Culture of Care

National Learning Session

Tuesday 29 April 2025 | 10:00 – 15:30

Edgbaston Stadium

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Neurodiverse Connection

Global Black Thrive

NCISH

Welcome

Harminder Kaur

National Advisor for the Culture of Care Programme

Culture of Care

Introduction to the day

The aims for today:

- Reflect on the first year of the programme
- Share learning and examples of a what trauma informed approach is, and what it is not
- Discuss the importance of the environments we provide services in and their capacity to harm or heal
- Discuss and reflect on race-based trauma
- Look at the role of leadership and the wider organisation in supporting the development of safe cultures
- Have plenty of time for reflection throughout the day

Introduction to the venue

- Main meeting room: Banqueting Suite (2nd floor)

- Catering / Refreshment: 1882 Suite (2nd floor)

- There are a few additional spaces that we invite you to use at any time:
  - The balcony at the back of the room
  - The catering room (1882 Suite)

Introduction to the venue

- There is a **wellness room** and a **sensory room** available throughout the day.

They are a couple of minutes' walk from this room. People wearing yellow lanyards will be able to guide you to these rooms.

Wellness room

Sensory room

Housekeeping

- There are **no fire alarm tests planned** for today. If the alarm does go off, please follow the ‘green man’ signs.
- **Toilets** are in the **lobby near the lifts**.
- Some of the material we cover may be **triggering**.

If you need to step away, please do so and make use of the wellness room and additional spaces. If you need to speak to someone, please approach anyone wearing a **yellow lanyard**.

Housekeeping

- **We have made a few adjustments today to try and meet everyone's needs.**

  If there is anything the team can do to help or you have any questions, **please let us know** (we are spread out across the room and are wearing **red and yellow lanyards**).

Questions

- We will be hosting our Q&A on Menti throughout the day!
- You can access the Q&A by scanning the QR Code.
- We will keep the Q&A open until Thursday for any questions that come to mind after today.

Join at menti.com | use code **7286 8681**

Today's agenda

Time	Event
10:00 – 10:10	Welcome and housekeeping
10:10 – 10:20	Picturing safety
10:20 – 10:45	Culture of Care so far
10:45 – 11:40	**SESSION 1: What is a trauma-informed approach**
11:40 – 12:00	**Break**
12:00 – 13:00	**SESSION 2: Critiques of a trauma-informed approach**
13:00 – 14:00	**Lunch**
14:00 – 14:15	Post lunch energiser
14:15 – 15:15	**SESSION 3: Implementing a trauma-informed approach**
15:15 – 15:20	Call to action
15:20 – 15:30	**Next steps and close**

Shared principles

Listen with openness and curiosity

Confidentiality

Acknowledge what's being said

Disagree with the point not the person

Collaborate and contribute

Respecting timing

Picturing safety

Matt Milarski

Head of Quality Improvement,

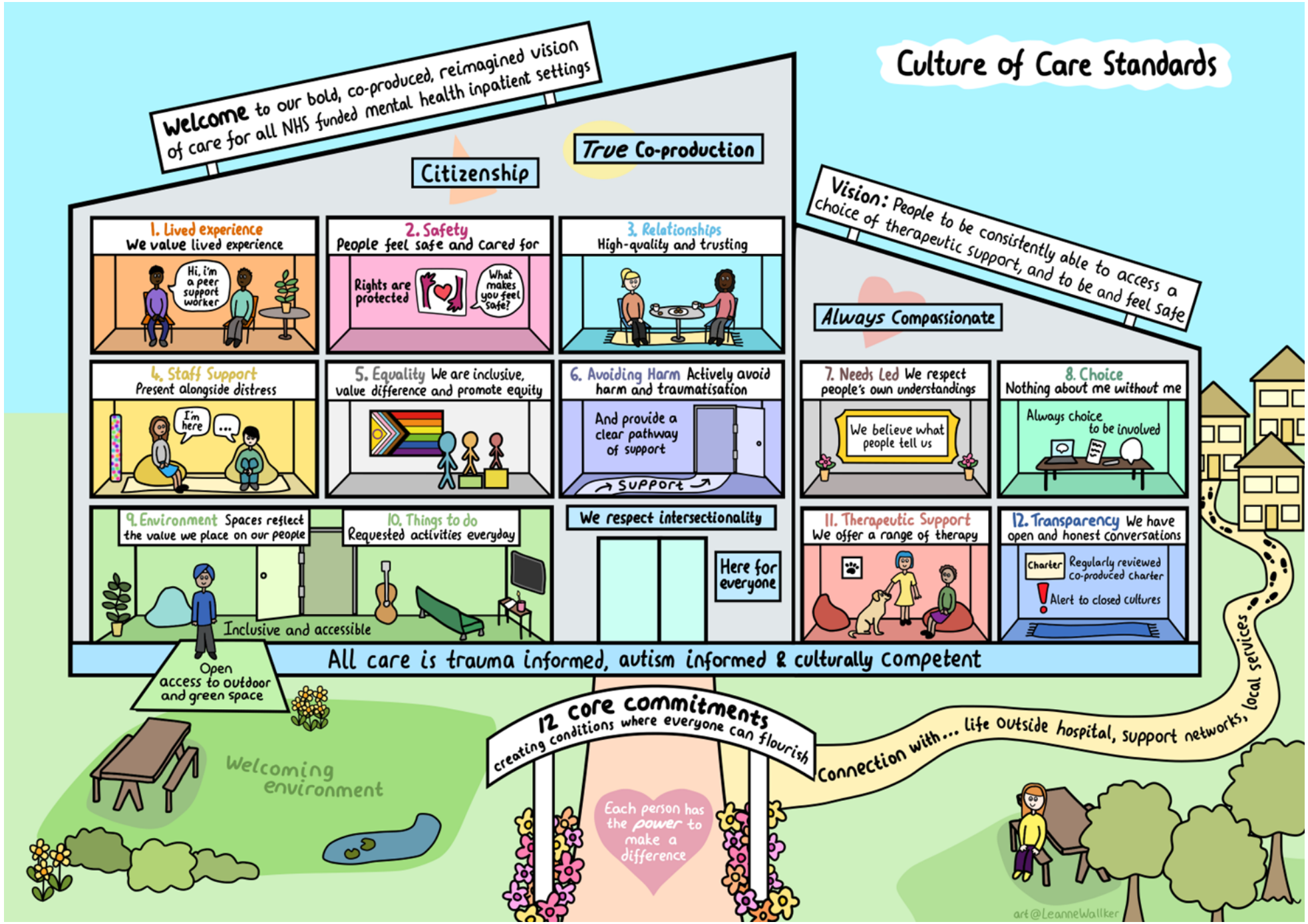
National Collaborating Centre for Mental Health (NCCMH)

Culture of Care

Culture of Care programme so far

Tom Ayers
Director,
National Collaborating Centre for Mental Health (NCCMH)

Culture of Care


Culture of Care Standards
Welcome to our bold, co-produced, reimagined vision of care for all NHS funded mental health inpatient settings
Citizenship
True Co-production
Vision: People to be consistently able to access a choice of therapeutic support, and to be and feel safe
Always Compassionate
1. Lived experience
We value lived experience
Hi, i'm a peer support worker
2. Safety
People feel safe and cared for
Rights are protected
What makes you feel safe?
3. Relationships
High-quality and trusting
4. Staff Support
Present alongside distress
I'm here
...
5. Equality We are inclusive, value difference and promote equity
6. Avoiding Harm Actively avoid harm and traumatisation
And provide a clear pathway of support
Support
7. Needs Led We respect people's own understandings
We believe what people tell us
8. Choice
Nothing about me without me
Always choice to be involved
9. Environment Spaces reflect the value we place on our people
10. Things to do
Requested activities everyday
Inclusive and accessible
We respect intersectionality
Here for everyone
11. Therapeutic Support
We offer a range of therapy
12. Transparency We have open and honest conversations
Charter
Regularly reviewed co-produced charter
Alert to closed cultures
All care is trauma informed, autism informed & culturally competent
Open access to outdoor and green space
Welcoming environment
12 core commitments
creating conditions where everyone can flourish
Each person has the power to make a difference
Connection with... life outside hospital, support networks, local services
art@LeanneWallker


WE CARE

"The healing power of relationships is perhaps the single greatest leverage point to fundamentally re-wire a system's behavior and the outcomes it produces."

Calderon de la Barca et al 2024

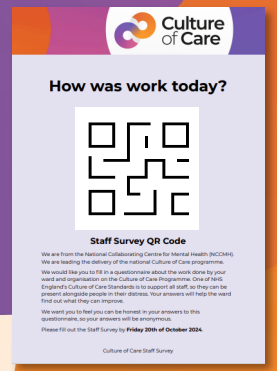
Feeling as knowledge


freedom
Mandela
Future
Mandela

Approach to programme delivery

- Trauma-informed
- Based on relationships
- Lived experience leader

Culture of care data...



Proxy measures

- Episodes of restrictive practice
- Incidents of sexual harm
- Number of days since absence without leave (AWOL)
- Use of bank and agency staff

Patient and staff experience

- Patient CARE survey
- Patient experience survey
- Staff survey
- Carer survey (launching soon)

Patient experience survey (Q1–Q6)

Q1: How often do you feel like you are listened to and understood by staff on the ward?

Q2: How often do staff help you feel safer on the ward? (Including physically, emotionally and relationally)?

Q3: How often do staff on the ward show you care and compassion, and connect with you as a person?

Q4: How often are staff available on the ward to be with you when you need them?

Q5: Do you feel you have ever been treated badly because of your ethnicity, age, disability, sex, gender, sexuality, neurotype or diagnosis?

Q6: Do you feel that your experiences on the ward have caused you any harm (including physical, emotional and relational)?

Patient experience survey continued (Q7-12)

Q7: How often have your needs been met with care and compassion?

Q8: How often are you involved as an equal in the decisions made about your care and treatment?

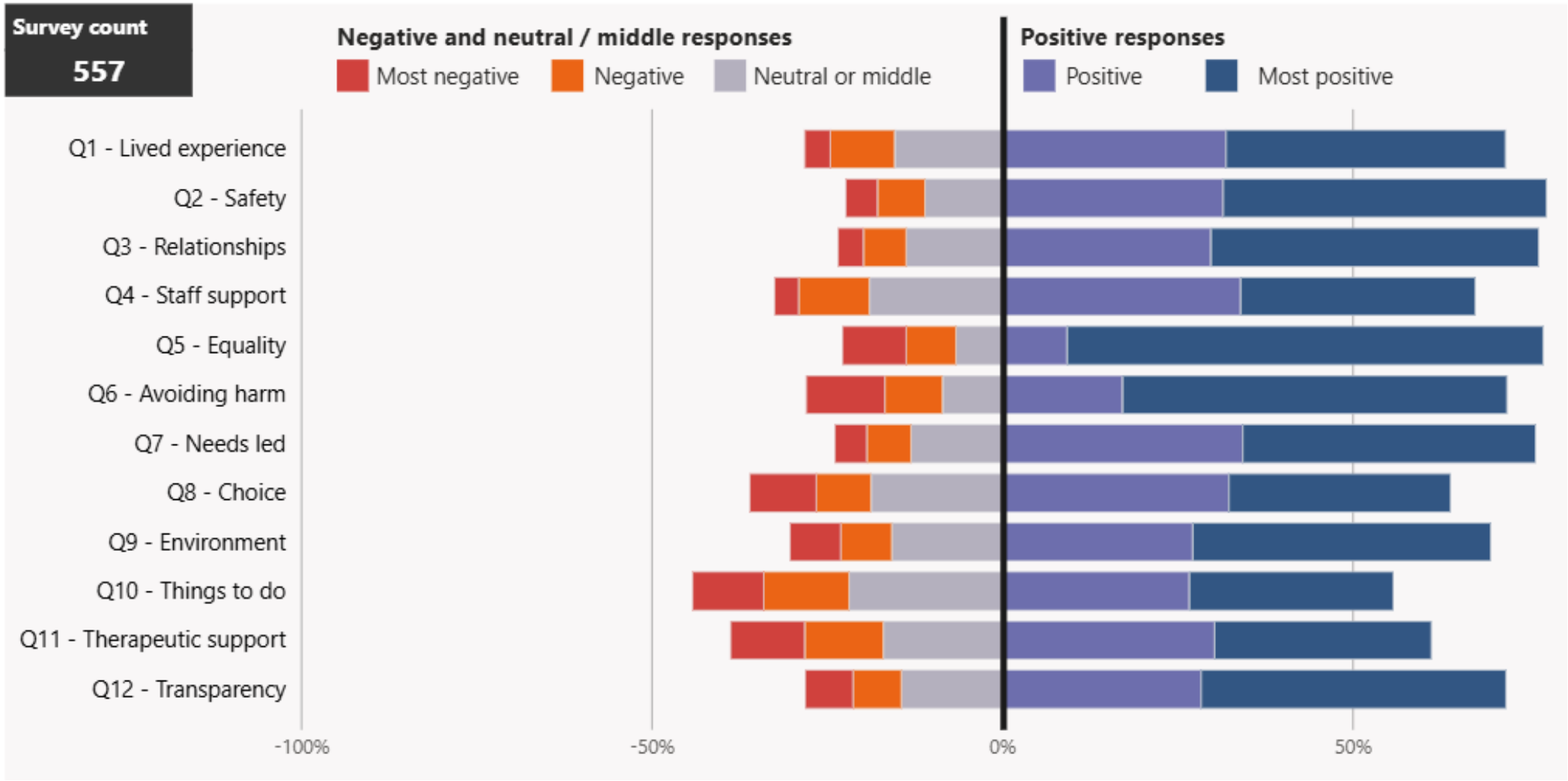
Q9: Does the ward feel like a place that supports you to get better (including the food, physical spaces and amenities provided)?

Q10: Do you have access to a wide range of things to do on the ward that stop you from being bored?

