

## MSU/LSU Issue 42, June 2019

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## WELCOME

Welcome to the 42nd edition of the Quality Network for Forensic Mental Health Services' newsletter on **'trauma informed care'**. Included are some excellent examples of how trauma informed care is being developed and delivered within low and medium security. We hope you find the contributions useful and thank you to those that have submitted articles.

We're now at the end of the review cycle; we have finished all of the peer-review visits and both annual forums have been hosted! Each forum was very well attended and included presentations on reducing restrictive practices, novel psychoactive substances, using technology to improve patient safety, gender identity and co-production. We'd like to thank everyone who participated in both events, with a special mention to our patient and family and friends representatives for chairing - Sheena Foster and Sarah Markham (pictured), and Louise Maclellan and Hannah Moore. We also delivered the preliminary findings from the review cycle, highlighting where services are performing well and where improvements are required. One of the areas in most need of improvement is staff support and training. As a result, the next newsletter will be on this theme.

Over the summer, we will be working on preparing for the next cycle, as well as pulling together the data for the aggregated reports. These will be with you in October.

Keep an eye out for reviewer training dates in September and October, and the trauma-informed event taking place in November (further information inside).

We hope you have a lovely summer and we look forward to seeing you again in the autumn.

### Dr Quazi Haque and Megan Georgiou



## Developing and embedding a trauma informed clinical model: Our journey of starting anywhere and following everywhere

### People own what they help to create

As part of the forensic service's drive towards quality improvement we set about establishing and embedding a sustainable clinical model. Previous attempts had failed largely because they were experienced as imposed, deskilling and unworkable. Informed by this lack of ownership we adopted a systemic approach that was guided by Myron's Maxims (Rogers, 2015, seen as headers in the paper) which prioritised the process of change over the end result.

### Those who do the work do the change

A group of multi-disciplinary staff from all parts of the service were invited to participate in a year long process of model development supported by an organisational development consultant. The first step was to surface and articulate the current model of the service. This process helped us realise our implied model was dominated and shaped by the requirements of the Mental Health Act and ministerial oversight. Whilst these structures are clearly important clinicians felt constrained and acknowledged the complexity of our client group were not fully addressed.

The second step involved a detailed reflection on our values as professionals and a service. Trauma Informed Care (TIC) surfaced as aligned to these values. However, we also recognised the principles of TIC could create tensions with the tasks of a forensic service. Similar conflicts have been explored when implementing the recovery principles in a secure setting (Drennan and Alred, 2012). The concept of "secure recovery" explicitly acknowledged the power dynamics, limits of true choice and capacity for autonomy for detained patients.

To ensure value alignment, and to work with tensions rather than ignore them we contextualised the model within a wider frame as seen in figure 1.



Fig. 1. Our Clinical Model as an Emblem.

The central symbol was designed by our service users and the tag line "Nurturing Safer Futures" highlights our primary task of ensuring the safer futures of our service users. But also denotes the often conflicting roles of our duty to protect the public from future harm and maximise the physical and psychological safety of our staff.

### Connect the system to more of itself

With the clinical model established, we moved towards implementation. In contrast to previous attempts there was no launch date, no mass training and no change in paperwork. Instead the focus began and remains on connecting and ensuring the model runs through the heart of everything the service does. The emphasis has been on experiential learning through existing structures, reflective spaces, and multi-professional work streams rather than classroom based didactic learning.

### Real change happens in real work

Different groups of professionals have led on a variety of workstreams to ensure a journey towards strengthening the trauma lens for our service.

To date, some of the elements of the system that have been connected include ensuring the clinical risk process and training has a strength based focus and links violent behaviour and adverse child experiences. The service consistently adopts a trauma informed approach to case formulation sessions and policies are reviewed through a trauma lens to minimise the risks of retraumatisation.

Our reflective practice draws attention to the risks of vicarious traumatisation and the importance of self-care. All staff receive supervision and supervision training with an adapted version of The 7-Eye model (Hawkins and Shohet, 2012) to include trauma prompts under each level of reflection.

Safety huddles are informed by the question "What has happened to you?" rather than "What is wrong with you?" And our recovery college has developed an information leaflet for new staff and service users. Taken together this work ensures we are considering client's current presentation in the context of their past experiences.

### **The process you use to get to the future is the future you get**

In keeping with the principles of a journey, there is no endpoint in mind. Informed by the 10 ingredients of TIC, we have mapped

out our achievements, our current work and our aspirations.

We are now 18 months into our journey. Staff have adopted the principles to different degrees but collectively the focus of the service has shifted. In terms of formal evaluation, many indicators demonstrate an improving service, for example staff absence figures, retention rates and staff survey questionnaire. But perhaps most notably the repeat round of our patient experience questionnaire has demonstrated an improvement in our scoring on questions capturing feelings understood by staff. Moving forward we hope to quantify change further by introducing a trauma specific measure and repeating the staff wellbeing measure after implementing actions from our recent baseline.

**Dr Kerry Hinsby, Lead Consultant  
Clinical and Forensic Psychologist,  
Leeds and York NHS Partnerships  
Foundation Trust**

## **Taking forward the trauma informed care agenda into a medium secure hospital**

As a medium secure hospital, it is essential that the assessment and treatment of patients staying in the unit is holistic. This means not only focussing on risk, but also patients as a whole, including their individual life stories and any difficulties they have been faced with. As research has shown, there are a high number of forensic patients who have a history of complex and interpersonal trauma, which is not dissimilar to our hospital. As a team it is therefore our duty to be trauma informed and recognise that individuals may have experienced different types of trauma in their lives and the need of each individual is unique.

### ***So what did we do about this?***

In early 2018, the psychology team formed a *trauma informed care working group*. The overall aim of the group is to improve and maintain the awareness and practice of trauma informed care within our hospital. Upon group development, the following objectives were established:

- To ensure the acknowledgement and effective working through trauma related issues for all patients
- Improving awareness of trauma at all levels of the hospital
- Ensuring interventions consider the trauma related needs of patients when addressing mental health difficulties, personal distress and managing safety.

Meetings were planned to be held every other month and had regular agenda items.

### ***What have we achieved over the past year?***

The first goal was gaining membership from the hospitals full MDT. This was achieved through a global email advertising the working group, meetings with nursing, occupational therapy and ward staff who showed an interest in becoming a member and presenting case studies and audit results to doctors and senior management. In doing so, we gained interest from every discipline within the hospital and a total of seventeen members. A combination of each of these members attends the meeting within the

hospital to discuss and reflect upon progress of the group and trauma informed practices within the hospital.

We have completed an audit of the prevalence and nature of trauma within our hospital that has helped to highlight the need for the group to continue and improve on trauma informed practice.

A psychological therapies booklet has been developed for patients and carers to highlight all therapies on offer within the hospital, which includes individualised trauma therapy.

A promotional board explaining trauma informed care and trauma therapy available within the hospital was developed and placed outside the patients shop for a four month period to be viewed leisurely.

The group are currently in the process of designing a service evaluation exploring the awareness of trauma and trauma informed care within the hospital to identify any learning needs of staff.

Having the working group has helped develop links with the recovery college in the hospital and we are currently in the process of exploring the possibility of developing a course to add into their catalogue.

Two members of the group are currently organising their attendance at the hospitals carers forum to advertise the group and provide further information on trauma informed care and the treatment of trauma

available in the hospital.

There has been anecdotal evidence from group members that trauma and its effects have been acknowledged more in MDT meetings and patients have been considered and referred for individual trauma therapy.

Finally, continued professional development opportunities for those facilitating trauma therapy and information on national and local guidelines have been shared and disseminated.

### **Going forward?**

A challenge going forwards will be the maintenance of the membership and momentum we have gained over the past year. Having one member of staff take a lead on this has been working well so far to ensure that meetings, actions and liaison with group members can be communicated across the working group and the hospital. This year we plan to continue maintaining our links with other services, complete the service evaluation to highlight any treatment needs, attend the local carers forum, continue with promotional opportunities, maintain contact with the recovery colleague and review the hospitals policies and procedures to ensure they are trauma informed.

**Jayde Midgley, Assistant Psychologist in Forensic Training, Wathwood Hospital Trauma Informed Care Working Group, Nottinghamshire Healthcare NHS Trust**



Standards for Forensic Mental Health Services: Low and Medium Secure Care (Third Edition) - now available!

You can find the standards on our website:

[www.qnfmhs.co.uk](http://www.qnfmhs.co.uk)

## The delivery of trauma-informed care in secure settings

As we all know, there is growing evidence that trauma-informed services and practices result in better outcomes for service users, staff and services as a whole. It is our ambition to integrate trauma-informed care principles into the current model of care delivered throughout secure hospitals within BSMHFT.

It is envisaged that building upon our current practices, developing effective trauma-informed services will not only improve outcomes for service users, but also have a significant positive impact on staff wellbeing. In turn, this will be associated with a reduction in the use of restrictive interventions, shorter length of stay, and crucially improve the experience of care for service users.

In our experiences working within a men's service, trauma has tended to be understood within the context of a service users' individual formulation as a historic factor that has impacted upon their current presentation or emergence of mental health difficulties. There is a growing commitment to looking beyond this, to thinking about how that person's experience impacts on their relationship with the care system and their recovery pathway, and how practices, procedures and the environment within our hospitals may improve or exacerbate traumatic symptomology.

