Transitioning to a Trauma Informed forensic unit:

Staff perceptions of a shift in organisational culture.

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We do indeed stand on the shoulders of giants.

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Abstract

Background: Trauma-informed care can be defined as "a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological, and social development" (Patterson, 2014). It is widely acknowledged that trauma informed approaches are designed to have a positive influence on both staff and service users. However, there is limited evidence that exists on implementing trauma-informed approaches in service provision. This limited evidence has also focused mainly on the influence of trauma-informed care on service users rather than staff members (Hales et al. 2017). Given the high prevalence of trauma in forensic populations and the fact that staff members are participants in an organisation's culture and the processes through which services are delivered, it would be important to gain an understanding of how staff members are impacted by the process of moving towards trauma informed care within the NHS context in the UK.

Aims: The aim of this study is to provide an in -depth description of the impact of transitioning to a trauma-informed service model on staff working in an inpatient forensic unit in the North of England and the factors that influence the progress of this transition.

Method: The study employs a qualitative design and the data were collected via four focus groups comprising of staff members working in the four wards of a female forensic unit. All participants in this study were female. Thematic analysis (Braun and Clarke, 2006) was used to analyse the data through a social constructionist epistemology (Burr, 1995).

Findings: Four themes were identified: Reconstructing your professional identity; Redefining group dynamics; Navigating new clinical practices; Managing longer term challenges of trauma-informed change.

Implications: Implications for policy, practice and research are discussed.

CHAPTER 1: Introduction

1.1 Chapter Overview

This project will explore the perceptions of staff members, of transitioning to a trauma informed care model within a forensic unit. In this introductory chapter, I will begin by defining my personal and epistemological position in order to demonstrate how my understanding and interpretation of the findings have been formed.

I will continue with defining and exploring the key concepts which will be used throughout the text. I will explore how our understanding of psychological trauma has been formed and its prevalence in populations accessing mental health services before focusing on the prevalence within populations accessing forensic services. Subsequently, I will present how the practices of the current mental health system can be retraumatising for both trauma survivors and the workforce especially in inpatient units, with a focus on forensic units. Finally, I will present the framework of trauma informed care as an alternative to the current service system.

In the second half of the chapter, a systematic review will be carried out which will aim to critically evaluate the existing research of trauma informed care being implemented within forensic populations across the world. Finally, I will provide rationale for this present study.

1.2 Personal and epistemological position

1.2.1. Positioning myself as a researcher

Working in the field of mental health for more than a decade, I have observed that the majority of service users I had been in contact with, in a variety of services such as brain injury, learning disability and dementia services have experienced trauma. The same observations continued as I begun training to become a Clinical psychologist.

On one hand, I kept seeing service users on placement who have been affected by experiences of prolonged abuse and neglect regardless of their psychiatric diagnosis or the kind of service they were accessing. On the other hand, I observed significant lack of support for the workforce working with trauma survivors and how this led most of the time to high turnover of staff and a lot of tensions within teams. From my experience, these tensions a lot of the time were negatively affecting the language used towards service users and they were leading into a disconnection from the values of empathy and kindness which traditionally guide people in helping professions.

These observations made me wonder how the current mental health system, which is located within the wider NHS, and subsequently within the current political climate of austerity, is impacting on both service users and staff. It seemed to me that I was finding myself in systems which were on survival mode. This usually translated as staff being off sick very often or feeling very disconnected from colleagues and service users. I wondered if there is an alternative way of working which would not perpetuate this survival mode and

subsequently the othering of service users. A way of working which recognises that staff members working under the most challenging of circumstances are also affected by both their own experiences but also by the practices they are asked to perform or witness.

These thoughts led me to reading about how trauma theory can be applied in the designing of services and the concept of trauma informed care. Given that trauma informed care has recently made its way from the USA to the UK, I became really interested in investigating how the implementation of trauma informed care could potentially work within the NHS context in the United Kingdom.

1.2.2. Epistemological position

My journey through training as described above has also led me in undertaking a complex trauma specialist placement. As a clinician, I formulate and plan interventions within an ecological framework of psychological trauma which indicates that responses to trauma and recovery patterns are determined by multiple complex interactions between people, events and environmental factors (Harvey, 1996).

Consequently, as the researcher in this project, I adopted a social constructionist epistemological position because I felt that it best reflects my understanding of the impact of trauma as a systemic, rather than an individual issue, dependent on context. Social constructionism suggests that there is not one 'truth' and that what we think as 'true' is dependent on a specific period of time, culture, place and political context (Burr, 1995). Social constructionism also centres around the notion that meaning is constructed collectively in co-ordination with others rather than separately within each individual

(Leeds-Hurwitz, 2009). Therefore, I will be looking at the meaning that staff members have collectively made as they transition to a new way of working and the multiple levels of influence their conclusions are resulting from. Additionally, social constructionism assumes that our experience of the world is facilitated via culturally shared concepts (Harper, 2012). It would be interesting to see how a changing working culture has been shaping the experience of staff. I hope this will allow for valuable insights into the different aspects of a cultural change within an organization, which need to be considered for successful implementation outcomes.

As someone who has worked in inpatient units, I recognise the emotional and physical challenges that this line of work entails and believe that systemic changes are absolutely necessary and in line with my values of social justice and accountability as a mental health professional. Thus, it would be impossible to approach this project from a position of neutrality. Nevertheless, I aim to be honest and open about my own biases and assumptions via being self-reflexive throughout this project.

1.3 Key concepts

1.3.1 A Brief history of psychological trauma

"Psychological trauma is an affliction of the powerless. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning"

Judith Herman, Trauma and Recovery, 1992, p.33

Psychological trauma has been broadly defined as events or circumstances which are experienced as hurtful or life-threatening and that have lasting effects on the emotional, physical and/or social wellbeing of a person (SAMHSA, 2014). Trauma may include witnessing or experiencing a single event such as an accident or trauma may result from repeated exposure to extreme external events and circumstances such as ongoing abuse or torture (Terr, 1991).

There are three main points in most recent history that the concept of psychological trauma has entered public consciousness. The first point was the study of hysteria, a predominantly female psychological 'disorder', in the late nineteenth century (Herman, 1992). The second was shell shock or combat neurosis following the end of the First World war and later the Vietnam War (Herman, 1992). The third point in most recent history is the increasing awareness of sexual and domestic violence (Herman, 1992) following the emergence of the feminist movement. Despite the studies of psychological trauma for over a century, it was only in 1980 that post-traumatic stress disorder (PTSD) was introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association, 1980) and subsequently revised in the DSM-V in 2013 and ICD-10 (World Health Organisation, 1992).

In the DSM-5, PTSD comprises four distinct clusters of symptoms which include re-experiencing, avoidance, negative alterations in cognition and mood and alterations in arousal and reactivity which have to be present for at least a month following exposure to threatened or actual death, serious injury or sexual violence.

Elhers and Clark (2000) have proposed a cognitive model of PTSD in order to explain the clinical symptoms observed in some people following traumatic events. The model suggests that PTSD occurs when a person processes the traumatic event and/or its aftermath in a way that produces a sense of current threat (Elhers and Clark, 2000). When activated by a matching trigger the sense of current threat can be followed by intrusions and other re-experiencing symptoms, anxiety and other emotional responses. Additionally, Elhers and Clark (2000) suggested that the perceived current threat produces a series of behavioural and cognitive responses or coping mechanisms which intend to reduce the sense of threat and the distress experienced by the person. For example, people may drink excessive amounts of alcohol, self-harm to release tension or avoid talking about happened and avoid anything that could potentially remind them of the trauma. However, even though these mechanisms can be successful in reducing the anxiety and the distress in the short term, they tend to prevent cognitive change and thus maintaining the symptoms of PTSD in the long term (Elhers and Clark, 2000).

Judith Herman (1992) was one of the first mental health professionals who coined the term ‘complex PTSD’ in an attempt to emphasise that repeated, inescapable and overwhelming experiences can be found in the root of many adult mental health presentations.

Bessel Van der Kolk (2009) has added that children exposed to chronic traumatising events suffer from 'developmental trauma' as a consequence of these experiences. Complex PTSD is yet to be formally recognised by the DSM, but it formally entered the ICD-11 in 2018 and it is defined as:

"A disorder which arises after exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible. The disorder is characterised by the core symptoms of PTSD as well as the development of persistent and pervasive impairments in affective, self and relational functioning, including difficulties in emotion regulation, beliefs about oneself as diminished, defeated or worthless, and difficulties in sustaining relationships." (Maercker et al., 2013, p.200)

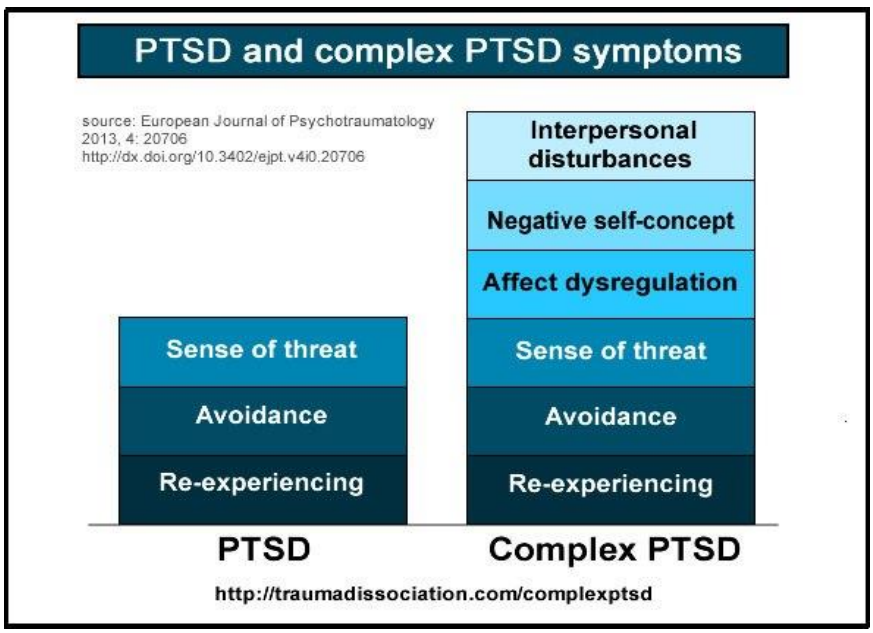


Figure 1: PTSD and Complex PTSD

Even though PTSD was a useful concept in describing the impact of psychological trauma at a behavioural and cognitive level, it was the concept of complex PTSD which has encapsulated the systemic effects and chronic adaptations to repeated and prolonged inescapable events (UKPTSD, 2017).

Research by Cloitre et al. (2014) and Karatzias et al. (2016) has provided evidence which suggests that complex PTSD is associated with exposure to childhood stressors and repeated traumatisation. Similar links have been found for adult victims of domestic violence or political torture (Herman, 1992; Ter Heide et al. 2016).

1.3.2 Prevalence of trauma in populations accessing mental health services

There has been growing recognition over the past few decades of the widespread pervasiveness of early traumatic experiences and their association with both physical health problems and psychological distress later in life (Edwards et al. 2003). The *Adverse Childhood Experiences* (ACE) study (Felliti et al. 1998) highlighted the association between the different types of maltreatment/abuse experienced early in life such as child abuse, parental substance abuse or domestic violence and adult health risk behaviours and a range of consequent mental health and medical conditions (Anda, 2007).

It has been demonstrated in research that people in contact with mental health services have experienced higher rates of interpersonal violence than the general population. Half of the people accessing mental health services had experienced physical abuse and more than one third had experienced sexual abuse in childhood which is significantly higher than the general population (Mauritz et al., 2013). In a study of adolescents in an acute psychiatric ward the rates of reported abuse were even higher (Lipschitz et al. 1999). The study indicated that 87% of adolescents reported physical abuse and 71% reported sexual abuse.
A third of those exposed to childhood traumatic experiences met PTSD criteria (Lipschitz et al. 1999). A link has also been demonstrated between substance abuse and PTSD among men and women with trauma histories (Keane & Wolfe, 1990).

In more recent years, research evidence has supported the link between the experience of trauma and increased likelihood of experiencing psychosis (Shevlin et al. 2008).

It is important to mention that the field of neuroscience has provided evidence for the link between trauma and neurological development. Perry (2005) demonstrated that trauma affects the developing brain of a child which subsequently affects the structure and function of an adult brain. The negative impact on neurological development implies that trauma survivors may respond to present situations that reproduce the experience of loss of power, choice, control and safety in ways that may appear excessive, when their history of trauma is not being considered (Sweeney et al. 2016).

Even though the ACE study has provided us with a link between individual risk factors and poor mental health outcomes, the original design of the study did not account for adverse events occurring in the community such as exposure to acts of racism or violence (Thurston et al.2018). However, several studies have demonstrated the link between exposure to community violence and racial discrimination and adverse outcomes such as depression, anxiety and PTSD symptoms (Burt et al. 2012; Fowler et al.2009; Priest et al. 2013).

