developed to support workers in carrying out these assessments (Trauma and Mental Health Screening –

TAMHS). Developing this guide and screening tool was an iterative process, with input from managers at each stage of the process. When a first draft of the tool was developed, input was then invited from front line staff based on their early experience of using the tool. This process of involving managers its development ensured that they were familiar with the tool and were in a better position to support their staff in its use.

Another area where leaders in the service played an important and active role was in the development and provision of group supervision. Group supervision sessions were jointly facilitated by the clinical psychologist and a front line manager; the manager's presence and input was deemed critical (discussed in further detail below).

Managers on site access to coaching, guidance and clinical psychology expertise

Based on the experience of the Willow Service, as well as findings from research into organisational change, a coaching approach was adopted whereby the Sector Manager and Senior Clinical Psychologist (SCP) were available to provide on-site support and guidance and to collaborate with front line managers in situ. This allowed for a quick response to any problems in comprehension and the approaches they adopted to practice related issues as and when they arose. In turn, front line managers would, through planned 1:1 supervision, team development sessions and more formal training sessions, provide support to social workers and group workers. This helped promote their knowledge and understanding in relation to trauma and associated mental health difficulties, how these matters can be recognised in services users' presentations as well as helpful and effective practice approaches and interventions that front line practitioners could adopt in their work with service users.

The SCP was embedded in the service, sitting in the CJSW office alongside frontline managers. In order to develop capacity managers were encouraged to consult the SCP on matters relating to service users' presentations following discussion with front line staff in routine 1:1 supervision, specifically where trauma and mental health issues were evident. This might involve, for example, asking for clarification about aspects of the TAMHS, or seeking guidance on how to use particular psychometrics.

This process allowed supervisors to build their own knowledge and understanding to enable them to assist front line staff. In practice, this was a relatively infrequent occurrence and generally a one-off consultation (sometimes involving the frontline practitioner) was sufficient to clarify the issues concerned and develop a plan of action. Where this proved insufficient, a more formal case consultation meeting was held, involving all staff involved with the service user. This happened only 3 or 4 times over the course of the Project.

Leadership: Evaluation

Evaluation of this component of the Project involved questionnaire data (both quantitative and qualitative) as well as the findings from an independently run and analysed focus group.

The questionnaire, which was developed specifically for the Trauma Project, sought staff views about their overall experience of being involved in the Project as well as a number of specific areas of activity covering impact on knowledge, confidence and practice (including direct work with service users). There were additional questions for seniors and team leaders in relation to their role as leaders.

In addition, staff were invited to participate in focus groups run by an external facilitator. These groups were designed to discover more about participants' experience of the process and progress regarding the move towards being a trauma informed service. Two focus group were held for social workers and groupworkers and a separate one for front line managers. The format of these groups involved a series of prompts, which covered the following areas:

- participants' hopes and expectations
- what supports have been in place
- the impact training and coaching on practice,
- participants' experience of the journey towards being a trauma informed service.

The external facilitator provided a report analysing and summarising findings from the manager's focus group. As is evident in the quote below, feedback was generally very positive:

> **It is apparent that the process has been positive for mangers as well as everyone else involved in the process. It has clearly been a challenge and teams have had to find time and resources, but overall there is a clear sense that this is the right direction of travel**
>
> **(External evaluator, Community Justice Scotland, Focus Group Report)**

Looking at the results from the questionnaire in more detail and specifically at those areas identified in the earlier discussion regarding the importance of managers' involvement in the Project, we again find very encouraging results. For example, the figures below provide strong evidence that managers felt involved in the Project and viewed their experience as enhancing professional development:

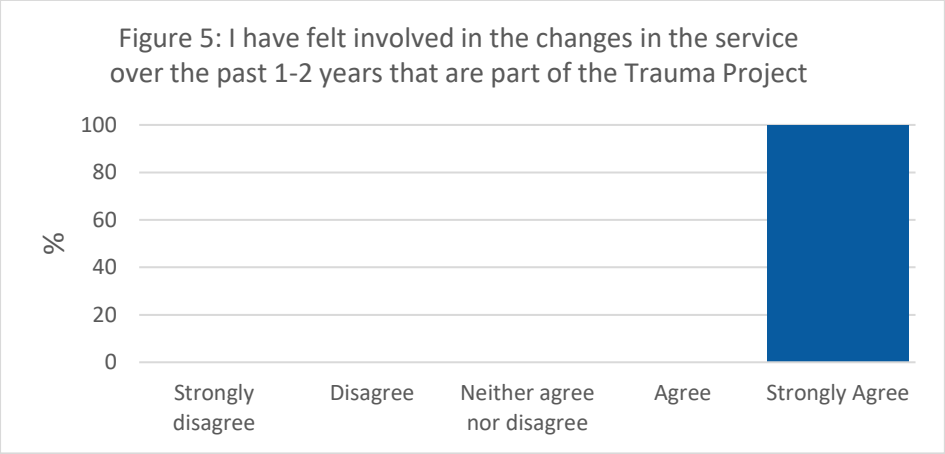


Figure 5: Managers' Involvement in the Project

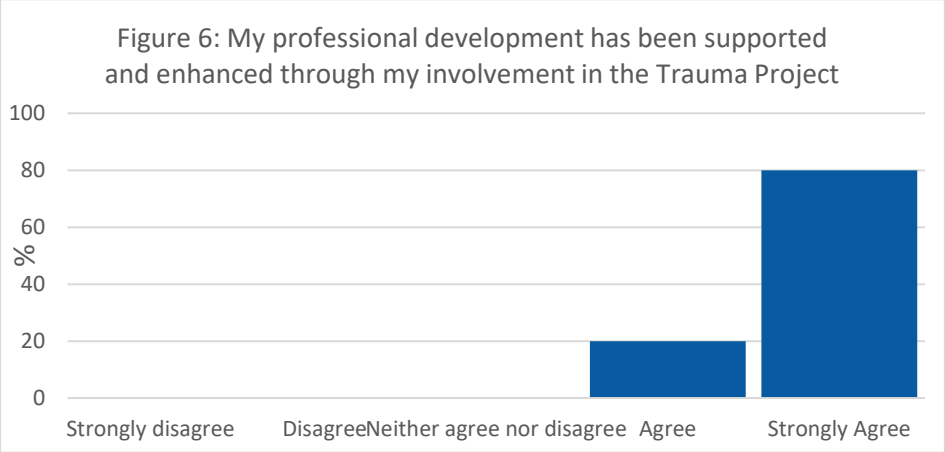


Figure 6: Managers' Views on Professional Development

The questionnaire also asked managers about their confidence in working in a trauma informed way (for example in screening for trauma and mental health difficulties) as well as their own appraisal of their skills in supporting service users in managing some of the experiences commonly associated with trauma. Again, as we see in the figures below, it is clear that managers had grown in confidence in both asking about and responding to issues relating to trauma and mental health:

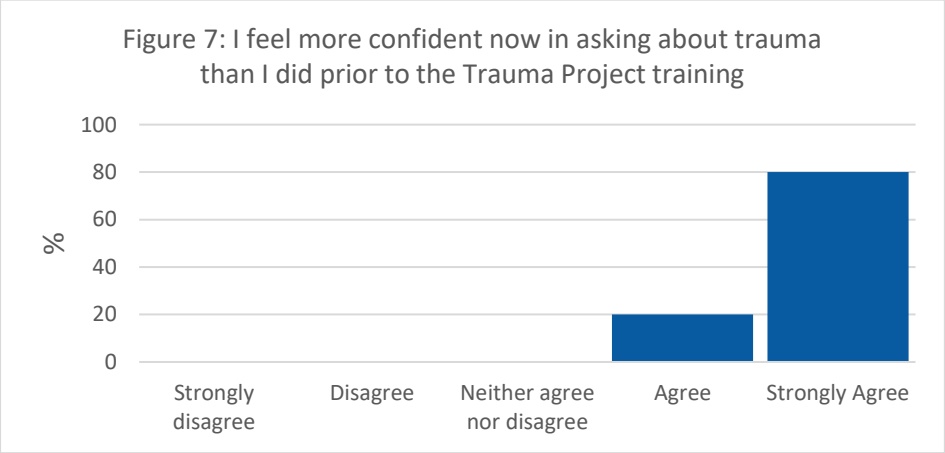


Figure 7: Managers' Confidence in Asking about Trauma

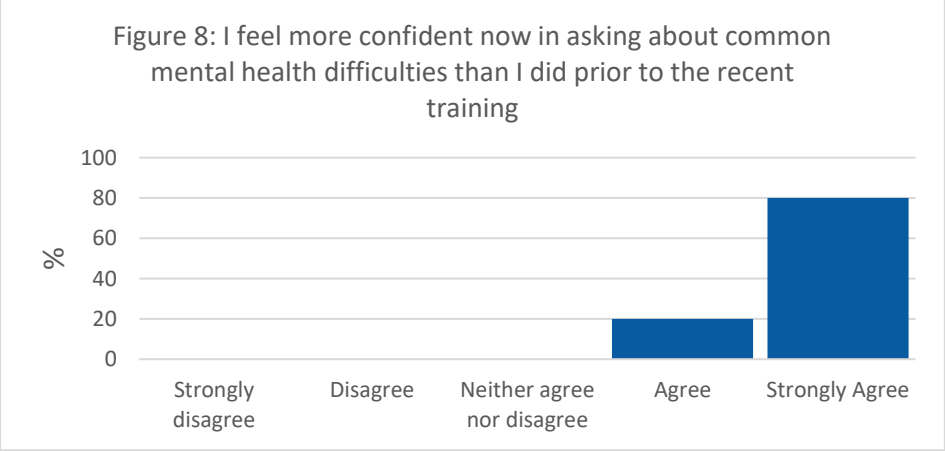


Figure 8: Managers' Confidence in Asking about Common Mental Health Difficulties

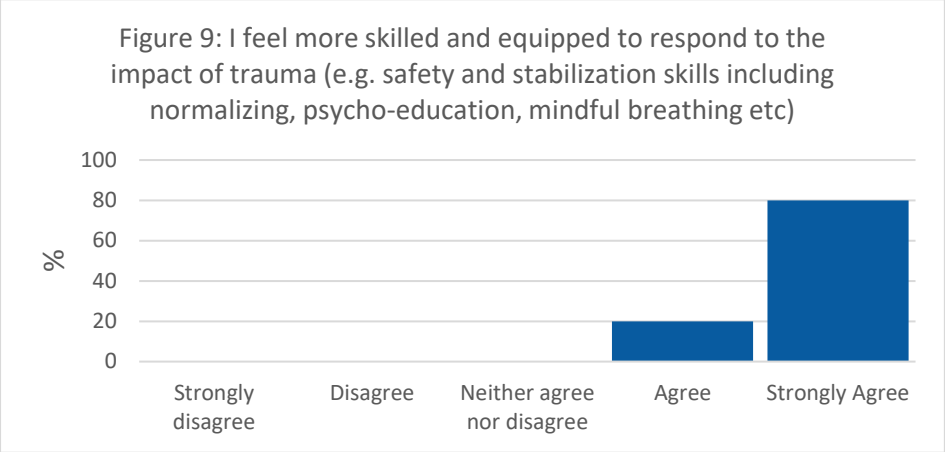


Figure 9: Managers' Skills in Responding to Impact of Trauma

Managers were also asked about their views on having a clinical psychologist embedded in the team. Once again, the results are unambiguous: this was clearly seen as a critical component to the success of the project.