In addition to our current areas of good practice, we have identified the following areas for future development:

### **Putting trauma on the agenda**

As part of a trauma-focussed away day, 70 members of the services' psychology team inputted their expertise and views into the overall trauma strategy that we are currently implementing across our secure hospital sites.

Having initially started as a small psychology special-interest group, the trauma strategy group has now developed and merged with the Psychological Well-being programme, encouraging the integration of trauma-informed care principles throughout our care-pathway model.

In order to raise awareness and buy-in from wider clinical leadership, *Against Violence & Abuse* are providing training for managers in

relation to the implementation of trauma-informed care principles within secure environments.

### **Scoping our current practice**

A baseline scoping exercise is planned to ascertain service user's and staff's views on how trauma-informed our current practice is. Informed by Stephanie Covington's work, we are developing a questionnaire around the 5 core values of trauma-informed care principles with a view to highlighting strengths and weaknesses in our current practices. This will be used to identify priorities.

### **Shaping our training programme**

Our aim is to offer 100% of staff training in trauma-informed care principles. This includes a tiered approach of bespoke face-to-face training and development of an online training package.

Learning objectives include:

- To understand what a trauma-informed environment is and why adopting a trauma-informed approach is appropriate in health services.
- To understand the impact of trauma.
- To develop a vision of what being trauma-informed might look like.
- To explore how to practically implement a trauma-informed approach.
- To understand what secondary or vicarious trauma is and to explore strategies for self-care.
- To take away practical, adaptable tools that will improve policy and practice.
- To develop an action plan for becoming trauma-informed.

We are encouraged that clinical leaders across the directorate recognise the value of investing in understanding the service users that we work with in the context of their traumatic life experiences rather than the risky behaviours that they present with as a consequence of this, and that the implementation of trauma-informed care principles across our services will lead to improved service outcomes and heightened wellbeing for all.

**Kate Adamson, Principle Psychologist,  
Caitlin Anderson, Consultant  
Psychologist & Louise Pearson, Principle  
Psychologist, Birmingham & Solihull  
Mental Health Foundation Trust**

# Compassion focused training for staff in mental health settings

## Introduction

Compassion Focused Therapy has been developed as an intervention for people who experience difficulties in expressing compassion to themselves and others, and who experience high levels of self-criticism and shame. The therapy was developed by Professor Paul Gilbert (Gilbert, 2009) and is based on evolutionary, cognitive and behavioural psychology and falls under the umbrella of 3<sup>rd</sup> wave CBT approaches. In the current study, compassion focused training was presented to a group of staff nurses and healthcare assistants working on complex needs wards in a low secure mental health care setting. The monthly training aimed to support staff to develop alternative and more compassionate ways of relating to themselves, the service users on the wards and others (Cole-King & Gilbert, 2011).

The Fears of Compassion Scales (Gilbert, 2010) were identified as the outcome measure for this training programme and were collected both prior to the start and on the six months point of the monthly training that was presented for the year. Continual evaluation forms were also collected during the progression of the yearly training, and included both quantitative and qualitative feedback on the experience of the attendees in the training.

The training sessions aimed to provide staff with an overview of the compassion focused model and to assist them to develop their own individualised models of compassion focused therapy. Once staff members had an understanding of the development and maintenance of their difficulties they were then invited to try new skills and strategies that they can apply in their everyday lives. It is hoped that this will help them to develop a repertoire of tools to draw on in times of difficulties and to cultivate more of their own self-compassion and kindness towards others (Cole-King & Gilbert, 2011).

The compassion focused training for staff members aligns with the care values (Fig. 1) of the organisation as identified by St. Andrew's healthcare, where the organisational values have been identified

as CARE: Compassion, Accountability, Respect and Excellence (St. Andrew's healthcare values, 2015 - 2020).

## Methodology



## Participants

The group composition was made up of seven qualified staff nurses and 17 healthcare assistants who work on the male and female complex needs personality disorder wards at St. Andrew's Essex low secure hospital. The gender ratio was mixed and not accounted for as the data were collected anonymously and confidentially. Respondents volunteered to complete the questionnaire and the rationale of the assessment was explained prior to completion.

## Design

Each individual was asked to complete The Fears of Compassion Scales and these were collected both prior to the start and upon completion of six months of the years' training. Continual evaluation forms were also collected during the progression of the training, and included both quantitative and qualitative feedback on the training.

The complex needs training consisted of monthly sessions of three hours presented by senior management staff and experts in the field, for the full year period. The topics covered included training on various themes applicable to working on complex needs wards, reflection and supervision practice, and case presentations from a positive behavioural management perspective (RAID, Davies, 2014). Staff members were

given examples of how to speak to or about service users with more kindness and compassion, how to get to know each other, how to develop safe wards, how to maintain respectful boundaries and how to show more kindness and compassion on the wards.

## Results

Overall, the staff training was well attended by both staff groups who were off shift. For this reason the monthly training was presented twice (Tues & Thu) to capture staff members from both shift patterns in the hospital. Permanent staff members on both day and night shifts were invited to attend. Individual reports indicated that staff found the training enjoyable, found it highly relevant and helpful in empowering them with the knowledge of how to deal with service users.

## Quantitative results

Over the yearly training period results from continual monthly feedback forms indicate that 97% of the staff who engaged in the training found it helpful to very helpful.

The Fears of Compassion Scales were repeated after a six month period, seven nurses and 12 health care assistants took part in the pre-measures and post measures. Results indicated in figure 2 shows that nurses reported similar scores in fears of compassion towards others and themselves, and an increase in fear of responding to compassion from others. These findings can be understood by a possible increase in awareness of fears of showing compassion thus elevating these scores at six months measure. Gilbert (2010) notes that often respondent scores might increase as awareness of compassion awakens for the respondent. This fluctuation would be investigated further, perhaps given a longer time period for post measure. Healthcare assistants experienced a marked decrease in fear of expressing kindness and compassion towards the self; while exhibiting an increase in fears of compassion expressed to others. Again, this might be accounted for by the process of becoming more mindful of compassionate action and navigating how to learn to express more compassionate care to others (Gilbert, 2010).

## Qualitative responses

Overall the feedback on the training responses reflected a grateful attitude from staff with various extracts expressing gratitude for the training.

*"Thank-you. A very good training that encourages a compassionate approach towards the care of service users";  
"Always informative & interesting".*

*"It (the training) gives me a fresh approach to deal with situations when I return to my personality disorder ward"*

*"Very helpful & brings more awareness"  
"Being able to enforce the boundaries in an empathetic, respectful way, without sounding uncaring".*

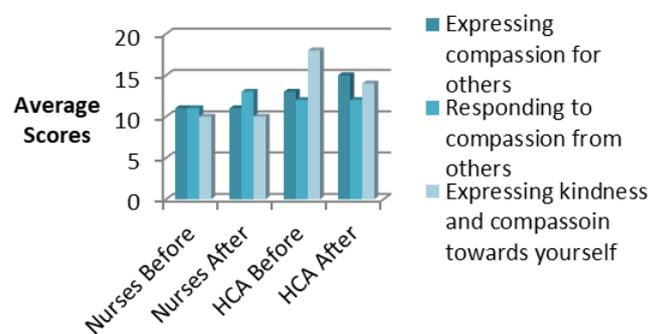
*"Useful to learn how to use positive thoughts towards staff and patients, not to focus on the negative behaviour, how to communicate with patients, not saying 'no' but explaining and talking to them"*

*"Helpful in dealing with patients with complex needs"*

*"Understanding specific patients' history, circumstances and their specific care needs"*

*"It was a good case presentation and was helpful. The five Ps (formulation) are useful to know"*

## Fears of Compassion Scales



## Recommendations

Nursing staff and healthcare assistants appeared to benefit from the training and valued the opportunity for reflection. The combination of training, case presentation and experiential exploration and reflective practice allowed staff to take on board new ways of dealing with situations on the wards and clearer understanding of patient needs. Participation and sharing of personal examples was promoted and encouraged.

In summary, the compassion focused training for staff working on complex needs wards appeared to have shifted staff perceptions of compassion and kindness. Questionnaires are to be repeated annually from this base-line, in order to capture changes in staff perceptions over time.

De Lange & Chigeza (2015) highlighted the importance of compassionate self-care for persons working in mental health settings, as an anti-dote to compassion fatigue, where staff experience a reduced capacity to show compassion and stress of conscience, where staff might experience negative feelings on their conscience for expressing care. The compassion focused staff training therefore assisted with developing such resilience in staff members by creating an awareness of our own individual capacity for compassion. If the training needs of staff working on complex needs wards are adequately fulfilled, staff would therefore be better equipped to deal with the demands of their patients. It is recommended that the overall focus of care is from a Compassion Focussed perspective. Not only are staff then able to develop compassionate practice towards others, but also better able to express compassion towards themselves.

**Erica De Lange, Consultant Clinical Psychologist and Pieter Snyman, Head of Psychology, St Andrew's Healthcare**

**Have you joined our discussion forum?**

If not, head to page 23 for more information on how to join Knowledge Hub

## **Restorative Justice: A process of healing and moving forward in recovery**

A female service user (Alice) on a female low secure unit recently engaged in restorative justice in relation to their IO. Alice had no offending history and she was experiencing symptoms of psychosis at the time of her offences. Alice reported deep remorse over her actions and wanted the opportunity to apologise directly to the victims. RJ provided an appropriate channel to do this using the process detailed below.