Acknowledging that the original ACE study collected data mainly from white participants, Cronholm et al. (2015) expanded the ACEs to include adverse community risk factors such as racism, witnessing violence, bullying and being in foster care. The researchers presumed that given the racial and ethnic inequalities already existing in healthcare, these experiences may have already been impacting on health outcomes (Cronholm et al. 2015). The expanded study found that minority ethnic communities and lower income populations experience higher levels of adversity. Therefore, just relying on the original adverse childhood

experiences without considering the adverse community risk factors would considerably minimize the prevalence of trauma experienced by certain populations (Cronholm et al. 2015). An example of the compounding effect of individual and community risk factors is the overrepresentation of black people in the mental health system. It has been demonstrated that black people are more likely to experience negative pathways to care and to be over-diagnosed with psychotic disorders (Mohan et al. 2006). Unfortunately, despite the evidence social factors are rarely recognised as fundamental to poor mental health outcomes by clinicians or even service users themselves (Sweeney et al. 2016).

It is finally noteworthy to mention, that the *Adverse Childhood Experiences* (Felliti et al. 1998) study was carried out in the USA and the use of such studies in non-US populations is scarce. In the UK, Bellis et al. (2014) conducted the first ACE study on British soil. It was a retrospective cross-sectional survey of 1500 residents and 67 substance users aged between 18 and 70 years in a relatively deprived and ethnically diverse UK population. The key finding was that adverse childhood experiences contribute to poor health and social outcomes in a UK population. These adverse experiences were linked to involvement with violence, incarceration, inpatient hospital care, chronic health conditions and unemployment (Bellis et al. 2014). The authors also suggested a cyclic effect where those with greater exposure to adverse experiences in childhood were at higher risk of exposing their children to adverse childhood experiences.

1.3.3 Prevalence of trauma in populations accessing forensic services

Childhood trauma is reported as having high prevalence rates within forensic populations (Macinnes et al. 2016). Victims of several types of childhood abuse have been found to be at a greater risk of offending in adulthood (Avery et al.2002) and prolonged exposure to trauma in childhood has also been associated with increased risk of involvement with the criminal justice system (Rosenberg et al. 2011). In a study by Spitzer et al. (2006) it was reported that 69% of forensic populations have experienced physical abuse, 69% emotional abuse, 47% sexual abuse and finally 41% have experienced neglect in childhood.

Austin (2011) in her study with forensic inpatients in Scotland found that childhood traumatic experiences were very frequent with physical neglect being reported by 58% of her sample, followed by emotional neglect at 55%. Significant levels of physical abuse were reported by 46.4% of the participants while 44.6% reported emotional abuse and 28.6% reported sexual abuse. In a study by Macinnes et al. (2016) in Northern Ireland and Scotland they found very similar rates with sexual abuse being significantly higher at 46.9%.

The rates of co-morbidity associated with substance misuse, PTSD and having received a personality disorder diagnosis are also exceptionally high within forensic patients. It has been suggested (Read et al. 2009) that instead of seeing these as separate diagnoses, they should be seen instead as overlapping symptoms of abuse.

1.3.4 Retraumatisation in the mental health system

Retraumatisation is a term which refers to being traumatized again and it can happen when a person has an experience in the present which reminds them of a past traumatic experience (Sweeney et al. 2016).The current experience could potentially induce similar physiological and emotional reactions which are associated with the past experience (Sweeney et al. 2016). Hence, the concept of retraumatisation can also be understood via the cognitive model of PTSD as proposed by Elhers and Clark (2000) which postulated that matching triggers-events/circumstances associated with the past traumatic experiences-may create a sense of current threat and may lead to re-experiencing what happened in the past.

In the current mental health system, a service user's trauma history is rarely explored or conceptualised as the source of presenting problems (Butler et al. 2011). This may lead to a failure to fully understand the presenting issues and their context. Subsequently it may lead to a failure to recognise that some of the practices employed can work as matching triggers of traumatic events but also as traumatic events in their own right (Freuh et al. 2005).

It has been reported extensively that the operating principles of coercion and control, which are very frequently found within the mental health system, can inadvertently retraumatise service users (Freuh et al. 2005). In particular, the procedures employed historically by inpatient units, such as restraints, seclusions and body searches, may trigger trauma symptoms or reenactments of previous responses to trauma such as dissociations, flashbacks, withdrawal, aggression and self-harm (Butler et al. 2011). For example, restraining a service user who experienced sexual abuse in the past may mimic the force

used during the initial traumatic events. This may lead to panic symptoms, freezing or reinforcing feelings of shame. As a further result, the service users may constantly perceive the system as threatening and may reinforce the need for using unhelpful coping strategies such as self-harm or drug use (Sweeney et al. 2016).

Besides, there can also be implicit messages in the way that care is delivered that can also be triggering for a trauma survivor. For example, staff disregarding valid needs or requests as "attention-seeking" may indicate to service users that they don't matter. Over-emphasising compliance rather than collaboration sends messages of powerlessness. Finally, being excluded from treatment planning conveys messages of helplessness induced by trauma (Butler et al. 2011).

1.3.5 Impact on staff

There is growing recognition of the psychological impact on staff working in healthcare settings (Kurtz and Jeffcote, 2011). General mental health staff has reported high levels of stress in large scale questionnaire studies (Commission for Health Improvement, 2004). This may be even more so for staff working in forensic mental health services in which the clinical tasks have a background of tension between therapeutic activity and management of risk (Kurtz, 2007; Kurtz and Jeffcote, 2011).

Psychoanalytic organisational theory has tried to explain the particular challenges present in forensic settings by indicating that the contact with the distress of forensic patients is especially difficult with staff resorting to highly defended ways of dealing with it unless the working environment is very supportive and containing (Winnicott, 1949; Hinshelwood,

2004). Within the same psychoanalytic framework, a team dysfunctioning may be attributed to displacement and projection onto colleagues of what are unmanageable feelings towards the patients and clinical tasks (Kurtz et al. 2011). The independent influence of organisational difficulties should always be considered as well (Kurtz et al. 2011). Additionally, there is a potential in forensic mental health services for staff building up both conscious and unconscious anxiety by having to care for both vulnerable and challenging patients (Hinshelwood, 1993). Kurtz and Jeffcote (2011) in their study of experiences of forensic mental health staff have concluded that if there is no ongoing focus on how to help staff reflect on the difficulty of the task and in particular on the direct work with psychological distress in the face of organisational and social ambivalence towards this specific group of patients, staff will find ways of surviving which are less than adaptive and functional.

Consequently, if we want to use trauma theory in order to better understand the impact on staff, we may see that in order to cope with this amount of stress, staff members may 'shut down' in an attempt to survive and lose their ability to empathise and instead start viewing service users as the "other" (Sweeney et al. 2016).

A loss of sense of safety may result in someone becoming more authoritarian and directive (Harris & Fallot, 2001) which may be more prominent when services place a higher priority on risk management than human relationships (Sweeney et al. 2016). Overall, the impact of services which lack awareness of trauma on their workers could be analogous to the impact of trauma on service users- it could reshape and re-construct someone's identity and fragment individual meaning and purpose (Knight, 2015).

Bloom (2006) argues that many staff members could have also experienced traumas similar to those of service users therefore trauma un-informed organisations can be toxic for staff as well.

1.3.6 Towards trauma-informed approaches

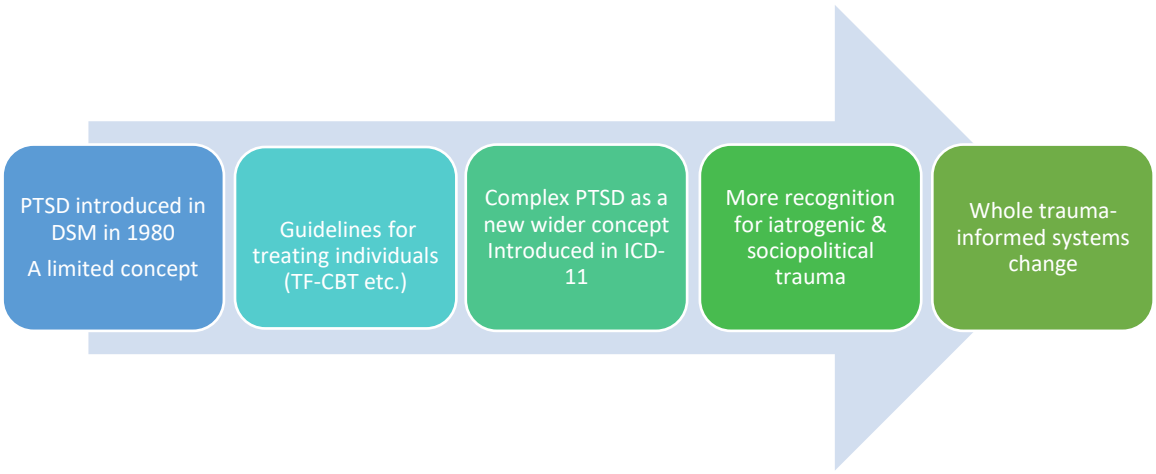


Figure 2: Towards trauma informed systems change

1.3.6.1 Therapeutic communities and the Sanctuary Model

The separation of therapeutic services from the daily environment of inpatient units and particularly forensic services has been a historic problem (Elwyn et al. 2017). It has been argued that an hour of a clinical psychotherapeutic intervention may promote growth and rehabilitation but may be counteracted by other many hours of interaction with other residents and direct care staff who are responsible for behaviour management which includes practices such as restraints and seclusions (Elwyn et al. 2017). As it has been already demonstrated, these kinds of interactions impact negatively on both staff and residents.

As early as the 1940s the concept of therapeutic communities, where every interaction involving every staff position in residential setting was designed to be therapeutic, was promoted. The term 'therapeutic communities' is a term coined by psycho-analytically inclined psychiatrist Tom Main and originated out of recognition of the potential value of using the therapeutic factors of a supportive and affirmative social climate (Shuker, 2010).

An example of a prison which opened as a therapeutic community was Grendon in the UK in the early 1960s where residents took responsibility within the treatment setting (Shuker, 2010).

In the 1980s, building on the concept of therapeutic communities, Sandra Bloom (1997) introduced the Sanctuary Model which outlines the steps for clinical and organisational change that promotes safety and recovery through the creation of a trauma-informed community. Bloom's (1997) premise was that since trauma deconstructs the social and personal world of the individual, the development of Sanctuary reconstructs and restores the social and personal world. The aim of the Sanctuary model is to guide an organisation in the development of a culture with seven dominant characteristics: Culture of Nonviolence; culture of emotional intelligence; culture of social learning; culture of shared governance; culture of open communication; culture of social responsibility; and culture of growth and change (Bloom, 1997). As a whole system approach, it requires strong leadership involvement during the process of change and service user involvement at every level (Farragher and Yanosy, 2005).

In 2001, Harris and Fallot, published their seminal work '*Using Trauma Theory to design service systems'* which has influenced the development of trauma-informed organisations since then. A trauma informed approach can be defined as "a system development model

that is grounded in and directed by a complete understanding of how trauma exposure affects service users neurological, biological, psychological, and social development" (Patterson, 2014). Therefore, on one hand being trauma informed means to have knowledge of service users' history of trauma and its impact and on the other hand to utilise this knowledge to design service systems which accommodate service users' vulnerabilities while allowing them to actively participate in their treatment (Harris and Fallot, 2001).

It is important to make the distinction between trauma-specific and trauma-informed services. A trauma-specific service has been designed to provide therapeutic input to help trauma survivors with symptoms of traumatic experiences such as dissociations, flashbacks etc. by providing trauma focused therapies such as trauma-focused CBT or Narrative exposure therapy. On the contrary, a trauma-informed service, regardless of its primary aim-to provide therapy, housing support, help with addictions, or even a primary care service such as a GP practice- its commitment is to provide services which are appropriate to the survivors of violence and victimization by taking into account their histories and how these may play out in their contact with the service (Harris and Fallot, 2001).

Becoming trauma informed has implications for the practitioners and the organisation in which care is provided (Butler et al. 2011). At an organisational level, an update of all aspects of the organisation's functioning is essential. This includes reviews of organisational policy and procedures, education and training about trauma for all staff and universal screening of all service users for trauma histories.

"*To provide trauma-informed services, all staff of an organisation, from the receptionist to the direct care staff to the board of directors, must understand how violence impacts the lives of people being served, so that every interaction is consistent with the recovery process and reduces the possibility of retraumatisation" (Elliot et al. 2005, p.462).*

Table 1: The Key Principles of Trauma Informed approaches	
1.Recognition	Recognise the prevalence, signs and impact of trauma. Routine enquiry about trauma sensitively asked and appropriately timed. It can create feelings of validation, safety and hope.
2.Resist Re-traumatisation	Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can retraumatise survivors and staff. Take steps to eliminate re-traumatisation.
3. Cultural, Historical and gender contexts	Acknowledge community specific trauma and its impact. Ensure services are culturally and gender appropriate. Recognise the impact of interesectionalities and the healing potential of communities and relationships.
4. Trustworthiness and transparency	Decisions taken, organisational and individual, are open and transparent with the aim of building trust. Essential to building relationships with survivors who may have experienced secrecy and betrayal.
5. Collaboration and mutuality	Understand the inherent power imbalance between staff and survivors and ensure that relationships are based on mutuality, respect, trust, connection and hope. This is critical since abuse of power is inherent in traumatic experiences, often leading to feelings of disconnection and hopelessness. It is through relationships that healing can occur.
6. Empowerment, choice and control	Adopt strengths-based approaches with survivors supported to take control of their lives and develop self-advocacy. This is vital as trauma experiences are often characterised by lack of control with long term feelings of disempowerment.
7. Safety	Trauma engenders feelings of danger. Give priority to ensuring that everyone within services feels and is, emotionally and physically safe. Environments must be physically, psychologically, socially, morally and culturally safe.
8. Survivor partnerships	Understand that peer support and co-production of services are integral to trauma-informed organisations.
9. Pathways to trauma specific care	Survivors should be supported to access appropriate trauma-specific care where this is desired. Such services should be provided by mental health services and be well resourced.