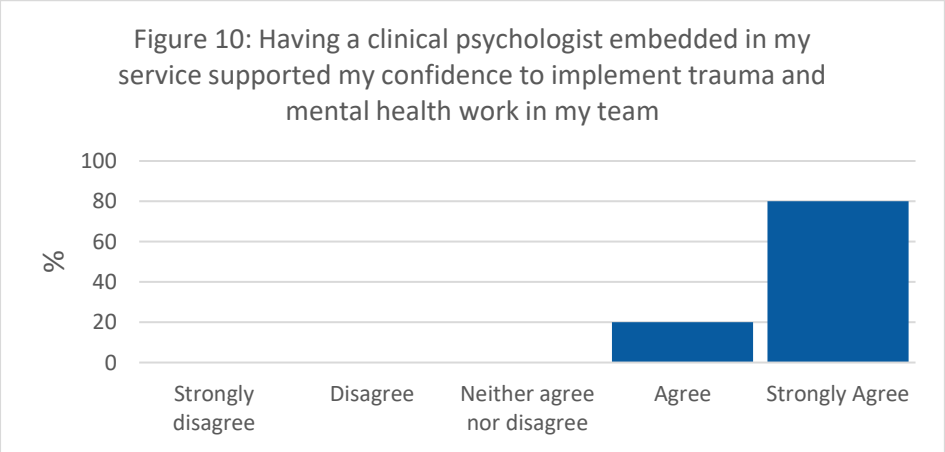


Figure 10: Managers' Views on having a Clinical Psychologist Embedded in Service

The quote below, from the focus group report, links the psychologist's availability to the requirement to practice at a 'trauma enhanced' level of expertise.

> **I feel we must have a Psychologist in place in order to aspire to become a trauma enhanced service. Without group supervision and delivery of the specialist intervention (Survive and Thrive) we cannot work to level 3 'enhanced' status. (Frontline manager)**

Managers reported feeling equipped to provide direction in relation to trauma informed service provision and to supervise and coach staff in their teams. The figures and quotes below indicate that they shared the view that leadership commitment was a key consideration and that they felt confident in their ability to support staff working in a more trauma informed way:

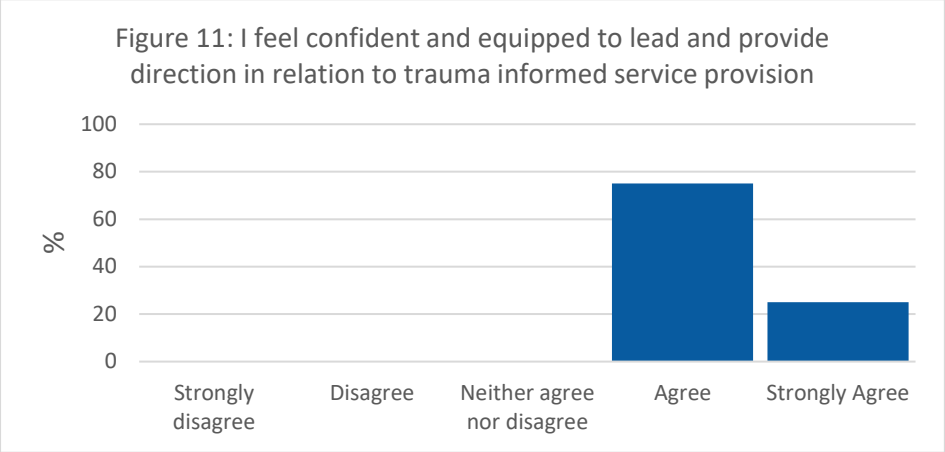


Figure 11: Managers' Confidence in Providing Leadership in Trauma Informed Service

"I'm aware that the leadership and coaching role of managers is key to this being successful. Becoming trauma informed and enhanced is a significant change for the service and needs appropriate management and planning." (Frontline manager)

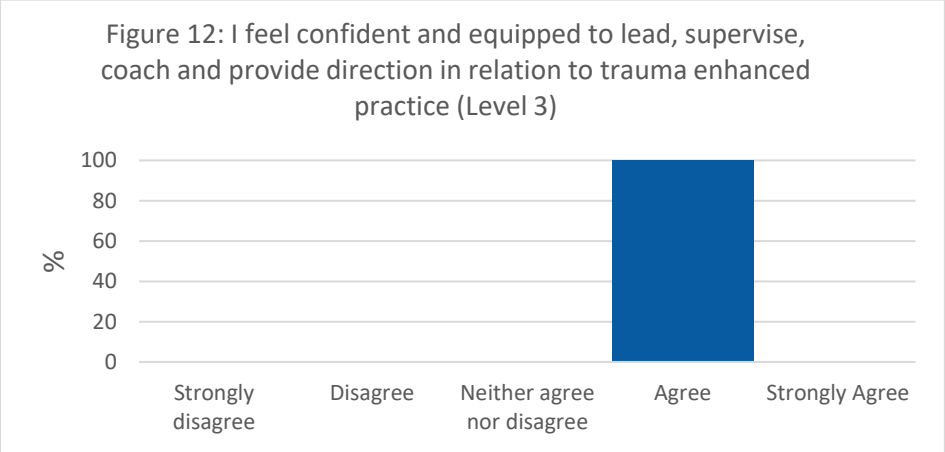


Figure 12: Managers' Confidence in Supervising and Coaching in Trauma Informed Service

"I think the training has been great and has given me confidence both in recognising and working with trauma, but also in supervising staff in their work with traumatised service users." (Frontline manager)

While the feedback from both the focus groups and the questionnaires was overwhelmingly positive, some front line managers identified feeling less confident about the introduction of the TAMHS screening tool. Here, we found a broader range of responses (albeit still positive) suggesting that additional support may have been beneficial and/or that the tool itself may benefit from further modification to meet the needs of the service.

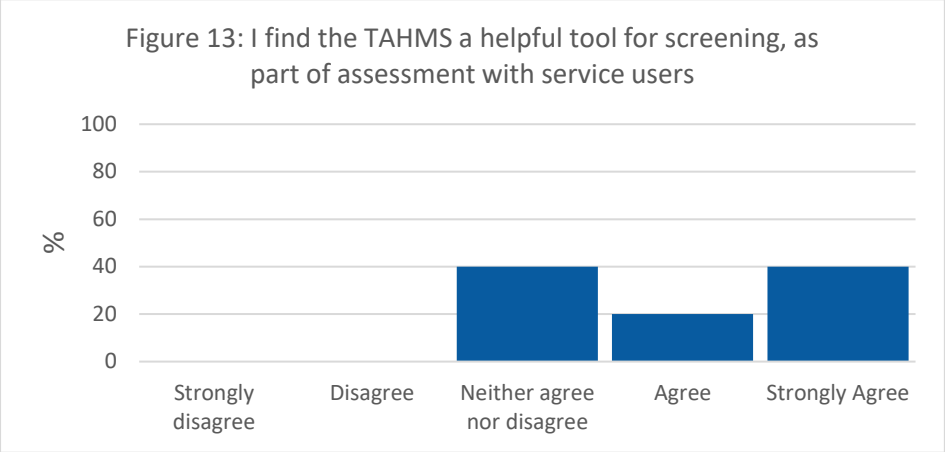


Figure 13 Managers' Views on Usefulness of TAMHS

The focus group analysis also noted other themes identified by the group. Firstly, the limited input from service users was seen as something which needs to be addressed as the work develops. On the views of staff in the focus group:

> **They would like to move towards more service user involvement; they want service users' voices in the service, to give them representation and to develop it. (Focus Group Facilitator's Analysis)**

Finally, it is important to acknowledge that while front line managers expressed strong support for the changes associated with the Trauma Project and enthusiasm for this way of working, there was also a reminder that such changes put significant pressure on services that have to continue to operate with limited resources, as summarised by the focus group facilitator

"Participants stated that it is hard to be trauma informed with the resources we have".

Staff training, development and support: Domain 2

A competent and supported workforce

"A workforce is competent when attention is paid to ensuring that the right people are selected for and receive the right training and that, after receiving the training, workers are supported through coaching and supervision to apply and embed their skills and knowledge."

(NES 2019, p34)

Staff training and staff support are crucial considerations in developing and implementing trauma informed approaches to service delivery. The NES (2019) Training Plan proved a useful resource against which to benchmark our planned approaches in both these areas of work. It is essential that staff have the knowledge and skills required to carry out their roles effectively and that there is recognition that staff will be impacted by working with those who have experienced trauma.

Staff training and support clearly overlap in that they are both aimed at ensuring staff are adequately prepared for and resourced to carry out their work at a trauma enhanced level of practice. It was crucial to this project that there was considerable follow-up and support given to staff during and after training. The provisions provided to staff as part of the Project, namely the availability of supervision with a highly specialist clinician (the SCP), as well as ongoing coaching from leaders with additional knowledge about trauma, align with specific requirements of the trauma enhanced practice level.

As noted earlier, the particular training needs of staff can be determined by the functions of the service. The roles of staff within criminal justice social work mean that front line staff should be functioning at the 'trauma enhanced' level of practice.

Staff Training

An important preparatory step in deciding training content was assessing the particular training needs of staff within the service. In addition to drawing from prior experience of training other criminal justice staff, a staff survey was conducted to seek staff's views of their training needs.

The eight domains of competence and knowledge noted below (NES 2019 p61) were taken into consideration.

1. Understanding Trauma
2. Trauma informed practice and systems
3. Trauma-informed risk assessment and management
4. Disclosure and routine enquiry and response
5. Working with interpersonal difficulties linked to trauma
6. Assessing people with trauma-related difficulties (including knowledge of mental health and substance use)
7. Delivering interventions for people with trauma-related difficulties (including psychosocial support and advocacy and protocolised stage 1 interventions for trauma)
8. Recovery and connection.

Training activities

It was clearly necessary to develop a bespoke training package to meet the particular needs of criminal justice staff working in the service. The training package developed consisted of 4 days of face to face training, representing a significant commitment on behalf of the organisation.

In developing this training package, certain prerequisites in attendees were assumed. In particular, the content of the training assumed a degree of prior knowledge and experience, specifically a recognition that participants already had general social work skills as well as experience of working in a criminal justice service and knowledge of the needs of this population. By way of example, it was assumed that participants were already familiar with and used standard risk assessment protocols. As such, this training did not focus on risk assessment as a topic in its own right, although some consideration was given to how some practices (such as routine enquiry about trauma) would relate to pre-existing standard risk assessment and management processes (in the context of Community Payback Orders, Caledonian and MF:MC delivery etc).