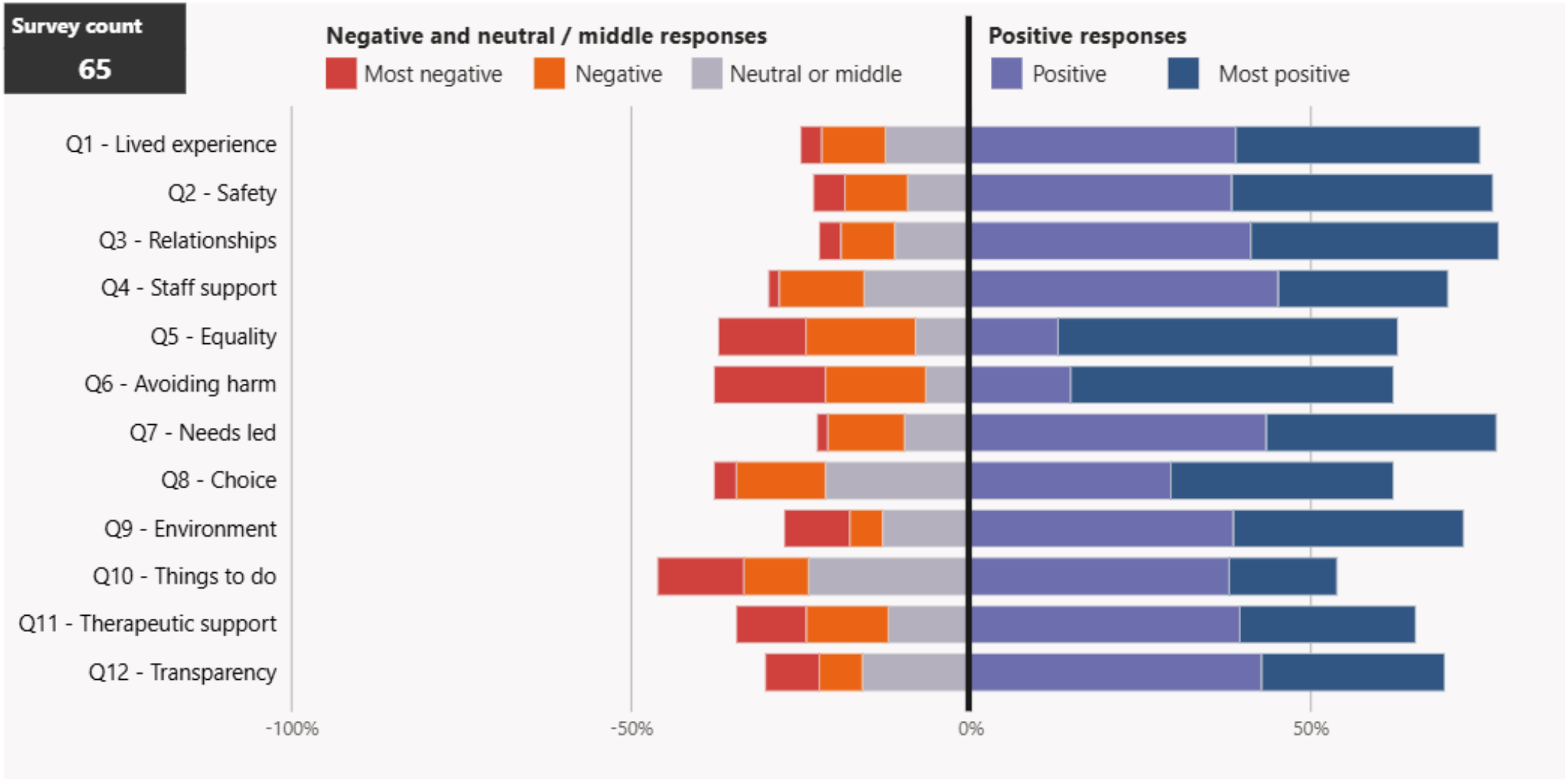
Q11: How often do you have choices about what care and treatment you are able to get on the ward?

Q12: Do you feel staff are honest with you about your care and treatment, and explain things clearly?

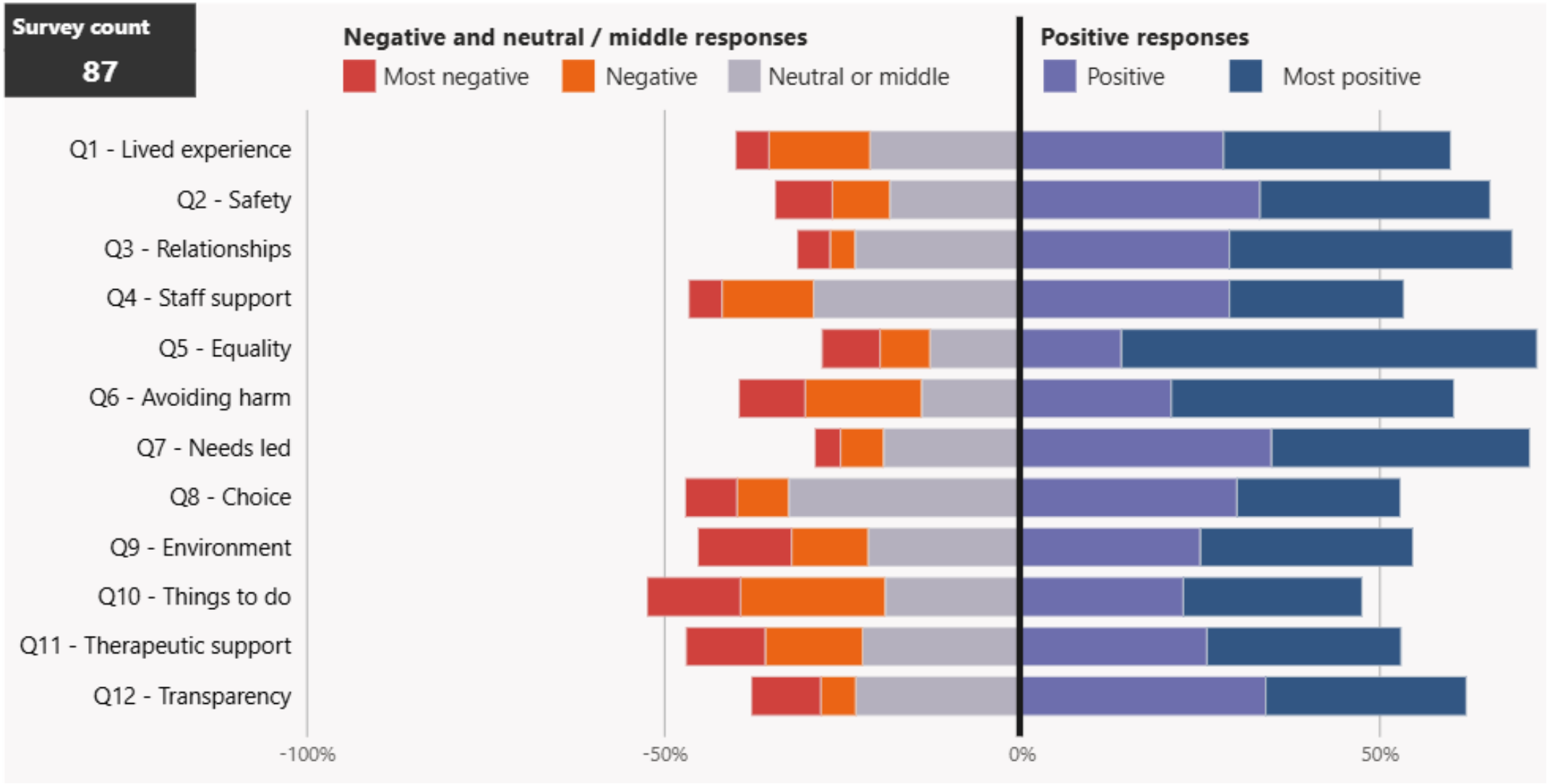
Total patient experience survey responses



Black patient experience survey responses



Autistic patient experience survey responses

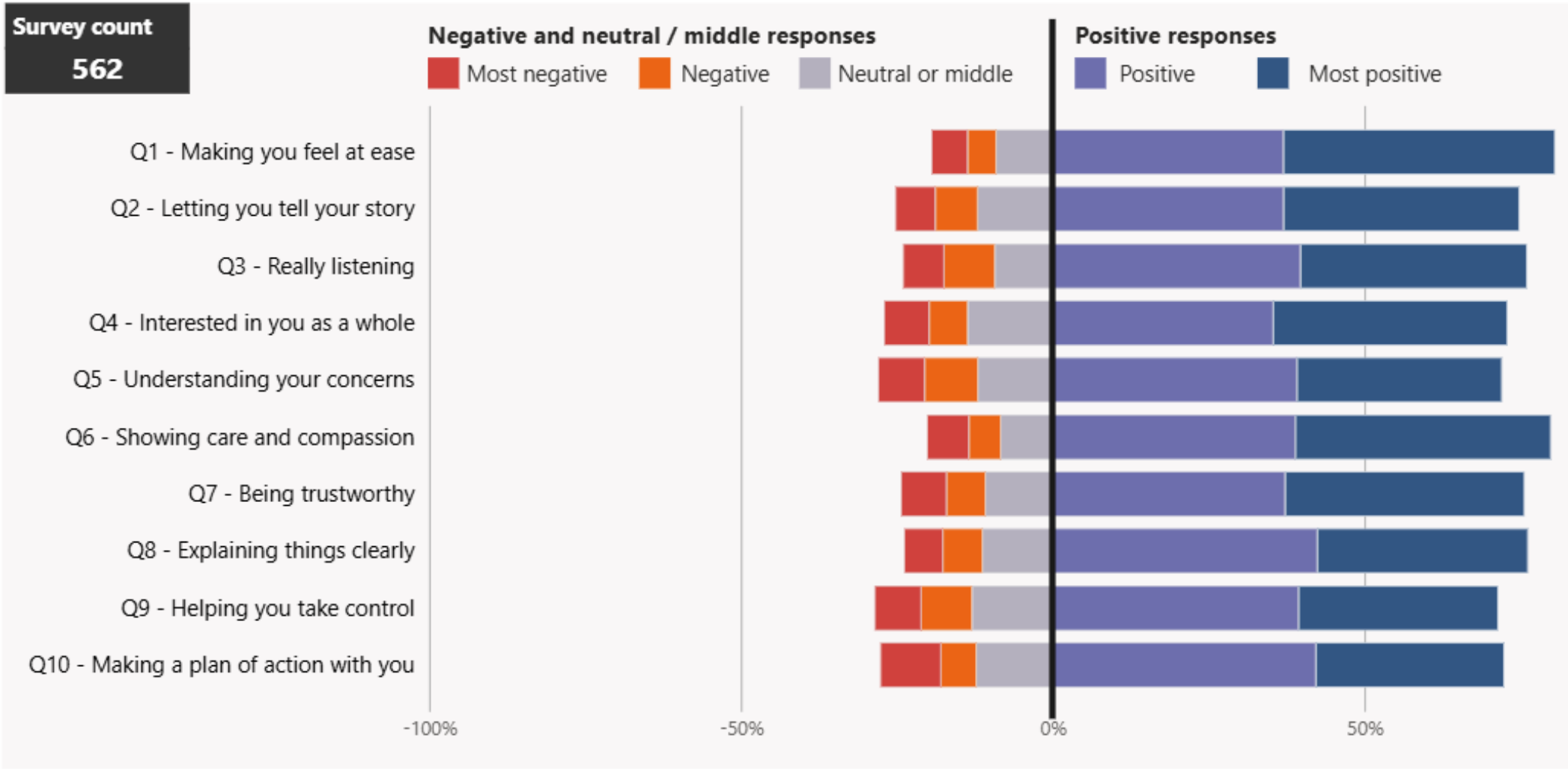


Patient CARE (Consultation and Relational Empathy) survey

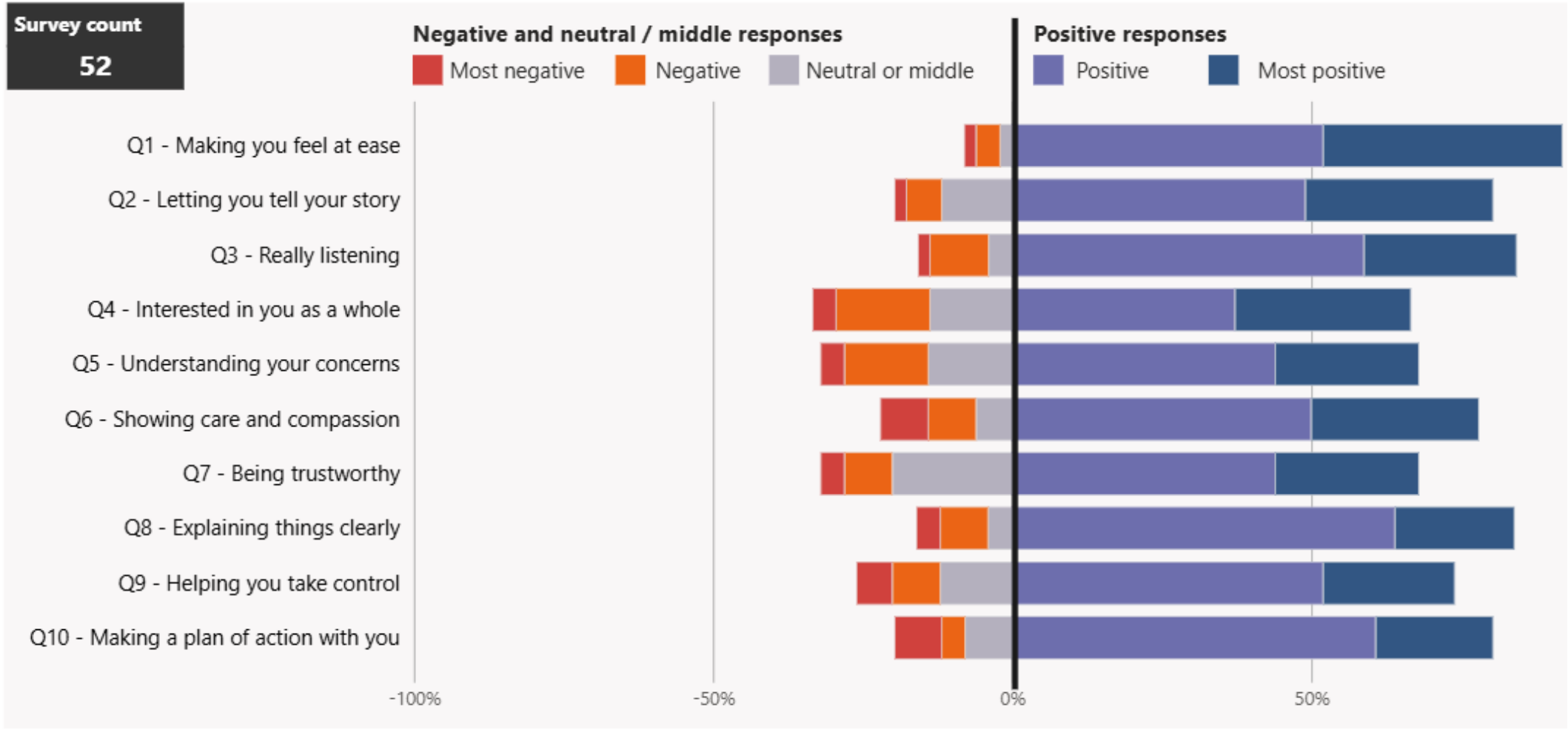
How good was your clinician at:

- Q1: Making you feel at ease
- Q2: Letting you tell your "story"
- Q3: Really listening
- Q4: Being interested in you as a whole person
- Q5: Fully understanding your concerns
- Q6: Showing care and compassion
- Q7: Being trustworthy
- Q8: Explaining things clearly
- Q9: Helping you take control
- Q10: Making a plan of action with you