(Table taken from Sweeney et al. (2016) p. 178)

The research evidence we have so far, has demonstrated that a trauma-informed approach has several benefits including: decreased use of restraints and seclusion (Azeem et al. 2011), increased service user satisfaction and staff proficiency and competency (Brown et al. 2012) and decreased stress, increased empathy and increased confidence in staff working with individuals with behaviour that challenges (Greenwald et al. 2008).

1.3.6.2 Trauma informed approaches in the UK

TIAs have mainly been developed in the USA. In 2005 the United States Federal Substance Abuse and Mental Health Services Administration (SAMHSA) established a National Centre for Trauma-Informed Care (Sweeney et al. 2016) and up until recently the USA was the only nation to have national policy relating to trauma. However, TIAs have begun reaching the UK.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) which is a mental health provider in the North of England has embarked on a program to develop trauma-informed services throughout its adult division (Sweeney et al. 2016). It has developed a pathway of care and a staff training programme to implement the pathway. The pilot project on an acute mental health ward included all staff from senior medics to health care assistants. It was found that three quarters of the people admitted were able to link their current difficulties to trauma (Sweeney et al. 2016) while 80% had substance misuse issues and reported self-harming. Staff working on the ward reported that they felt more equipped to have discussions about trauma and subsequently to develop formulation-based care plans which led to reduction of PRN medication use (Sweeney et al. 2016).

Another example of trauma informed care being implemented in the UK is the Drayton Park Women's Crisis House and Resource Centre which was established in 1995 by Shirley McNicholas and offers an alternative to admission for women in mental health crisis and trauma informed services. Some of the trauma-informed principles include a.) Involving women who have used services in the design, functions of the service while creating an on-going system for feedback, b.) Embedding a culture of acknowledging the social and political

context of women's lives and c.) The service works as if every woman they meet has been traumatized and therefore routine enquiry is essential.

In terms of policy development, NHS Education Scotland (NES) was commissioned to develop the "Transforming Psychological Trauma: A knowledge and skills Framework for the Scottish workforce" as part of the Scottish Government's commitment to developing a National Trauma Training strategy. The training strategy has the goal of "providing guidance and outlining the steps that can be undertaken within and across organisations, services and agencies to develop, commission and embed the use of high-quality trauma training. The Trauma Training Plan also proposes organisational and leadership structures which are likely to support the development of a trauma-informed workforce." (NES, 2019). Finally, NHS England (2018) has outlined its strategic direction for working with victims of sexual abuse and highlighted the need for services to be trauma informed by making explicit the links between trauma and mental health.

1.3.6.3 Potential pitfalls of the notions of trauma and trauma informed approaches

It would be important to acknowledge that as with any kind of paradigm shift in the understanding of mental health distress or in the way that services are organised and delivered, we will need to proceed with cautiousness. Attempting to replace one system such as the biomedical illness model with trauma-only explanations could be quite concerning for a number of reasons (Sweeney and Taggart, 2018).

An over-emphasis on the relationship between trauma and mental health distress may lead to the misconception that all service users have experienced trauma and could potentially position them primarily as victims (Sweeney and Taggart, 2018). Therefore, instead of imposing one-size fits all explanations, trauma informed approaches will need to allow service users to develop their own narratives (Fassin and Rechtman, 2007).

The most up-to-date understanding of trauma and complex trauma which also underpinned the development of trauma informed approaches has been based on recent developments in the field of neuroscience (Van der Kolk et al. 2005). This understanding though could potentially lead to a new way of medicalising human responses to traumatic events (Wastell and White, 2017) and subsequently maintain the dominant "brain-illness" paradigm by limiting the influence of psychosocial factors (Cromby et al. 2016). This discourse has been particularly prominent around the use of the Adverse Childhood experiences study (Felliti et al. 1998) as a framework of understanding both physical and mental health outcomes later in life. Even though the ACEs has provided useful evidence for population level or structural policies, it can be an insufficient tool for individual implementation by services (Kelly-Irving and Delpierre, 2019) which can be stigmatising for service users. An example of using the ACEs for diagnostic purposes is the use of the original ACEs questionnaire in order to calculate an ACE score for an individual. Using the questionnaire in this way has posed a lot of ethical questions for the services which promote this use. Individualising the problem could potentially take a deterministic form and put the responsibility back to the individual to act instead of promoting systems change (Kelly-Irving and Delpierre, 2019).

Finally, similarly to the recovery movement (Harper and Speed, 2013) trauma informed approaches come with an agenda of deeply reforming our understanding of mental health distress, and of redistributing power and responsibility within services. Thus, there is a risk of co-option and traditional care models being rebranded as trauma-informed (Sweeney and Taggart, 2018). Therefore, any service being rebranded as trauma-informed will need to do that through actively making real systemic changes and being very transparent about the process.

1.3.7 Organisational culture and change

Organisational culture, refers to the values and behaviours that contribute to the social and psychological environment of a service. It represents the beliefs and principles of staff members (Ravasi & Schultz, 2006). The organisational culture impacts on how people interact, how they create meaning about what they do and how they receive change therefore it has considerable implications for both staff and those receiving services (Keesler, 2016). In order to effect change within an organisation, it is paramount to understand its current culture and the shifts needed to make successful changes (Damschroder et al. 2009).

In terms of moving towards a Trauma Informed service, Harris and Fallot (2009) developed a self-assessment and planning protocol which can support an organisation's implementation of trauma informed care. If the principles of trauma informed care are reflected in the culture of an organisation for example in the environment, relationships and activity for service users and staff then the organisation can be called trauma informed (Harris & Fallot, 2009).

Table 2: Harris and Fallot's key steps for implementing TIA in an organisation	
Key Step	**Activity**
Planning	Including leadership commitment, formation of trauma work group to lead and oversee change and the identification of a trauma champion
An initial training event	For as many staff as possible plus service users, encompassing the principles and practice of TIA, care and support for staff, trauma work in the organisation, future directions and implementation
Short-term Follow up	The trauma workgroup develops and implements the plan using the protocol and further training is provided to staff
Long-term follow up	Progress is reviewed including barriers to implementation. Ongoing processes are implemented such as TIA questions in service user experience surveys and implementation plans added to quality assurance processes

(Table taken from Sweeney et al. 2016 p. 186)

1.4 A systematic literature review on Trauma informed approaches implementation within forensic environments

So far, it has been demonstrated that a trauma informed care approach can be potentially beneficial for both staff and service users. Trauma informed approaches were developed with inpatient units in mind and the particular need to reduce coercive and restrictive practices such as restraints and seclusion. In a recent review of the literature which focused on the implementation of trauma informed care in inpatient units, it was found that effective trauma-informed services were the ones where staff were aware and sensitive to doing no further harm to survivors (Muskett, 2014). Therefore, services are not designed to just treat symptoms of trauma but to promote the enabling nature of the nurse-client relationship and client-centred care (Muskett, 2014).

Implementing a trauma informed care approach in a forensic residential environment may be of particular interest given firstly the higher prevalence of trauma in forensic populations and secondly the added pressures on staff. Therefore, a systematic review of the literature was conducted with the aim of finding out how trauma informed approaches have been implemented within forensic environments and what the outcomes for both service users and staff members were.

1.4.1 Search strategy

The search strategy aimed to identify papers which investigated the implementation of a trauma informed approach within forensic residential environments ranging from low secure to high secure settings internationally. Given the lack of literature on TIC, this review looked at research which reported outcomes of trauma informed approaches for both service users and/or staff members working in forensic environments. Particular attention was paid to approaches which explicitly recognise the impact of trauma and used trauma theory within the interventions. The literature review was carried out from January 2019 to February 2019. The search terms were identified after searching the literature around implementation efforts of trauma informed approaches and following consultation with my supervisors. Details of the search process in each of the databases used can be found in Appendix 1, and a summary of these terms can be found in Table 3 below. Additionally, an overview of the inclusion and exclusion criteria can be found in Table 4. An in-depth presentation of the systematic review process can be found in Appendix 2.

Table 3: Search terms for systematic review

Search Terms		
Trauma-informed AND *Care* OR *Practice* *OR* *Sanctuary AND model*	*Forensic* OR *Correctional* OR *Offend** OR *Prison* AND	*Staff* OR *Service* Use**

Table 4: Inclusion and Exclusion criteria

Inclusion Criteria	Exclusion criteria
Inpatient /residential forensic environments	*Outpatient or community forensic services*
Adult and adolescent forensic environments	*Research on prevalence of trauma in forensic populations or prevalence of trauma on staff working in forensic environments*
Research involving staff training and/or a trauma informed intervention with service users	*Research on just trauma-focused direct clinical interventions with forensic populations such as TF-CBT or EMDR*
Research involving outcomes of trauma informed approaches for staff and/or service users	*Research referring to trauma informed care as an implication*
Male and female forensic populations	
Research papers in English	
Grey literature	

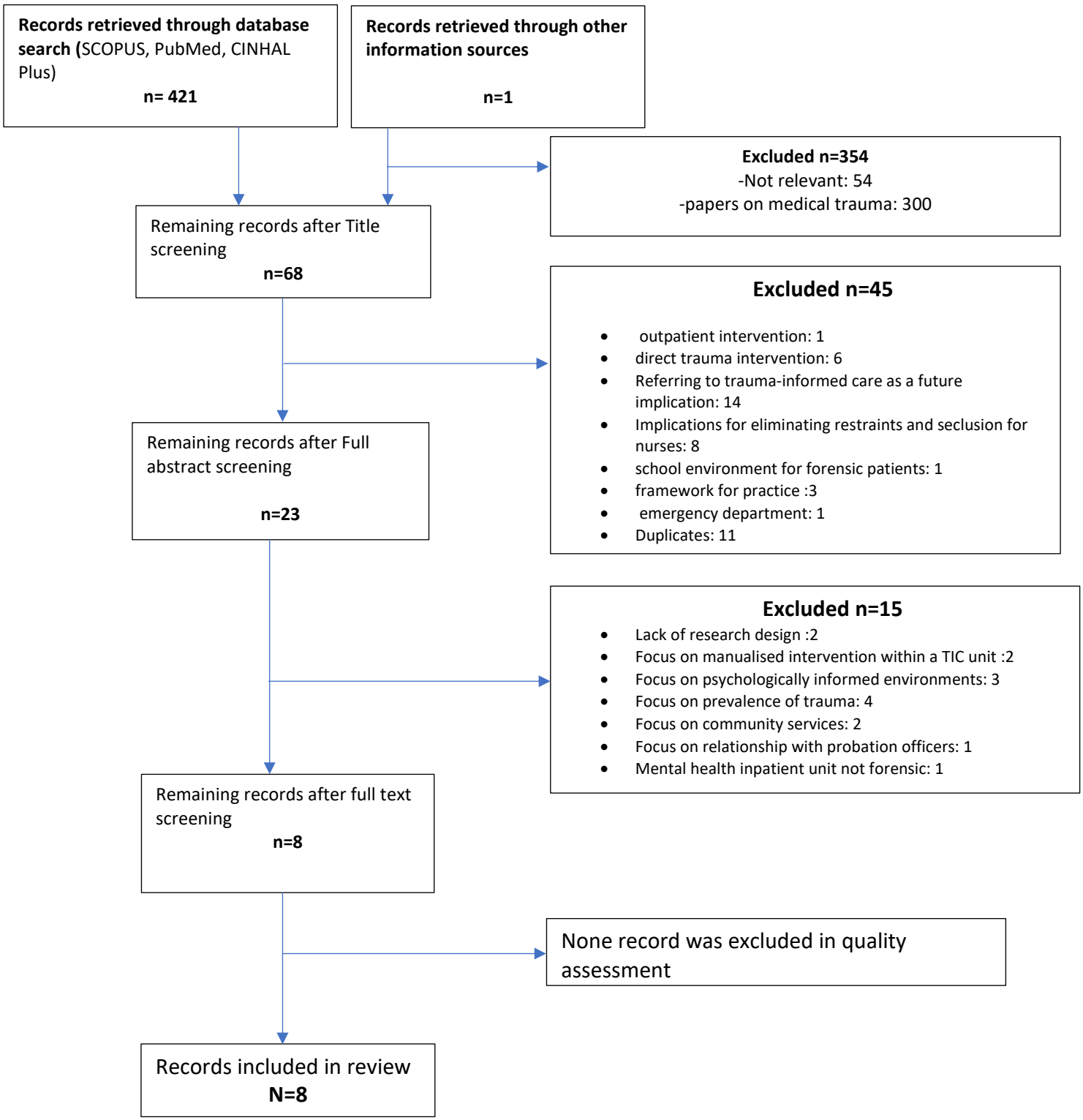

Records retrieved through database search (SCOPUS, PubMed, CINHAL Plus)
n= 421
Records retrieved through other information sources
n=1
Excluded n=354
-Not relevant: 54
-papers on medical trauma: 300
Remaining records after Title screening
n=68
Excluded n=45
outpatient intervention: 1
direct trauma intervention: 6
Referring to trauma-informed care as a future implication: 14
Implications for eliminating restraints and seclusion for nurses: 8
school environment for forensic patients: 1
framework for practice :3
emergency department: 1
Duplicates: 11
Remaining records after Full abstract screening
n=23
Excluded n=15
Lack of research design :2
Focus on manualised intervention within a TIC unit :2
Focus on psychologically informed environments: 3
Focus on prevalence of trauma: 4
Focus on community services: 2
Focus on relationship with probation officers: 1
Mental health inpatient unit not forensic: 1
Remaining records after full text screening
n=8
None record was excluded in quality assessment
Records included in review
N=8