Restorative Justice (RJ) is widely used in the community and can help build relationships and repair harm on a

voluntary basis. RJ brings those harmed by crime and those responsible into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward.

RJ conferences (meetings between victim and offender) are led by trained facilitators who support and prepare participants ensuring the process is safe. Alternatives can include an exchange of letters, verbal messages and phone calls. Victims can ask questions and explain the impact of the offence on their lives which can promote closure and offenders can assuage harmful feelings of shame by taking responsibility and making amends.

In this instance, RJ was provided by Remedi, a national charity specialising in restorative services for a variety of community needs. Alice is the second service user within secure services that the Cheshire Remedi team have engaged with. It's a very effective process for the right people, at the right time and with the right support.

#### **Details of IO:**

Alice was convicted of malicious communications (threats were made to local police, strangers, and friends using social media) and attempted arson. These offences were related to Alice's delusional belief related to police tampering with her food.

Alice was transferred to a female low secure unit from prison. She engaged well in all aspects of her treatment and rehabilitation on the unit. She felt deep guilt and shame so requested staff help her engage in RJ so she could apologise to her victims for her crimes. I recommended RJ to Alice.

#### **The Process:**

The practitioners from Remedi liaised with me and met with Alice and myself to explain the process/ principles of RJ and to explore Alice's expectations (with clinical support). Alice wanted to engage in RJ and shared her apology/explanation for the offence with them.

Remedi contacted the victims and 2 engaged - the owner of the takeaway (Peter) and local police who had received abusive threats and messages via phone/social media.

Peter preferred indirect communications. Peter knew that Alice was ill when the offence happened, and therefore they held 'no grudge against her'. He also stated he was glad Alice was receiving treatment and support for her illness and he wanted Alice to 'move on and have a positive future'.

A DI from local police met Alice at the hospital to represent all the police who received the obscene tweets. Alice explained the background to her offences and apologised for upset caused. The DI explained how her crimes had impacted on his staff. He then urged Alice to continue to engage with mental health services following her discharge from hospital to ensure that this situation with the police never arises again.

#### **Alice's perspective:**

I was grateful to have had the opportunity to apologise to my victims. I appreciated the chance to explain why these crimes occurred (suffering a psychotic episode at the time). The written/verbal feedback from them aided me in my recovery. It helped me feel less guilt and shame about my offences. I felt deeply humbled and surprised by the compassion that both of my victims had shown to me and their encouragement for me to move on with my life. This experience made me even more determined to stay well and lead a productive life.

#### **Clinician's perspective:**

This process was led by the service user and it was reassuring to know that the practitioners from Remedi safeguarded both Alice's needs and those of her victims at all times. The practitioners took plenty of time to reassure Alice that she could withdraw from this process (as could her victims) at any point without any consequences. They were also open about not only the positives but the challenges of engaging in this process. They were engaging and warm and were really keen to support this process in whatever way that was needed. RJ made a significant difference to this service users recovery.

Many service users within secure care have experienced trauma, and the links with offending behaviour for both genders is well established. It's difficult for people who have experienced trauma to recognise the impact of their actions on others (that is, recognising the offender/ perpetrator within themselves). However, my clinical experience of RJ shows it's a very supportive way of ensuring that service users can acknowledge and take responsibility for the harm caused within a compassionate framework. This allows them to develop compassion for themselves (and 'permission' to live a good life) by experiencing the compassion of their victims.

**Alice, Service User, Louise Roper, Consultant Clinical Psychologist, North West Boroughs Healthcare Foundation Trust and Julie Woolvine, Restorative Practitioner, Remedi Restorative Services**

## Trauma-informed—Harm-aware – The Restorative Circle at SLAM

The Restorative Circle is committed to exploring innovative ways to recognise trauma and repair harm. Based on a model that we have developed to introduce restorative justice practices into the service, the Restorative Circle promotes awareness of harm at all levels of the organisation, and in all social settings, including between service users and their friends and family, the mental health staff that support their recovery, members of the wider community and each other. An awareness of harm is fundamentally an awareness of trauma, but most importantly, it brings with it a focus on relational trauma and how to respond to it.

We began our service journey towards a 'harm-informed' service five years ago through the first ever pilot delivery in a mental health setting of a victim awareness programme called Sycamore Tree, in partnership with the Prison Fellowship. The aim of the 6-session programme is to invite the patients, or 'learners', to begin to understand how harm can be repaired and how harm can be avoided in future. The active ingredient of the programme, the 'X factor', is that survivors of serious crime, attend the third and sixth session of the programme to share their story and how they have moved on through restorative practices. Many of the learners commented that this was the first time that they had ever met representatives of victims and been able to engage in a restorative dialogue with them.

In the course of delivering Sycamore Tree, we encountered many service users who needed to attend to their own experiences of traumatisation or victimisation before they had the emotional resilience to consider the harm they may have caused others. Together with the Recovery College Forensic Campus we co-produced a new course: Kintsugi. Based on the Japanese practice of repairing broken ceramics with 'golden joinery' and its underlying philosophy of 'honour the journey' and 'nothing is ever truly broken' we began to enable a creative expression of harm and trauma. The 6-week Kintsugi Course involves an opportunity for learners to make something that is meaningful to them from air-drying clay, to

personalise it through decoration, to break it in a process held and supported by the other learners and then to repair their broken objects together. Through this process we host conversations around personal narratives of harm and trauma.

Learners have said of their experience of undertaking the course:

"I have learnt how to repair things and how to talk about my feelings"

"I have learnt that everyone has a breaking point but one can recover from this through the journey of life."

"I learnt I can cope with trauma and I have hidden depths which will enable me in my journey of life"

"It has helped me to see it is possible to repair things that are broken like in my own life"

"All is not lost"

This course is part of a tapestry of initiatives to create trauma-informed interventions that are part of an over-arching model of trauma-informed and harm-informed care. Another aspect of the model is raising awareness through events, engaging with family, carers and staff. The Occupational Therapy team at River House hosted an event for service users and staff for 'World Book Night' where free copies of a book called *'The Forgiveness Project – Stories for a vengeful age'* were given out by the founder of The Forgiveness Project. The event was also attended by a harm survivor who shared her journey to forgiveness of the man who took her father's life.

This course is part of a tapestry of initiatives to create trauma-informed interventions that are part of an over-arching model of trauma-informed and harm-informed care. Another aspect of the model is raising awareness through events, engaging with family, carers and staff. The Occupational Therapy team at River House hosted an event for service users and staff for 'World Book Night' where free copies of a book called *'The Forgiveness Project – Stories for a vengeful age'* were given out by the founder of The

Forgiveness Project. The event was also attended by a harm survivor who shared her journey to forgiveness of the man who took her father's life.

We will also shortly introduce The Reflective Circle, a regular, facilitated safe space for family, carers and friends of service users to reflect on their experiences of harm and trauma within their social networks in order to explore restorative ways forward together.

Through expanding the Restorative Circle as a relational framework in response to harm, we will continue to embed a set of relational values that has universal applicability; a trauma-informed response to harm wherever and however that takes place; to develop a set of relational skills accessible to all staff, service users and their family and friends; and to offer a set of interventions that addresses the needs of the harmed, the harmer and the wider community, in recognition that trauma-informed care is of benefit to all.

**Dr Gerard Drennan, Head of Psychology and Finlay Wood, Restorative Justice Practitioner, South London and Maudsley NHS Foundation Trust**



## Developing a trauma informed care model of learning and development for staff at Langdon Hospital

Delivering Trauma Informed Care (TIC) in a forensic setting presents a unique set of challenges. The secure correctional environment, however compassionate it aims to be, can be a very traumatic place for everyone in it. We care for those with significant histories of complex psychological trauma, and risk of harm to themselves and others, including us as caregivers. The primary author's many years' experience of working in prisons and secure mental health settings underpinned a view that deficits in appropriate training, supervision and senior organisational support, particularly for the least professionally credentialed frontline staff, can lead to catastrophic systemic

failures and significant, enduring trauma to staff and service users.

In late 2016, the primary author began developing an in-house training package to meet the developmental needs of the critical mass of freshly recruited staff who were not only newly qualified to practice but were also new to forensic mental health. A typical model of bought-in, expensive and inequitably distributed specialist training was not going to meet the needs of our large, growing workforce. Aside being informed by the most up to date evidence, any training needed to be relevant, brief and accessible. For staff, it needed to lead to effective outcomes in terms of reduced negative impact of traumatic events (which are inevitable in this environment), increased resilience, reduced sickness rates and increased levels of job satisfaction. Overall, the goal is to grow into a more trauma-

informed culture benefiting everyone in it.