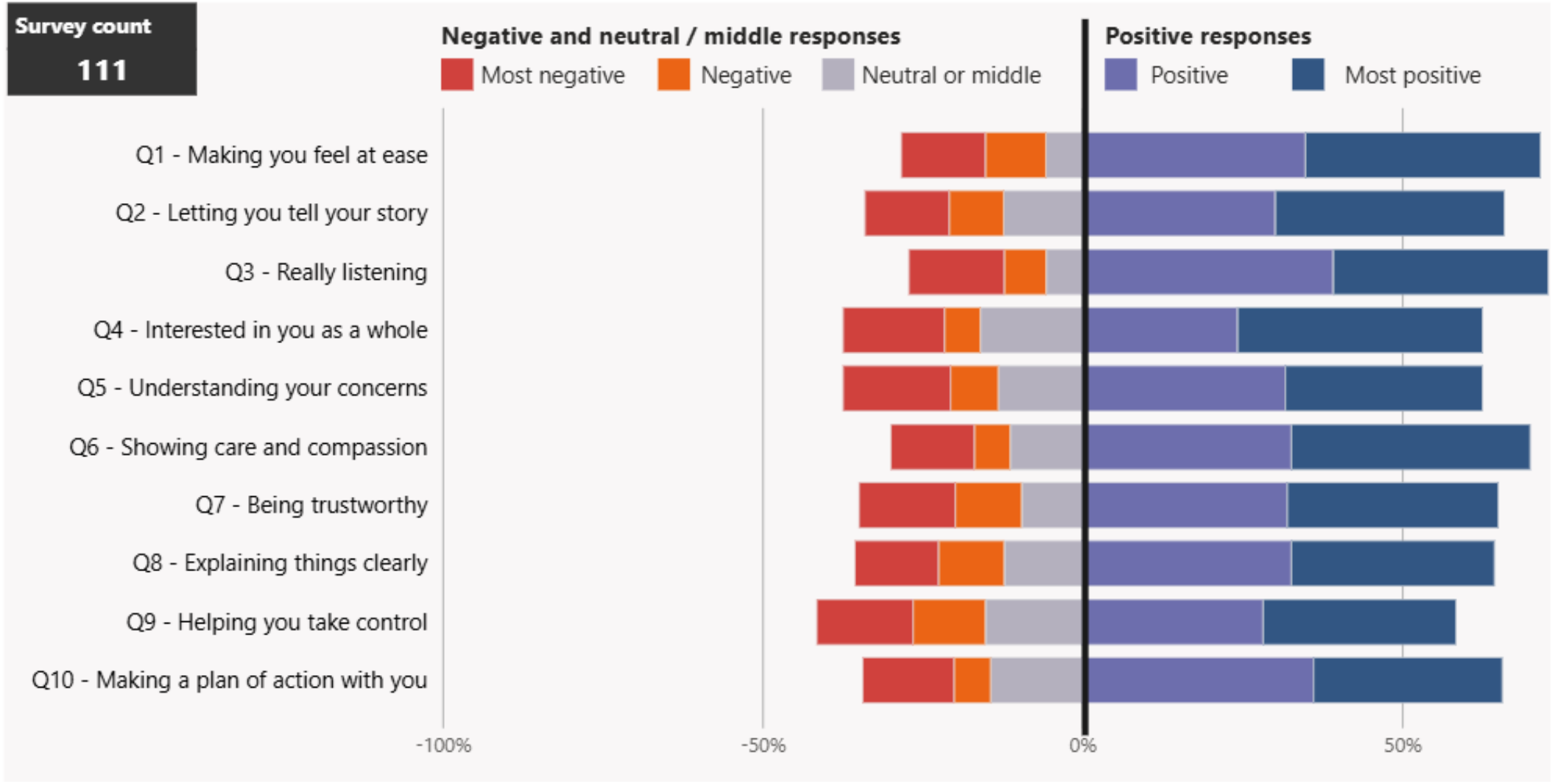
Total patient CARE survey responses



Black patient CARE survey responses



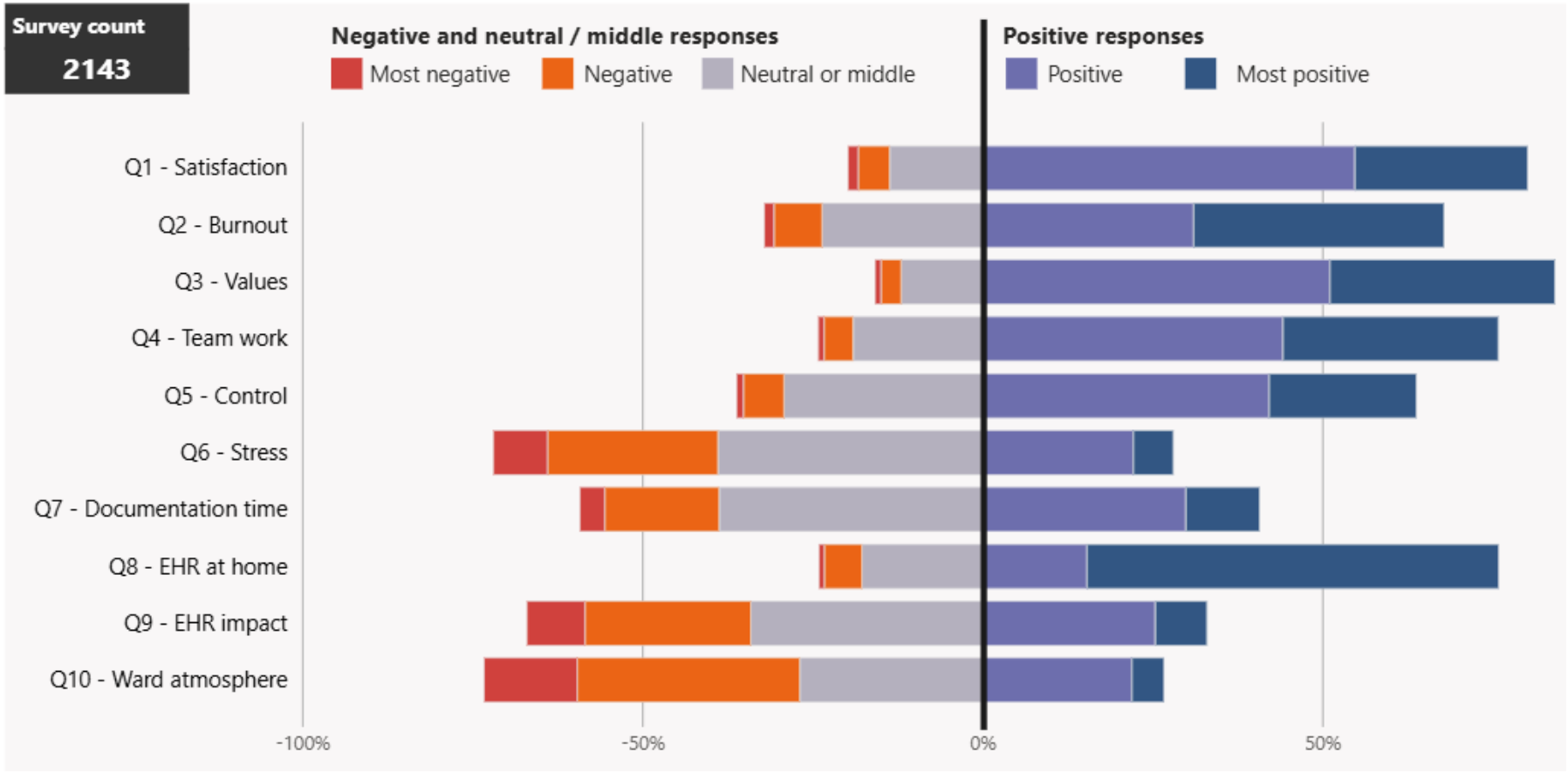
Autistic patient CARE survey responses



Staff burnout survey

1. Overall satisfaction with your job
2. Level of burnout (using your own definition of burnout)
3. How much your values are aligned with your ward leaders
4. How efficiently the ward team works together
5. How much control you have over your workload
6. How much stress you feel because of your job
7. How much time you have for documentation
8. How much time you spend on work at home
9. How frustrating the electronic patient record is
10. How calm or chaotic the atmosphere on your ward is

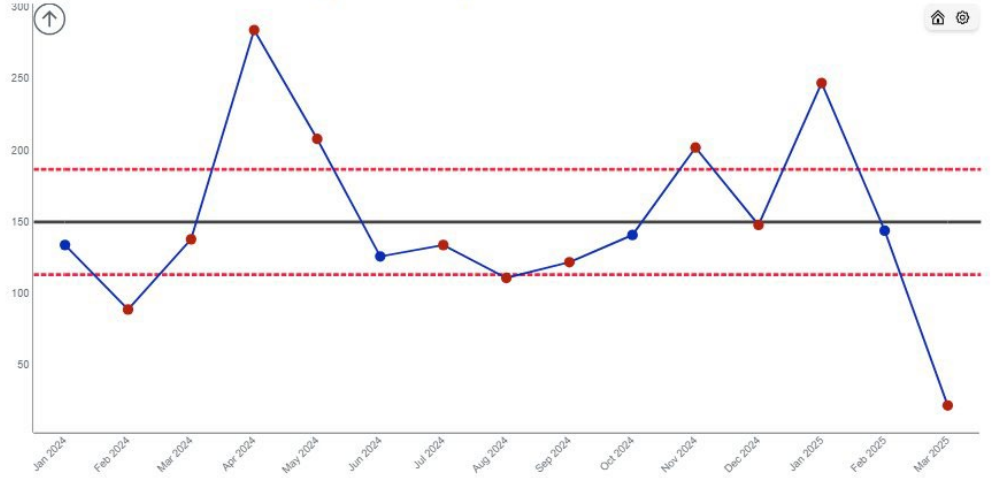
Total staff survey responses



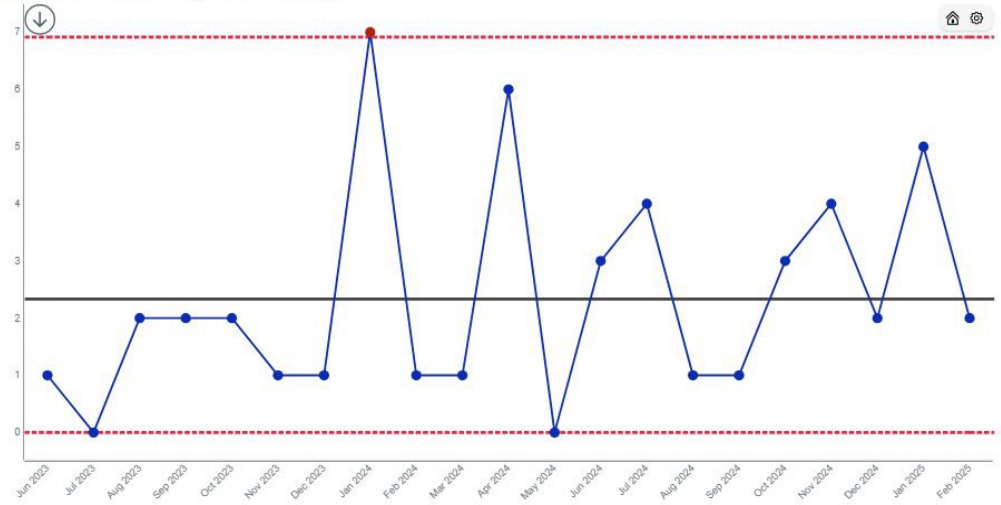
Proxy measures

Please note: This data is based on a small number of organisations that shared their data with us for testing purposes to help us build the dashboard

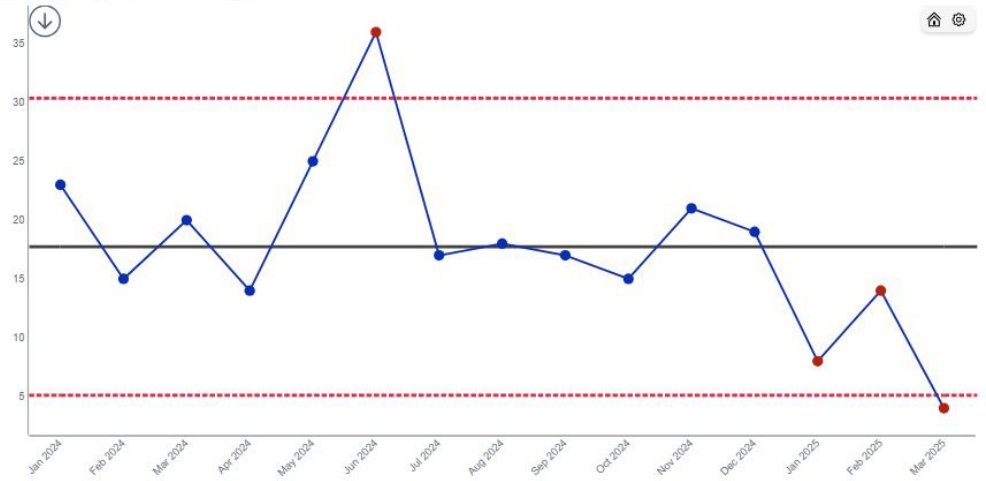
Restrictive Practice (C Chart)



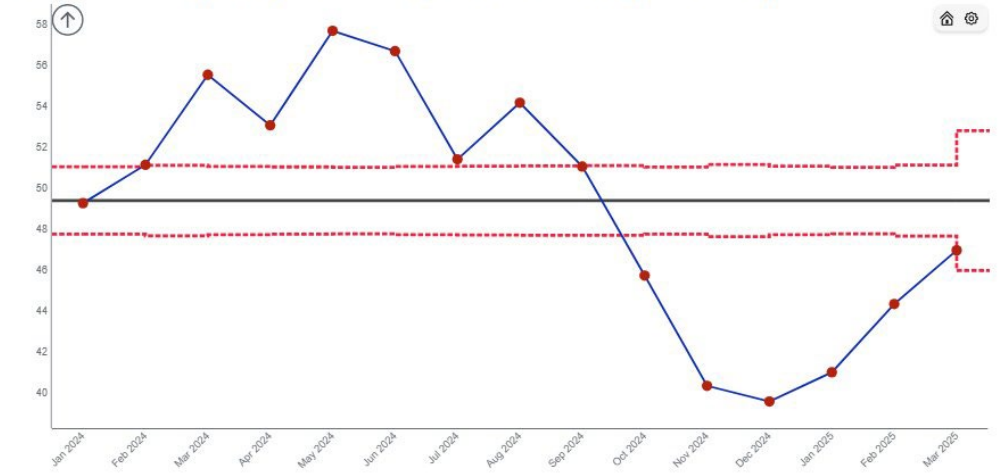
Sexual Harm (C Chart)



AWOL (C Chart)



Bank and Agency ratio against Shifts (P Chart)



Session 1

What is a trauma-informed approach?

Philippa Greenfield | Trauma informed advisor

Jason Grant-Rowles | Trauma informed advisor

Julie Redmond | Trauma informed advisor

Culture of Care

Trauma Informed Approach

- A trauma informed approach is a framework grounded in the understanding of how traumatic experiences affect individuals.