The training content also reflected the fact there is currently no pre-existing required or recommended training for criminal justice social work staff in relation to trauma. Nor is there detailed input relating to common mental health impacts such as anxiety, depression, dissociation or other post-traumatic stress reactions. The content of our training had to explicitly address this gap. The training content covered all core and essential trauma training requirements for trauma enhanced practice level (NES 2017, pp 64-96). Specifically, the training consisted of the following modules:

1. Understanding and working with complex trauma (1 day)
    a Understanding trauma and its impact
    b Asking about trauma as part of standard/routine assessment
    c Routine enquiry about trauma as intervention
    d Responding to disclosures.
2. Responding to common trauma symptoms/trauma skills practice (1 day)

    a Enhancing current skill set
    b Helpful interventions in working with the impact of trauma
    c Psycho-education strategies (normalising)
    d Safety and stabilisation
    e Coping strategies (mindfulness, distress tolerance etc).
3. Mental Health and Trauma (1 day)
    a Routine screening for mental health difficulties
    b The role of trauma in common mental health presentations
    c Recognition of value of relationships.
4. Staff well-being and self-care (half day).
5. Developing Trauma Informed Services (half day).

Drawing on prior experience of supporting trauma training into practice in CJSW as well as feedback received from staff who undertook the training, there were plans to develop a further half day's development session to support staff in the application of trauma informed approaches in carrying out a number of statutory tasks (such as writing court reports). The Covid19 lockdown meant this additional development work did not happen. However, teams did go on to establish their own development sessions thereafter to discuss changes in practice and to reflect on how these were being incorporated.

In total, 78 workers undertook training as part of the Project.

Training Evaluation

The training delivered was evaluated through:

- pre and post training measures
- staff questionnaires
- focus groups.

In the questionnaire, practitioners and managers were asked questions about the training package, with additional questions for managers relating to the leadership training and development sessions. As it was assumed that managers and practitioners would apply the training in slightly different ways (for example, frontline managers' practice included providing supervision to practitioners) responses from managers and practitioners are presented separately below.

Feedback from staff was overwhelmingly positive, demonstrating they clearly recognised how this training related to the overall aims of the Trauma Project. The feedback also shows that staff felt the training enhanced their understanding of trauma and its impact. Importantly, staff reported feeling more competent and more confident in asking about trauma as part of routine practice, responding to any disclosures made and providing support and interventions to clients in managing some of the common impacts of trauma. As we see in the table below, 94% of staff who received the training felt it enhanced their understanding of trauma and that it would inform their practice in working with service users.

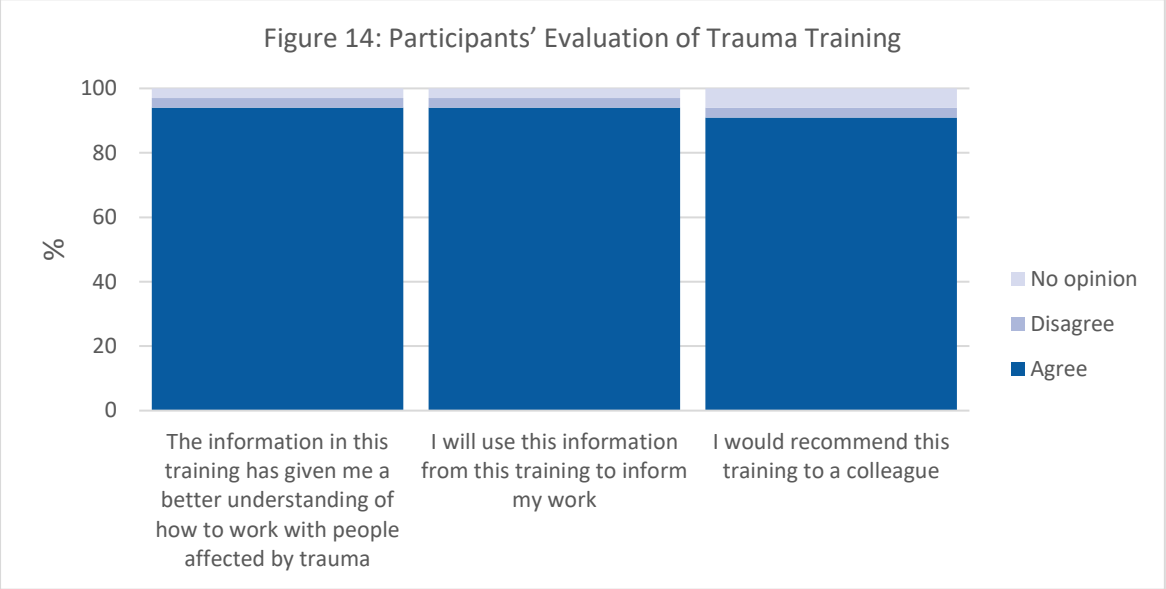


Figure 14: Participants' Evaluation of Trauma Training

When asked about the relationship between the training and practice the feedback from both practitioners and managers shows that the vast majority of staff felt that the training supported them in working in a trauma informed way:

Practitioners:

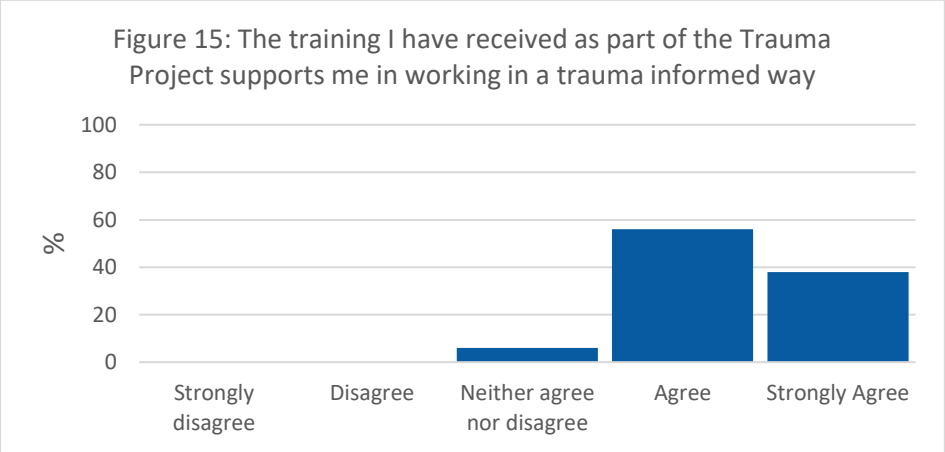


Figure 15: Practitioners' Views on Training Supporting Working in Trauma Informed Way

Managers:

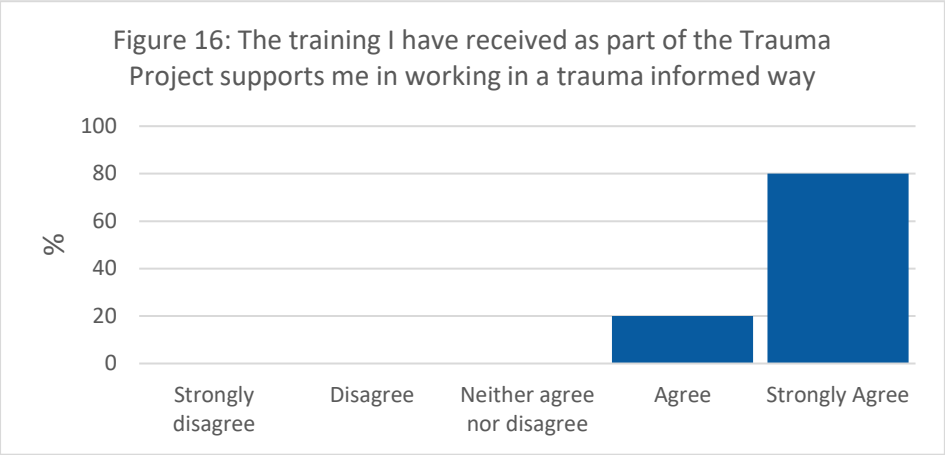


Figure 16: Managers' Views on Training Supporting Working in Trauma Informed Way

As the service moved towards adopting trauma informed approaches to working, an early concern expressed by some staff had been their feeling uncertain about routine enquiry about trauma. This was addressed through the training and subsequently staff expressed greater confidence in asking about trauma history as a routine part of their work after training:

Practitioners:

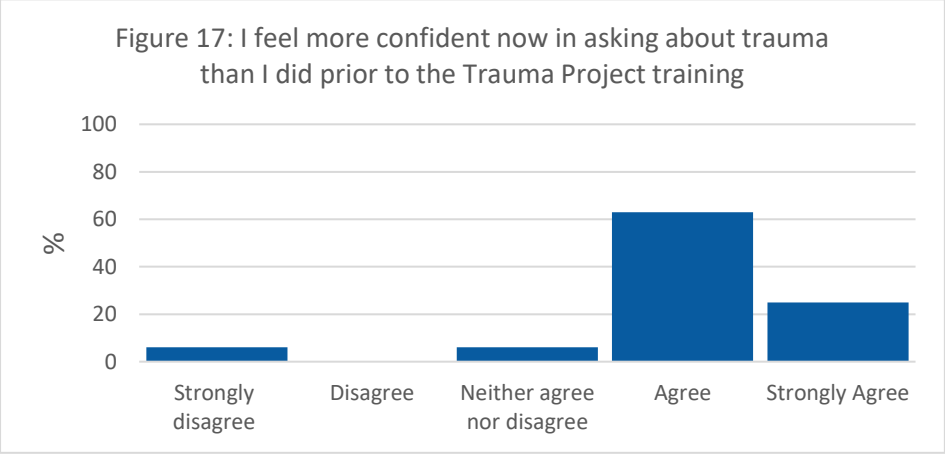


Figure 17: Practitioners' Confidence in Asking about Trauma

Managers:

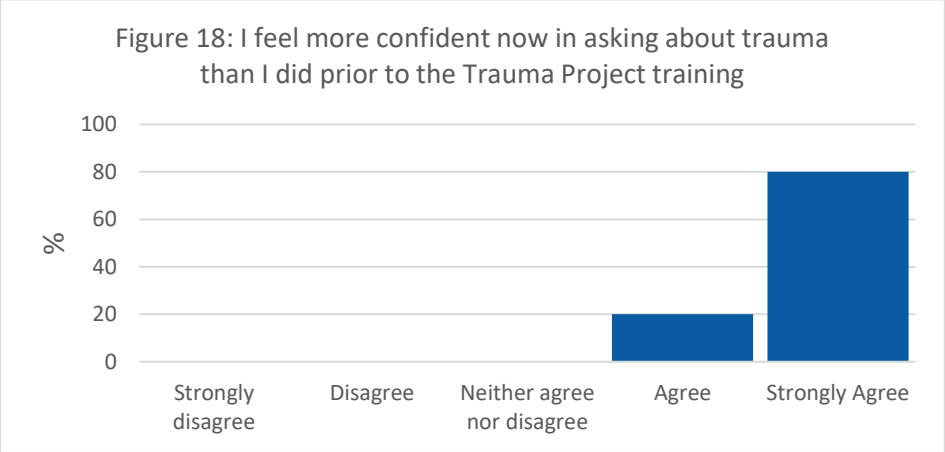


Figure 18: Managers' Confidence in Asking About Trauma

Another concern voiced by staff prior to the training related to their knowledge and confidence in asking about the common mental health difficulties that are associated with a history of trauma. Again, feedback from staff demonstrates that following the training, the vast majority felt better equipped to ask about these common mental health difficulties as a routine part of assessments with new clients (figure 19). The manager's response to this question (see figure 8) was also very positive.