Table 5: Summary and evaluation of records included in the review

Title and Location	Participants and Aims	Research Methodology	Key Findings and Implications	Strengths and Limitations
Kubiak et al. 2014 **Assessing the feasibility and fidelity of an intervention for women with violent offenses.** **Michigan, USA**	*Participants:* Three groups of women offenders who have committed violent crimes including women with life sentences (n=13, n=10 and n=12) *Aims:* To assess the feasibility and fidelity of a trauma informed and gender responsive intervention for women offenders. The intervention has a goal of preventing violent perpetration within the institution and later in the community.	*Data Collection* Mixed methods data collection including participant and facilitator surveys and focus groups. *Data analysis* Descriptive statistics and thematic analysis	*Key Findings* Overall feasibility of implementing the programme within an institutional setting is high. High attendance rates with 90% of women completing 19 out of 20 sessions. High rates of satisfaction about participating in the programme by both participants and facilitators. The environment felt safe.	*Strengths* Study drew attention to a population of women who are usually marginalised within the forensic system. Design recognises the different needs of women in the justice system. Mixed methods led to richer results and gave the opportunity to the women to give feedback on the implementation of the intervention. Positive results increase the likelihood of dissemination to different settings. Surveys included staff as well.
			Implications Women with violent offense histories lack treatment or rehabilitation programmes that meet their unique needs. Important to think about long term accounts of these kind of interventions. Scope for randomised control trials.	*Limitations* Study accounted only for short term outcomes. No control groups. Maybe difficult to generalise results given the small proportion of women being convicted of violent offenses.

Olafson et al. 2018 **Implementing trauma and grief component therapy for adolescents and Think Trauma for traumatised youth in Secure Juvenile Justice settings.** **Ohio, USA**	<u>Participants</u> 142 Service users both male and female of six juvenile justice residential facilities. Trauma focused group treatment coupled with trauma-informed staff training <u>Aims:</u> To determine1. if trauma informed interventions can be implemented in complex juvenile justice systems 2. If they contribute to reduced incident reports 3. Do they reduce PTSD symptoms in young people	<u>Data Collection</u> Pre and post assessment questionnaires were administered to each participant. The measures were *The Trauma Symptom checklist for children (TSCC), The UCLA posttraumatic stress disorder research index* and *The Adolescent dissociative experiences scale (ADES)*. 69 complete and valid pre- and post-assessment packets were analysed. Finally, incident reports were also collected. <u>Data analysis</u> Statistical analyses using SPSS 22, *t* tests and two-way ANOVAs were performed on continuous data. McNemar's nonparametric exact tests were applied to determine difference for dichotomous dependent variables.	<u>Key Findings</u> It was possible to implement the TI practices in complex juvenile justice systems. Significant decrease in trauma related symptoms. Facilities with higher incident reports experienced large reductions. The study observed positive outcomes which were beyond the scope of the initial design including staff attitude changes and the intervention becoming self-sustaining in all facilities.	<u>Strengths</u> Large number of facilities participating.
			<u>Implications</u> Increases in incident report during staff turnover highlights the importance of providing immediate in-house training for new staff. The group processing of trauma narratives proved to be key component in building group cohesion and harnessing peer relationships for support. Future implications for a matched control group could help determine whether the standard care in juvenile justice settings results in reduction of trauma symptoms.	<u>Limitations</u> Post group assessments were not completed by 73 participants (51.4% of the sample). The sample of female adolescents was very small (n=11) therefore the effectiveness of the programme cannot be determined. Participants were not selected randomly and may differ from the larger juvenile justice population. Variables such as total length of time spent in the facility and in the treatment group have not been accounted for and may have contributed to the result. Incident reports for youth who took part in groups were not tabulated separately from facility-wide incident report data.

Messina et al. 2014 **Trauma Informed Treatment decreases Posttraumatic stress disorder among female offenders.** **Los Angeles, USA.**	*Participants:* Women offenders in gender responsive and trauma informed services were compared to women in non-gender responsive treatment in regard to their change in trauma symptoms. *Aims:* This study combined data from two previous studies of women offenders in order to provide greater statistical power in examining the trends found in the individual studies.	*Data Collection:* Data collected between 2007 and 2011 as part of an experimental pilot study and a demonstration project for women offenders primarily assessing reductions in drug use and recidivism. Both studies were on programmes which followed principles of gender-responsive and trauma informed curricula. *Data Analysis*: Hypothesis was tested at the .05 significance level using a two-tailed test. T tests were used to compare the GRT group and the non-GRT group. Chi-square analysis was used for between subjects' comparisons using categorical and binary variables. A GEE model for repeated measures approach was used to consider changes over time.	*Key Findings* The between group comparisons of trauma and related symptoms indicated that the two groups were similar at baseline. However, comparisons at follow up indicated significant differences for each of the measures of trauma symptoms between the groups. It is possible that the gender responsive and trauma informed protocol created a safe environment for women to explore their symptoms. The educational part of trauma informed services such as understanding one 's trauma and the impact on behaviour and emotion regulation may have been the most beneficial.	*Strengths* The combined sample allowed allows to examine with greater statistical power the trends found in the individual studies relating to PTSD symptoms. Pooling the samples also resulted in a more diverse sample of women offenders in terms of level of criminal history, ethnicity and other demographic features. The combined sample also provides diversity in types of criminal justice setting and treatment programme length. For the purposes of this study the dichotomous PTSD variable allowed the examination of the effectiveness of the gender responsive treatment in eliminating PTSD symptoms.
			Implications The strong relationship between substance abuse and PTSD symptoms in response to trauma among women offenders further supports the need for integrated treatment. The gender responsive element of the trauma informed approach furthers the debate surrounding appropriate services for women offenders and the need for programmes specifically designed to meet women's needs.	*Limitations* Generalisability is potentially limited by conditions that are unique to the California context including the higher prevalence of methamphetamine use and the availability of a range of treatment options within the criminal justice system. The non-GRT group was a combination of treatment-as-usual group and a no-treatment group thus differences in measured outcomes between groups were possibly minimised due to the fact that half of the women in the comparison group received at a minimum the standard of care in the community. The study used a dichotomous indicator of PTSD diagnosis that did not completely capture the range of clinical presentations

			Both past trauma exposure and subsequent retraumatisation need to be addressed as well.	that could manifest.
Elwyn et al. 2015 **Safety at a girls' secure juvenile justice facility. New York, USA.**	*Participants:* Staff and residents of a female secure juvenile residential facility *Aim*: To explore whether implementation of a trauma-informed intervention that aims to change the therapeutic stand of the organisation, the Sanctuary Model, corresponded with improved indicators of physical and psychological safety of staff and residents of a secure juvenile forensic facility.	*Data collection*: Administrative and performance-based standards data routinely collected at the facility. These included demographic data and 12 measures of safety and perceived safety such as incidents of youth misconduct, physical restraints, injuries to youth, injuries to staff, assaults on staff etc. *Data analysis* Descriptive statistics	*Key findings* The facility was a safer place for both residents and staff after implementation of the model. Out of the 12 measures of safety and perception of safety for youth and staff the data showed statistically significant and generally substantial improvement on eight of them. Findings consistent with the major focus of the model to make organisational cultures safer. Its safety indicators also compare favourably to those of the juvenile justice system in general.	*Strengths* The first study to examine the impact of a structured trauma-informed organisational change intervention on staff and residents in a secure juvenile forensic facility. Data covering the whole four years of implementation. Measures for both staff and residents.
			Implications Implementation of trauma informed models that target organisational culture may be a fruitful approach for creating safer and more therapeutic environments in juvenile justice systems and even more generally. Focusing on change in organisational climate and culture to create an environment that promotes change and growth in juveniles rather than just specific clinical treatments alone deserves renewed attention by practitioners	*Limitations* Safety and demographic measures were provided in aggregate format, lacked desirable detail and were available only at two months during a given year. Lack of a comparable field group of girls' facilities to provide a more accurate comparison analysis. Difficult to separate the impact of other concurrent changes in the facility and be clear what brought about improvement in the measures. Did not account for any changes in mental health presentations of residents such as trauma symptoms.

			and administrators.	
McEvedy et al. 2017 Sensory modulation and trauma informed care knowledge transfer and translation in mental health services in Victoria: Evaluation of a state-wide train-the-trainer interventions. Victoria, New Zealand.	*Participants* Staff members of 19 mental health services in Victoria including forensic inpatients. *Aim* The study aimed to evaluate the effectiveness of a trauma informed intervention focusing on transfer of knowledge and translating knowledge into practice for staff. The focus was on equipping trainees with knowledge and confidence to educate nursing , medical and allied health colleagues upon return to their services.	*Data Collection* Semi-structured interviews with senior staff (n=21) focus groups discussions with trainees (n=10) one paired in-depth interview with master trainers (n=2). *Data Analysis* Content analysis.	*Key Findings* Through this intervention knowledge of TIC was transferred to a substantial number of mental health service staff. Most services facilitated further knowledge transfer to end-user clinicians. *Implications* Ongoing support is required to maintain a focus on SM and TIC, sustain and encourage further knowledge transfer and translation, and assess the impact on consumer and staff health outcomes. Further research could include a staff survey and to review service policies, procedures, job descriptions regarding TIC would be useful. Since reducing restrictive practices in mental health care is an important issue in mental health nursing it was recommended that TIC should be addressed in undergraduate and postgraduate nurse education to support and promote this improvement in the delivery of mental health care.	*Strengths* All mental health services across Victoria were invited and agreed to participate. Used a variety of qualitative methods to collect data. Multi-disciplinary development of the intervention and collaborative dissemination *Limitations* Given that 140 participated in the training a relatively small proportion participated in focus groups therefore their views may not be representative of all trainees. Limited anecdotal evidence of translation TIC into practice was provided. The study was not focusing just on forensic services, but forensic services were included therefore this is a borderline study in regard to this systematic review. The study did not capture any quantitative data regarding the extent of knowledge of TIC translation or the impact of implementation of TIC.

Elwyn et al. 2017 **Importance of leadership and employee engagement in trauma-informed organisational change at a girls' juvenile justice facility. New York, USA**	*Participants:* Staff members working at a secure female adolescent unit in Pennsylvania. *Aim* To explore the process of implementation of the Sanctuary model over a four-year period	*Data Collection:* Semi-structured interviews and focus groups with a cross-section of staff (n=17; 45%) including youth development aides, aide supervisors, counsellors, and clinical, community transition and nursing staff were carried out on the premises by two researchers. Key informant interviews included the campus director and one manager of the programme. Staff have been in the facility for an average of four years. The interview protocol asked about implementation of the model and impressions of changes in youth outcomes. *Data analysis:* Thematic analysis.	*Key Findings* Substantive improvements including physical and psychological safety; staff morale; accountability and attitudes towards their work; the relationships of staff members with administrators, other staff and residents. Climate in the facility changed from negative and chaotic to resolving problems and conflict openly. Most importantly study concluded that it was not just the implementation of the model that changed the culture in the facility but the combination of the introduction of the model with investment in leadership and staff and residents buy-in. *Implications* Important finding for field of implementation science which point to the importance of evaluating key intervention components and also implementation issues such as organisational context, readiness and facilitative administration. Increasing the uptake of evidence-based practices will also depend on implementation interventions that	*Strengths* Explored a four-year period of implementation not just a point in time. Most participants had substantial experience of working in the facility prior to the implementation of the model and during the implementation. Although changes can be linked to the model there were other environmental changes happening occurring at the same time that are hard to separate from model implementation. Therefore, the researchers endeavoured to investigate further before reporting results in order to examine all variables. Good cross section of staff participating. *Limitations* Only descriptive data and retrospective. Staff members interviewed not necessarily representative of all staff. Data collected originally to address slightly different questions. Small unit may not be able to generalise.

			focus on improving climate and culture.	
Kramer, M.G. 2016 Sanctuary in a residential treatment centre: Creating a therapeutic community of hope countering violence. Pennsylvania, USA.	*Participants* Staff members and residents of a male adolescent forensic residential facility. *Aim*: To explore how this forensic residential facility implemented and utilised an organisational change and treatment trauma informed protocol over a three years' time period called the sanctuary model	*Data Collection via*: Observations of groups and meetings, quantitative data, focus groups with staff members and residents and individual interviews with staff. *Data Analysis:* Content analysis for observations of groups, agency documents, meetings and existing quantitative data. Grounded theory for focus groups and interviews.	*Key Findings* Sanctuary model decreases the symptoms of complex trauma. Recovery occurs as shaped first by the therapeutic community that supports the level of interpersonal relationships experienced with staff along with shaping the organisational culture. Decreases in all forms of violence including reduced restraints and increases in all forms of safety for staff and residents. *Implications* Implications for future research how to continue enhancing staff-resident relational integration vis-à-vis staff training and finding ways to offer residents more of a representative voice while on placement. Long term research is needed to capture long term effects of the model and how it develops in time	*Strengths* Incorporated a variety of data collection methods such as individual interviews, focus groups, observations etc. Data collected from both staff and residents. Used qualitative methods to explore in depth how and why the model contributes to its working in a residential forensic facility. *Limitations* The implementation of trauma-informed care is a complex intervention which cannot be reduced to its components and as such it cannot fully be understood by observing it at single points in time. This study offers a snapshot in time. The study offers weak representational power of the resident population with only 10% of the residents participating in the project.