- The primary goal is to create safe and supportive environments that prevent re-traumatisation, to encourage the promotion of healing and resilience.

Instead of asking ‘What’s wrong with you?’, a trauma informed approach asks, ‘What’s happened to you?’

Embedding Core Principles

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment
- Equity

Lived Experience Activism

- Challenging traditional paradigms
- Emphasizing key principles
- Demanding change and accountability
- Bringing authentic expertise

Whole Organisation Change

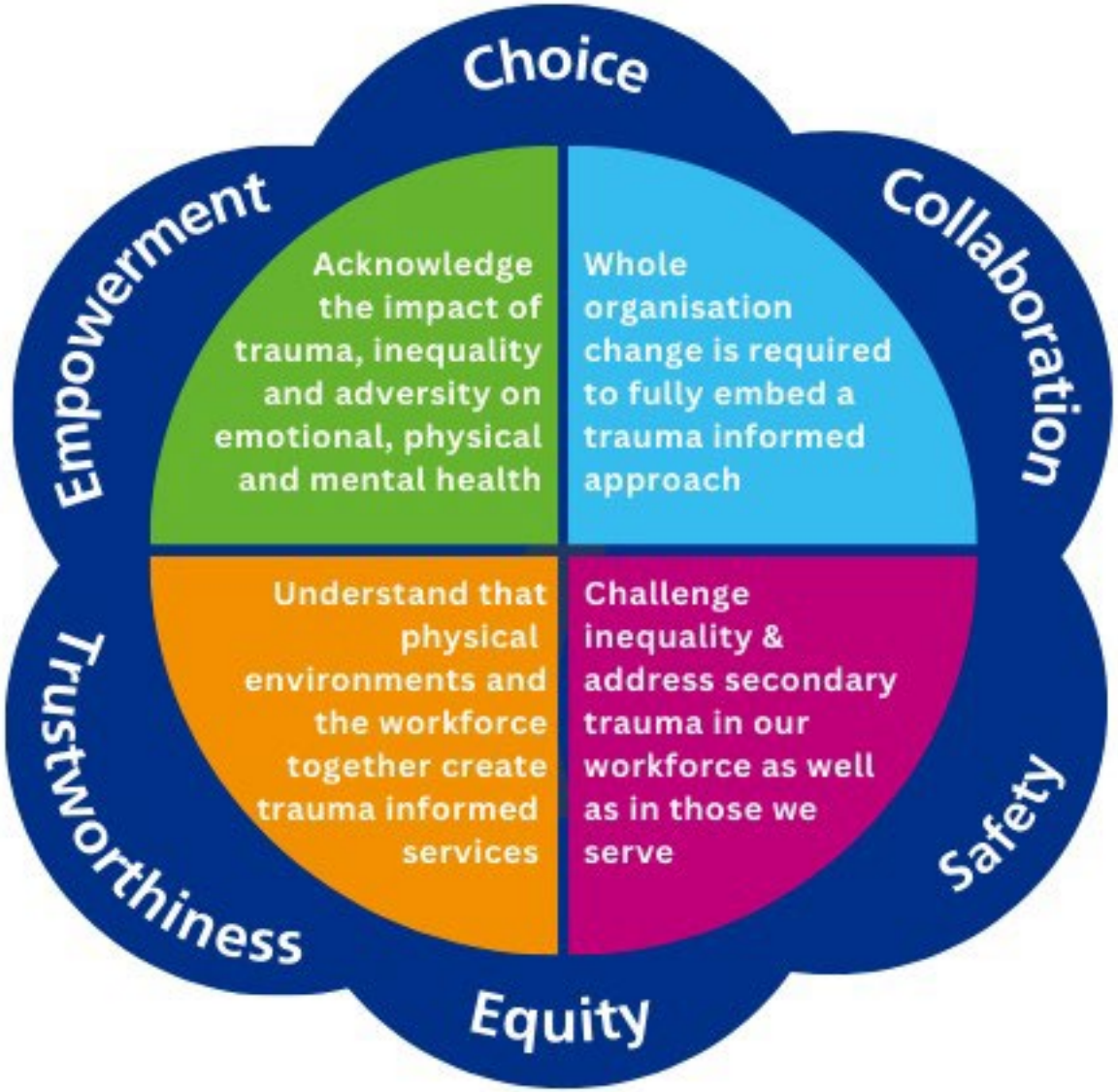
- Governance structures
- Board leads
- Divisional leads
- Strategic leads
- Lived Experience leads
- Service users/carers
- Staff
- Environments

‘For individuals who have experienced trauma, safety is not a given; it is the essential foundation upon which trust can be built and healing can begin.’

A Trauma Informed Organisation

- **Recognise and acknowledge that adverse childhood events, inequality and trauma causes or contributes to the development of mental health problems**
- **Develop its policies and practices to reflect this trauma awareness**
- **Seek to create conditions that reduce harm and promote healing, especially for individuals who have already experienced trauma**
- **Have guiding principles and values**

Requires a cultural shift within the whole organisation…



C&I Trauma Informed Organisation. 2021

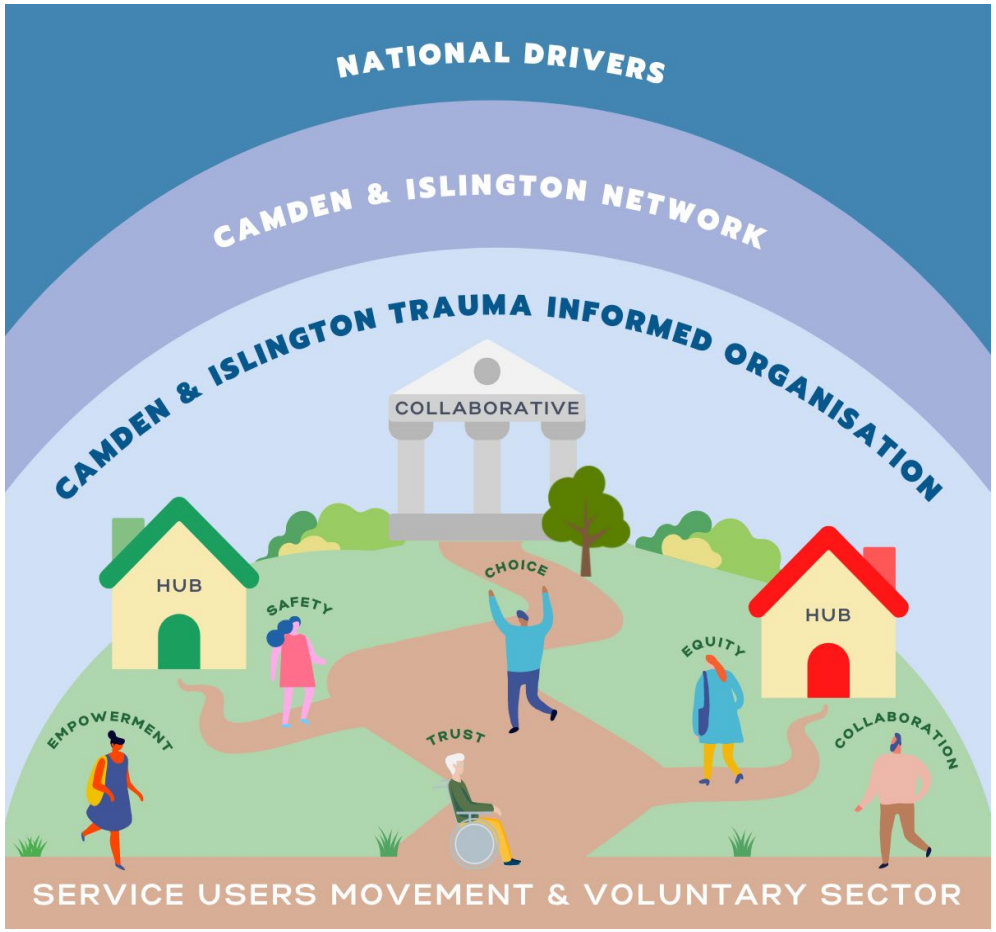
McNicholas S, Greenfield P, Rose A

Learning from lived experiences

- Structured feedback and learning
- Enabling involvement
- No decisions about us without us!
- Structures to develop our lived experience workforce at all levels of the organisation
- Supporting our peer workforce

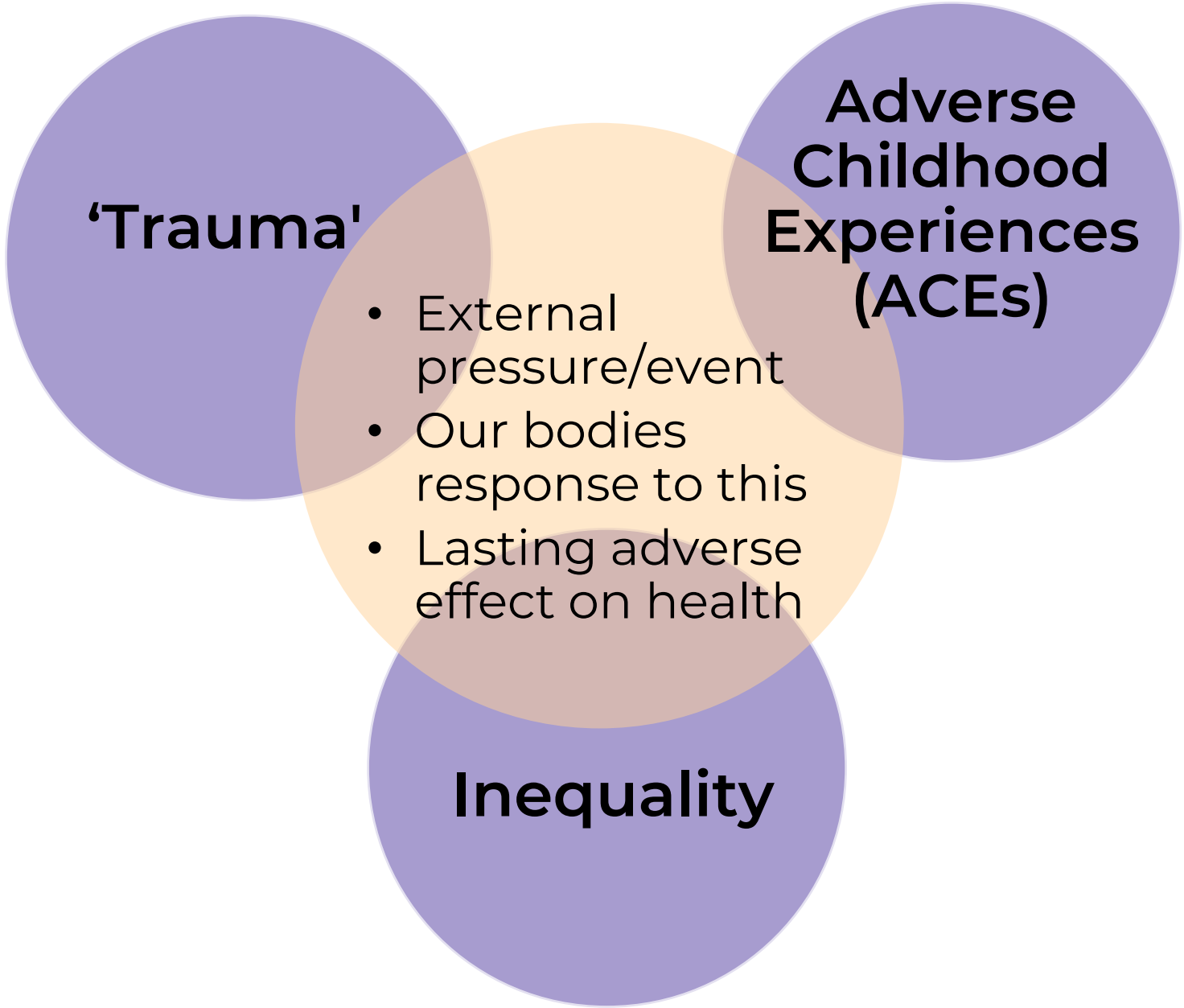
This is not ‘something else to do’, but a ‘lens’ to achieve shared goals!

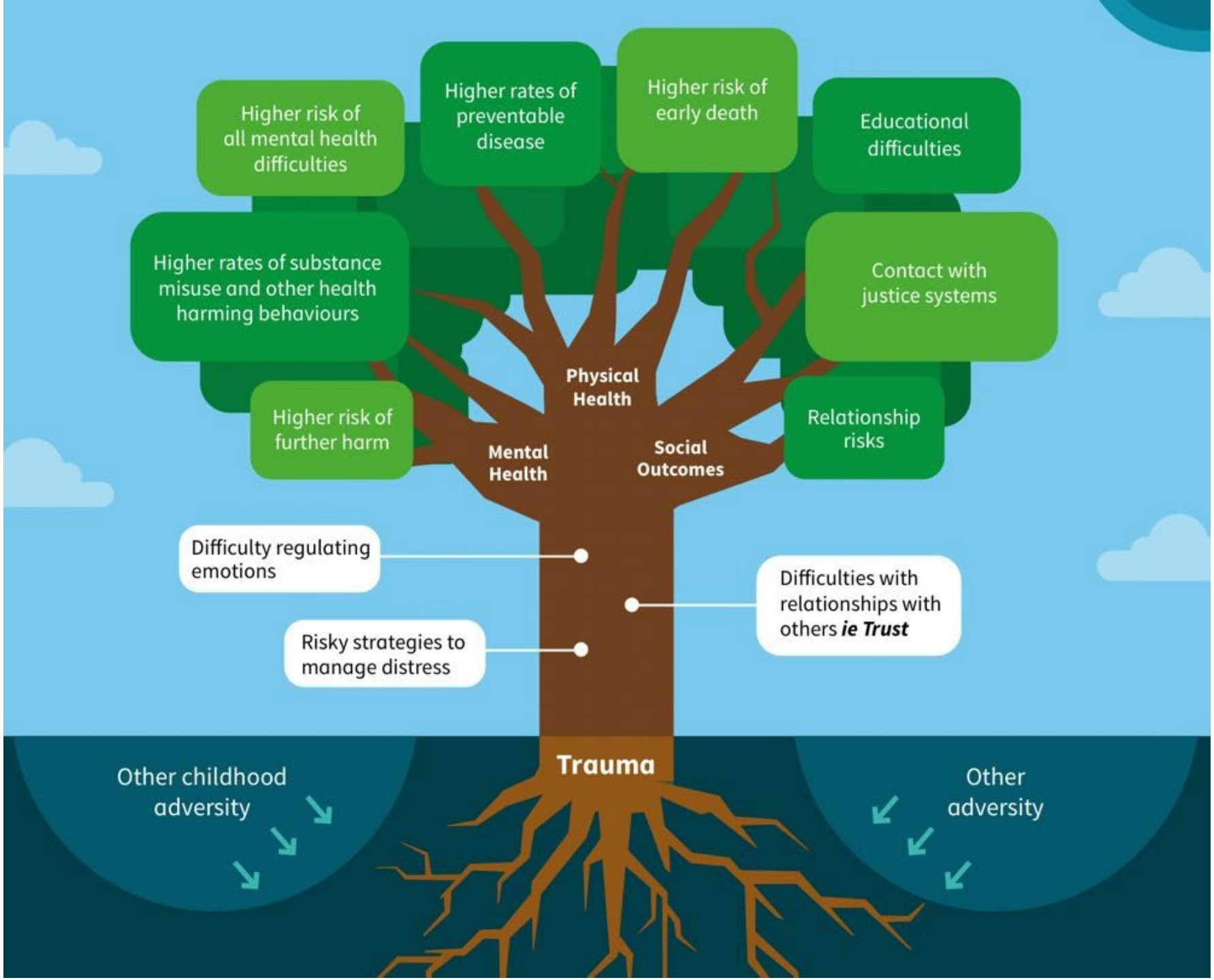
A TIA supports achieving and embedding key strategic priorities **e.g. suicide prevention, reducing violence and aggression strategy, responding to domestic and sexual abuse, population health, addressing inequity, cultural competence, being autism informed restorative justice and staff wellbeing**