Practitioners:

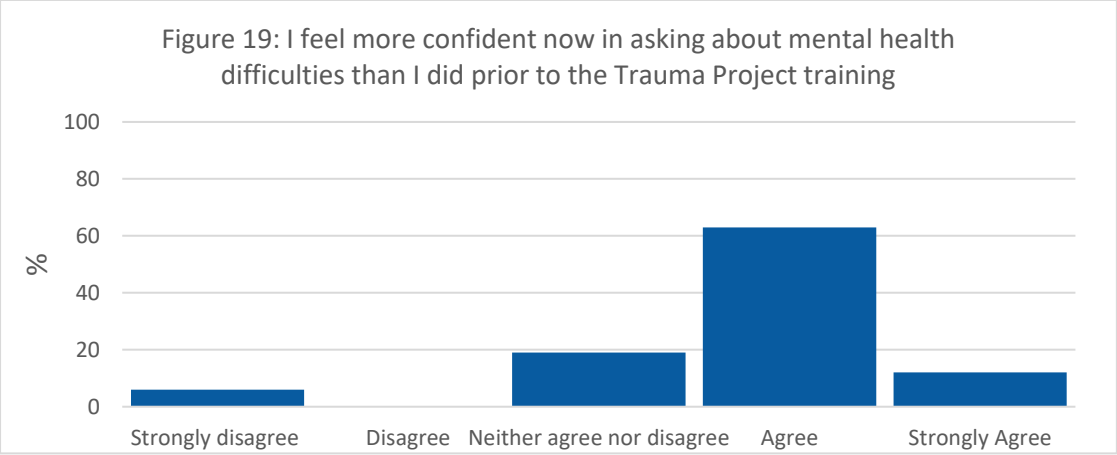


Figure 19 Practitioners Confidence in Asking about Common Mental Health Difficulties

We were also interested in how staff viewed their involvement in the Trauma Project (including, but not limited to their experience of the training provided) in relation to their general professional development.

Again, the findings here are convincing (figure 19), as evidenced by both the quantitative feedback and the comments below and were echoed by Managers' views (figure 6 above):

Practitioners:

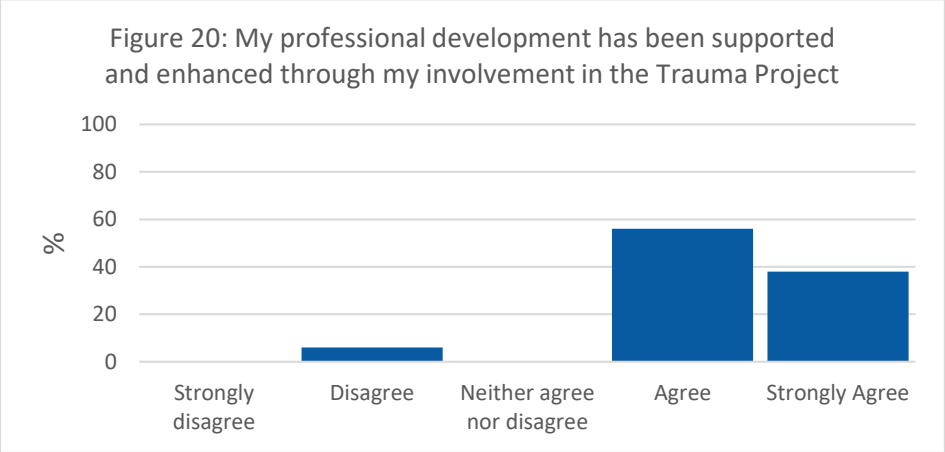


Figure 20: Practitioners' Views on Professional Development and Trauma Project

The training and supervision has been excellent and has really helped me improve and develop as a practitioner. I have already seen how the people I work with have benefited. (Social worker, Focus Group)

Front line managers play a key role in implementing and embedding any systemic change within a service by virtue of their leadership role which means they perform a range of functions within the service (including staff supervision and in this case training delivery) which can be pivotal if systemic change is to be achieved. This was certainly the case within the Project which would not have been possible without commitment from the frontline managers. Encouragingly, the quantitative and qualitative feedback received indicates that managers felt they had access to training that focussed specifically on their leadership role and that they were aware of the importance of their contribution to the project:

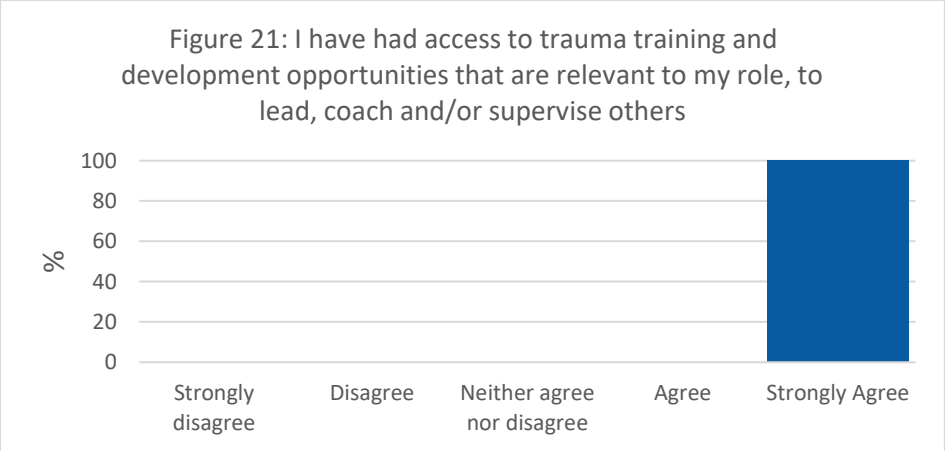


Figure 21: Managers' Views on Access to Relevant Training and Development Opportunities

Front line managers who had prior training and experience in the delivery of standardised stage one trauma interventions were asked to contribute to the delivery of some of the training modules. Some co-facilitated trauma informed supervision groups with the SCP and others led staff development discussions in their teams. Again, these were considered key in both

engaging managers fully in the Project and in disseminating the knowledge and skills required for the successful implementation of trauma informed practice. Feedback clearly indicated that frontline managers felt involved in the implementation:

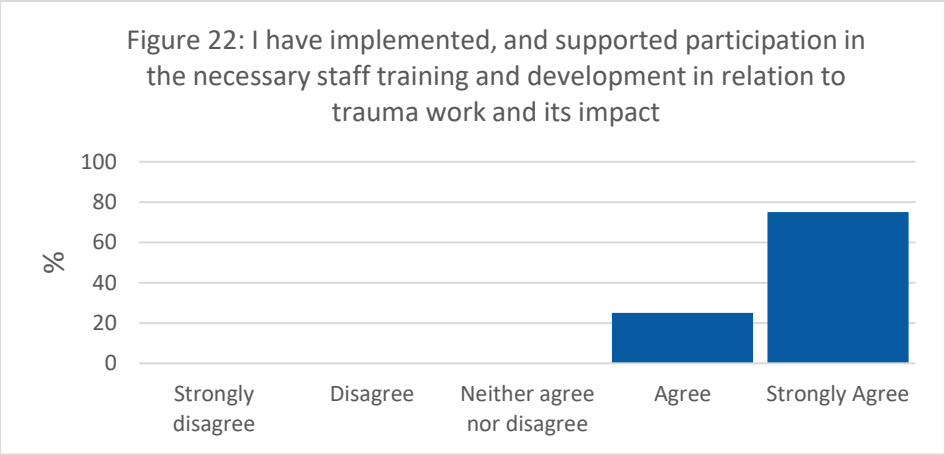


Figure 22: Managers' Views on their Involvement in Project Implementation

I'm very aware that some workers feel less skilled than others and that the pacing of the training has been very important. Further, I'm aware that the leadership and coaching role of managers is key to this being successful. Becoming trauma informed and enhanced is a significant change for the service and needs appropriate management and planning. (Frontline manager)

The Trauma Project has been something of a paradigm shift for services allowing criminal justice social workers to reclaim the 'social work' part of their role. This has been done in an evidenced-based but compassionate manner to try to ensure that no workers are left behind. (Frontline manager)

Consistent with this finding, when practitioners were asked if they believed managers and senior staff adopted trauma informed principles in their approach to work, there was, by and large, consensus that this was the case:

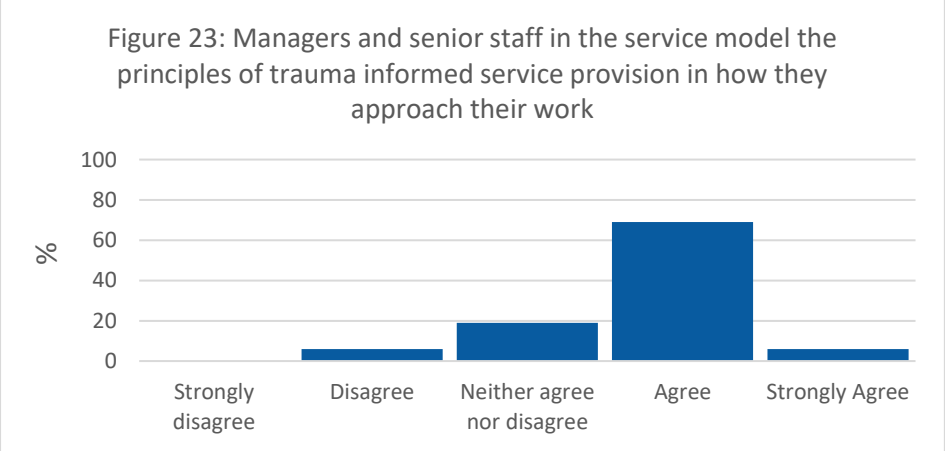


Figure 23: Practitioners' Views on Adoption of Trauma Informed Principles by Managers and Seniors

It is important also to be cognisant that staff members themselves may well have personal history of traumatic experiences. As noted in the Ministerial Foreword of the Trauma Training Plan (NES, 2019):

> **The workforce is also affected by trauma, through their own personal experience and, in many cases, in the course of the work as well. It is important to enable appropriate training and support to keep the workforce well, and respond as effectively as possible to people they are there to help.**

Within a trauma informed service approach to working, staff well-being is a key consideration. There is recognition that working in this way can and does impact on staff. The service therefore has a responsibility to provide appropriate support to staff to manage this impact. Further, given the widespread prevalence of traumatic experiences in the community, it is inevitable that staff working in the service will have their own personal experiences of trauma. Here, the focus is on the staff well-being and self-care package as part of the training programme offered to staff.

As part of the staff questionnaire, staff were asked if they have developed their own well-being plan. 80% of staff reported that they had subsequently developed their own well-being plan.