A high-intensity-interval-training (HIIT) model from the physical health/fitness field was adopted. Short bursts of intense physical exercise have been linked to superior outcomes with respect to reduction in risk of cardiovascular disease and improved physical endurance. It was felt that this could hold true from a psychological perspective, with learning resulting in increased "therapeutic capacity" and resilience of the workforce, protecting against the impact of traumatic experience. The overall model includes the implicit assumptions that: a) trauma *need* not (rather than *should* not) be treated as a feared pathological entity that only exists in our service users; b) trauma lives in the relationships we have with our service users, our colleagues, with ourselves and with the organisation; and c) we can build a Good (professional and/or personal) Life "in spite of" our traumas when we commit to learning together.

This workshop-style training is one key part of an overall developing TIC model for learning and development at Langdon. It is:

- Delivered to entire ward teams, inclusive of all disciplines and grades
- Divided into five modules, each lasting between 1.5 and 2.5 hours, taking between 1.5 and 2 days to complete
- A shared exploration and "shopfloor" understanding of mental disorder, substance misuse, risk/offending and institutional relationships in the context of complex psychological trauma and attachment pathology. Core concepts from Dr Stephen Porges' Polyvagal Theory provide the "backbone" for understanding how traumatic stress manifests at a person through to organizational level, and how social engagement is more helpful for achieving safety, rather than "survival" responses of withdrawal, dissociation or attack
- Progression through the modules is anchored by three service user cases from the ward, selected as the focus using a repertory grid style group task

Since June 2017 HIIT has been delivered across four wards at Langdon Hospital.

Approximately 50 multidisciplinary staff have taken part. Participants completed qualitative feedback forms and responses have included:

"Trauma - most interesting and biggest gap in knowledge but integral part of patients' presentations"

"Gives the knowledge in a way you can put into practice"  
"Should be mandatory for all staff"

"Trauma shapes a person for life, our role is to provide the tools to cope despite it"

Despite indisputable positives, the pace of service expansion at Langdon has arguably depleted therapeutic and reflective capacity in response to events such as repeated physical assaults. There is insufficient awareness about traumas that are unconscious and insidious e.g. cumulative undetected invitations into professional boundary violation situations which might be linked to a surge in safeguarding investigations for example. Paradoxically, such investigations might serve to further traumatise rather than increase psychological safety.

Traumatized staff, particularly those new to their profession and/or this setting, cannot be expected to deliver safe and effective trauma-informed care without access to adequate learning opportunities and support. While much further work is needed and delivering these necessary interventions in a sustainable and equitable way is challenging, fortunately it is not unachievable even in conditions of heightened organisational stress.

**Dr Malinder Bhullar, Principal Forensic Psychologist & Amy Brayley, Assistant Psychologist, Langdon Hospital, Devon Partnership NHS Trust**

## Complex psychological trauma among inpatients in a medium secure hospital

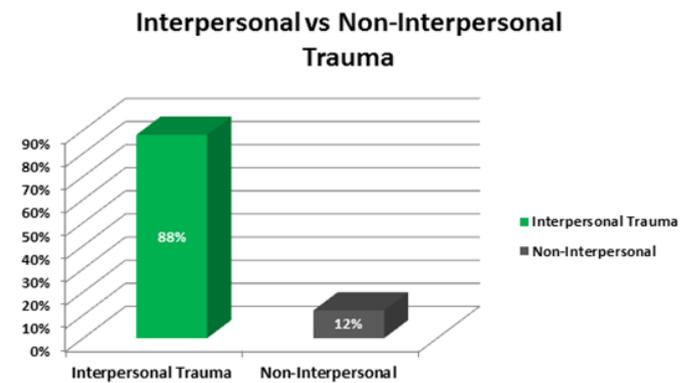
Prolonged exposure to repetitive traumatic events may lead to emotional and physical responses to stress, psychological avoidance, affect individual's sense of safety and reduce an individual's capacity to trust others (Hopper, 2009). There is increasing recognition that people in forensic settings often have a history of cumulative psychological traumas. However, such traumas among male forensic psychiatric patients remain a relatively unexplored area.

In 2017, we undertook an audit that assessed historical psychological trauma among inpatients of Wathwood Hospital, a medium secure forensic psychiatric service, Nottinghamshire Healthcare NHS Foundation Trust. Prior to this audit, we understood that most of the patients in Wathwood Hospital experienced trauma, based on clinical assessments. However, we needed a clearer picture of types and frequency across Wathwood Hospital. We felt this would help us to take further steps in providing more relevant treatment and address possible causes of the existing patients' mental health problems.

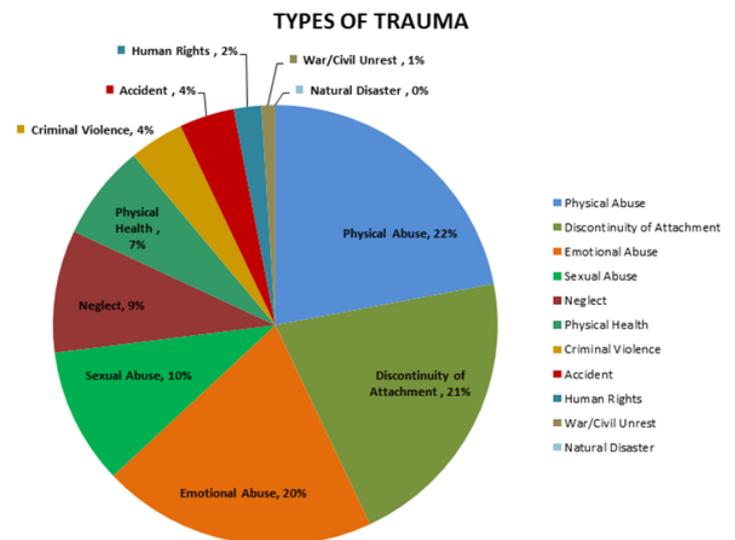
We assessed clinical cases of patients being in treatment at Wathwood Hospital in August 2017. In total, we reviewed cases of 75 adult male inpatients, age 18-65. We used a number of sources such as referrals, assessment reports, psychological formulations, daily nursing records and input from social workers. We designed a trauma screening tool, which included a number of interpersonal and non-interpersonal traumas, how often such traumas occurred, and whether it happened in childhood or adulthood. Interpersonal psychological trauma is a traumatic event that is repetitive, chronic and complex in nature, and is caused by the action of a closely related person (Kuczynska & Widera-Wysoczanska, 2010).

Our audit included such interpersonal types of trauma as physical abuse, sexual abuse, emotional abuse, neglect, discontinuity of attachment, war/civil unrest, human rights abuse, and criminal violence. Non-interpersonal traumas included accident, natural disaster, and significant problems/changes to physical health.

A total of 87% patients experienced at least one psychological trauma in the past and 65% patients experienced multiple types and incidents of trauma. With regard to the frequency of trauma, we identified 205 incidents of interpersonal/non-interpersonal types of trauma. 88% of such incidents showed the prevalence of interpersonal traumas, which is shown in the graph below.



The whole range of traumas and frequency of relevant incidents is presented in the pie chart below.



**Olga Swales, Assistant Psychologist & Anna Maciak, Assistant Psychologist, Wathwood Hospital, Nottinghamshire Healthcare NHS Foundation Trust**

## Trauma and Compassion— the blocks to effective CBT

### Introduction

Trauma Focused Cognitive Behavioural Therapy (TF-CBT) is an evidence-based treatment which draws on a number of theoretical approaches such as neurobiological, developmental, attachment theory, and cognitive-behavioural. It has been endorsed as an effective treatment for PTSD (see Bisson et al., 2007) across a wide range of traumas (Ehlers et al, 2013).

Prevalence of PTSD is higher among women than men (Brady, 2001; Kessler, 2000; Stein et al, 2000) and has become a common diagnosis in psychiatric inpatient settings (van der Kolk, 2002). Shame based flashbacks, feelings of guilt and emotional dysregulation are common characteristics of PTSD. Using Compassion Focused Therapy (CFT) within CBT to reframe critical thinking to one of compassion for the self has been shown to be effective in PTSD treatment (Lee, 2005; 2009).

### Aim

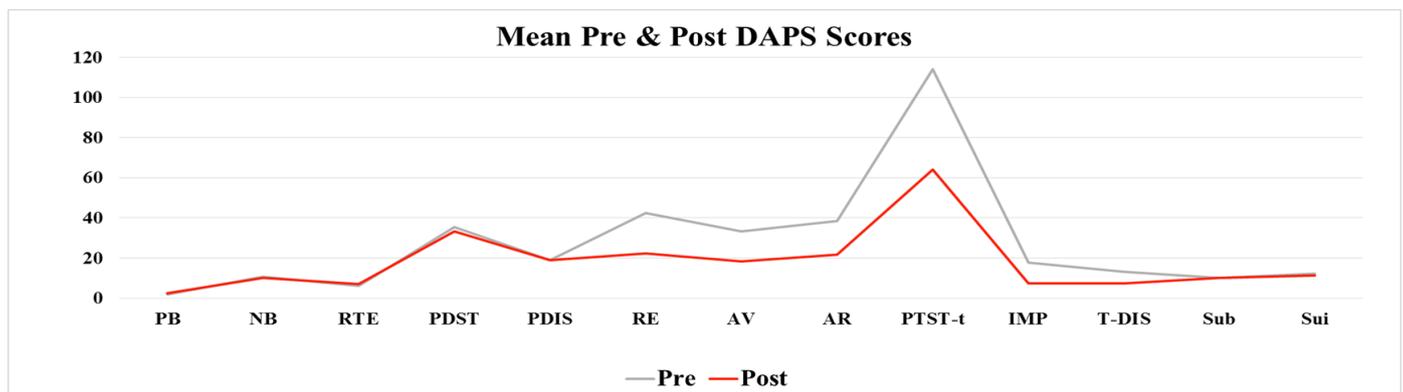
To evaluate the effectiveness of an individual TF-CBT intervention using CFT in a low secure female psychiatric unit.