Understanding the Impact of Trauma

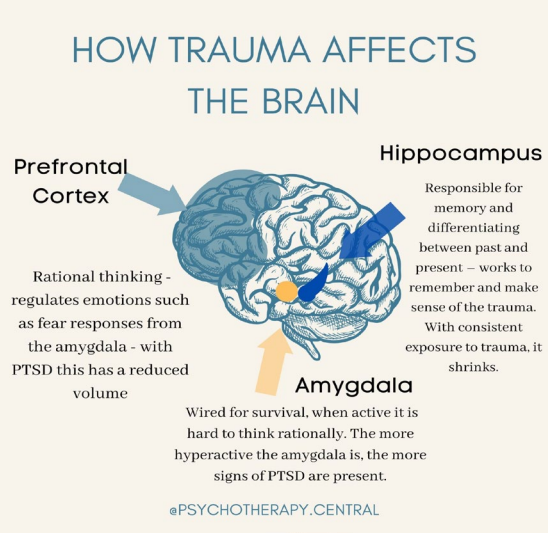
What is ‘trauma’?



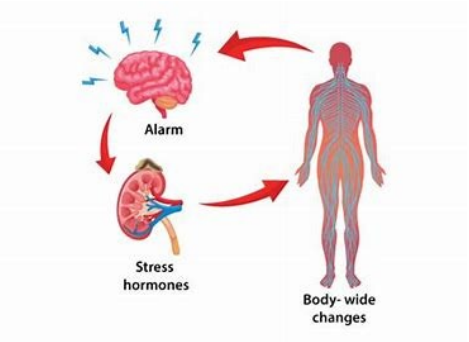

Higher risk of all mental health difficulties
Higher rates of preventable disease
Higher risk of early death
Educational difficulties
Higher rates of substance misuse and other health harming behaviours
Contact with justice systems
Physical Health
Higher risk of further harm
Relationship risks
Mental Health
Social Outcomes
Difficulty regulating emotions
Difficulties with relationships with others ie Trust
Risky strategies to manage distress
Trauma
Other childhood adversity
Other adversity

Understanding the impact of trauma – Biopsychosocial approach

The brain



Stress hormones

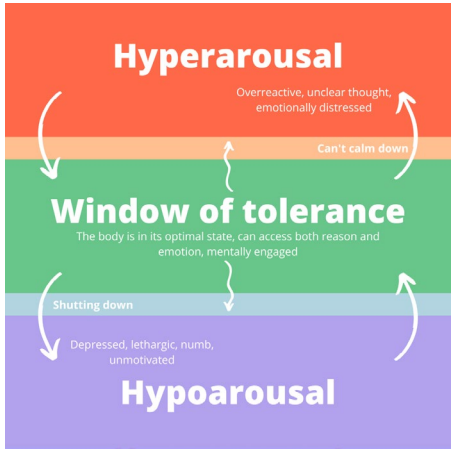


Social political climate

Psychological experience

'The core experiences of psychological trauma are disempowerment and disconnection' (Herman, 1997)

Health 'behaviours'



Trauma and Mental Health Services Use

Domestic & Sexual Abuse

- Bidirectional relationship between MH service use and experiences of Domestic & sexual abuse (Kalifeh 2015, Devries et. al 2013)
- 30-60% of psychiatric in-patients experienced domestic abuse (Howard et al., 2015)
- High rates of non-recent childhood sexual abuse

Racism & Mental Health

- Black women more likely to have experienced a common mental disorder
  (Race Disparity Audit UK Gov, 2017)
- Black men are 10x more likely to have been diagnosed with a psychotic disorder
  (Race Disparity Audit UK Gov, 2017)
- Minoritised ethnic groups disproportionately impacted by trauma, but less likely to be treated for PTSD *(Roberts, 2021)*

Trauma History

A Trauma history is associated with poor outcomes including:

- A greater likelihood of attempting suicide & self-harming,
- Longer & more frequent hospital admissions
- Higher levels of prescribed medication

(Read 2007, Mauritz 2013)

Suicide

- Socio economic disadvantage and suicide rates *(Sinyor et al., 2024)*
- Past year suicide attempt x 2·82 higher in those who have ever experienced IPV *(McManus et al., 2022)*
- Amongst those with a personality disorder diagnosis the majority had experienced childhood abuse F 71%, M 59% and many reported domestic abuse, F41%*(NCISH, 2023)*

Psychiatric symptoms, pathways to care and services themselves have the potential to be traumatic

Trauma Informed clinicians

Embed Core Principles

How do we live out these principles in all that we do?

- Collaboration
- Empowerment
- Choice
- Safety
- Trustworthiness
- Equity

What has happened to you?

‘I was essentially disconnected from any context that could have explained the chaos in and around me. This is what happens when the individual is viewed as the problem, rather than the world the individual lives in. When the actions we take to cope, or adapt, or survive are deprived of meaning, we look – well, *crazy*’ (Filson 2016: p. 21)

From Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances, 24*(5), 319-333. doi:10.1192/bja.2018.29

Understanding someone in their context…

- **Create** space where people are comfortable to be, speak and share their experience.
- **Ask** Are you frightened of anybody, are you at risk from anyone? ACE's, neurodevelopmental history?
- **Acknowledge** responses to trauma *('Fight, flight, freeze) when they are happening. (Autism dysregulation)*

Understanding someone in their context…

- **Recognise** trauma 'symptoms': too afraid to sleep, hyper vigilance but also the person's resilience (they have survived and are here).
- **Offer** choice and control everywhere possible.
- **Respond** and not react to agitation, anger reducing the threat and minimising the likelihood of violence & aggression.
- **Understand** their duty to safeguard vulnerable others.

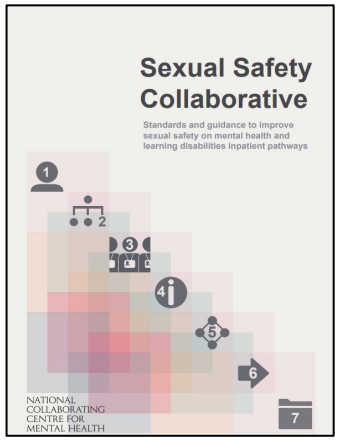
Reduce the risk of re-trauma

Re-traumatisation: new events that re-enact/ cause a powerful reminder of past trauma

- Forced medication – injection sites
- Locked in – 'imprisoned'
- Control and coercion – core feature of domestic abuse
- Privacy invaded – entering bedrooms and bathrooms
- Re enacting trauma with restraint – rape, sexual assault
- Racism/misogyny/ homophobia/ transphobia – multiple layers of oppression
- Oppressive practice – abusing our power
- Body worn cameras, wearing keys

A Trauma Informed Organisational Approach

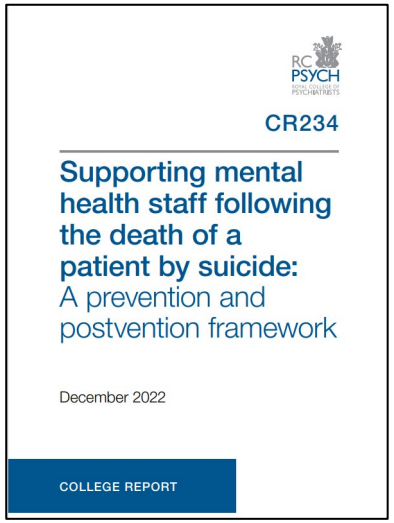
Not just about our clinical practice…



Environments

Soothing environments	Traumatising environments
• Access to **natural light and nature**	• **Doors slamming**
• **Control of heat and light** in bedrooms	• **Hard floors** and edges
• **Soft closers** on doors so they do not slam	• **Aggressive language** in information and imagery e.g., 'zero tolerance'
• **Carpeted areas** and **soft furnishings**	• **Technical observation** that invades privacy
• **Privacy notices** for bedroom areas	• **Windowless** rooms (for staff and service users)
• **Single sex** areas	• **No control** of light or heat, access to outside space
• Positive **disability access**	• **No choice** – for medication, refreshments or snacks
• **Diverse imagery** in art and information	

Staff support



Leadership

Safety & quality measures?
Incidents of restrictive practice
Incidents of sexual harm
Incidents of AWOL
Number of bank staff on shift
Staff burnout questionnaire
Patient experience questionnaire

"without a supportive social environment, the bystander succumbs to the temptation to look the other way" (MJ Lerner, 1980)

What do Trauma Informed services look like?

Trauma Informed Elements

- Safety, trust & Psychological Containment
- Collaboration & Service User Voice
- Staff skilled in working with Trauma
- Compassionate Routine Enquiry
- Choice & Empowerment
- Intersectionality & Diversity
- Environment: calm, fresh air, light
- Visibility – staff present & approachable

“Trauma informed spaces are not created by chance – they are intentionally co-created with service users, prioritising safety & trust to build environments where people feel truly seen, valued & able to focus on their healing”

Trauma informed Interventions

- Being alongside people, holding their distress with empathy and care
- Creating a sense of emotional safety through presence, patience & humanity
- Compassionate routine Inquiry
- Disclosures of harm will be believed and responded to with care
- Endings must be prepared for with transparency from the start

Environments: Part of the Healing or Part of the Trauma?

- Spaces communicate safety – or threat - even before word are spoken
- Calm, welcoming environments support emotional regulation and enable trust
- Harsh, chaotic or controlling spaces can re-traumatise and isolate
- A healing environments respects privacy, dignity and choice

Creating safe services

- Safety is a feeling, not just a policy – it must be experienced in every interaction
- Believing and responding to disclosures is essential for rebuilding trust
- Staff relational acts – kindness respect, humility – matter as much as clinical skills
- Choice and collaboration should be offered wherever possible
- Language must honour people's experiences – not minimise them
- Ask what supports individual safety and what choices are available to support this.

Safety planning: When it Works Well

- Built on trust, not fear or pressure
- Collaborative – developed together, not imposed
- Focuses on emotional safety as well as physical safety
- Reviewed through regular check-ins, encouraging openness
- Supported within a calm, reassuring, and supportive environment

What Makes Safety Planning Trauma Informed

- Developed together – empowering the service user and respecting their choices
- Focuses on what matters to the person, not just risks
- Flexible and responsive – evolves as trust builds
- Supported by the whole service, not individual clinicians
- Recognises systemic and historical trauma, alongside personal experiences

How Language Can Hurt or Heal

- Speak about the person, not their diagnosis
- Avoid reducing people to labels or categories
- Choose words that restore dignity, not reinforce stigma
- Use language that respects autonomy and human experience
- Recognise that careless language can re-traumatise – words have power

Inspired by Trauma Informed Practice: A Real Example

- Drayton Park Women's Crisis House – safely supporting women for three decades
- Safety, trust, empowerment and choice are embedded at every level of care
- Support is based on working alongside women, respecting their autonomy
- Healing is fostered through dignity, respect and authentic human connection

Drayton Park Women's Model
Founded in 1995 as a trauma informed service.
Shirley McNicholas.

1- Collaboration & collective voice

Invite women who have used services to collaborate with development, design & future. Build into op policy. Collective voice of women.

2- Language

Creates the world & our relationships. How we speak to & about someone, speak with awareness.

3-Intersectionality & diversity.

World view of women, poverty, inequality, oppression in society & politically, FGM, honour based violence, harmful practices. Impact of racism, homophobia, mothering or not.

4-Recognition of violence against women & girls

Acknowledge violence against women & girls, routine inquiry referral & assessments about childhood & adult abuse. Validate & give space. Acknowledging the past & the connection to the present.

5- Staff wellbeing

All staff matter, their input is valued. Team decisions- creative and holding risk together.

6- Psychological containment

Honest & transparent about concerns for safety. Contacts & not observation, trust & agreements. Agreement plans not care plans.

7- Power & control

Acknowledge power & control. Maximise choice & empowerment. Expectations of staff, knocking three times policy, self referral.

8-Women only skill based

Skills based women only team Authenticity & vocation. Political understanding of trauma. What has happened to this women not what is wrong with her. Experiences and responses not diagnosis based. Compassion.

9- Iatrogenic trauma

Impact of oppressive services or harmful practice,re-trauma & not being believed.
Validate & believe experiences, do not re-traumatise.
Impact of claiming benefits or dealing with the system.

10- Body work

Holistic healing approach, connecting mind & body. Safe touch, grounding.

11- Soft environment

Soft & warm environment. Art & objects reflect diversity. Plants & flowers, fresh air & light. Own space. Who comes into the building, supervision of visitors & colleagues.

12- Creativity & community

Space for creativity, art, poetry. Explore & tell story in other ways. Document who you are. Women adding to the environment as they live or come into it. Ongoing contact. Support groups & events

Autism and trauma-informed environments

Jill Corbyn

Director, Neurodiverse Connection |
Leadership Coach, Culture of Care Programme

Culture of Care

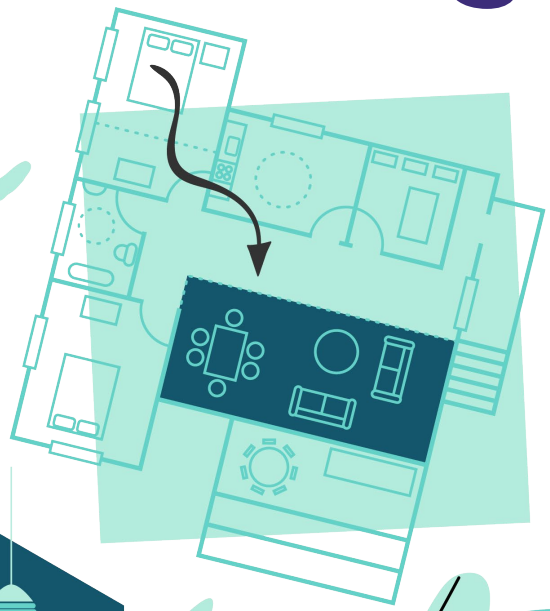
C&I Trauma Informed Organisation. 2021
McNicholas S, Greenfield P, Rose A

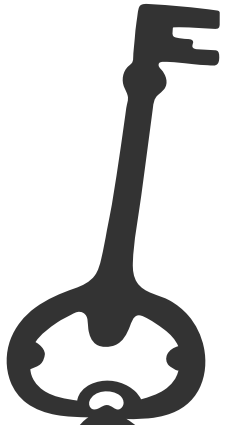
Neurodiverse Connection

What are autism & trauma-informed approaches?