Service evaluation of forensic inpatient unit in the UK	Participants: Staff and service users of a female secure ward Aim: To evaluate the implementation of trauma informed approach within a female forensic inpatient unit	Data Collection: Via routinely collected measures on the ward Data Analysis: Descriptive statistics	Key Findings: Reduction in incidents Better environment on the ward Increased job satisfaction for staff	Strengths: First known evaluation of trauma informed care in a forensic ward in the UK Included both staff and residents
			Implications: For further piloting of trauma informed care on all forensic wards in the unit	Limitations: Local report for use by the service Used only quantitative measures therefore may lack detail

1.4.2 Summary of records selected

Seven peer reviewed studies and a relevant service evaluation report which was sent to the author of this project were included in the systematic review. One was a mixed methods study (Kubiak et al. 2017), three were quantitative (Messina et al. 2014; Elwyn et al. 2015; Olafson et al. 2018), and three were qualitative (McEvedy et al. 2017; Elwyn et al. 2017; Kramer, 2016). The service evaluation was an internal report produced at one of the female forensic inpatient wards where this project later took place. The evaluation took place six months after transitioning to a trauma-informed care model therefore it is highly relevant to this review. In line with systematic review guidelines by Siddaway, Wood and Hedges (in press), the strengths and limitations of each study were considered using the relevant quality criteria. These were: The Critical Appraisal Skills Programme (CASP, 2017) for the quantitative studies, the Mixed Methods Appraisal Tool (Pluye et al. 2011) for the mixed methods study, and the Eight "Big-Tent" Criteria for Excellent Qualitative Research (Tracy, 2010) for the qualitative studies. An assessment of the quality standards of all papers can be found in Appendix 3, 4 and 5.

The literature presented and critiqued below was divided into subsections in order to create a coherent narrative throughout (Baumeister & Leary, 1997). The decision on how to group the studies was broadly informed by the research question taking a scaffolding approach starting from studies presenting outcomes for individuals either staff and/or service users and building this up to research reporting on changes at an organisational level.

Therefore, this section will begin by reviewing literature on trauma informed care implemented in forensic environments reporting on the impact of trauma informed care interventions on service users and staff, followed by studies which looked into the feasibility of implementing trauma informed care principles within forensic systems. Finally, the studies which reported on implementation of the model with a focus on organisational change will be presented and critiqued.

1.4.3 Research exploring the impact of trauma informed approaches on service users and/or staff in forensic settings

There were two studies and a service evaluation which reported outcomes of implementing a trauma informed approach on service users and/or staff in forensic settings (Messina et al. 2014; Elwyn et al. 2015, Robinson et al. 2018).

The first study used a quantitative design and combined data from two previous studies of women offenders in order to provide greater statistical power in examining the trends found in the individual studies (Messina et al. 2014). The studies on which this research was based were both carried out in the USA.

Messina et al. (2014) collected data between 2007 and 2011 as part of an experimental pilot study and a demonstration project for women offenders primarily assessing for reductions in drug use and recidivism. Both studies were on programmes which followed principles of gender-responsive and trauma informed curricula. Both studies involved a control group.

The researchers reported that even though at baseline the intervention and control groups were similar, comparisons at follow up indicated significant differences for each of the measures of trauma symptoms. Messina et al. (2014) suggested that the trauma informed gender responsive protocol created a safer environment for women to explore their symptoms and that the educational part of trauma informed services, such as understanding the impact of trauma, may have been the most beneficial.

The study reported a relationship between substance abuse and trauma for female offenders, which further supports the need for integrated treatment within trauma informed services. Additionally, the gender responsive element of the approach supports the need for programmes specifically designed for women's needs. Finally, Messina et al. (2014) suggested that both past trauma exposure and subsequent retraumatisation within forensic systems need to be addressed by trauma informed forensic services. The combined sample provided a more diverse sample of women offenders in terms of level of criminal history, ethnicity and other demographic features. It also provided diversity in types of criminal justice setting and treatment programme length.

However, the generalizability of the study may be limited by conditions that are unique to the USA context including the higher prevalence of methamphetamine use and the availability of a range of treatment options within the forensic system. Moreover, the control groups were a combination of treatment-as-usual and a no-treatment group thus the differences in measured outcomes were possibly minimized due to the fact half of the women received at least the standard of care in the community. Finally, a dichotomous indicator of PTSD was used which did not completely capture the range of presentations that could manifest.

Elwyn et al. (2015) recruited both staff and residents of a female secure juvenile residential facility in order to explore whether the implementation of a trauma informed intervention which aimed to change the therapeutic stand of the organisation led to improved indicators of physical and psychological safety of staff and residents.

The study employed a quantitative design and collected data via administrative and performance-based standards routinely collected at the facility. These included demographic data and 12 measures of safety and perceived safety such as incidents of youth misconduct, physical restraints, injuries to youth, injuries to staff and assaults on staff. Descriptive statistics were used to report the results.

The key finding was that the facility was a safer place for both residents and staff after the implementation of the model. Out of the 12 measures of safety and perception of safety for youth and staff the data showed improvement on eight of them. This key finding is consistent with the major focus of the trauma informed model to make organisational cultures safer.

This was the first study to examine the impact of a structured trauma-informed organisational change intervention on staff and residents in a secure juvenile forensic facility. The researchers suggested that the implementation of trauma informed models that target organisational culture may be a fruitful approach for creating safer and more therapeutic environments in juvenile justice systems and even more generally. Therefore, focusing on change in organisational climate and culture to create an environment that promotes change and growth in young offenders rather than just specific clinical treatments alone deserves renewed attention by practitioners and administrators.

The study also reported limitations. The safety and demographic measures were provided in aggregate format, lacked desirable detail and were available only at two months during a given year. Also, there was a lack of a comparable field group of girls' facilities to provide a more accurate comparison analysis. Moreover, it was difficult to separate the impact of other concurrent changes in the facility and be clear what brought about improvement in the measures. Finally, the study did not account for any changes in the mental health presentations of residents such as trauma symptoms.

The service evaluation took place when a trauma-informed approach was piloted within a female forensic mental health ward in the UK. Baseline outcome measures were collected, and implementation of the trauma-informed approach began in March 2018. The approach was implemented via staff training on the impact of trauma and on skills in crisis intervention, via the development of safety plans with service users, via the introduction of Core sessions of art, emotion regulation, and mindfulness for service users and the introduction of one-to-one debrief sessions for both staff and service users following incidents of seclusion, self-harm or restraint.

Midpoint evaluation data was collected at the three-month point in June and end point data was collected at the six-month point in September 2018. The outcome measures completed by service users included The SWEMWBS which is a short version of the Warwick–Edinburgh Mental Well-being Scale (WEMWBS) and The Essen Climate Evaluation Schema (Schalast et al., 2008) which is a 15-item well-validated and reliable questionnaire developed for forensic wards, which measures three aspects of a ward's social climate; a) therapeutic hold, b) patient cohesion and mutual support and c) experienced safety vs. the threat of

aggression or violence (Schalast & Tonkin, 2016). Staff members completed The Professional Quality of Life: Compassion satisfaction and fatigue measure (Stamm, 2009) which is a tool designed to measure the negative and positive effects of helping others who experience suffering and trauma. The endpoint data were completed by six service users and twenty staff members. Lastly, the number of incidents was also measured and accounted for in the evaluation. The aim of this project was to assess the impact on implementing a trauma informed approach on staff and service users.

Overall, the service evaluation concluded that the implementation of a trauma-informed approach within a female forensic mental health ward had a positive effect on increasing service user wellbeing, improving ward climate, increasing staff compassion satisfaction and decreasing staff burnout. Implementation of a trauma-informed approach also had a lasting positive impact on reducing the number of risk incidents that occur on the ward, particularly with regards to self-harm incidents and patient to patient violence. The authors of the evaluation suggested that It could be that service users are learning new ways of coping with their emotions, dealing with personal skills and learning to build positive relationships in a safe environment that contributed towards the reduction of incidents.

It is important to recognise that this is a service evaluation of a small unit within a larger forensic unit therefore the evidence may not be able to be generalised. The number of participants was small and especially the very small number of service users that participated may not be representative of the population. The authors of the evaluation are also the people who delivered the training and are clinically involved with both staff members and residents of the unit.

However, this is the first reported evaluation of a structured trauma informed intervention being implemented in a forensic ward in the UK that the author is aware of. Thus, the results appear to be promising for future implementation efforts.

Both studies and the service evaluation have used quantitative designs and used measures of trauma symptoms and measures of safety in order to assess the effectiveness of trauma informed practices. All three projects also covered both adult and adolescent populations as well as staff members. This is really important as it demonstrates how trauma informed practices can easily be adapted to different populations across the lifespan and the positive impact at different levels of the forensic system. The common finding across the three projects was that, the environment in the facilities felt safer for all those involved which is also in line with the protocol for trauma informed care. However, by using quantitative designs which focused on trauma symptoms, incidents and job satisfaction we are not given any in depth insights on what other factors contributed to the observed changes or how the organisational culture of the systems adopted and adapted the practice.

The two peer-reviewed studies were carried out in the USA therefore it would be difficult to generalise the evidence provided to the UK and NHS contexts given the differences in how the mental health and forensic systems work in the two countries. As it is reported by Messina et al. (2014) changes can even be observed between states in the USA in terms of populations and forensic systems. The service evaluation was conducted in the UK and even though, it is difficult to apply quality criteria to a local service evaluation of a small forensic ward the aim of the report and the results are very relevant to the purpose of this

systematic review and it meets all of the inclusion criteria. Most importantly, it is the only known evaluation of a structured trauma informed approach being implemented in a forensic ward within the UK which offers a lot of hope for trauma informed approaches being adapted within the current NHS forensic system.

1.4.4 Research exploring the feasibility of implementing trauma informed care approaches in forensic settings

Three studies focused on the feasibility of implementing trauma informed care approaches (Kubiak et al. 2014; McEvedy et al. 2017; Olafson et al. 2018).

Kubiak at al. (2014) conducted a study in a high secure setting. The aim of the study was to assess the feasibility and fidelity of a trauma informed and gender responsive intervention for women offenders who have committed violent crimes. The goal of the intervention was to prevent perpetration of violent behaviours within the institution and later in the community. The participants were (n=35) women convicted of violent crimes including women who have been given life sentences.

Data was collected via participant and facilitator surveys and focus groups with the participants. Descriptive statistics and thematic analysis were used respectively to analyse the data. The key finding of the study was that the implementation of a trauma informed programme within an institutional setting was highly feasible. The researchers reported high attendance rates by the participants and the surveys revealed high levels of satisfaction for participating in the programme by both the participants and the facilitators. Finally, the participants reported that the overall environment felt safer.

This is an important study because it drew attention to a forensic population which is traditionally marginalised within the system. There are not many women offenders convicted of violent crimes and historically there has been a lack of treatment or rehabilitation programmes that meet their unique needs. The gender responsive element of the programme recognised the different needs of women within the justice system and of this particular population. However, the study accounted only for short term outcomes and there were no control groups. Finally, it may be difficult to generalise the results given the small proportion of women being convicted of violent offences.

Olafson et al. (2018) wanted to determine firstly if trauma informed interventions can be implemented in complex juvenile justice systems, secondly If they contribute to reduced incident reports and thirdly if they reduce trauma symptoms in young offenders. The participants were 142 Service users both male and female of six juvenile justice residential facilities. The intervention consisted of a Trauma-focused group treatment coupled with trauma-informed staff training. The study had a quantitative design. Pre and post assessment questionnaires were administered to each participant.