### Materials and methods

Five patients who had endorsed significant levels of PTSD on the Millon Clinical Multiaxial Inventory –III (MCMII-III; Millon, Millon, Davis & Grossman, 1997) personality assessment or the Trauma Symptom Inventory (TSI; Briere, 1995), were identified as needing trauma therapy. They were assigned between 4-12 sessions of TF-CBT with Compassion Focused therapy to support a phased based approach and assist with self-critical / judgmental statements within the re-scripts. The effectiveness of this was then measured pre and post intervention using the Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001) which is a 104 item test of trauma exposure.

### Results

The results showed a significant reduction for Re-experiencing, Avoidance, Hyperarousal, Post-traumatic Stress Total, Post-traumatic Impairment ( $p > 0.001$ ) which was a reliable change with the exception of Avoidance for one individual who appeared less able to develop and maintain compassion for herself when scripting. Re-experiencing, Avoidance, Hyperarousal, Post-traumatic Stress Total were clinically significant at 2 SDs below the 'functional' mean (Jacobson & Truax, 1991) for three individuals and Posttraumatic impairment was for all. Trauma-specific Dissociation showed a significant reduction ( $p > 0.01$ ) which was a reliable change at an 'improved' clinical significance just outside the functional range. The one individual who focused on an emotional trauma had reliable change at a clinically significant level within the functional level on every scale of the DAPS, for clarity she is not referred to below.



The scores on the validity scales had increased slightly for some individuals. The trauma specification scales of Relative Trauma Exposure (RTE), Peritraumatic Distress (PDST) and Peritraumatic Dissociation (PDIS) had no reliable or clinically significant change and had increased for some. There was no change for the scores on suicidality and individuals had all measured within the 'functional' range on the pre-TFCBT DAPS indicating that pre-therapy stabilisation had been effective.

### Conclusions

The evaluation showed that the intervention was effective in meeting the treatment targets to reduce how the trauma was impacting on the patients in the present. The lack of change for the Trauma Specification Scales is unsurprising as these questions ask about how the individual historically viewed the trauma. Where a slight increase was observed this may be due to patients having more awareness of how they felt at the time.

The results indicated that using CFT effectively whilst scripting was a crucial part of the treatment as those who were less able to do so did not move into the functional range. This suggests that developing compassion would be a beneficial precursor to treatment.

In terms of Trauma Specific Dissociation, the findings suggest that individuals would benefit from further intervention targeting dissociation specifically as many have histories of extended and severe childhood trauma. The findings support a Treatment Pathway for Complex PTSD in women's forensic services.

### Patient feedback

"To go a night without a flashback after years was surreal"

"I definitely don't think I could have coped without the CFT skills work first"

**Phil Coombes**  
Clinical Director, Farndon Unit

**Elysium Healthcare**  
[phil.coombes@elysiumhealthcare.co.uk](mailto:phil.coombes@elysiumhealthcare.co.uk)



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And use **#qnfmhs** for up-to-date information

# Recent events update!

## Our annual forums 2019

We recently held our annual forums for medium and low secure services in May and June. We had a range of fantastic speakers presenting on topics including reducing restrictive practices, novel psychoactive substances, using technology to improve patient safety, gender identity and co-production.



Wayne Harvey (MPFT) discussing the effects of novel psychoactive substances (NPS) and managing this in secure services.



Derek Tracy (Oxleas NHS) and Abu Shafi (ELFT) discussing NPS types and the differences between them.



Colleagues from Sussex Partnership presenting on changing the culture of a low secure unit in a medium secure specification.



Examples of co-production at Fromeside Hospital.



Callum Ross and Paula Murphy (West London NHS) discuss gender identity in secure care.



Hannah Moore and Louise MacLellan brilliantly co-chairing the low secure annual forum.



Megan Georgiou providing an overview of the preliminary findings of Cycle 12-6 of the Quality Network.



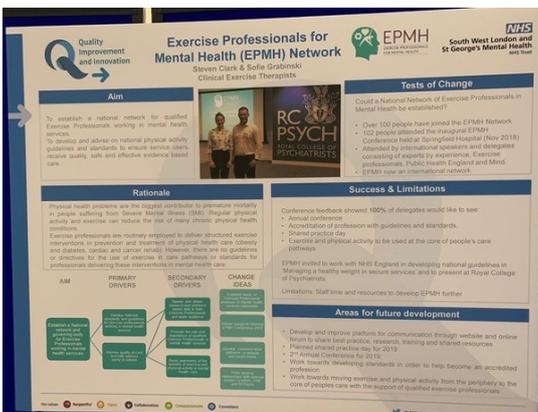
Findings from Care Quality Commission (CQC) on restrictive practice.



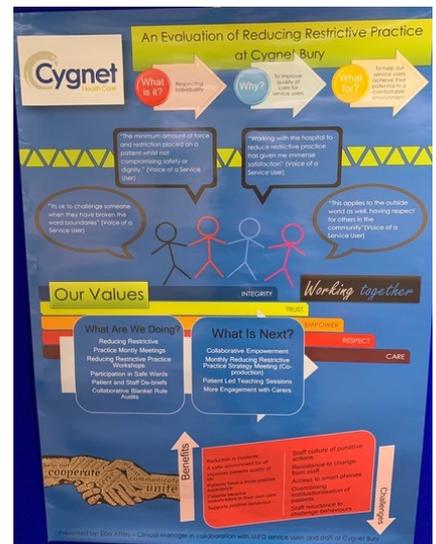
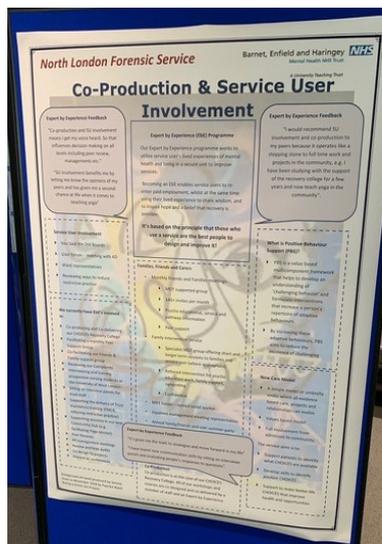
Colleagues from Cygnet Healthcare sharing findings from their evaluation of reducing restrictive practice at Cygnet Hospital Bury.



Colleagues from Northumberland, Tyne and Wear NHS discuss their work on reducing restrictive practices using collaboration and co-production.



Some fantastic poster presentations on display at the annual forums.



## How trauma informed are we? Evaluating the extent to which Ardenleigh Women’s Service adheres to the principles of trauma-informed Care

### Context

Trauma is prevalent within mental health services, detrimentally impacting individuals’ lives and hindering recovery. Emerging evidence indicates that trauma-specific interventions alone are insufficient in overcoming such difficulties (e.g. Substance Abuse and Mental Health Service Administration, 2014). Services are therefore becoming increasingly aware of the importance of becoming trauma-informed in their practice.

A trauma-informed service understands the role of trauma in individuals’ lives, evaluating and delivering its services accordingly, adhering to the key principles of trauma-informed care: safety, trustworthiness, collaboration, choice and empowerment (Harris & FalLOT, 2001a). In line with this, Ardenleigh Women’s service is planning to embed a trauma-informed care model. This evaluation therefore aims to

evaluate the extent to which the service is currently operating in a trauma-informed way, in order to highlight areas for improvement to facilitate this process.

### Evaluation

The evaluation involved the development of two Likert-scale questionnaires, with additional qualitative questions, based on a pre-existing assessment protocol (Fallot & Harris, 2009). The questionnaires explored staff’s and service user’s opinions regarding delivery of care based on the of the five key trauma-informed care principles. Using opportunistic sampling, the questionnaires were completed by 14 service users and 24 clinical staff (including psychology, ward and medical staff).

### Findings

An overall percentage score, as well as scores for each trauma-informed principle were calculated, with higher scores indicating better perceived clinical practice in that domain.

Overall, the service obtained a total trauma-informed score of 72%. Scores for the individual principles can be seen below:

Principle	Total % Score
Safety	73
Choice	66
Trustworthiness	74
Collaboration	71
Empowerment	75

Table 1. Scores for each trauma-informed principle.

### Recommendations

Based on these findings, the primary focus moving forward should be on improving service user’s experiences of choice, although results indicate room for improvement across all principles. Recommendations concerning how the service can best do this were developed by consulting qualitative responses and current relevant literature.

Key recommendations should include:

- Ensuring that all service user opportunities for choice and collaboration are made as open and transparent as possible.
- Integrating smaller, day-to-day choices for service users.
- Establishing clearer mediums through which service users can exercise their choice.
- Improving confidentiality.
- Establishing more regular ward staff.
- Further promoting strengths based approaches.