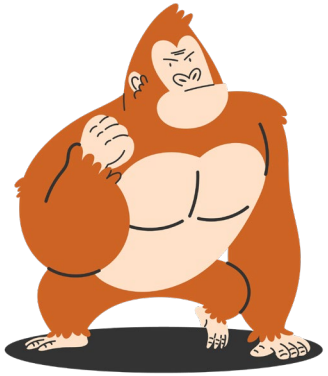
- Consider and accommodate sensory, social, processing and perceptual differences.
- Understand, identify signs and recognise the impact of trauma, stress, and nervous system activation on everyone.
- Actively seek to not re-traumatise or generate more trauma for anyone.
- Actively advocate that everyone works on self-regulation and co-regulation.

Some of our findings





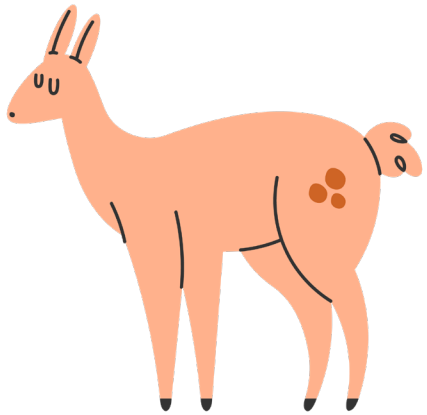
How we perceive, label, and respond to survival responses



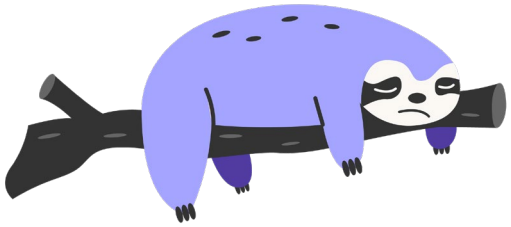
- Aggressive
- Violent

- Absconding
- Restless

- Attention seeking
- Moody



- Sulking
- Difficult



- Manipulative
- Fine

AUTISTIC

(Physical Processing Emotional)

Sensory Predictability Acceptance Communication Empathy

Relationships are central to patient experience

“There’s one member of staff who turns up with an ice pack whenever I’m overwhelmed. I don’t know how she knows and finds me.”

Reflective Space

Emily Daly

National advisor for the Culture of Care Programme

Culture of Care

Reflective Space Questions

1. What are your first thoughts and feelings from what you've heard so far?

2. What do you feel in your body?

3. What feels easier / more difficult to engage with?

Reflective Space Slido

If you'd like to share your thoughts, you can also use the QR Code.

Joining link:
https://app.sli.do/event/bDa9BQmmYjYs8C1QhfvzEU

Break

15 minutes

Session 2: Critiques of trauma-informed approaches

Sal Smith

Head of lived experience and co-production

Robert Horton

Peer Mentor & Advocate, Black Thrive Global

Culture of Care

Trauma Informed Approaches

What it is not;
misunderstandings and misconceptions

Sal Smith

Head of Lived Experience and Coproduction

Sal.smith@rcpsych.ac.uk

BETH FILSON 2016

“Trauma matters. It shapes us. It happens all around us. It destroys some of us, and it is overcome by many of us. To ignore it is to ignore who we are in all our complexity”.

What might it mean to be trauma informed?

- Expect trauma
- Check your power
- Consider the environment
- Culture matters

What might it mean to be trauma informed?

- Trauma specific therapy
- Do no harm
- Relationships matter
- Create the opposite as the antidote

What trauma informed care is not?

Editorial > J Ment Health. 2018 Oct;27(5):383-387. doi: 10.1080/09638237.2018.1520973.
Epub 2018 Oct 22.

(Mis)understanding trauma-informed approaches in mental health

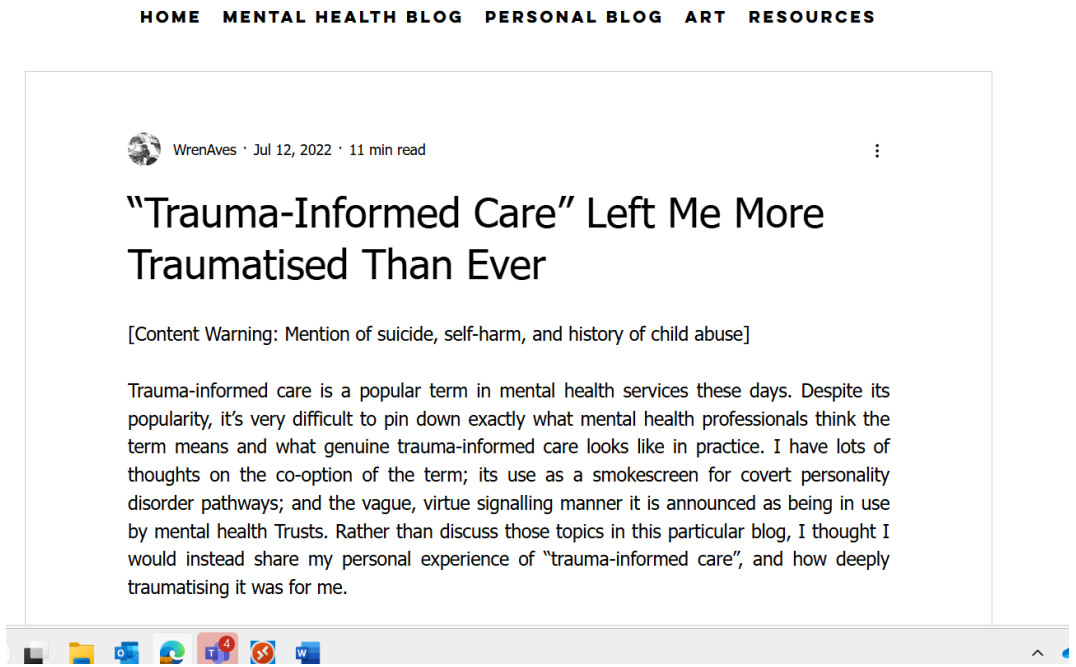
Angela Sweeney [1], Danny Taggart [2]

Affiliations + expand

PMID: 30345848 DOI: 10.1080/09638237.2018.1520973

No abstract available

PubMed Disclaimer

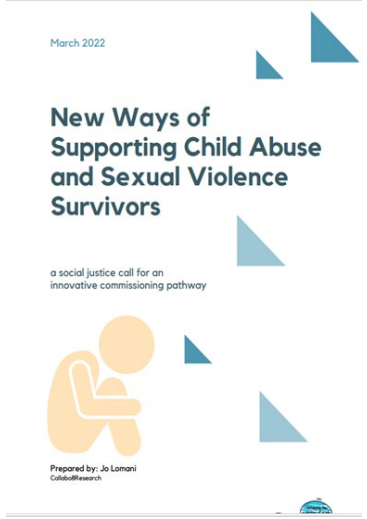


What trauma informed care is not?

- Dogmatic approach
- A rebrand but business as usual
- Simple narrow understanding of trauma
- A way to deny access to care and support
- A way to neglect people labelled BPD/EUPD
- Forced positive risk taking
- Breech of people's privacy – way to idly discuss trauma

What might TIC look and feel like in practice?

- Way of being
- Staff support
- Language
- Lived experience roles
- Trauma specific therapy and supports
- Reducing restrictive practice
- Built environment
- Nothing about me without me
- Harmed patient pathway



Thank You

Sal Smith

Head of Lived Experience and Co-Production

Sal.smith@rcpsych.ac.uk

Racialised Trauma

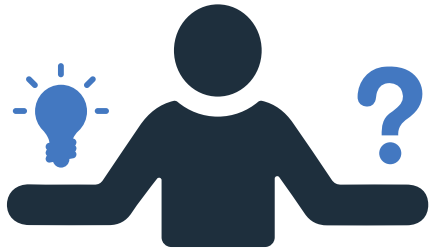
Robert Horton

Peer Mentor & Advocate, Black Thrive Global

What is Racialised Trauma?

Racialised trauma AKA race-based traumatic stress (RBTS) refers to the psychological and emotional harm caused by experiences of racism, discrimination, and racial violence. It can result from direct experiences (e.g., being targeted with racial slurs, hate crimes, or microaggressions) or indirect exposure (e.g., witnessing racial violence against others in media or real life).

What is Racialised Trauma?

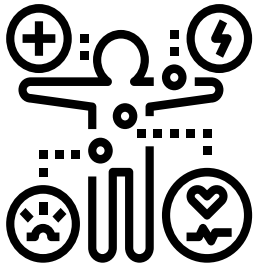


Causes can be

Interpersonal racism
Direct discrimination, harassment, or hate crimes

Systemic racism
Unjust policies (e.g., racial profiling, workplace discrimination)

Microaggressions
Subtle, everyday slights that accumulate over time



Symptoms can be

Emotional
Anxiety, depression, anger, shame

Physical
Fatigue, headaches, insomnia

Cognitive
Hypervigilance, difficulty concentrating

Behavioural
Avoidance of certain places or people, social withdrawal

Long-Term Effects can be

Chronic stress, low self-worth, internalized racism

Distrust of institutions or majority racial groups

Intergenerational trauma (passed down through families)

Challenging the BBD Myth

(Big, Black & Dangerous)

This stereotype dates back to slavery and Jim Crow, where Black men were falsely portrayed as “brutes” to justify violence and control. Today, it fuels racial profiling, police brutality, and systemic bias in workplaces, schools, and media.

The psychological effects of being stereotyped as big, Black, and dangerous can be profound and damaging, impacting mental health, self-perception, and social interactions. This stereotype is rooted in racist historical and cultural narratives that associate Black men (and sometimes Black women) with hyper-aggression, criminality, and threat.

Challenging the BBD cont.

Some Key Psychological Effects

Internalized Stereotype Threat	Racial Trauma & Chronic Stress
Self-doubt and hyperawareness Constantly being perceived as a threat can lead to anxiety about one's movements, tone, and presence in public spaces.	**Hypervigilance** Always being seen as dangerous can lead to a state of heightened alertness, similar to PTSD symptoms, due to fears of racial profiling, police violence, or social rejection.
Overcompensation Some may feel pressured to appear over friendly, soft-spoken, or non-threatening to counteract the stereotype, leading to emotional exhaustion.	**Anger & Frustration** The injustice of being unfairly judged can cause resentment, helplessness, or rage, especially when coupled with experience of discrimination.

Challenging the BBD cont.

Some Key Psychological Effects

Internalized Stereotype Threat	Racial Trauma & Chronic Stress
Impact on self-image & identity Internalized racism: Some may unconsciously absorb negative stereotypes, leading to self-hatred or distancing themselves from their racial identity.	**Social & Emotional Isolation** Loneliness & Mistrust: Being perceived as dangerous can lead to social exclusion, making it harder to form trusting relationships.
Body Dysmorphia or Shame Those who are tall or muscular, may feel ashamed of their natural physique, associating it with fear in others.	**“Strong Black Person” Pressure** The expectation to endure racism without showing vulnerability can suppress emotional expression, leading to depression.

Challenging the BBD cont.

Some Key Psychological Effects

Internalized Stereotype Threat	Racial Trauma & Chronic Stress
Effects on Mental Health Increased anxiety and depression. The cumulative stress of racial stereotyping contributes to higher rates of mental health struggles among Black individuals.	**Coping Mechanisms and Resistance** Community and affirmation. Many find strength in black-affirming spaces, therapy, and activism to counteract negative stereotypes.
Survivors Guilt Those who avoid direct violence may still feel guilt when others in their community suffer due to the same stereotypes.	**Reclaiming Power** Some embrace their size and presence as a form of resilience, rejecting racist narratives.

Examples / Case Studies

- Had a diagnosis of schizophrenia
- Clunis had been failed by multiple agencies. No single agency took responsibility.
- Highlighted the dangers of poorly coordinated care
- Introduction of the Care Programme Approach (CPA)
- Structured care plans, named care coordinators
- Compulsory Community Treatment (CCT)
- Later, Community Treatment Orders (CTOs)
- Public Perception & Stigma public safety vs patient rights

Christopher Clunis – 20+ Years ago

Tabloids framed Clunis as a "mad killer," fueling stigma

- Before Clunis: implementation was patchy
- Lost to follow-up; tick-box exercise
- Better coordination today, but funding cuts (e.g. social care) still cause gaps
- “Public Protection” over patient rights
- Rising SMI (Severe Mental Illness) cases since COVID-19
- Underfunding and workforce shortages persist
- No clear reduction in relapses
- Trauma from forced treatment

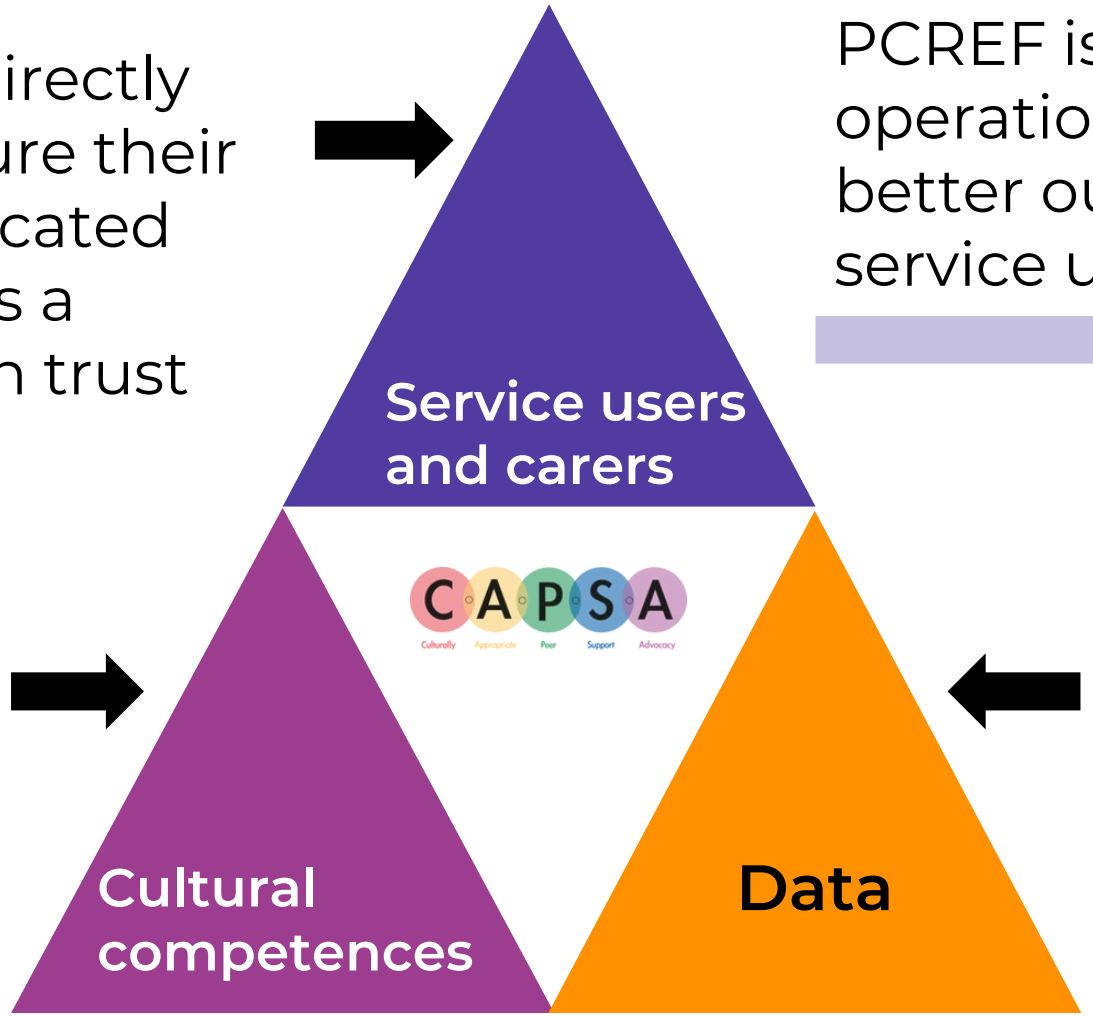
CAPSA APPROACH

- CAPSA is a Service which provides Peer advocacy and Peer Support for Black service users.
- Short-term service which works within the full lifecycle of an individual's journey.
- Cultural needs advocacy enshrined through Afrocentric Empowerment Frameworks.
- A multiagency approach which is underpinned by the statutory legislation and CAPSA framework.