Staff were also asked a number of questions immediately before and after the staff well-being component of the training package. These questions invited staff to reflect on their awareness of:

- their own strengths and vulnerabilities
- strategies and supports available for dealing with the impact of working with trauma
- the role of supervision in staying well.

The figures below indicate levels of awareness among staff were reasonably high prior to the training. However, these levels of awareness were significantly greater following the training:

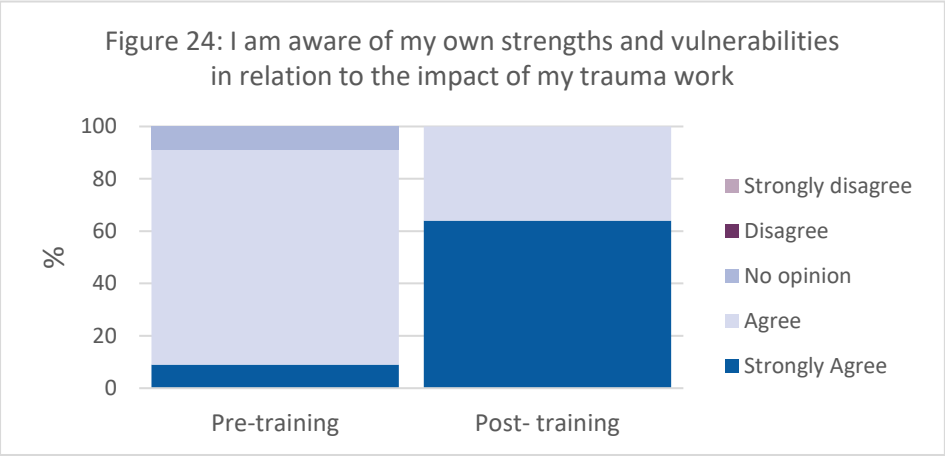


Figure 24: Pre and Post training measures – awareness of own strengths and vulnerabilities

Similarly, at baseline staff reported fairly high levels of awareness of strategies and supports available to them to maintain their well-being and understanding the role supervision plays in relation to staying well at work. Again, both these baseline levels increased post training.

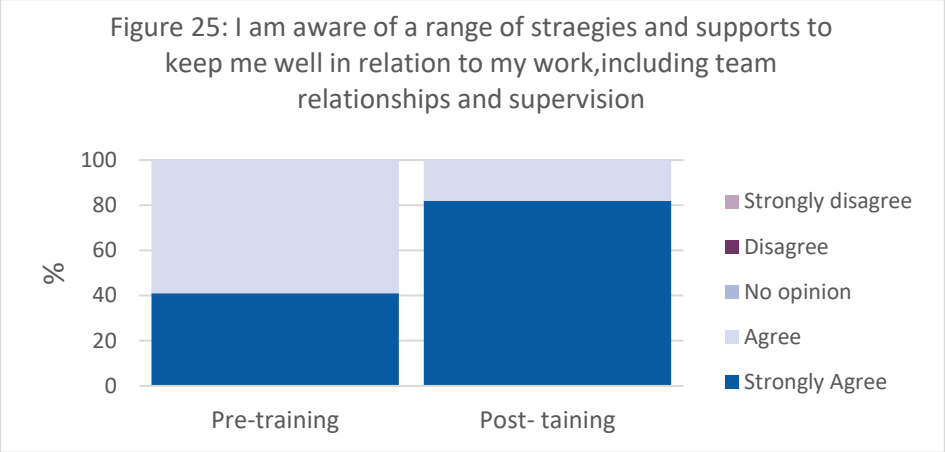


Figure 25: Pre and Post training measures – awareness of strategies and supports for well being

Finally, when asked about understanding the role of supervision in staying well at work, we again see levels of reported understanding were increased in the post training measure and the quote indicates that staff experienced supervision as important to support well-being and to develop practice:

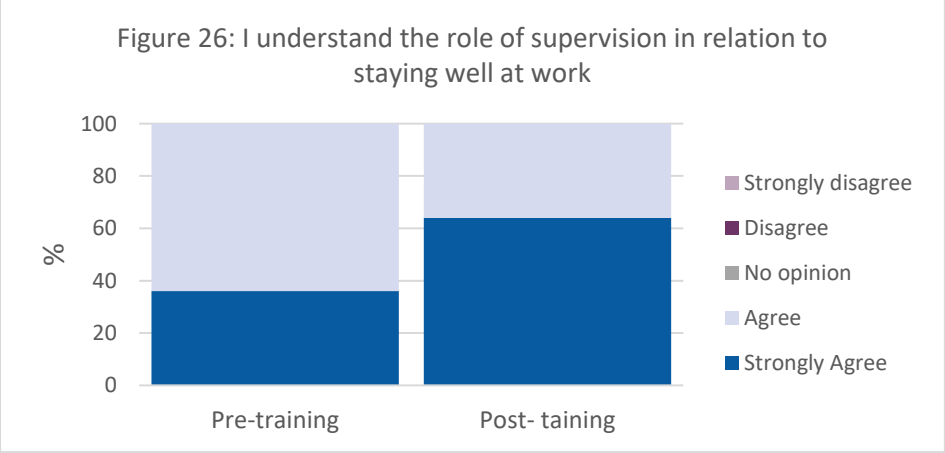


Figure 26: Pre and Post training measures – awareness of role of supervision in well being

Trauma Informed Group Supervision

The importance of staff well-being was a central aspect of the project. A key element of how this was operationalised was the provision of group supervision, in teams. The format of these varied, with different staffing and organisational issues impacting on start dates, frequency and group numbers.

This group supervision, delivered within teams, served a range of functions. Chief among these, as already noted, was to provide a supportive and reflective space for staff where they could discuss and explore their experience of working in the service, including, but not limited to their work with specific service users.

Another primary function of the group supervision was to support the implementation of trauma informed approaches to the work and to embed some of the training and coaching that staff received. This involved reinforcing some of the general principles of trauma informed

approaches, rather than focussing on specific areas of practice (these could be addressed in separate team development sessions). This was aided by having key components of the approach printed and readily available in group supervision sessions whereby the SCP, front line manager involved and all other participants, referred to these as helpful reminders of the principles and as ways of framing parts of the discussion.

A broad range of more general issues were also the focus of group supervision discussions. These included, for example, the role of social justice in social work, the mental health presentation of service users, the experience of working across different agencies, or considering the meaning and implications of a diagnosis of 'personality disorder'. It's worth pointing out that even when the focus of the discussion was on a specific service user, the discussion always broadened out to issues of a more general nature relating to broader aspects of social work practice.

The SCP and frontline manager had complimentary but different roles in the sessions. While the nature of these roles was discussed and agreed as part of the preparations for providing group supervision, inevitably these evolved over time and through experience as both became more accustomed to each other's ways of working. Each tailored their approach to the specific process that emerged over time in each team. Some aspects of these roles were made explicit in the group supervision agreement.

Experience of running the group supervision helped the process of elaborating the important but challenging role for managers. Within the group the manager functions as part-participant, part-facilitator, drawing from and sharing their experience of frontline practice, making connections between social work practice and trauma informed principles and approaches. The manager also brought knowledge of specific criminal justice interventions (e.g., CJSW reports, Community Payback Orders, the Caledonian Men's Programme, social worker role and tasks) as well as a broader overview of criminal justice services. At times this proved an important and helpful resource in addressing certain issues and enhancing the discussion.

Another crucial element of the role of the manager in group supervision was that through self-disclosure (for example, acknowledging and normalising being impacted by the work), the manager was able to model appropriate ways of recognising and expressing personal vulnerabilities within the group supervision setting. This helped create a safe environment where other participants felt comfortable to reflect on and share their own experiences of being impacted by the work.

Managers also brought a supervisory element to the team supervision process. This was particularly useful where, for example, legal and/or practice issues were of relevance to the discussion. This was essential to promote confidence in managers that there were clear governance structures in place relating to social work practice and in particular to the assessment and management of risk within public protection. The presence of a frontline manager in each group supervision session also helped demonstrate the commitment of managers in the process.

While both the frontline manager and the clinical psychologist overlapped in a number of areas, the psychologist attended more to the flow of the discussion. At times the SCP guided the team to explore and make explicit principles and values that underpinned the discussion and consider how these related to trauma informed approaches. The psychologist also brought and shared

specialist level knowledge of psychological understandings, including of mental health and other trauma related difficulties. These were used to provide appropriate expertise in relation to the new practices of assessing experiences of trauma and its impact, including mental health, and to support the team to articulate and develop formulations of particular issues and/or of particular clients.

As a non-social worker, the psychologist was at times able to present alternative perspectives on issues, for example, by sharing relevant theoretical conceptualisations and/or empirical findings from the psychological literature. A further advantage of the facilitator not being a social worker was that this provided opportunities for 'holding a mirror' to participants by pointing out some of the implicit, taken-for-granted assumptions that may have been evident in the discussions.

Trauma Informed Group Supervision Evaluation

Feedback on group supervision was sought through the staff questionnaire as well as the focus groups. Practitioners were asked if they had found group supervision sessions helpful. As can be seen below, around 80% of practitioners agreed or strongly agreed with this statement.

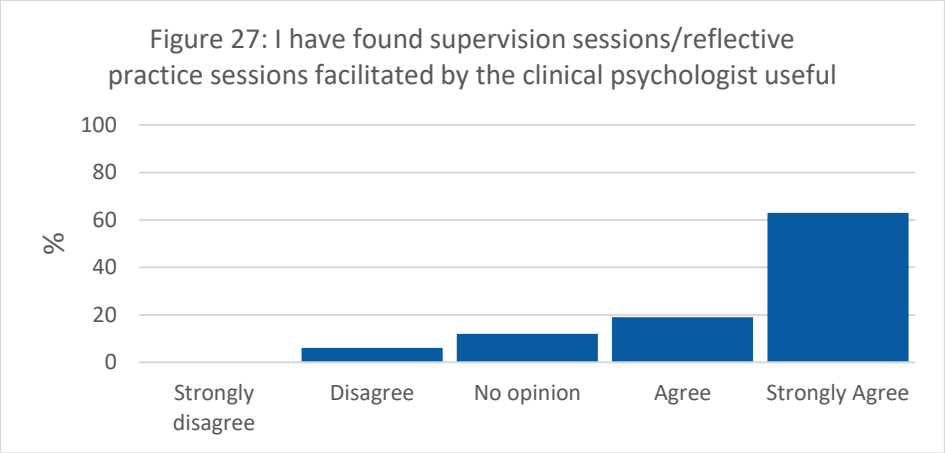


Figure 27: Practitioners' Evaluation of Trauma Informed Group Supervision

Practitioners were invited to discuss and reflect upon their experiences of group supervision in the focus groups. On the whole staff were very appreciative of these groups, even if they reported having had some initial reservations about the process. It is clear from the focus group report that staff valued group supervision as an important element of self-care and well-being support.