This evaluation served as a good scoping exercise for establishing the service's baseline in trauma-informed practices. This will be invaluable in guiding the implementation of the service's trauma-informed care model, and for subsequently assessing the effectiveness of the outlined recommendations, through follow-up

evaluations.

**Gage Whittaker, MSc Student, Trauma Strategy Group and Ardenleigh Women's Service, Birmingham and Solihull Mental Health NHS Foundation Trust**

## **Schema Therapy: A model of trauma-informed care in secure settings**

The objective of trauma-informed care is for the workforce to have a greater understanding and appreciation of the impact trauma can have on the service users that we work with, with the aim to prevent further re-traumatisation through the care that is offered. An understanding of the impact of trauma is increasingly on the agenda not only in mental health settings, but also in physical health and social care. Given the high prevalence of trauma experienced by service users of secure care, it is clearly something we have to consider within the services that we offer. This is especially important in these settings given the more explicit and routine procedures and protocols that may parallel or mimic previous traumatising experiences, such as restrictions, enforced treatment, and the explicit and innate power imbalances. These aspects are clearly there for valid reasons, and this is not an argument for these to be removed. However it is a chance to consider how these are used and the impact they may have on our service users.

Transforming the way an established service understands and approaches their work is a monumental task. This is especially true given the range of disciplines and training backgrounds a secure care workforce derives from. Reflecting on the clinical work I do individually with service users in that is trauma-informed, highlighted how well Schema Therapy encapsulates the trauma-informed care ethos (and in an accessible way). This model was first developed and described by Jeffrey Young (1990), and was a psychological therapy treatment approach meant to assist those with entrenched and chronic psychological problems where traditional CBT was not effective. I will not be able to fully describe and explain the model

in order to do it justice here, but will provide a brief overview of the salient aspects and their applicability to the secure care context.

In essence, the model is based on the premise that every child has core emotional needs; such as safety, autonomy, stability, freedom to express needs/emotions etc. When these needs are continuously not met, this causes a toxic frustration, and "maladaptive schemas" develop. A schema is a broad, pervasive theme or pattern, comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one's relationships with others. There are three ways that people can respond to their schemas; over-compensate, avoid, and surrender to them. These can be compared to the primitive fight, flight and freeze responses of survival respectively. For instance someone with a 'Mistrust/Abuse' schema believes that others are out to cheat, manipulate and take advantage of them. This is likely to have developed from repeatedly being used, abused and exploited when growing up. Therefore a 'fight' or over-compensative response would be to use and abuse others ("get others before they get you"), the 'flight'/avoid response would be avoiding becoming vulnerable and trusting anyone, keeping to themselves. The 'freeze' or surrender response would be to select abusive partners and permit the abuse. As can be seen, maladaptive schemas cause great distress to the individual, and as a consequence to those around them also.

This approach provides insight into the internal workings and structures of people's minds, and how they view the world, themselves and those around them. As such, it helps us understand why people think, feel and behave based on their early experiences. Understanding the context in which someone has come from, developed in, and learnt to survive can help us understand a lot more about their interactions and behaviour in

adulthood. So for example, what can often be described as problematic behaviour on the ward; shouting, fighting, assaulting others etc., are often described as people being difficult, demanding or causing trouble. However, if this is viewed through the schema model they could be viewed as ways of coping with a threatening, scary or uncomfortable schema that has been activated for them. Understanding this would then allow us to work with the individual to prevent this from happening again, rather than reacting in a punitive way which may further exacerbate the 'trauma' and prevent healing.

Schema therapy is developing some promising outcomes within forensic settings (e.g. Bernstein, et al. 2012). As well as using this model as a psychotherapeutic approach, it can also be used to help us formulate and understand how people may have ended in the current situation, i.e. engaging in criminal behaviour or how they interact within the unit. This suggests that the principles of schema theory can also be used as a basis for consultation and developing a shared language within a unit, and not just for individual psychotherapy. This approach encourages the workforce to

consider someone's development and early experiences and how these may interact with how they cope and behave in the present; in essence, making a service trauma-informed.

This model helps a service move away from the typical and ingrained question of "What is wrong with you?", to a more underlying understanding and trauma-informed "What has happened to you?" approach. The aim of this is not to eradicate potentially schema or trauma-triggering practices (as this could include everything and anything), but instead it is about supporting individual service users, teams and services to reflect on schema-triggering situations, ways of coping that reinforce the schema, and to support alternative ways of coping that are less re-traumatising. By enabling a whole service to become schema-informed is way for a whole service to become trauma-informed.

**Dr Michael Woodcock, Clinical Psychologist, North London Forensic Service, Barnet, Enfield and Haringey Mental Health NHS Trust**

## **Trauma Informed Care V. Iatrogenic Harm? Addressing the harms trauma informed care can't reach**

Definitions of trauma may vary according to context and agenda, but in general, trauma refers to processes, events or circumstances that are experienced as distressing or harmful and that may have long-term biopsychosocial impacts. In other words trauma is bad, best avoided, or failing that minimised, addressed and resolved. The link between trauma and mental health is well supported by clinical research. For instance there is significant evidence that trauma is linked to adult psychosis and other forms of psychological distress. Academic research has also indicated that the notion of causal relationships between trauma and mental ill health is supported by the general public, and is in effect a common wisdom.

Apropos the patient experience of mental health services, the concern exists, and is supported by the findings of the recent Mental Health Act Review 2018 that people can and do find care and treatment in inpatient mental health settings re-traumatising. The restrictive and coercive measures people may experience in hospital settings, for instance via restraint or forced medication, can evoke the same emotional and physiological responses associated with past trauma. Traumatization enacted and re-enacted by mental health care systems and staff may be unintentional and unanticipated, but is nonetheless damaging and needs to be acknowledged and properly addressed. This form of trauma has a specific name; iatrogenic harm.

Detention under the MHA invariably occurs when people are at their most vulnerable and in need of safety, reassurance and compassion. Failure on the part of services to take account of, protect against and address trauma enacted on patients via the

implementation of policies, procedure and even personalised care plans, can frustrate and even reverse the recovery process. Experiencing the designated healer as a source of harm or abuse can discourage patients from compliance and engagement with care and treatment, leading to them returning to reliance on habitual maladaptive coping strategies, such as self-harm, substance misuse and even violence.

The culture of practice on wards may be compromised by a prioritisation of the functional running of the ward over the needs of the patient population. As a recipient of secure mental health care, my repeated experience was that loss of choice, individualisation and blanket restrictions were inevitably 'justified' as being necessary for the staff to 'run the ward'. Ward managers demonstrated little if any regard for the retraumatising effects of deprivation, and staff would shrug away the issue, claiming "it's not up to us, there is nothing we can do." The daily message communicated from staff to patients in the implementation of uncaring and non-compassionate routines is that they, the patient do not matter. Furthermore this effects a culture of traumatisation that the patient is unable to escape, must endure and very often resents.

In extreme cases rigid working practices and routines on wards can dehumanise both staff and service users and lead to the excessive use of coercion and other restrictive practices. This is often in the context of patients being viewed as the inferior 'other' and infringement of already qualified human rights being the norm.

Trauma informed care (TIC) is touted as a possible cure for the aforementioned ills. TIC is based on a comprehensive understanding of how trauma exposure may affect service user's neurological and biopsychosocial development. It gives credence to the complex and pervasive impact trauma may have on someone's sense of self, worldview and relationships.

In a trauma-informed service, services would be structured and implemented in ways that promote a sense of safety and trust and do not retraumatise. On an intuitive, naïve level this sounds like heaven, but as a former inpatient I've had far too much experience of

the anti-thesis of this; of ward 'hell', to believe that a trauma-informed revolution is at hand which will sweep away all the harm of the past and issue in a new era of nuanced compassionate and patient aware care in secure settings.

Furthermore trauma-informed approaches interpret complex and maladaptive behaviour as a trigger induced situational or relational coping mechanism. By focusing on behaviour and similar visible outcomes it may fail to identify or address invisible harms that don't lead to overt distress or actions, or those experienced by less reactive, more withdrawn service users. In a trauma-informed care the focus is not so much 'what is wrong with you?', but more 'what happened to you?' I would like to suggest a caveat with this approach; some service users (myself included) do not attribute their mental disorders and associated problems primarily to trauma. For some of us, our mental health condition may be totally unrelated to our life experiences, except when the symptoms themselves compromise our functioning and social development. For our problems to be attributed to trauma we may never have experienced can be both confusing and harmful. Worse it can prevent us from receiving the (non trauma-informed) interventions which will actually help us. So yes, whilst trauma informed care may be essential to some people's recovery, for others it can be a disadvantageous distraction.

What may be more common to patients' diverse experience in mental healthcare settings is the aforementioned iatrogenic harm which both encompasses and goes beyond trauma and re-traumatisation. Iatrogenic harm refers to the damage caused inadvertently and otherwise by the process of treatment. This may manifest for instance as uncertainty and anxiety caused to the patient by a failure of staff to provide them with important information regarding their care or to include them in the decision-making process. Other examples include adverse reactions to drugs; negligence; or unnecessary treatment resulting from a psychiatrist's decision. Potential for iatrogenic harm also stems from the impact of epistemic injustice; the experience for the patient of having their capacity as a person with knowledge of their condition wrongfully

denied.