CAPSA APPROACH

CAPSA works directly with SU to ensure their needs are advocated for and to act as a bridge to regain trust

CAPSA helps to ensure PCREF is understood operationally to ensure better outcomes for black service users



CAPSA have started to do some training with both inpatient and community teams

Using the data based on the needs of SU able to use this to support and educate partners

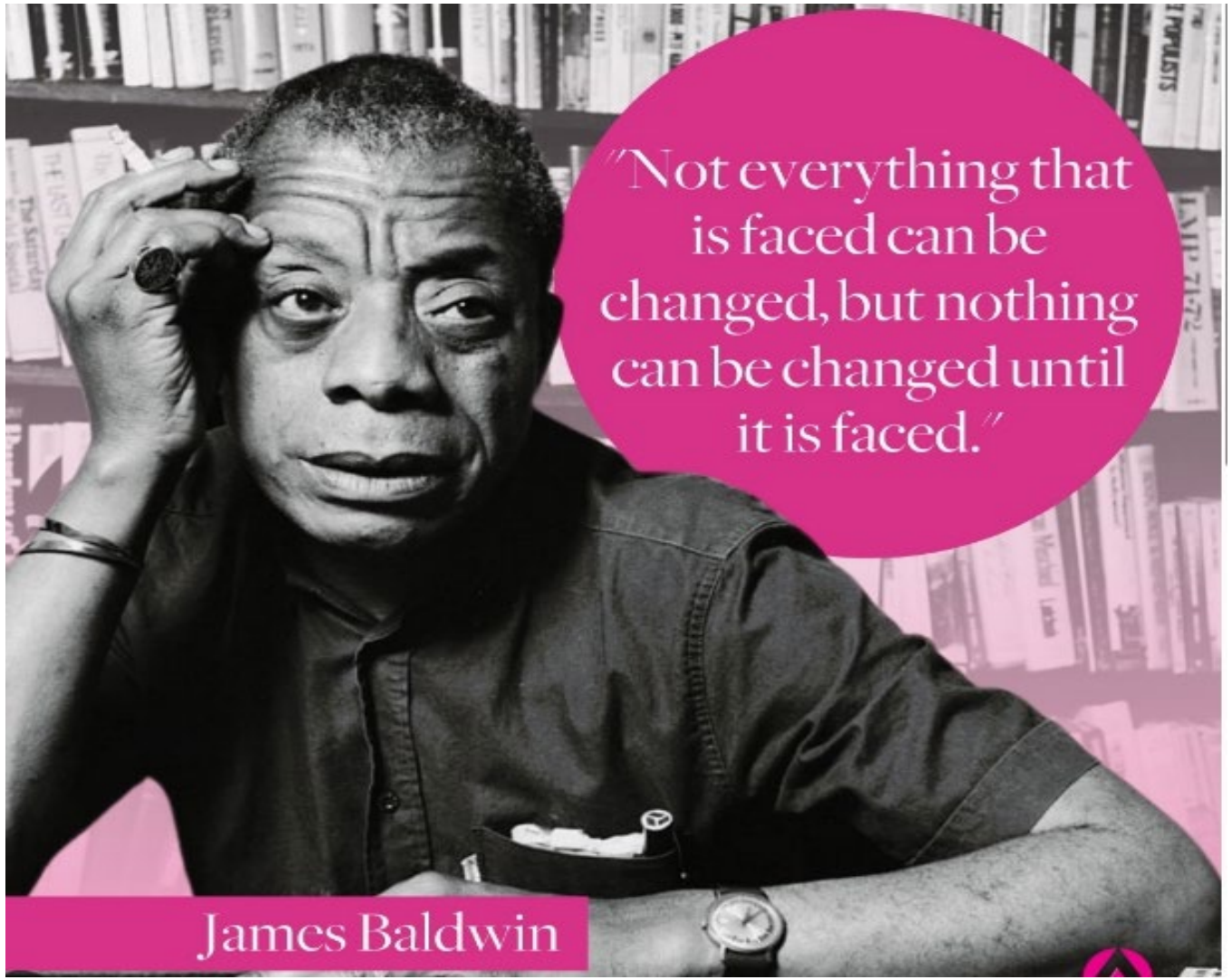
Key takeaways

- Racial trauma is often overlooked because racism itself is normalised or denied. Recognising it helps validate the experiences of marginalised groups and promotes healing.

- Being labelled as "big, Black, and dangerous" is not just a social issue but a psychological burden that requires systemic change and individual healing.

- Cultivating self-love, seeking therapy (particularly from culturally competent professionals), and challenging stereotypes can help mitigate these effects.

- Culturally appropriate partners can break down the stigma within the system leading to better outcomes for marginalised groups.


"Not everything that is faced can be changed, but nothing can be changed until it is faced."
James Baldwin

Reflective Space

Emily Cannon
Head of Quality Improvement,
National Collaborating Centre for Mental Health (NCCMH)

Culture of Care

Prompts

1. Where is harm or good practice happening, specifically in relation to race-based trauma and anti-racism?

2. How does focusing on race-based trauma link to existing commitments made by your organisation, including PCREF?

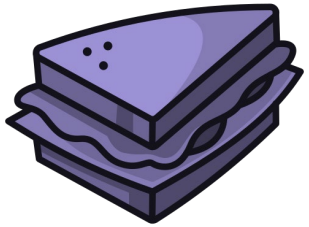
3. Reflections on how the equity principles can work together

Reflective Space Slido

If you'd like to share your thoughts, you can also use the QR Code.

Joining link:
https://app.sli.do/event/bDa9BQmmYjYs8C1QhfvzEU

Lunch



13:00 - 14.00

Post lunch energiser

Heather Mason

Founding Director, The Minded Institute

Culture of Care

Session 3

Implementing a trauma-informed approach

Julie Redmond | Trauma informed advisor

Mark Allan | Peer leadership advisor

Pea Meyer Higgins | Lived experience lead – relational care

Culture of Care

Moving away from video-based surveillance

Julie Redmond | Trauma informed advisor

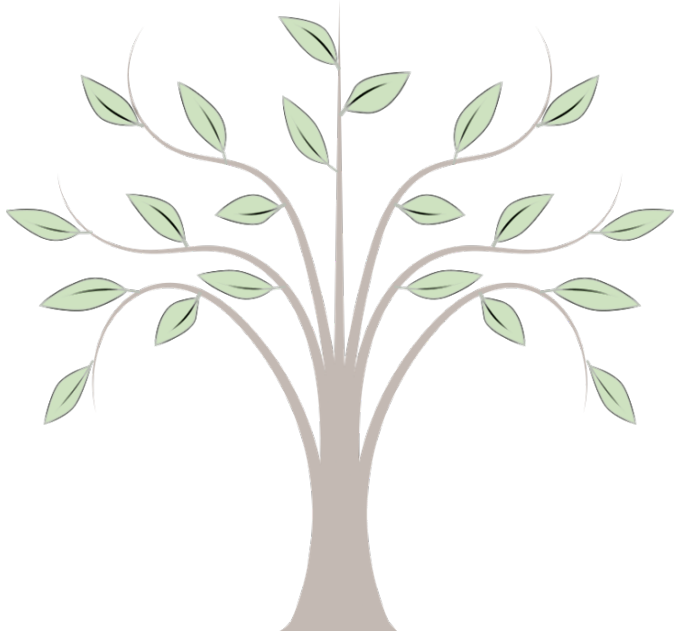
Pea Meyer Higgins | Lived experience lead – relational care

Sophie Bagge | Lived Experience Advisor

Culture of Care

Trauma informed peer support

Mark Allan | Peer leadership advisor



Culture of Care

Definitions & Models

- **Peer Support**
  When people with lived / living experience (LE) connect & support each other

- **Peer Support Workers (PSW)**
  People with LE employed to deliver ‘peer support’

  Formalises the practice of drawing on your LE, while working to peer values, to create peer relationships

Definitions & Models contd.

Models of Implementing PSW

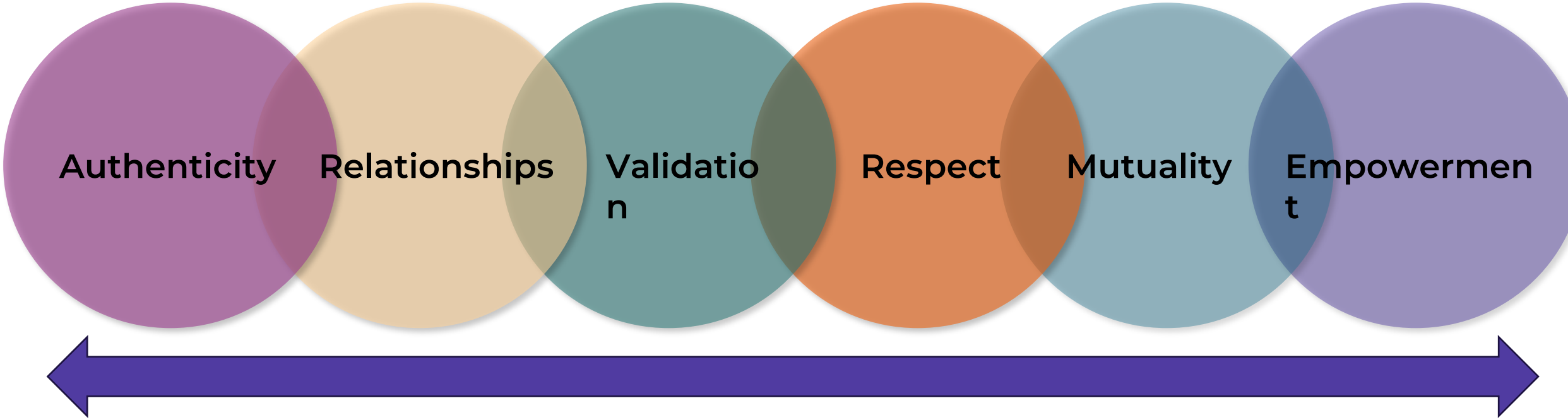
Provider employed PSW in teams

VCSE employed in-reach PSW –

Culturally Appropriate Peer Support and Advocacy Service - Black Thrive – Lambeth

Key Foundation: Peer Support Values

- The Key Foundation of Peer Support: Inform our peer support practice, and our work within our peer structures
- TEWV Peer Support values were co-produced with a reference group including peers, service users, carers and VCSE representation



Foundations: Peer Support Values

Peer support and trauma informed care

Share many of same values:

- Relationships & Relational Safety
- Trustworthiness and Transparency
- Collaborative
- Empowerment & Choice
- Reflexive about power dynamics
- Commitment to equity
- Importance of lived experience(s)

What peer support workers do

One to one peer support

- Presence on ward – reaching out to connect and bring compassion
- Walking alongside – providing mutually agreed emotional and practical support
- Supporting people to navigate and engage with services
- Supporting people to access the resources available in their ward or communities

Facilitate Peer Support Groups

- Bringing people together to connect with and support each other

Work within team processes (huddles, meetings, formulations, service development)

- Bringing lived experience and peer expertise to the skill mix
- Bridging the gap between care teams and service users
- Supporting service users to have their voices heard in their care
- Promoting and embedding Trauma Informed Approaches and the Culture of Care Standards

What we don’t do

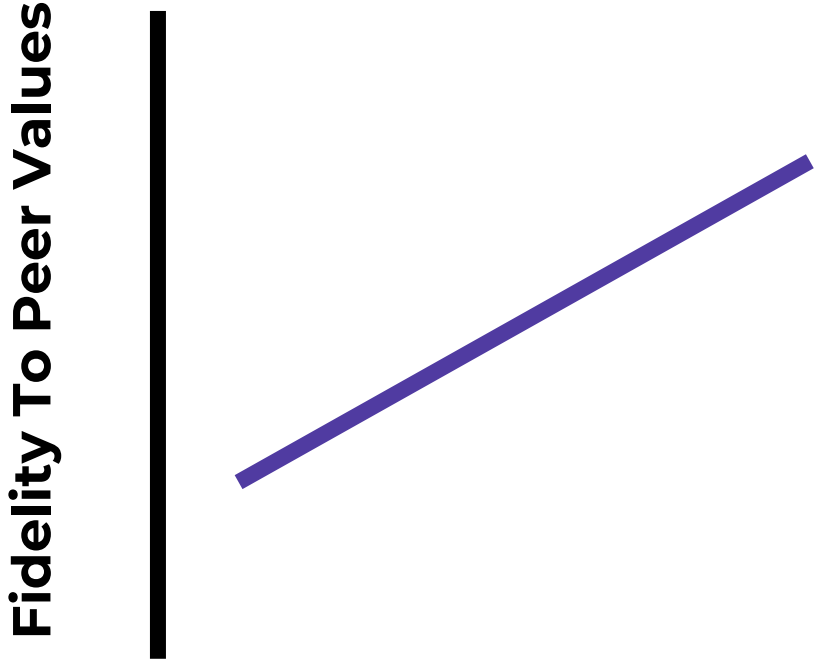
Not involved in coercive or invasive practice including:

- Control and restraint
- Observations
- Personal care
- Persuading compliance (or non-compliance)

Not HCA / Support Worker Roles

Peer Support Workers must not be included in inpatient staffing numbers

Evidenced benefits of role fidelity



Research & experience shows that a clear role remit with fidelity to peer values is crucial to successful implementation of PSW roles:

- Increases engagement in peer support from SU
- Creates roles that match with peers values
- Focuses peers work on what uniquely they offer
- Provides clarity for colleagues
- Minimises overlap with other posts – research on new posts clearly defines peer support as about innovation not re-tasking

In short: Peer roles are an innovation that is about adding peer support to teams that don't have it. It is not about bringing in LE to do (often cheaply) more of that which is already done!