The key finding was that it was possible to implement the trauma informed practices in complex juvenile justice systems. There was a significant decrease in trauma related symptoms among the young people and the facilities with higher incident reports experienced the large reductions. Additionally, the study observed positive outcomes which were beyond the scope of the initial design including staff attitude changes and the intervention becoming self-sustaining in all facilities.

There was an observed increase of incident reports during staff turnover periods which highlights the importance of providing immediate in-house training for new staff. It was also observed that the group processing of trauma proved to be a key component in building group cohesion and harnessing peer relationships for support.

The post group assessments were not completed by only 51.4% of the original sample. Moreover, the sample of female adolescents was very small (n=11) therefore the effectiveness of the programme could not be determined for both male and female service users. The participants were not selected randomly therefore they may differ from the larger juvenile justice population. Finally, variables such as total length of time spent in the facility and in the treatment, group have not been accounted for and may have contributed to the result.

McEvedy et al. (2017) recruited staff members of 19 mental health services in Victoria, Australia including staff members of forensic inpatient units. The study aimed to evaluate the effectiveness of a trauma informed intervention focusing on transfer of knowledge and translating knowledge into practice for staff. The focus was on equipping trainees with knowledge and confidence to educate nursing, medical and allied health colleagues upon return to their services. The development of the intervention was multidisciplinary, and it focused on collaborative dissemination.

The key findings indicated that through this intervention, knowledge of trauma informed care was transferred to a substantial number of mental health service staff and that most services facilitated further knowledge transfer to end-user clinicians. However, limited anecdotal evidence of translation of trauma informed care into practice was provided.

For the purpose of this review, it needs to be acknowledged that the study did not just include forensic services, so it would be difficult to evaluate the effectiveness of this intervention specifically for staff working in forensic services. Finally, given that 140 trainees participated in the training, a relatively small proportion participated in focus groups therefore their views may not be representative of all trainees.

The study offered some implications. Firstly, ongoing support is required to maintain a focus on trauma informed care in order to sustain and encourage further knowledge transfer and translation, and to assess the impact on consumer and staff health outcomes. Further research could include a staff survey and how service policies, procedures, job descriptions were reviewed after the introduction of trauma informed care. Secondly, since reducing restrictive practices in mental health care is an important issue in mental health nursing it was recommended that trauma informed care should be addressed in undergraduate and postgraduate nurse education to support and promote this improvement in the delivery of mental health care.

The studies presented above demonstrate the feasibility of implementing trauma informed care principles and transferring knowledge of trauma in forensic systems. In the studies, this was achieved by both on-site training by external agencies but also by training staff already working in the service and equipping them to disseminate the model to other staff. Again, as with the previously presented studies we have an example of trauma informed care with an adult population, an example with an adolescent population and research with staff, therefore demonstrating the adaptability of the model across different populations and systems. Finally, two of the studies were carried out in the USA and the third in Australia.

Hence, the question remains if the implementation of a structured trauma informed care approach within the current NHS context of forensic services is feasible.

1.4.5 Research exploring the longitudinal impact of trauma informed care approaches on organisational culture

Two studies have taken a more longitudinal view of implementing trauma informed care in forensic settings while they both have a particular focus on organisational change (Kramer, M.G. 2016; Elwyn et al. 2017).

Kramer, M.G. (2016) explored how a forensic residential facility for male adolescents implemented and utilised an organisational change and treatment trauma informed protocol over a three years' time period; the Sanctuary model. Both residents and staff members of the facility participated in the study. However, only 10% of the resident population participated in the study which may decrease the study's representational power. Data was collected via observations of groups and meetings, quantitative data, focus groups with staff members and residents and individual interviews with staff.

The key findings were that the Sanctuary model decreases the symptoms of complex trauma. Recovery occurs as shaped first by the therapeutic community which supports the level of interpersonal relationships experienced with staff along with shaping the organisational culture. There were decreases in all forms of violence including reduced restraints and increases were observed in all forms of safety for staff and residents.

The implementation of trauma-informed care is a complex intervention which cannot be reduced to its components therefore the use of qualitative methods to explore in depth how and why the model contributes to its working in a residential forensic facility is one of the strengths of this project. Additionally, as a complex organisational intervention it cannot fully be understood by observing it at single points in time therefore even more long-term research is needed in order to capture the long-term effects of the model and how it develops over time. Another implication for future research is how to continue enhancing staff-resident relational integration regarding staff training and finding ways to offer residents more of a representative voice while on placement.

Finally, Elwyn et al. (2017) conducted research with staff members working at a secure female adolescent facility and aimed to explore the process of implementation of the Sanctuary model over a four-year period. Semi-structured interviews and focus groups with a cross-section of staff (n=17) including youth development aides, aide supervisors, counsellors, and clinical, community transition and nursing staff were carried out on the premises by two researchers. Key informant interviews included the campus director and one manager of the programme. Staff had been in the facility for an average of four years and the interview protocol asked about implementation of the model and impressions of changes in youth outcomes. Thematic analysis was used to analyse the data.

The reported improvements included increased physical and psychological safety; increased staff morale; changes in accountability and attitudes towards their work; positive changes in the relationships of staff members with administrators, other staff and residents. The climate in the facility changed from negative and chaotic to resolving problems and conflict openly.

Most importantly the study concluded that it was not just the implementation of the model that changed the culture in the facility, but the combination of the introduction of the model with investment in leadership and staff and residents buying into the model.

These findings point to the importance of evaluating both key intervention components and also implementation issues such as organisational context, readiness and facilitative administration in order to have a better picture of how a complex organisation intervention such as trauma informed care is best translated into practice. Therefore, increasing the uptake of evidence-based practices will also depend on implementation interventions that focus on improving climate and culture and not just on direct clinical interventions.

The study also has limitations. This was a small unit therefore it may be difficult to generalise to larger organisations. The data was only descriptive and retrospective, and they were originally collected to address slightly different questions. This occurred because although changes could be linked to the model there were other environmental changes happening which occurred at the same time as the research that were hard to separate from the model implementation. Therefore, the researchers endeavoured to investigate further before reporting results in order to examine all variables.

Both studies were conducted in juvenile justice systems and included both male and female populations along with research on staff. Both studies have reported similar findings with previous research on reduction of trauma symptoms and on increases in staff and residents' sense of safety.

Both studies used qualitative designs which allowed for an in-depth investigation of the factors leading to these changes. Thus, both studies indicate that implementing trauma informed care principles in an organisation may lead to changes such as in climate and culture therefore future research on the model should take these variables into account. Finally, both studies were also carried out in the USA which demonstrates that research within a UK context is necessary to determine the factors affecting the implementation of trauma informed care in British forensic services.

1.4.6 Summary of key findings

The current systematic review revealed that there is little research available for implementing structured trauma informed care interventions within forensic organisations. The evidence that exists, comes mainly from a US context. The research studies which focused on organisational culture change are even more limited and were mainly done in juvenile forensic systems. However, most of the studies presented had some implications for further research on service context, culture and climate.

There is an observed increase in the sense of safety and a decrease of symptoms of trauma within systems. These two findings seem to be in agreement with the model and its aims. Moreover, most studies demonstrate an understanding of the recovery/rehabilitation process of forensic populations not just as an outcome of direct clinical interventions but rather as an outcome shaped by the relationships built within a safe environment.

All studies have demonstrated the potential feasibility of adapting and implementing the principles of trauma informed care across different forensic services from low secure to high secure and across different populations of offenders. Two studies have specifically accounted for the impact of gender on the successful implementation of trauma informed care hence implying that trauma informed, and trauma responsive forensic services will also need to include gender responsive elements to the intervention as well. Lastly, there is investment in staff training and wellbeing throughout the review.

1.4.7 Rationale for the current research project

The literature reviewed so far begins to shed some light on the factors which have led to successful implementations of trauma informed approaches in forensic settings as well as the outcomes for service users and staff members. However, there is a marked lack of research in the area with very few studies currently exploring the impact of structured trauma informed organisational change interventions. Additionally, there is a marked lack of research in the UK and within the NHS context where trauma informed care is a fairly new approach in service delivery systems. The even fewer studies from staff members' perspectives leave a lot of questions to be answered. Also, the reliance on quantitative methodology and outcome measures give the existing studies a lack of depth and detail in describing how an organisational change and a transition to a different way of working is being experienced by the people who are expected to practice it. Thus, the current study aimed to provide a more in-depth exploration of the perceptions of staff members following a transition towards a trauma informed forensic service in the North of England.

CHAPTER 2: Methodology

2.1 Chapter Overview

This chapter will describe in detail the methodology used to explore staff perceptions of transitioning to a trauma-informed forensic unit. I will start by explaining the choice of a qualitative design and the use of focus groups for data collection. Following this, I will describe the service where the focus groups took place and the participants of this study. Subsequently, I will present the recruitment process, and the ethical considerations before detailing the data analysis process.

2.2 Design

2.2.1 Choice of qualitative design

A qualitative design was chosen because as it was demonstrated in the systematic review a lot of studies looking into the transitioning of an organisation to a trauma informed care model have used quantitative measures including measures routinely gathered in forensic settings such as number of incidents. Moreover, most studies have focused on service users, but we do not know as much about the experiences of staff members. Furthermore, since there is an overall lack of research in the UK on trauma-informed care it would be valuable to use a design and a methodology which could account for context as well as for experience. Qualitative methodologies are ideal for exploring understanding and meaning making of people's experiences (Willig, 2013).

2.2.2 Choice of thematic analysis

This study used thematic analysis as outlined by Braun and Clarke (2006). Thematic analysis allows the researcher to identify and analyse patterns of meaning within a data set (Braun & Clarke, 2006). It is well suited to shed light on how a group makes meaning of the phenomena under study (Joffe, 2012); and therefore, is well-matched for exploring staff members' conceptualisation of a change in organisational culture and the impact this has on them. Furthermore, as thematic analysis is not tied to one particular epistemological position. It is appropriate for exploring the process of social construction in line with this study's epistemology, allowing the investigation of staff members' experiences and meaning making processes (Braun & Clarke, 2006). Thematic analysis is the most commonly used method of analysis with focus group data (Wilkinson, 1999) and therefore, appeared the best fit of analysis for this study design.

2.2.3 Consideration of alternative methodologies

In the process of designing the study grounded theory was also considered as a potential method of qualitative analysis. Grounded theory (Glaser and Strauss, 1967) is a qualitive approach which enables the researcher to construct a theory 'grounded' in the data, with the aim of developing a model of (a) social process/es (Charmaz, 2014). In some ways, grounded theory appeared a suitable mode of analysis for the current study, as it is suited to questions which focus on processes and meaning in context (Tweed and Charmaz, 2012). However, the current study was approached with the aim to explore and construct common factors which the flexibility of thematic analysis appeared more suited to (Braun and Clarke, 2006), rather than work towards an 'inductively driven theory' (Tweed and Charmaz, 2012).

Choosing to explicitly carry out a thematic analysis meant this study had the flexibility to not subscribe to grounded theory's explicit theoretical commitments (Braun and Clarke, 2006).

2.2.4 Data Collection via focus group

Focus groups traditionally use the synergy in the group interaction to enhance the collection of deep, strongly held beliefs and perspectives and prompt greater breadth and depth of information (Carey and Asbury, 2012). This method of data collection is especially useful for exploring new topics and examining complex issues (Carey and Ashbury, 2012). Therefore, it was considered the best way to explore a new and complex trauma-informed care organisational change model. Exploring behaviour and beliefs can be especially useful in situations in which there is little information to serve as a foundation for research.

Focus groups can provide insights into attitudes and beliefs that underlie behaviour and by providing context and perspective they enable experiences to be understood more holistically (Carey and Ashley, 2012). The descriptions of experiences can provide unique insights on how members give meaning to and organize their experiences. Therefore, data collection via focus groups is also consistent with the social constructionist (Burr, 1995) epistemology of the study (Bateson, 1979). Finally, there were also two practical reasons for choosing focus groups as the data collection method. Firstly, as a researcher residing in London collecting data from the north of the country, I did not have the flexibility to be available for individual interviews with staff. Focus groups allowed me to travel two times and collect my data over a few days. Secondly, data collection took place during the unit's working day, hence focus groups allowed the recruitment of a bigger number of participants.

2.3 The Service

2.3.1 The service context

The service which participated in this project is a female inpatient forensic Mental health service in the North of England. The female forensic service comprises of four wards. Details of the wards can be found in the table below:

Table 6: Service Overview

	Number of beds	Gender	Security Level	Presentation
Forensic Ward 1	12	Female	Medium Secure	Mental health
Forensic Ward 2	6	Female	Low Secure	Learning Disability
Forensic Ward 3	5	Female	Medium Secure	Learning Disability
Forensic Ward 4	13	Female	Low Secure	Mental Health

Within the forensic mental health service, 29 out of 31 of the female service users had warranted a definite 'yes' in response to the traumatic experiences item on the HCR-20 V3 risk assessment, suggesting that 94% of the women within the service from December 2017 had previously experienced some form of traumatic event(s). The service has been reporting high numbers of restraints and seclusions.