The independent review of the Mental Health Act 2018 gave patients and carers the opportunity to share their personal experiences and views of detention under the act. These accounts of what it is like to be detained or have a loved one detained, have helped to raise awareness of the need to significantly improve the quality of mental health services and the ways in which individual patients and their “carers” (family and close friends) are treated. By acknowledging and centring the knowledge and concerns of patients and carers, rather than ignoring them, the review has demonstrated significant epistemic regard for patients and carers.

One of the findings of the initial data gathering part of the review was the struggle that patients detained under the Mental Health Act have in terms of self-determination and asserting their choice within mental health settings. This can be a very prolonged and deeply traumatising experience. The review revealed that both patients and carers may often find themselves at the painful end of damaging epistemic relations with clinicians and other mental health staff. Patients described how their experiential knowledge of which treatments work best for them can be disregarded without explanation or justification by clinicians, and far too often patients who disagree with their treating team may be labelled by default as ‘lacking insight’ or ‘non-compliant’. If a patient or a carer raises a concern, they can often find themselves facing an impenetrable wall of denial from both the service provider and practitioners concerned.

Unfortunately it is only too evident that the organisational norm of credibility within mental healthcare services is biased against patients and carers. This means that regardless of the conscientiousness of individual practitioners in giving due regard to their patients’ views and requests, the wider services may function to suppress patients’ input in decision-making regarding their care and increase the epistemic marginalization of the patient body. It is important to remember that patients, even when oppressed by the disabling effects of a mental health condition have knowledge and agency which is essential to their recovery. Disregarding or suppressing the patient’s viewpoint and contribution may

traumatise them; eroding their sense of self and potential to achieve meaningful outcomes for themselves.

The media often report on cases of patients who have raised concerns about their treatment at the hands of mental healthcare services. The interim report of the MHA review acknowledges that these concerns go beyond the harms mentioned above, and states that there are ‘serious issues’ with the use of the Mental Health Act. Nowhere is this warning more pertinent than in secure and forensic services where levels of restriction and lengths of stay are most pronounced.

A possible means of addressing iatrogenic harm and resolving associated trauma is via the truth and reconciliation process of restorative justice, known as restorative practice. Restorative practice brings those harmed by conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. There are already positive evidence-based examples of the value of restorative practice in meeting the needs of victims and reducing reoffending. Restorative practice isn’t limited to the criminal justice system and can be used anywhere, including within healthcare systems, or other settings in which marked power differentials can predispose practice to enact abuse. The focus of restorative practice within a mental healthcare setting would be to facilitate a full exchange of testimonies and experiences in a manner which ensures that the recipient of harm is able to express all their concerns and opinions to the healthcare provider in order for them to learn from the process, and implement necessary changes in their clinical practice or the service provision.

Integrated working between a restorative justice practitioner and a regulator, such as the Care Quality Commission (CQC) would facilitate the identification and embedding of learning gained from the restorative practice via a process of monitoring and review. Let’s all put a firm foot forward along the pathway of addressing and resolving the trauma caused by iatrogenic harm.

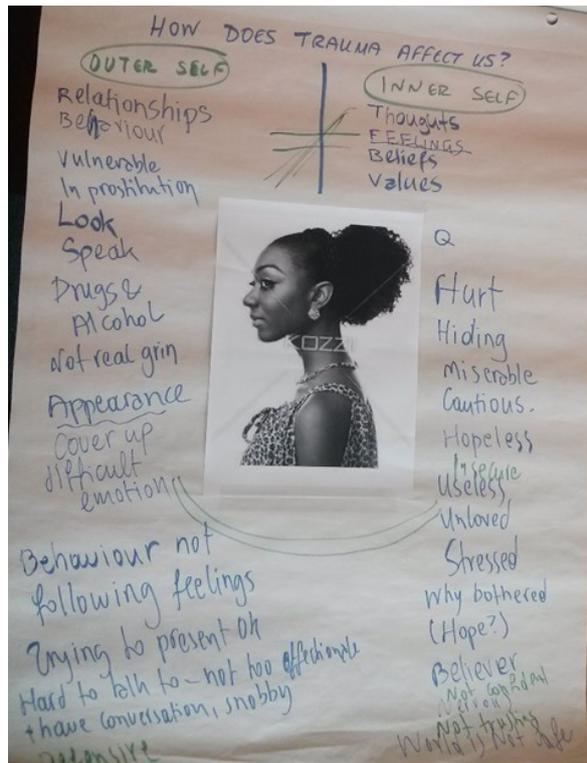
**Sarah Markham, Patient Reviewer,  
QNFMHS**

## Engaging with the trauma-informed approach in a women's service

Trauma-informed Care (TiC) in Forensic and Personality Disorder services is becoming increasingly discussed and applied, with a recognition that service users (especially women) with complex trauma histories are over-represented in these settings. Understanding the impact of traumatic experiences can enhance formulations and risk management plans; improve interactions between staff and patients with the potential to reduce re-traumatisation in crisis situations and to engage patients more in their treatment; and reduce the impact of this work on staff wellbeing.

In 2017, we introduced TiC on Spring Ward, a medium secure ward for women at River House, Bethlem Royal Hospital. Initially, we held team consultations to consider trauma-informed formulations, care plans and risk management plans for patients with very complex and challenging presentations. A brief presentation at Spring Ward's Away Day spurred great interest in the team who saw direct links between TiC and everyday challenges in interactions with patients. We discussed questions, concerns and attitudes towards TiC.

We then offered the Healing Trauma programme, a gender-specific group programme developed in the U.S. by Dr Stephanie Covington. It was run as a closed group, and was well received by the participating women, who found it challenging yet evaluated it very positively. During the programme they gradually opened up about their lives, experiences, relationships, and how these were still affecting them in terms of emotional safety, anger, and aggression. They appreciated the gender-focused perspective inviting them to consider their lives as women, mothers, daughters, female partners and carers. They especially valued the grounding techniques practiced in the group, but struggled to use them between sessions. The women participants implored us to support staff



to become more aware of how their experiences impact their lives, interactions and treatment.

In 2018, with funding from the Forensic Service Education & Training Committee we delivered a series of training dates aimed at introducing the concepts and clinical applications of TiC to all staff working in SLAM's Forensic Services (male and female wards, community and Criminal Justice Pathway). The Becoming Trauma-Informed Programme, a Covington curriculum for forensic professionals, provided the opportunity to consider the extent, nature and impact of trauma among mental health populations, links to risk and challenging behaviour, and practical skills that can be used across disciplines. We explored the core principles and how they link to existing frameworks of good practice in forensic settings.

There was strong commitment among the 90 staff members of varied disciplines and banding who attended. Participants thought jointly about the extent of triggers in forensic environments and what changes can reduce re-traumatisation. They worked

extensively on understanding triggers in interactional situations and managing them in escalating situations. Participants were invited to consider in groups specific ways of taking the learning forward: commitments for themselves as individual practitioners; ideas to take to their teams to improve practice; and suggestions for the organisation to enhance the physical and emotional safety and wellbeing for staff. We considered the concepts of Empowerment, Choice and Safety in relation to staff, and prevention of secondary trauma.

The feedback was excellent (rated 4/5-5/5) with most of the attendees having found it very informative, practically applicable and relevant to their roles. The self-care section was highly commented on. Many asked that this training be mandatory. The message strongly voiced was: "We need everyone on board, to be able to do this". To have a fully trauma-informed service, it is crucial that all staff are involved. Good momentum was built, with trained staff members bringing a pool of knowledge and enthusiasm in their teams. Future challenges include addressing how

more staff can be released to attend and how the knowledge can be sustained over time, e.g. through trauma-informed reflective practice and group supervision.

TiC is an interdisciplinary approach that needs to be owned by every member of an organisation to benefit the service users. As with any therapeutic environment, shared responsibility and consistency are key. It takes time to embed this approach in culture, so that it becomes the base from which we support, challenge, think about and interact with our service users. We have now secured funding to train all staff in the Women's Pathway of the South London Partnership.

**Eva Roussou, Clinical & Counselling Psychologist, External Consultant on Trauma-Informed Practice, Dr Maria Fotiadou, Consultant Forensic Psychiatrist, Lambeth Community Forensic Team, and Dr Gerard Drennan, Head of Psychology & Psychotherapy South London and Maudsley NHS Foundation Trust**

## **The Life Patterns Group—working with trauma and complexity in a long-term psychological therapy group in a secure setting**

### **The Context**

The far-reaching and life-long impact of adverse childhood experiences (ACEs) and subsequent trauma throughout the life course is well documented (Shonkoff et al. 2012), and its high prevalence in forensic population universally accepted (Wolff & Shi 2012). Trauma responses, including ways of coping with experiences which are 'uncopeable', and which may subsequently be described as 'maladaptive coping strategies', are often the visible behavioural manifestation of past trauma – and can simultaneously represent the reason why some individuals come into contact with forensic mental health services and the wider Criminal Justice System (CJS). In addition, the nature of forensic mental health units (as well as the wider

CJS) can further contribute to re-traumatisation through the inherent emphasis on exerting control/coercion, and thereby often unhelpfully challenging learned coping responses through punitively and 'unempathic' responses; we highlight that those coping strategies developed in response to earlier traumatic experiences. In our view, developing trauma-sensitive services and interventions capable of providing an exit from the cycle of 'trauma -> unhelpful coping response -> re-traumatisation' should therefore be considered a core business of forensic mental health services.