> **Having fortnightly supervision allows me to better understand myself as a practitioner but also better understand the presenting needs of my clients and how to work with them more effectively (Practitioner, Staff Survey)**

Staff recognised the connection between their own well-being and their practice, particularly in relation to working with service users, especially where trauma may be an important component of the service user's presentation. This was summarised in the focus group report:

> **"It was recognised that service users were not "triggering" staff anymore. In the past staff would have been "an empty bank" (no resources/reserves) and the service users would have been "less well looked after"**
>
> **Focus Group report**

In addition to finding group supervision a reflective and supportive space to consider the impact of the work, practitioners were also clear that they found this space and process supported practice development and in particular issues relating to working in a trauma enhanced way. The focus group report notes

> **"One of the biggest benefits identified was that of learning from each other and discussing practice issues. Participants articulated shared commonality of and experience."**
>
> **Focus Group report, p9**

One of the issues discussed in the focus group was participants' views on the involvement of a front line manager in the team supervision. While there was some ambivalence expressed about this, on the whole it was evident that practitioners understood the rationale for this and comments about the involvement of a manager were generally very positive. Further, a number of participants commented that the presence of a manager demonstrated 'buy-in' from management, which was viewed as essential and helpful to the process.

> **"Management "buying in to the process" as well as staff was thought to be a major benefit, as "everyone is involved in the process". Managers were perceived to be validating practitioners work because of the investment in supervision.**
>
> **Focus Group report, p10**

Other practitioners noted that the participation of managers in the team supervision was an important element of the whole service moving towards working in a trauma enhanced way.

> **"I love it – it's vital to have space to process and practice to be safe and to improve. Space to be vulnerable, no judgement if things are hard, or if we cry" (Practitioner, Focus Group)**

Impact of the Covid-19 pandemic: working from home

In March 2020, in response to the Covid-19 pandemic, many services, including GWS, ceased to be office based, as a majority of staff in the Council's CJSW services were required to work from home. Very early on it was recognised that this would impact on staff who were now, isolated from their usual support from colleagues and adapting to doing all their direct client work by telephone while work-related meetings with other staff shifted to online platforms.

While there was considerable uncertainty about how long this situation would last, it was evident that staff would benefit from additional support as they continued to work in such challenging circumstances, while also being impacted personally by the pandemic. In response to this, pre-existing group supervisions increased in frequency from fortnightly to weekly. In addition, groups

were offered to teams within criminal justice social work that had not previously had access to these groups, including some who had not been within scope of the Trauma Project.

These new groups were facilitated by a wider group of Clinical Psychology staff working in GWS. As some participants in these new groups had not completed the trauma training outlined above there was less explicit focus on promoting trauma informed approaches to the work and greater emphasis on staff well-being and staff support.

Participants in group supervisions run during the lockdown spoke frequently about the impact of working in isolation, with the absence of regular access to colleagues being something that they found particularly challenging. Participants were invited to complete a brief feedback survey after 6 months and staff indicated these groups had been particularly helpful during the months of working in isolation from colleagues, they would previously have seen most days. Although feedback from the survey was not universally positive. For example, a couple of people reported feeling that groups should run fortnightly rather than weekly even though they were generally content with the process. However, it was apparent for some people these groups were an important source of support during this difficult time, as is evident in the quotes below from participants the newly formed groups:

> **Particularly during full lockdown, having this group in a fixed slot every week was a vital anchor for me in terms of sustaining positive mental health. (Feedback from 'Lockdown' Group Supervision Participant)**

> **"I've never had the opportunity to take part in group supervision before so I did not really know what to expect. But pretty much from the first session, I felt comfortable and gained huge benefits from involvement in the process. I've said this to my group: we have shared a unique and unprecedented time in history together and group supervision has undoubtedly helped me to cope with an incredibly personally and professionally challenging time period which is still ever-changing as I write this." (Feedback from 'Lockdown' Group Supervision Participant)**

Trauma knowledge inherent in practice: Domain 3

The Trauma Project was designed to support the implementation of cultural and systemic change within the service, which involved new areas of practice working with service users. In this section we will focus on three specific areas, namely

- Developing routine screening for trauma and associated mental health difficulties
- Developing practice in how workers respond to common trauma related difficulties
- Piloting a psycho-educational course (Survive and Thrive).

Asking about trauma and its impact: Trauma and Mental Health Screening (TAMHS)

A key element of operating at a Trauma Enhanced level of practice requires that services routinely screen for trauma experiences of service users and modify practice accordingly, by providing appropriate interventions. As such, enquiring about experiences of trauma in itself was deemed insufficient within the context of professional social work assessments. Staff practice had to develop to ascertain potential impacts of trauma and understanding about how these may affect not only the individual but professional relationships and interactions with the service. This assessment process included asking routinely about common mental health difficulties experienced by service users. To do this practitioners are asked to move beyond taking a personal and offence focused history to also considering the role of trauma and the impact it has had on the individual's life. This would include asking routinely about common mental health difficulties. To support this practice change a screening tool was developed for routine use in assessments of Group Work Services' service users: The Trauma and Mental Health Screening (TAMHS[2]). The tool is for use in new assessments, for example, post sentencing, so when a new Community Payback Order is imposed, at the early stages of undertaking work to develop a Case Management Plan.

This TAMHS is a screening tool that supports and guides workers in asking service users about traumatic experiences and a range of mental health issues that are commonly associated with a history of trauma. It evolved from prior experience of supporting and training staff at Willow to

[2] Available on request from the authors.

routinely assess in this manner and through consultation with GWS managers and frontline staff. This was an iterative process where feedback from workers on earlier versions of the TAMHS was taken into account as the final version was developed. A ‘users guide’ was developed alongside the TAMHS, with detailed guidance for workers undertaking the semi-structured interviews required, including examples of the kinds of questions that might be used to complete different sections of the TAMHS.

The training package involved training in asking about and, crucially, being able to respond to disclosures of trauma, as well as a section on screening for common mental health problems, particularly as these relate to a history of trauma. This content and structure of the TAMHS was purposively aligned with the training and as such, the training is an essential requirement for workers carrying out TAMHS assessments.

An important component of the TAMHS is the development of a psychological formulation (including the service user’s own understanding) using a template designed to support this. This aspect of the TAMHS was included to encourage practitioners to consider the relationship between the service user’s personal history, including experiences of trauma, current life circumstances, mental health issues and coping strategies. The TAMHS was designed to emphasise resilience in survivors of trauma, by recognising the connection between traumatic experiences and what might be construed as mental health difficulties but which can also, perhaps more helpfully, be reframed as potential survival strategies in the context of someone’s experiences of trauma and their subsequent efforts to cope with the impacts.

It is important to point out that the TAMHS does not include a specific section on risk assessment and management. This is because the risk assessment and management processes and measures already in place within the service were well established as a routine part of work and well-suited to this purpose. Rather, the TAMHS was designed to enhance and compliment existing assessment and formulation processes and be incorporated into pre-existing case management planning.

A range of psychometric measures was introduced as an integral component of the TAMHS and to support the screening process. These included measures of adverse and benevolent childhood experiences (ACE and BCE), measures of anxiety (GAD7) and depression (PHQ7), a general measure of psychological distress (CORE10) and a measure of Post Traumatic Stress responses (ITQ).

In addition, in recognition of the paucity of local data in this area, it was hoped that including psychometrics would provide some indicative data in relation to rates of trauma and mental health difficulties in male community justice service users. The intention was to use these psychometrics as part of the assessment process for new individuals coming to the attention of the service with the longer term aspiration to conduct follow up post-intervention measures to establish if there was any measurable evidence that the intervention had impacted on levels of anxiety, depression and general distress.

When the country first went into lockdown in response to the Covid19 pandemic, all routine face to face contact with service users ceased, which impacted considerably on both the nature and extent of client work that front line staff were able to do. This occurred just as the service was in the early stages of routinely conducting the TAMHS, including the related psychometric measures. With all client contact being conducted by the telephone, some of the initial

momentum in conducting the TAMHS was lost as workers felt unsure about if and how the TAMHS could be safely carried out this way. Similar reservations were expressed about the feasibility and appropriateness of completing psychometrics by telephone. These reservations e were not unique to the TAMHS. Concerns were also expressed by practitioners about the use of a range of standardised interventions that had been designed for inclusion in face-to-face work with service users.

After some discussion, it was agreed that it was helpful to modify the TAMHS protocol to make it usable for phone consultations. A truncated TAMHS (T-TAMHS) was developed for this purpose along with modifications to the suggested psychometric measures. Despite these adjustments, the impact of working from home during the pandemic was great on all areas of client work, including but not limited to the TAMHS. One consequence of this was that the database that we were able to build up over the course of the Trauma Project was much smaller than had originally been projected.

The psychometric data reported here is from a relatively small sample size (N = 28) of community justice clients. This sample includes clients referred to the Caledonian Programme, Crossroads and to CISSO. While this sample size is small, there is no obvious reason to assume it is unrepresentative of community justice service users. The data presented below support the hypotheses that community justice service users present with high rates of traumatic experiences and a range of common mental health difficulties, of varying degrees of severity and that their access to specialist mental health services is very limited, indicating that there are high levels of unmet need in this population.

ACEs and BCEs: Adverse Childhood Experiences (ACE) and Benevolent Childhood Experiences

Research into adverse childhood experiences consistently and convincingly demonstrates that these experiences are associated with an increased risk of a wide range of health and social problems in later life. Much of this research has used a 10-item scale to measure ACEs. This scale was selected for use in the current project. As part of its commitment to developing a trauma informed workforce, the Scottish Government has identified ACEs as an area of central importance to both prevent and understand the range of adverse outcomes ACEs are associated with.

While there has not yet been a Scotland-wide ACE survey, Public Health Scotland has proposed that “we could assume similar prevalence of ACEs in the Scottish population as has been found in Wales”, where such a study has been conducted by Public Health Wales (Ashton et al 2016).

The Welsh study reported that almost 50% of the population experienced 1 ACE and 14% experienced 4 or more. An English study reported that almost 50% experienced 1 ACE and over 8% reported 4 or more ACEs (Bellis et al, 2014).

The Welsh study found that those with 4 or more ACEs were at greater risk of a range of adverse outcomes, including being at increased likelihood of mental ill health, self harm and substance use. Of particular relevance to our work, the Welsh study also found that those with 4 or more ACEs when compared to the general population, were 15 times more likely to have been a perpetrator of violence over past year, 14 times more likely to have been a victim of

violence over the same time period and twenty times more likely to have been in prison at any time in their life (Ashton et al 2016).

Data from our Trauma Project, based on completed ACEs for 27 of our service users, gave an average score of 4.2 ACEs (with a standard deviation of 3.0). Over half of our sample (56%; N=15) reported 4 or more ACEs, considerably more than reported in both the Welsh and the English studies.

More recent research into the impact of childhood adversity has investigated factors associated with resilience which may, to some extent at least counter or mitigate the impact of childhood adversity in health and social outcomes. This important research is at a very early stage, with as yet no universal consensus on how best to measure resilience factors. One measure which has been used in a number of studies is the Benevolent Childhood Experiences (BCEs), often considered a helpful counterpart to the ACEs measure.