2.3.2 Steps to implementation

Implementation of the trauma-informed care approach started in February 2018 as a pilot project within one of the wards and the rest of the wards followed later in the year. The trauma-informed approach was implemented in the forensic service through the following:

- Staff received a two-day development and training programme to increase their knowledge of the impact of trauma, to develop skills in crisis intervention and to develop practical skills to work with trauma on a ward level. Details of the training delivered to all staff can be found in Appendix.

- Staff were encouraged to utilise the skills learnt during the training to minimise ways in which the ward may contribute to re-traumatisation, in order to cultivate a welcome and safe environment within the ward. Staff was also encouraged to allow for greater flexibility and support service user input when establishing norms and rules. Staff were encouraged to utilise the skills to help service users establish a feeling of safeness.

- Clinicians developed safety plans with service users through care planning and five sessions of CAT which identified triggers, emotions and coping strategies to prevent and manage crises.

- Core sessions of art, occupational activities, self-soothing, emotional regulation and mindfulness were offered within service user care plans as techniques to promote a sense of calm and safety.

- Service users were given a 1-1 debrief following incidents of seclusion, deliberate self-harm or restraint to promote healing, recovery and learning, as well as re-establishing the therapeutic relationship.

- A member of staff was nominated as the daily Trauma Champion. This role involved ensuring that core sessions followed the need of service users through the use of a

passport system that identified which activities were re-energising and which were grounding. The trauma champion also noted down issues which needed to be raised within reflective spaces.

- Staff and service users engaged in fortnightly reflective groups, including a CAT reflective group. Staff were also offered weekly supervision to explore any issues relating to the trauma-informed care pilot.

2.4 The Participants

2.4.1 Participants' roles

The inpatient unit employs a multi-disciplinary team which comprises nursing, psychiatry, psychology, occupational therapy, dietetics, speech and language therapy, social work and physiotherapy. Staff members provide direct patient care or are involved in supporting this care. They work directly with individual service users, their carers and families and aim to develop individual packages of care. The interventions offered aim to address risk, offending and other identified needs. Programmes offered by staff members include CBT, DBT, CAT, fire-setting programmes, inappropriate sexualised behaviour programmes and programmes addressing substance-related offending. The overall aim of the service is for the service users to be able to return in the community.

2.4.2 Recruitment of participants

Initial contact with the forensic unit was made via the field supervisor for this project who is the Trauma-Informed Care Lead for the NHS Trust and who has been overseeing the implementation of Trauma-informed care across the adult services during the last few years. Information about the project was emailed by the supervisor to the local Trauma Lead of the Forensic service who had been identified as my local contact for recruitment

purposes. Following our first contact via email, I visited the service in September 2018 and presented the project to the Trauma Lead in more detail. After receiving the final approval for the project in December 2018, a second visit was made to the inpatient unit in order to visit the units and disseminate information about the project to staff members in order to aid recruitment. Hard copies of the participant information sheets (Appendix 8) were given to the people who expressed interest on the day and extra copies were left in the staff rooms and with my local contact to disseminate to any staff who were not present or on shift during my visiting hours.

The location, dates and times for the focus groups were also agreed with the service during my second visit and presented alongside the study information to potential participants. It was decided that the first two groups would take place in January 2019 and the last two in February 2019. This was particularly important for recruitment purposes because given the nature of the job which is based on shifts, interested participants needed to know well in advance the location, date and time of the groups in order to arrange their shifts accordingly to be able to present on the day.

As a researcher, who resides in a different part of the country and considering the long distance and cost of travel, I did not have the flexibility to be frequently present in the unit or attend any team meetings in order to recruit participants. Thus, I relied heavily on my field supervisor and my local contact for recruitment and for identifying appropriate dates, location and times. I have wondered if I had been able to visit more often or spend more time within the unit, if the final participant sample would have looked any different or if it would have had more variety in terms of role within the units.

2.4.3 Participation criteria

The participants were staff members recruited from the four forensic wards and four focus groups were carried out. Participation was open to all members of the multi-disciplinary teams of the inpatient unit since according to the trauma-informed care organisational change model, all members of the MDT including admin staff would have received training on the trauma-informed protocol and be expected to implement it in the forensic unit.

Staff members were eligible to participate if they had been working on the wards prior to the implementation of the trauma-informed care protocol and after. All staff members meeting the criteria for participation were given information about the study. In order to manage any power dynamics emerging from senior staff members being present in focus groups with staff of lower pay grades such as health care assistants and nurses, it was decided that senior staff members would be seen in separate focus groups depending on the number of people interested in attending. Eventually, two focus groups were carried out with senior staff members such as clinical leads and ward managers and two focus groups with staff members such as Health Care Assistants and Nurses.

There were 20 participants in the study. All staff members who volunteered to participate met the inclusion criteria and came mainly from a nursing background even if they currently held leadership positions in the unit. Two participants had a psychotherapy background. Specific job titles have been removed in order to maintain confidentiality. The age range of the participants was from 24 to 62. The length of service in the unit ranged from 3 years to 20 years. The majority of participants identified as White British (N=18), one who identified as mixed race and one as Asian British. The whole sample identified as female.

During my two first visits in the service, it was made clear that the majority of staff members were female since the forensic unit comprised of female-only wards. Therefore, it was within my expectations as a researcher that the majority of my sample would have been female. One male member of staff who had expressed interest in attending one of the focus groups was unable to attend on the day of the group thus he did not participate.

2.5 Ethical consideration

2.5.1 Ethical Approval

This project required to go through the NHS ethics approval process since it aimed to recruit NHS staff as participants and also aimed to take place within an NHS setting. Initially, an ethics application was submitted to the University of Hertfordshire ethics committee. Following approval of the application by the ethics committee, a sponsorship application was submitted to the University of Hertfordshire's Research Sponsorship committee which requested a completed draft of the IRAS (Integrated Research Application System) form, the Informed Consent Form (Appendix 9) and the Participant Information form. Sponsorship in principal was granted to the project and sponsor authorisation was given in order to be able to submit the IRAS form for Health Research Authority (HRA) approval. HRA approval was granted to the project, therefore both the UH ethics approval and the HRA approval were both submitted to the Research and Development department of the NHS Foundation Trust. Following review of the relevant documents, the Research and Development department of the Trust gave the necessary site permissions including a letter of confirmation of capacity and capability to carry out the project.

Finally, the confirmation of capacity and capability letter was sent back to the University of Hertfordshire's Research Sponsorship committee. Subsequently, the committee issued the project with a Protocol number and a letter of confirmation of granting the project with sponsorship in full. The project was then allowed to commence. All approval documents can be found in Appendix 6.

As someone conducting research in an NHS setting for the first time, nothing could have prepared me for the lengthy and very frustrating process of seeking NHS ethics. The length and bureaucracy of the process impacted on several other parts of the project including recruitment and organising the focus groups which I found very distressing and difficult to manage. Additionally, many times, during the process I wondered if the NHS 'deliberately' discourages doctoral research by creating a process which assesses a project like this as any other commercial project or as a clinical trial. While conducting the focus groups one of the participants suggested that in the future I could go back and do a similar project involving service users. I immediately felt a knot in my stomach which is a strong aversive reaction for me. I realised that this reaction was linked to thoughts of undergoing the NHS ethics process again and nothing to do with any other research procedure. In retrospect, what kept me going was my genuine interest in systemic changes and wanting to deliver an outward looking project.

2.5.2 Informed Consent

All interested participants were given an information sheet which included the aims of the study, what participation would involve, the terms of confidentiality and storage of their data, potential benefits and risks of participating, their right to withdraw at any point and my contact details in case they had any questions or concerns prior to attending the group.

On the day of each focus group, time was given at the beginning for me to check if everyone who was present had a chance to read the information sheet or if they had any questions. Participants were encouraged and given time to re-read the information and they were also given the opportunity to decline from participating. Care was taken to stress that participation was completely voluntary. No participants declined at this point. Finally, prior to starting the focus groups all participants signed a consent form.

Given that focus groups took place during the participants' working hours, at the end of each group participants had to immediately return to their work duties. Unfortunately, this meant that I was not able to provide a debrief session straight after each focus group, so as to give participants the opportunity to reflect and process what they had heard and spoken about in the group. However, I decided to stay in the service for a day after conducting the focus groups in order to make myself available for any participants that wished to discuss anything about the group.

Additionally, prior to carrying out the groups, the local management team had been informed about the groups taking place and agreed that participants could use their supervision sessions or reflective groups to discuss any part of the focus group they found distressing. All this information, and additional out-of-hours local support service contact information, was provided to participants at the end of the groups (Appendix 10).

2.5.3 Confidentiality

In order to maintain confidentiality all data collected in this study and participant identifiable information was anonymised and stored electronically in password protected conditions. The NHS Trust provided me with a password protected Dictaphone which I used to record all focus groups. It was a requirement of the Trust's Research and Development

department to not use a personal device even if it was encrypted. An additional permission was obtained by the forensic unit to allow for the Dictaphone to be carried and used in the unit since any recording devices including mobile phones are not allowed in the wards according to the forensic units' security regulations. Participants were instructed not to use their names when addressing each other during the recording and not to refer to specific names of wards, services or service users' names. Additionally, participants were assigned a number and asked to say their number prior to answering any questions. This was done in order to maintain confidentiality and to facilitate an easier transcription process given that as an external researcher I wouldn't be familiar with all participant voices. While travelling, the encrypted Dictaphone was with me at all times. I personally transcribed all the audio data collected directly from the Dictaphone and stored the transcripts on a password protected computer. Once all data was transcribed, it was deleted from the Dictaphone which was subsequently returned to the service. Any identifiable information in the recording was omitted from the transcription. The signed consent forms collected by the participants were stored in a locked cupboard in my supervisor's office and agreed to be destroyed at the end of this project. The confidentiality of all data was kept in line with GDPR regulations.

2.6 Data Collection

2.6.1 Devising the focus group questions

An open-ended interview schedule was devised with the aim of providing a framework to open up discussion and enable multiple perspectives to be expressed within the group (Raibee, 2004). The focus group questions can be found in Appendix 11. Prompts were included whenever I felt it was necessary to further clarify a comment, deepen descriptions

and check out similar or different perspectives. The questions were mapped on the trauma informed care framework (Harris and Fallot, 2001). The questions did not strictly follow the principles of TIC, however, the decision was made to explicitly ask about aspects of the approach, such as the incorporation of choice, trust, empowerment and safety within the programme of change. Questions were discussed with my field supervisor and reviewed and revised according to her research and field-based knowledge. The interview schedule was also reviewed by one of the Trauma Leads in the forensic unit who had overseen the change within the organisation and her feedback was also kept in mind.

2.6.2 The focus group process

The focus groups were carried out with 3 to 7 participants each and lasted between 45 to 90 minutes each.

	Number of participants	Duration	Role in the unit
Focus group 1	7	90 minutes	Non-managerial
Focus group 2	7	90 minutes	Managerial
Focus Group 3	3	45 minutes	Non-managerial
Focus Group 4	3	60 minutes	Managerial

Table 7: Description of focus groups

In preparation for facilitating the focus groups, I extensively considered how the quality of the interactions within the group would affect the quality of the data collected and how the process could be enhanced by finding ways to establish rapport (Carey and Asbury, 2012).

It became apparent to me that being influenced by the content of this study, I was trying to apply the principles of trauma informed care such as trust, transparency, safety, awareness of power imbalances and context, on the group process.

I particularly reflected on my positioning on the continuum of an insider-outsider researcher (Hellawell, 2006). An outsider researcher is someone not *a priori* familiar with the setting or the people participating (Hellawell, 2006). This could have been said to describe myself as a researcher, given that I was coming from a different part of the country and have never worked in this unit. Though at the same time, I am female, as was my whole sample and have extensive experience of working in inpatient units as a mental health professional, not just as a trainee psychologist but also as a healthcare assistant in the past.

Therefore, I could identify with a lot of the experiences discussed. In a way, I was finding myself both inside and outside the perceptions of the group and as it has been argued, empathy and distancing are both useful qualities for a researcher (Hammersley, 1993). Additionally, I considered my role as a trainee psychologist particularly for the two focus groups consisting of HCAs and nurses and the power imbalance that this could create between me and them.

In order to address any issues that could potentially arise by my presence as an outsider in my participants' eyes, and even though the groups were pre-existing, therefore knew each other, I dedicated time before the recording began for introductions and a preliminary discussion about the study. During that time, I talked about myself to them and let them know a bit about my story and experience and what brought me to this project.

Furthermore, I wanted to be fully transparent about the project and its requirements in case there was any confusion. I felt this was important in order to put participants at ease and to establish some rapport before the recording begun.