Barriers to implementation & role fidelity

- Ward cultures vary in readiness
- Peer roles not always well understood
- Clinical cultures can lead to pressure or drift away from peer role remit & values
- Can be resistance to LE as colleagues
  - “What we need is more nurses”
  - “Just one more thing for ‘us’ to do”
- Re-traumatising environments
- A unique form of intellectual labour

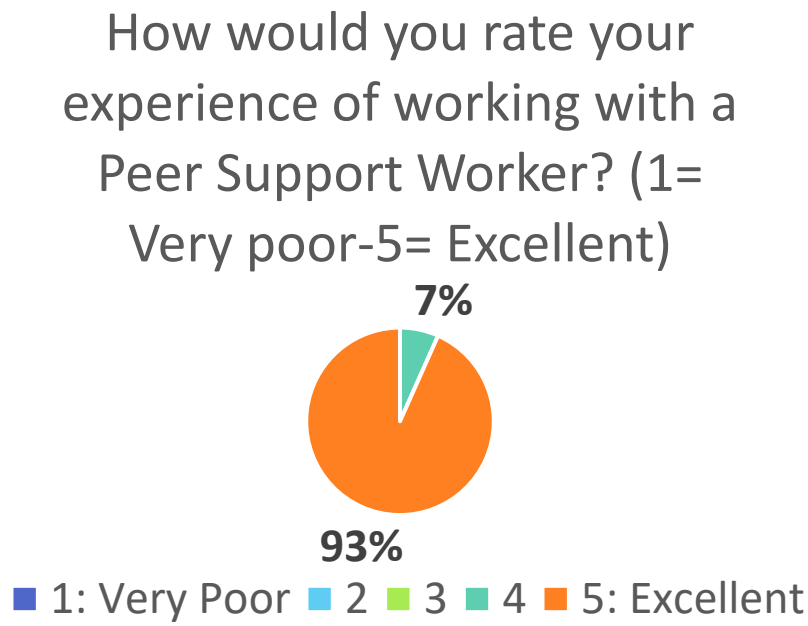
Evidenced benefits of peer work

Service User	Peer Support Worker	Service
Reduction of isolation	Access to work in a valued role	Key to culture change
Increase in hopefulness	Working to personal values	Core component of trauma informed approach
Increase in confidence	Source of personal meaning	Core to recovery values-based practice
Increase in well-being	Increase in self-belief	Brings LE expertise into team skill mix
Feeling more in control	Increased sense of competency	Bridges the gap between SU and staff
Some evidence shows reduction in in-patient re-admissions	Can support personal recovery	Improved SU experience
		Improved SU outcomes

Inpatient Impact: Service User Feedback

- “Knowing that I was understood and feeling able to express how I am feeling”
- “Made me feel at ease. Didn’t judge me. Listened to me”
- “Very supportive, caring, compassionate as they understand in a very good way”
- “Made me feel I wasn’t alone and the only one to go through things like this”
- “Point you in the right way to other services that may not normally be obvious”
- “Thank you for all your unconditional support and kindness”

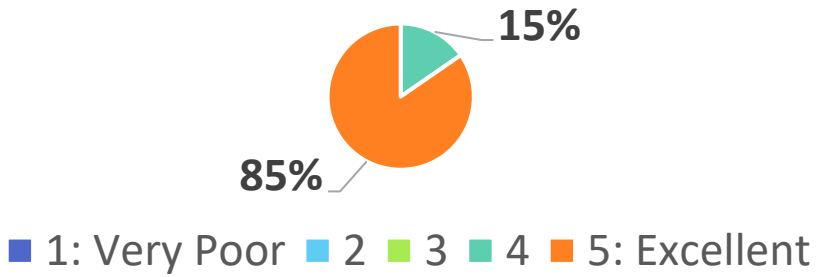
A number of our PSW wanted to come into this work after working with a TEWV PSW



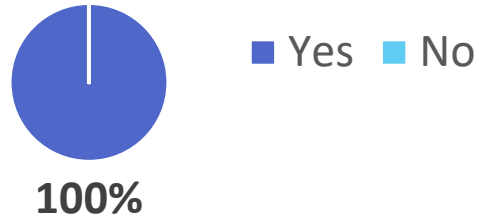
Inpatient Impact: Colleague Feedback

- “Peer support provides an open space for patients to discuss their care and can form more of a relational role.”
- “Having a bridge between staff & clients. They have been good for the team.”
- “Support for patients and staff”
- “They provide a different view”
- “Valuable insight”
- “Really insightful into patient experience - vital member of the MDT”
- “Excellent experience of working with the peer support team.”

How would you rate your experience of having Peer Support Workers as part of the team?



Have you valued having someone with lived experience/peer expertise as part of the team?



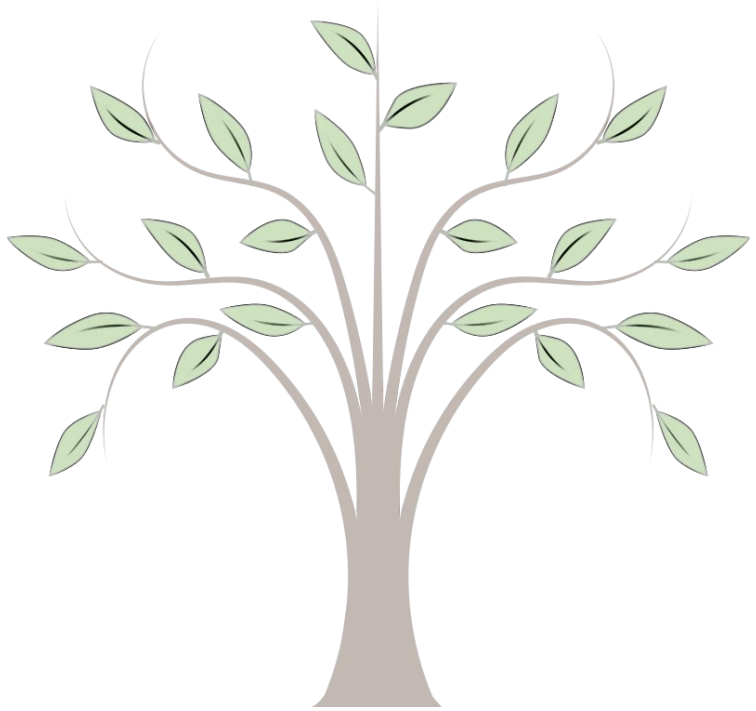
Recruitment Data

- **Recruitment:**
  - Prior to lived experience leading our recruitments a couple of LE roles were advertised and not able to be appointed to
  - 2018: 217 applications for 6 roles in Teesside community services
  - 2021: *120 lived experience applications* for 12 inpatient roles across the Trust
  - 2025: 236 applications for ~6 Secure Inpatient Services roles

Retention Data

- **Retention Rates From Inpatient Implementation Year (2022):**
  - Recruited 16 Inpatient and 3 community peers:
    - After 1 year: 100% still worked in LE roles in the Trust.
    - After 2 years: 95% still worked in the Trust, 89% in LE roles, 84% in the Peer service
    - After 3 years: 84% still worked in the Trust, 79% in LE roles, 74% in the peer service

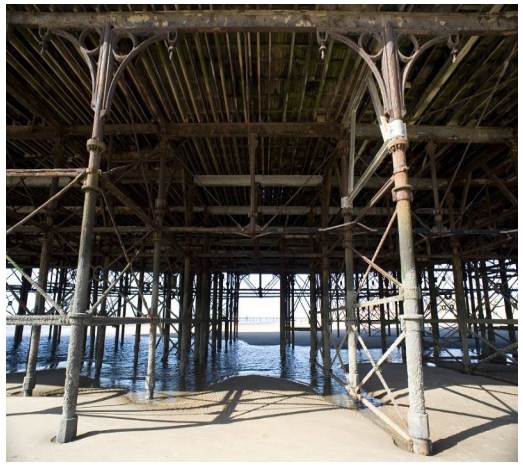
Personal Experience of Peer Work Role



“I absolutely love peer work. It’s honestly changed my life. When I first started I didn’t have much understanding or knowledge, it just sounded like something that could really make a difference and something I would have loved for myself. Now I can’t imagine doing anything else. I have met so many once-in-a-lifetime people through my colleagues and people I’ve built a peer relationship with, these people have changed me forever and I couldn’t be more grateful ❤”

Beth Gell

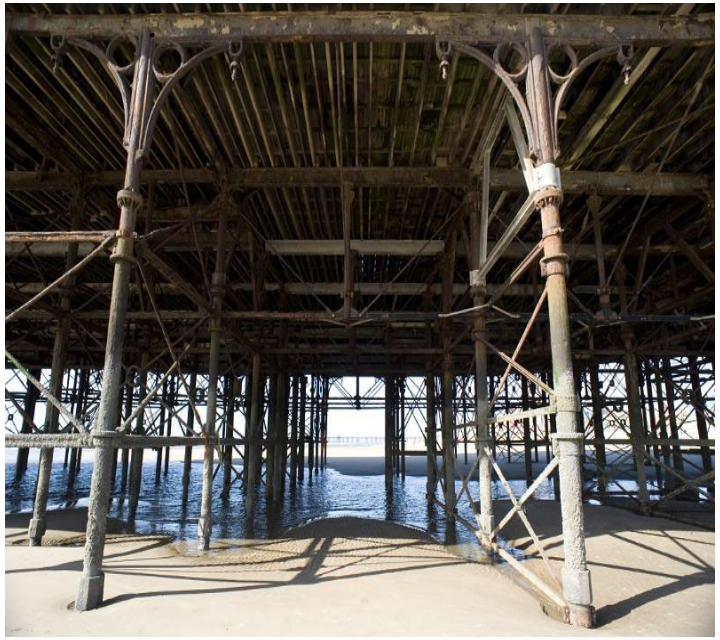
Supporting Peers: Creating Sustainable Roles



Peers are part of a Trust Peer Team with Robust Professional Governance and Support Structures

- Peer led professional structure
- Roles based on peer values
- Employing peers on teams in pairs (or linked roles)
- Team preparation
- Peer led recruitment process
- Start with peer support training
- Ongoing 1:1 supervision from peer supervisor
- Creating strong peer community:
  - Monthly: co-reflections; online social drop-ins; newsletter
  - Twice yearly: development days; Directors Forum
  - Systemwide networks alongside VCSE peers
- The Daily Debrief

Supporting Peers: Creating Sustainable Roles



Also part of the Service Team

- Line managed by team manager
- Champions within teams also key
- Service induction
- Access to team/Trust supports

- Tripartite Approach
  - Quarterly management supervision
  - Appraisal process
  - Sickness absence management

- Peer values are central to peer roles
- Peer roles bring something completely unique to a ward
- The roles are challenging – so should be introduced responsibly
- If we do this peer roles can be successfully implemented on wards

Culture of Care:
Monthly Peer Support Implementation Space

- Invites have gone to all providers
- First meeting will map what we want from the space
- Envisage combination of
  - Range of providers sharing good practice
  - Collective reflections on current challenges
- All providers are welcome

Reflective Space

Tom Ayers

Director | National Collaborating Centre for Mental Health (NCCMH)

Sophie Bagge

Lived Experience Advisor

Culture of Care

Prompts

Use ‘How I feel’ reflections to think about how to move forward in a way that honours those feelings and not in a way that avoids them

Reflective Space Slido

If you'd like to share your thoughts, you can also use the QR Code.

Joining link:
https://app.sli.do/event/bDa9BQmmYjYs8C1QhfvzEU

Call to action

Sophie Bagge
Lived Experience Advisor

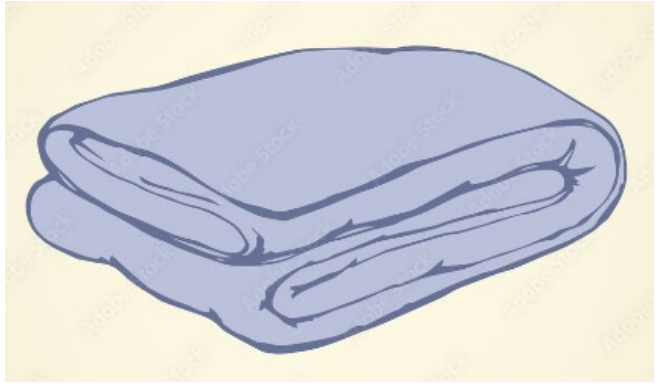
Culture of Care

BIG CULTURAL CHANGE!!!

TOGETHER

"Let's embrace our roles as positive disrupters to challenge and champion positive changes"

Why?



“If you think you are too small to make a difference, try sleeping with a mosquito.”

THANK YOU

Closing activity

Heather Mason

Founding Director,

The Minded Institute

Culture of Care

Next steps, upcoming events and training

Mark Farmer
National Advisor for the Culture of Care Programme

Upcoming events in 2025

Dates for your diary

- **May:** **Learning Network Events** (in person, all day)
  Contact your QI Coach for more information.
- **9 June:** **Culture of Care Workshops**
  (MS Teams, 2pm – 4pm)
- **10 June:** **Personalised Approach to Risk – safety plans for self-harm & suicide**
  (Zoom, 10am – 12pm)

Calendar of events on our website.

Reminder about training for ward staff

Dialogical & Relational Training (DARRT)	Autism informed care training	Race equity training	Sexual harm prevention training
21 May 2025 09:30 – 16:30	18 June 2025 10:00 – 13:00	5 June 2025 10:00 – 12:00	22 July 2025 10:00 – 12:00
17 June 2025 09:30 – 16:30	20 August 2025 13:00 – 16:00	4 Sept 2025 14:00 – 16:00	11 Nov 2025 10:30 – 12:30

These training sessions are delivered virtually.

Please visit our website for more information & how to register: www.rcpsych.ac.uk/improving-care/nccmh/culture-of-care-programme/learning-events

Feedback and close

- We value your feedback as this helps us to continue to improve these events.
- **Please use the QR displayed here:** or the paper copies on your tables.
- Thank you for making it to Birmingham, we appreciate your time and effort!