As research into the impact of BCEs is at an early stage, local population based measures of are not yet available. The research to date does, however, suggest that benevolent childhood experiences do contribute to resilience in later life. For example, a study by Public Health Wales (Hughes et al, 2018) found that higher resilience scores reduced, but did not eliminate, the risks of developing mental health difficulties associated with higher ACE scores. This study investigated childhood and adult resilience factors and reported that both contribute to reducing the increased risk of mental health difficulties associated with childhood adversity. However, they caution that focusing on resilience is not a panacea for eliminating the impact of adversity.

We included BCE measures as part of the TAMHS psychometrics to ensure that resilience factors were taken into consideration in working with services users. We also hoped the data collected might provide some useful preliminary information on rates of BCEs in our service user population. In our sample, the average number of BCEs reported was 6.3 (SD 2.6). The current lack of local population based norms (as well as the small sample size in our Project) limits the inferences that can be drawn from this finding. However, it may be worth noting that studies which have reported mean BCE scores have reported higher BCE scores in homeless parents (mean 7.56; Merrick et al, 2019), pregnant women (mean 7.84; Narayan, 2018) and students (mean 8.52; Gunay-Oge et al, 2020) although these were all conducted in USA, making direct comparison impossible.

Impact of trauma

We hypothesised that CJSW service users would have high rates of post traumatic related difficulties as well as other common mental health difficulties and that this would be evidenced through the psychometric data collected. The data is clearly supportive of this hypothesis.

Post Traumatic Stress related difficulties

The International Trauma Questionnaire (ITQ) provides information on the presence of a range of difficulties associated with Post Traumatic Stress Disorder (PSTD) and Complex Post Traumatic Distress Disorder (cPTSD). The ITQ has been used as a diagnostic indicator for research purposes. As such, the ITQ assesses the presence of complaints that form part of the ‘symptom clusters’ commonly used by diagnostic manuals. The presence of all 4 symptom

clusters is required for a diagnosis of PTSD, while a cPTSD diagnosis is made only if all PTSD and additional 4 cPTSD symptom clusters are reported.

- PTSD Symptom Clusters:
    - Re-experiencing; Avoidance; Sense of Threat; Functional Impairment
- Complex PTSD Symptom Clusters:
    - Affective dysregulation; Negative self-concept; Disturbances in relationships; Functional Impairment

We collected 28 completed ITQs. Of those, 10 (36%) clients reported all four PTSD symptom clusters (suggesting they met the diagnostic threshold for PTSD). In addition, 6 (21%) of those clients also reported all four cPTSD complaints, indicating that they met the threshold for a diagnosis of complex PTSD (which, diagnostically speaking, would supersede the PTSD diagnosis).

While the high rates of those meeting diagnostic thresholds is of concern, it is important not to assume that not meeting diagnostic thresholds suggests the absence of the difficulties associated with post traumatic distress. Indeed, from our sample of 28, only 3 clients failed to report the presence of any of the symptom clusters noted above. 22 clients (79%) reported at least 4 of the 8 symptom clusters listed above, which is indicative of significant levels of distress and impairment.

Anxiety, Depression and General Psychological Distress

As noted above, common mental health difficulties were measured using standardised instruments. The instruments selected all give a measure of both presence and severity (ranging from minimal to severe) of the relevant mental health difficulty. Again, we hypothesised that our client group would report high levels of these difficulties and this was confirmed in the preliminary results.

Anxiety

28 clients completed the GAD7, reporting a mean score of 11.1 (SD 5.6) indicative of the presence of ‘moderate’ levels of anxiety. Looking more closely at the results, 82% (n=23) reported clinically significant levels of anxiety with 61% (n=17) of service users reporting moderate (n=10) or severe (n=7) levels of anxiety.

Depression

28 clients completed the PHQ7, reporting a mean score of 12.0 (SD 7.8), indicative of moderate levels of depression. Again, looking in more detail at the results we see that 82% (n=23) reported clinically significant levels of depression, with 52% (n=16) of service users reporting moderate (n=8) or severe (n=8) levels of depression.

General Psychological Distress

18 clients completed the CORE10 (reasons for the reduced number of completers is uncertain at this point). The average score on the CORE10 was 15.7 (SD 9.6), indicative of ‘moderate psychological distress’. 22% (n=4) of clients who completed the CORE10 reported ‘moderate to

severe' levels of distress, while a further 17% (n=3) reported 'severe' levels of psychological distress.

It seems from the above data that our initial hypotheses about high rates of traumatic experiences, post traumatic difficulties and common mental health difficulties in our client group is supported. While the relatively small sample means we may need to urge some caution in how confident we can be about how generalisable these figures are the CJ population, as noted earlier, there are no grounds for assuming that the population reported here are not representative of our service users. Though the sample size is small, the data collected do, nonetheless, point to worryingly high levels of mental health difficulties present. At the very least, workers need to be cognisant of this and competent at working with individuals experiencing such difficulties.

We hypothesised also that there are high levels of unmet health needs in our service users. Acknowledging the same caveats about the sample size reported here, the evidence is again supportive of this hypothesis. Of the 28 service users for whom data was collected, only 3 (10.7%) were receiving specialist mental health input, although 11 (39%) were reported to be prescribed psychiatric medications (with varying degrees of adherence) by their GPs. There are also strong grounds for further, more extensive investigations to be conducted to get a better picture of the range and extent of what would appear to be largely unmet – or only partially met mental health needs in this client group.

Asking about trauma and its impact: Trauma and Mental Health Screening (TAMHS) evaluation

Anecdotal feedback from front line managers indicated that not all workers immediately adopted the TAMHS into routine practice. Some workers expressed reservations about this to their supervision or team meetings. Some of these reservations related to questions about the appropriateness of routinely screening for trauma and mental health (for example, the notion that these questions were 'invasive') and sometimes related to confidence (for example, workers expressing concerns that they did not feel adequately trained to ask these questions and, equally importantly, were unsure about how to respond if disclosures were made). This is perhaps not too surprising given that at the time of being asked some staff had only limited experience in using the TAMHS routinely as it had been adopted in different teams at different junctures in the project. Research has shown that some resistance to adopting routine enquiry is not uncommon in service providers (Pearce et al, 2019).

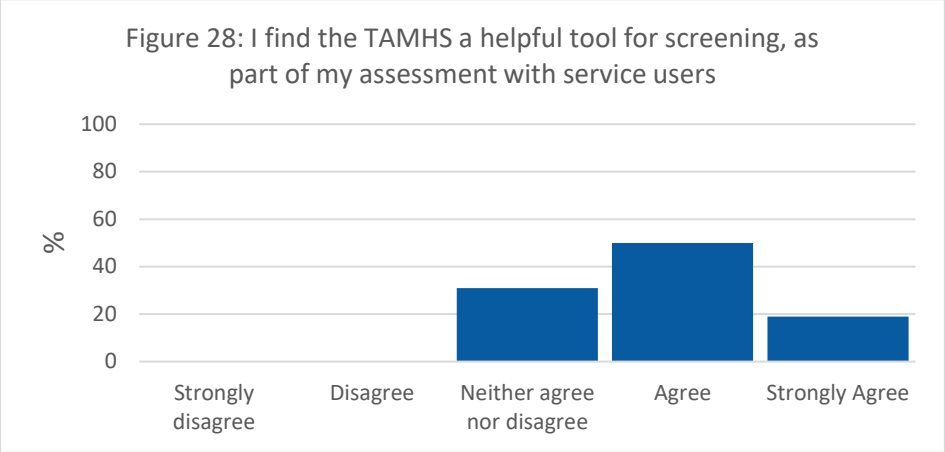


Figure 28: Practitioners' Views on the Usefulness of TAMHS

Later when seeking feedback from practitioners, their views on the usefulness of the TAMHS was largely, but not universally positive as can be seen above. Staff reported increased confidence in asking about trauma and about common mental health difficulties as part of routine assessments.

Responding to trauma and its impact

Through training, coaching and trauma informed group supervision, workers were not only being supported to ask about trauma and its impact but to respond differently by drawing from newly acquired skills to support service users in understanding and managing the impacts of trauma. These included adopting new practices (in line with UK PTS Guidelines, 2016) in relation to:

- Psychoeducation and normalising such as models of PTSD, how multiple trauma complicates presentation, impact of developmental trauma, window of tolerance, explaining dissociation, explaining symptoms and emotional responses
- Symptom management such as managing mood increased activity and reducing isolation, dealing with panic and anxiety
- Skills training such as mindfulness, interpersonal skills, emotion regulation, distress tolerance, self-compassion, grounding techniques.
- The use of new materials in response to disclosures about trauma and its impacts.
- The provision of specific information leaflets about common reactions to trauma, helping people to understand the wide range of trauma reactions, explaining and "normalising" these including anxiety and depression and how these can affect people.
- Practice changes also involved a greater focus on resilience and strengths, developing individual safety and staying well plans, introducing coping skills and helping service users to practice these, again with the use of new materials.

Responding to trauma and its impact evaluation

Staff went on to report they saw themselves as working in a trauma informed way and that this approach was of benefit both in terms of their relationships with service users and their effectiveness in supporting service users:

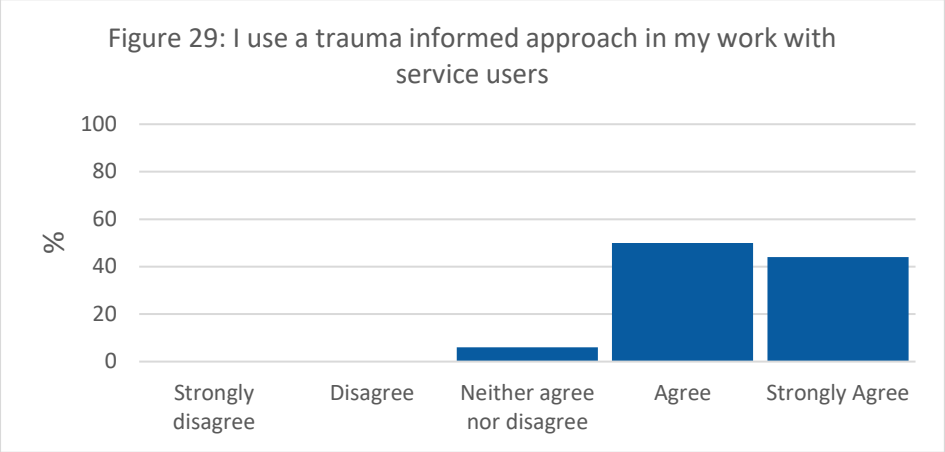


Figure 29: Practitioners' Use of Trauma Informed Approach in Work with Service Users