### **The LPG and the ST framework:**

From a Schema Therapy (ST) perspective, ACEs and early trauma equate to 'core needs' (e.g. needs of connections and acceptance, autonomy and performance, adequate limit setting) being unmet or frustrated, and abusive messages being internalised, leading to the formation of maladaptive schemas and coping modes. In order to deliver trauma-informed care and promote 'trauma healing', services and

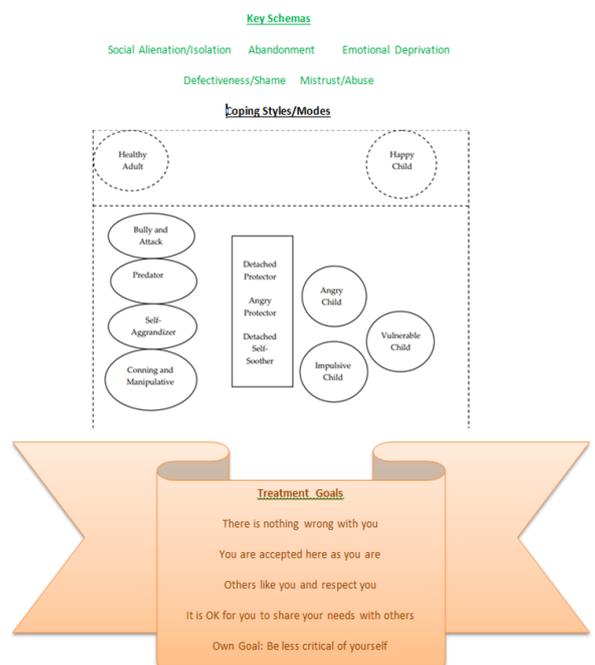
service users need to aim to collaboratively develop a detailed understanding of unmet core needs for a service user, and how they may have learned to cope in ways which at some point may have been 'adaptive' and ensured psychological or physical 'survival', but in the present impact on them and others negatively. Treatment planning should then focus on formulating new strategies of allowing unmet core needs to be met. The outcome should be a supportive framework which enables individuals to interact with others in a way that minimises the impact of unhelpful coping, and results in individuals getting their core needs met as far as possible. Central to this in a secure setting is carefully and sensitively setting limits to damaging behaviour, which in a Schema Therapy framework takes the form of 'empathic confrontation'.

While this is at the heart of much of the care provided within the John Howard Centre (a medium secure unit in East London), it is particularly embodied in the 'Life Patterns Group', a long-term Schema Therapy based group.

The group meets for a 1.5 hour session each week for a 12-18 month period. Individual key-working sessions are offered throughout, although at a greater frequency

near the start of the group during the 'forming' and 'storming' stages of the group/ before group members become familiar with each other and the safety of the group is established.) Throughout the group, facilitators stay active, prompt discussions, build the group life by facilitating cohesiveness and address the group process e.g. by naming coping strategies. 'Limited re-parenting', one of the defining elements of ST, is employed to meet the unmet core needs of group members to foster a secure attachment. Facilitators utilise experiential techniques such as roleplay, 'imagery' and chair work. The group is based on a similar group, which is part of a more extensive Schema Therapy programme at Rampton Hospital (Beckley and Gordon, 2010). The group includes four modules:

- 1. Introduction-** where group members learn the "language" of ST and relevant concepts as well as ensuring that the group is cohesive and emotionally connected.
- 2. Self-Formulation 'Hot Seat'**- group members are invited to present as much of their life story as they are happy to share to the group, from which a Schema formulation is drawn up for them. A 'made up' example of such a formulation is shown below:



**3. Schema Change** – applying cognitive, behavioural and experiential Schema strategies for working with maladaptive coping modes to 'moments' group members bring which triggered strong emotional responses in life outside the group (or within the group), while linking the moments to the formulation.

**4. Looking to the Future** – taking the learning from the group forward and outwards as the group ends.

### **Reflections:**

It has been our experience that providing a safe space is central to this approach; this involves allowing sufficient time for the group to form, providing an explanatory framework linking past trauma to current difficulties, significant (non-punitive) boundary setting, and 'radical openness' by all involved (including limited therapeutic self-disclosure by the facilitators). The relationships formed in the context of the group appear to translate into genuine connection. We also believe that principles consistent with ST are being incorporated on a system-wide basis; the recently published guidelines compiled by the Centre for Mental Health on trauma-informed care (Wilton & Williams, 2019) which summarised core components of trauma informed care under 'listening', 'understanding' and 'responding' provides a helpful framework consistent with this. More specifically professionals working in secure units can utilise schema concepts to understand an individual's historical trauma and current difficulties within a developmental context in order to make sense of the links between childhood,

personality, and current unhelpful (antisocial) behaviour.

One of the authors of this article (who is also a service user and a current group member) said the following about the group:

*The life patterns group has grown to be my favourite group. The greater length of the group (12-18 months) and the depth of the subject matter has allowed for strong bonds to be formed between other service users and I, as well as the facilitators and myself. Life Patterns and the Schema Therapy approach offer a different and often more helpful insight into mental health problems by identifying key childhood traumas and exploring their life impact or adverse effects on later life through schemas and maladaptive coping strategies. As I am coming to the end of the group, I can say that I have gained greater insight into the roots of my mental health issues and the various coping strategies I may adapt in response to any of the experiences life has in store for me. Because of this, I have greater control of my reactions and therefore can act in a more suitable manner in order to achieve a more desirable outcome'.*

**Ms Cansu Ozenc, Assistant Psychologist, Dr Kate Fillingham, Clinical Psychologist, Mr Edward Orhue, Dr David von Brandt, Consultant Clinical Psychologist, John Howard and Wolfson House, East London NHS Foundation Trust**



# Knowledgehub

**Join the Quality Network for Forensic Mental Health Services (QNFMHS) new online discussion forum!**

Joining Knowledge Hub will allow you to:

- **Share best practice and quality improvement initiatives**
- **Seek advice and network with other members**
- **Share policies, procedures or research papers**
- **Advertise upcoming events and conferences**

We will be using Knowledge Hub as our main way of communicating with our members, so in order to keep up to date with the Quality Network, ensure you sign up!

Email 'join Knowledge Hub' to [forensics@rcpsych.ac.uk](mailto:forensics@rcpsych.ac.uk)

## Upcoming Events

**Save the date!**

**Trauma-informed care within secure and prison mental health services**

**21 November 2019 (10:00-16:00)**

A joint event between the Quality Network for Forensic Mental Health Services and the Quality Network for Prison Mental Health Services. This event will be taking place at The Royal College of Psychiatrists, 21 Prescot Street, E1 8BB. Further information, including how to book, will be available shortly.

## Reviewer Training

Reviewer training is a free event for staff from member services of the Quality Network. The training is a great learning experience for those who are interested in participating in external peer-reviews at medium and low secure forensic mental health services.

**3 September 2019, 13:00–17:00 (Jury's Inn, Nottingham)**  
**11 September 2019, 14:00-17:00 (RCPsych, London)**  
**28 October 2019, 14:00-17:00 (RCPsych, London)**

**Booking forms for events and reviewer training can be found on our website [www.qnfmhs.co.uk](http://www.qnfmhs.co.uk)**

## Useful Links

### Care Quality Commission

[www.cqc.org.uk](http://www.cqc.org.uk)

### Centre for Mental Health

[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

### Department of Health

[www.doh.gov.uk](http://www.doh.gov.uk)

### Health and Social Care Advisory Service

[www.hascas.org.uk](http://www.hascas.org.uk)

### Institute of Psychiatry

[www.iop.kcl.ac.uk](http://www.iop.kcl.ac.uk)

### Ministry of Justice

[www.gov.uk/government/organisations/ministry-of-justice](http://www.gov.uk/government/organisations/ministry-of-justice)

### National Forensic Mental Health R&D Programme

[www.nfmhp.org.uk](http://www.nfmhp.org.uk)

### National Institute for Health and Care Excellence

[www.nice.org.uk](http://www.nice.org.uk)

### NHS England

[www.england.nhs.uk](http://www.england.nhs.uk)

### Offender Health Research Network

[www.ohrn.nhs.uk](http://www.ohrn.nhs.uk)

### Revolving Doors

[www.revolving-doors.org.uk](http://www.revolving-doors.org.uk)

### Royal College of Psychiatrists' College Centre for Quality Improvement

<https://www.rcpsych.ac.uk/improving-care/ccqi>

### Royal College of Psychiatrists' Training

<https://www.rcpsych.ac.uk/training>

### See Think Act (2nd Edition)

<https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services/see-think-act>

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### Twitter

Follow us: @rcpsych @ccqi\_  
And use #qnfms for up-to-date information

### QNFMS Knowledge Hub Group

[www.khub.net/group/quality-network-for-forensic-mental-health-services-discussion-forum](http://www.khub.net/group/quality-network-for-forensic-mental-health-services-discussion-forum)

### Royal College of Psychiatrists' Centre for Quality for Improvement

21 Prescott Street, London, E1 8BB

[www.qnfms.co.uk](http://www.qnfms.co.uk)