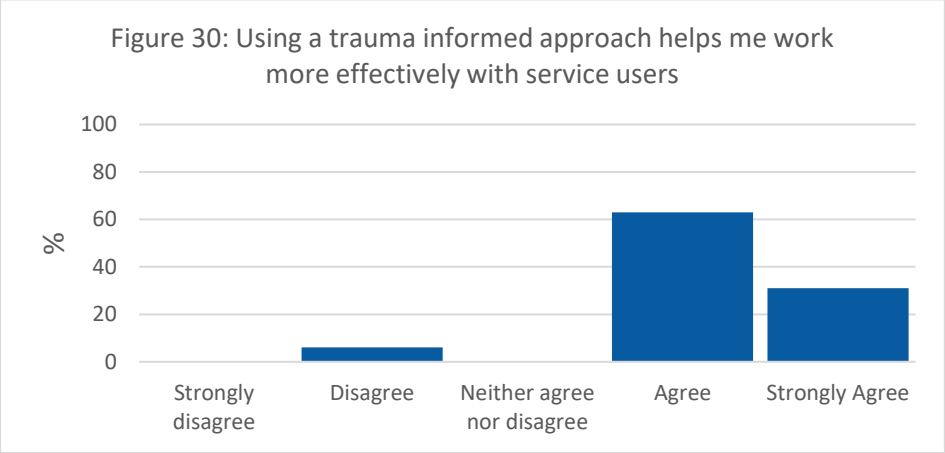


Figure 30: Practioners' Views on the Effectiveness of Trauma Informed Approach

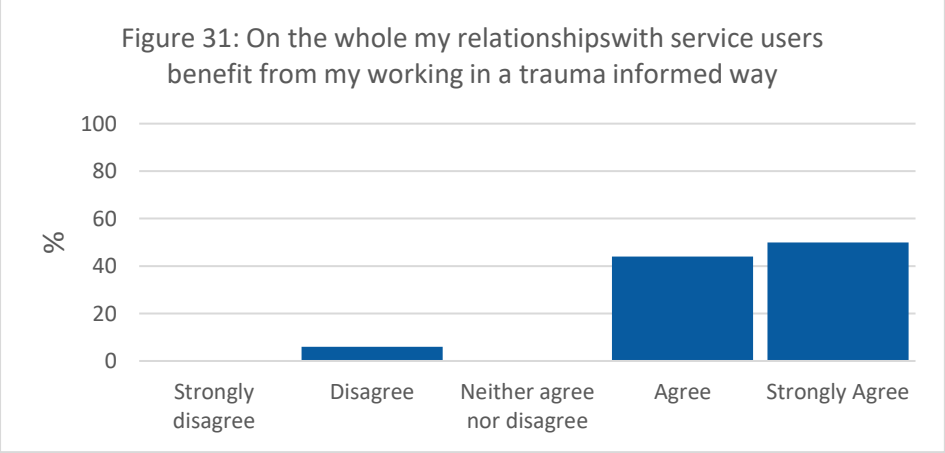


Figure 31: Practioners' views on impact of Trauma Informed Approach on Relationships with Service Users

Further, the comment below suggests that staff recognised that this constituted a significant and systemic shift in the way in which the service operated:

"The biggest difference in the service has been the responsiveness, we take the best route available at the time. We are more inclusive, before we matched men to the service and now we match the service to the men" (Practitioner, Focus Group)

Consistent with the above findings, as the figure below shows, 94% of staff agreed they felt "more skilled and equipped to respond to the impact of trauma with service users (e.g. safety and stabilization skills including normalizing, psycho-education, mindful breathing etc)".

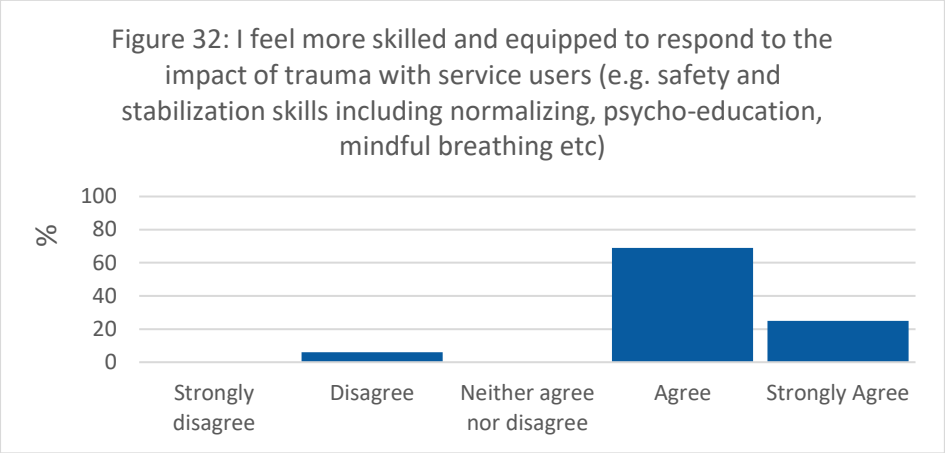


Figure 32: Practitioners' Appraisal of their Skills in Responding to Impact of Trauma in Work with Service Users

Survive & Thrive: Psycho-educational Intervention Course

'Survive and Thrive' is a psycho-educational intervention course for people who have experienced trauma, focusing on their safety and supporting efforts to create stability. The general purpose of the group is to help participants develop a better understanding of trauma and common reactions to trauma as well as to learn and practice coping strategies for dealing with some of the impacts of traumatic experiences. The standard Survive and Thrive package is a 10 week manualised intervention (Ferguson, 2008) designed primarily for a community mental health population.

Additional versions have been trialled for more specialised populations over a number of years including a "rolling" community version designed specifically for a population of women in contact with the criminal justice system, whose participation in weekly course sessions was irregular. A closed group format was ill-suited for the population. The rolling version involved a different application of the original course, whereby participants can attend session 1 as "induction" and thereafter join the next session which rolls continually from session 2 through 9 and then immediately recommences. This approach enabled a population of survivors of complex trauma whose lives were interrupted by life events (i.e. short periods of incarceration, crises such as homelessness etc), the ability to access the course. This flexible approach was deemed more suitable to the population of men in contact with our service during the project. This 'rolling' format was adopted, allowing participants who had attended the introductory session to attend subsequent sessions, even where course attendance was not routine or with linear consistency.

A version of the original course had also previously been adapted for a male prison population, and was briefly trialled with a small number of male prisoners in Scotland. The need for this version was established due to the prevalence of violence and abuse perpetrated by the male prisoner population. A distinct and specific approach was required to take account of the duality of being a survivor and a perpetrator.

This version of materials adapted for men involved in offending combined with the flexible "rolling" community model formed the basis of the intervention used in our Trauma Project.

Guidelines related to the delivery of Survive and Thrive include a requirement for at least two trained facilitators to deliver the intervention and to do so under the supervision of an appropriate qualified supervisor. Importantly, facilitators who delivered the intervention in this project were all very experienced in working with a population of men in contact with the criminal justice system.

Survive and Thrive was delivered in two settings and was available to men subject to various community supervisions including Community Payback Orders, Drug Treatment and Testing Orders, parole licence supervision and voluntary throughcare.

Survive & Thrive: Psycho-educational Intervention Course evaluation

The number who attended these groups was low (generally 2 - 4 participants per session) and the anticipated inconsistent attendance experienced in other community based courses targeting justice populations was the norm. Participants' life events interrupted frequent and consistent group attendance. However, feedback received from participants was generally encouraging as can be seen below:

"Information on trauma and addiction was helpful"

"Reading over information helped me understand some of what I am experiencing"

"Very encouraging to realise that I wasn't alone in my thoughts"

"Brand new – made sense"

"Was helpful to understand shared experience"

"Good having other people I could relate to"

Further research would be required to make any confident claims about the impact and efficacy of Survive and Thrive as an intervention with this particular community justice population. However, the trial demonstrated that for the service users who participated, an adapted version of Survive and Thrive, delivered in a more flexible 'rolling' manner, was an acceptable and generally well received intervention. As such, this warrants further investigation when the service is once again in a position to deliver group interventions face to face and to gather further data relating to post intervention impacts.

Course facilitators and project leads undertook to review the suitability of the adapted male 'forensic' version for our service users. Based on the experience of delivering the intervention,

significant changes to the materials were suggested. This collaborative process of reviewing and updating the materials (slides and workbooks) is ongoing, endorsed by the Survive and Thrive National Reference group.

Key findings and recommendations

Key Findings

Experiences of trauma are highly prevalent within the community population of men in contact with Edinburgh Criminal Justice Social Work services.

Very high levels of mental health impact are present in this population:

- Four out of five service users describe post traumatic symptoms indicative of significant levels of distress and impairment;
- Four out of five service users reported clinically significant levels of anxiety
- Four out of five service users reported clinically significant levels of depression.

The prevalence of trauma and its impacts, and the level of unmet need, indicates trauma informed approaches should be adopted across a range of services with a specific remit to work with people in contact with the criminal justice system, including other social work, support and mental health services.

The trauma informed service model and approaches adopted in this project were found to be highly acceptable to front line staff and managers.

Recommendations

The model, including routine screening for trauma experiences and mental health impacts and new interventions in response to these, should continue to develop in Groupwork Services and be extended across criminal justice social work services, involving:

- Further data collection on ACEs and BCEs would provide a fuller picture of the extent and range of trauma experiences and resilience factors and allow for more detailed analysis of impact
- Undertake further analysis of the higher volume of data gathered, including, for example the extent of unmet mental health needs within this population.

Structures to support service user participation should be established to ensure the service user voice helps shape future development work, including design and delivery of training and qualitative feedback on experience of interventions

Council and partner agency service providers services with a specific remit to work with people in contact with the criminal justice system, to consider applicability of these findings in relation to the delivery of trauma informed service provision including within other social work, support and mental health services.

Key Findings	Recommendations
Significant leadership resource and commitment is essential to bring about the necessary practice and culture change required to implement a Trauma Informed service model into existing Criminal Justice Social Work practices.	Continue to support the investment in leaders who have taken on a trauma champion role throughout the project with a view to supporting capacity building across criminal justice social work, and wider services A training package should be developed for front line managers who co-facilitate trauma informed supervision groups, drawing from the experience of front line managers who have provided this as part of this Project Criminal justice social work leaders to contribute to the development and delivery of structures and processes that can support implementation of trauma informed approaches across a range of council and partner service provision.
The NES (2017) knowledge and skills framework is helpful and relevant in the design of bespoke training for criminal justice social work professionals working towards trauma enhanced practice level. Having a highly specialist Senior Clinical Psychologist embedded within the criminal justice service to provide expertise and appropriate governance supporting delivery of interventions responding to trauma, was essential and highly effective. With appropriate leadership, training and supervision in place (NES, 2017) criminal justice social workers can be supported to embed trauma enhanced approaches into existing social work practices, including protocol based psychological interventions. Preliminary findings from this Project indicate that these interventions are valued by service users.	Trauma enhanced practice level training for criminal justice social workers should take account of pre-existing training and experience in the assessment and management of risk, whilst recognising the gaps in trauma and mental health training, specifically in relation to assessing for trauma experiences and common mental health reactions, and the provision of psychoeducation and safety and stabilisation interventions. Sufficient clinical psychology input is essential to ensure all staff have access to specialist mental health training, trauma informed group supervision to embed trauma training and new interventions into practice, and to provide the required governance in relation to delivering these interventions. Outcome measures should be used routinely in services which deliver these interventions to evaluate efficacy.

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