It would be important to also acknowledge that the focus groups happened in the North of England in an area which overwhelmingly voted for Brexit. As an EU Citizen and taking into account the rise of overt xenophobia and racism in the UK and the very uncertain political climate, I had major concerns about how my demographics would be viewed by the group and if that would affect my interactions with them and subsequently the data collection. Moreover, I was very much aware about how my own preconceived ideas about them and how they view European citizens could potentially affect the interpretation of the data. Following the completion of the second focus group, I received a message by my local collaborator who had received feedback by some of the participants about the focus groups which said, “Thank you for being so personable and warm, you may have actually shown nurses how research doesn’t have to be so scary”. Receiving this message made me feel relief and more trust in my abilities to be able to manage the focus group process and in the decisions, I made on how to introduce the process to the participants. I realised how important it was to dedicate time to build a relationship with my participants before asking them to be open and honest with me. Maybe it was the modelling of openness that allowed the participants to approach the questions with openness too. Finally, keeping a reflective diary prior to the start and at the end of each focus group allowed me to process my thoughts and feelings and better prepare myself for subsequent focus groups (Appendix 12).

2.7 Data Analysis

Thematic analysis was used to analyse the data as described by Braun and Clarke (2006). Themes were developed in an inductive 'bottom up' way so that they were closely linked to the data (Braun & Clarke, 2006). As it has been presented above, the interview schedule was partially mapped on the trauma informed care principles, yet the data was not actively interpreted through this framework. However, data was coded through a social constructionist epistemology lens, therefore the analysis is subject to my own assumptions and biases (Braun & Clarke, 2006). In order to ensure that my results were not influenced excessively by these, certain measures were taken which will be detailed below. Additionally, the thematic analysis focused on a latent level, therefore I looked beyond the explicit 'surface' level on the implicit concepts, beliefs and assumptions (Braun & Clarke, 2006).

Thematic analysis on a latent level is in line with a social constructionist epistemology (Burr, 1995). Hence, themes are considered to be socially constructed and do not just 'emerge.' Yet, this further highlights the significance of maintaining a reflexive stance throughout this project. Braun and Clarke (2006) have suggested six phases of completing a thematic analysis which will be described below as they were applied to the process of analysis for this study. The process of analysis usually involves moving back and forward between phases. For the purposes of this chapter they will be presented in a more linear order:

2.7.1 Phase 1: Familiarise yourself with your data

As it is recommended by Braun and Clarke (2006) the first analysis step was to familiarise myself with my data set. Since I transcribed the data, I started developing a deeper understanding of the content early on in the process. It has been argued that transcription

can be a key phase in data analysis (Bird, 2005) and it can be viewed as an interpretive act where meaning starts being created (Lapadat and Lindsay, 1999). Upon completing the transcription process, I spent time re-reading the whole data set. During this time, I took several reflective notes and noted down any coding ideas I had at the time and to which I returned during subsequent analysis phases. Transcription and familiarisation with the data of the first two focus groups was completed prior to conducting the last two focus groups since a month elapsed between the two data collection dates.

2.7.2 Phase 2: Generating initial codes

Following familiarisation with the data and having generated some initial ideas I proceeded with producing initial codes from the data (Braun and Clarke, 2006). All four transcripts were coded manually. An example of a coded transcript can be found in Appendix 13. Codes and corresponding quotes from each transcript were transferred from paper to Excel spreadsheets in order to facilitate later stages of analysis. An effort was made to code for as many potential themes as possible and to keep surrounding data when relevant so that the context was not lost (Bryman, 2001). The coding remained data-driven and remained close to the text. A second phase of coding allowed me to group the line by line codes in 23 overarching codes. An example of this process can be found in Appendix 14.

Finally, it was important not to ignore the accounts which strayed from the dominant story during coding. This was particularly important given that as a researcher I embarked on this project as a firm supporter of trauma-informed care. Therefore, every time I was becoming aware of my struggle to code an extract which did not agree with my own position, I would make a note of that and dedicate more time in coding that extract in order not to smooth

out or ignore any tensions. Finally, a transcript was also coded by a peer in order to check the credibility of the coding (Tracy, 2010).

2.7.3 Phase 3: Searching for themes

Having collated my coded data, I proceeded with sorting the overarching codes into potential themes (Braun and Clarke, 2006). To aid this process, I used Excel tables and mind maps. Subsequently, I spent time thinking about the relationship between themes and different levels of themes such as overarching themes and subthemes within them, as recommended by Braun and Clarke (2006). This stage of analysis ended with having constructed subthemes and further reviewing the data. An initial thematic map of the themes and sub-themes can be found in Appendix 15.

2.7.4 Phase 4: Reviewing themes

This stage involved two levels of reviewing and refining my set of potential themes (Braun and Clarke, 2006). In level one, the collated extracts for each theme were re-read in order to ensure that they were forming a coherent and meaningful pattern and to see if the themes were clearly identifiable and distinct (Braun and Clarke, 2006). In level two of this stage, the validity of the individual themes was considered in relation to the whole data set. Following discussion with both my supervisors, we agreed that the three initial overarching themes that I had constructed, were somehow limiting the breadth of my data and that I needed to consider if there was anything that had not be captured by that point. I went back to my data set and reconsidered the groupings that I had already made. This led to the construction of a fourth overarching theme.

2.7.5 Phase 5: Defining and naming themes

At this phase themes are 'defined and refined' to ensure that the 'essence' of each has been captured which fits with the story the researcher is telling about their data (Braun & Clarke, 2006). In order to do this the extracts for each theme were organised into a 'coherent and internally consistent account' (Braun & Clarke, 2006). The final thematic map following this process is included in Appendix 16.

2.7.6 Phase 6: Producing the report

In this final phase the analysis was written up in the results chapter. Consideration was given to the presentation of the themes and subthemes in a coherent narrative to allow the reader to easily follow the story of the data. Extracts were chosen with the aim of providing a rich description of each theme.

2.8 Quality assurance

The quality of the project was assessed using the Eight "Big-Tent" criteria for Excellent Qualitative research (Tracy, 2010). Please see table 8 below.

Criteria for Quality	Description of criteria and how it can be met	How the current study met this criterion
Worthy topic	The topic chosen for research is relevant, timely, significant, interesting	- Topic highly relevant to current NHS Long term plan, relevant to current climate of increased awareness about impact of trauma, relevant for increased awareness for staff wellbeing also relevant to the work of survivors of the psychiatric system
Rich rigor	Sufficient richness and abundance of data sources, samples. Rigorous data analysis procedure which is sufficiently complex and in-depth to be able to describe phenomena being studied	- Data supports the claims through a good sample size (n=20). Given this is a small unit a good proportion of staff were interviewed. - The sample and content are in line with the aims of the study. - A detailed account of the methodology was provided within the main texts and in the appendices.
Sincerity	Self-reflexivity about researcher's biases, goals. Honesty, transparency about research process including mistakes	- Self-reflexivity was achieved through using a reflective diary of the research process, openness about personal experience and how these might affect data collections and analysis - Reflective conversations with both supervisors assisted with sense making and for managing personal biases - Transparency was achieved through describing the research process honestly and reflectively
Credibility	Study demonstrates trustworthiness and plausibility of research findings	- In the results sections a lot of quotes were used in order to provide a rich narrative and to allow the reader to also make their own conclusions - Extracts were explored in their context and also corroborated by quantitative data collected in the unit.
Resonance	Study's ability to influence or move reader by presenting text which is clear, evocative, and promotes empathy and identification. Study's ability to generate knowledge resonance for different contexts, situations, audiences.	- The study was written up with the aim to allow the reader to connect with the experiences and descriptions of the participants. A high number of direct quotes was used in order to allow the reader to connect closely with the material. - Within the discussion the resonance of the findings was explored and linked with theory, research and current socio-political contexts
Significant contribution	Study makes important contribution to the field by improving/extending knowledge, theoretical understandings, or clinical practice	- The study is the first known study in the UK which explored the implementation of trauma informed care within an NHS context - It provides examples of clinical practice and contributes towards the development of a UK evidence base for trauma informed service models
Ethical	Adherence to professional/research ethics guidelines, responding ethically to issues which arise in research process	- Ethical approval granted from UH ethics board and the NHS ethics committee (HRA) and also approved by local R&D department - Power dynamics were considered thoroughly throughout especially around the formation of the groups - The impact of discussing work-related dynamics was considered and opportunities for debrief were offered to participants
Meaningful coherence	Whether study achieves its stated aims. Coherence between epistemological position of research and research design, data collection, and analysis	- Steps taken to carry out throughout the designing and write-up of the study to make sure that it is in line the epistemological position. - The initial study aims were re-visited in the discussion and clearly stated how they were achieved

Table 8: Quality criteria

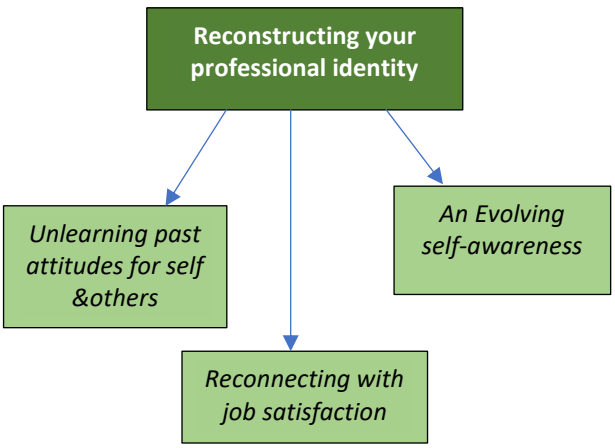
2.9 Dissemination

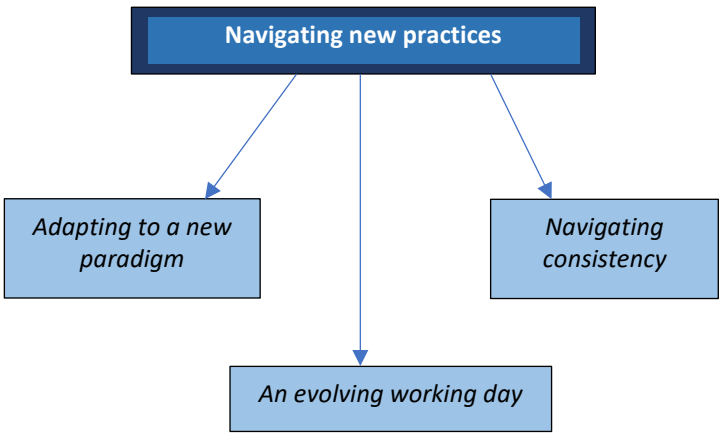
Preliminary results of the project were presented at the School of Life and Medical Sciences conference at the University of Hertfordshire on the 16th of April 2019.

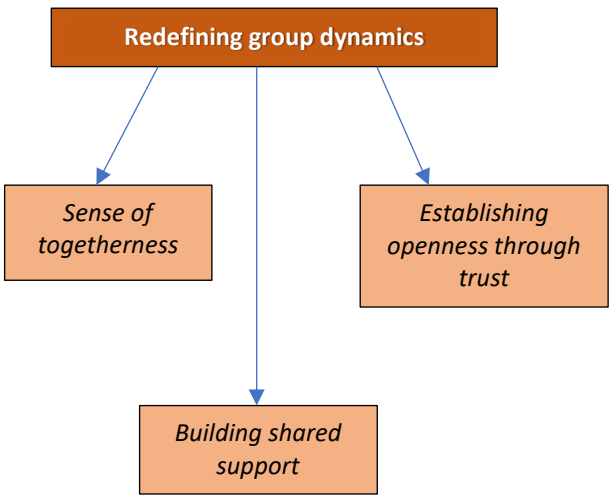
CHAPTER 3: Results

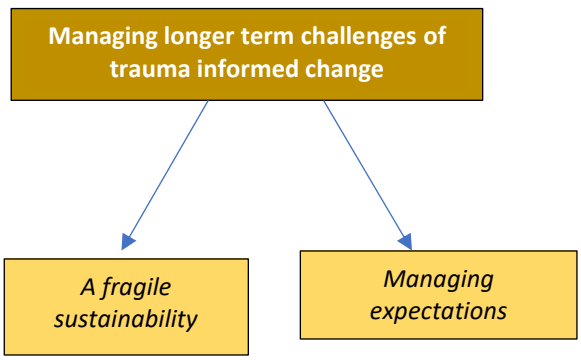
3.1 Chapter Overview

In this study, I aimed to explore staff perceptions of transitioning to a trauma informed care model within a forensic unit and particularly the impact of this change on them. In this chapter, I will present the result of the thematic analysis of the focus group data. Four main themes were constructed: '*Reconstructing your professional identity', 'Redefining group dynamics', 'Navigating new practices'* and *'Managing longer term challenges of trauma-informed change'*. Each theme and corresponding subthemes will be described in depth below.









3.2 Reconstructing your professional identity

Participants talked about how the process of transitioning to a trauma informed care model seemed to have initiated an internal process of re-evaluating and re-constructing their professional identities. Following the process of learning about trauma informed care, the participants identified that a parallel process of unlearning appeared to be taking place particularly around their attitudes towards both how they should be at work and how they saw service users. At the same time, they described how the model's focus on both them, and the service users in equal measure, felt like a new way of being at work which they were not familiar with. Participants talked about viewing the trauma-informed workplace as a rewarding space which reconnected them with the values of empathy and compassion which they held very close when they first chose their career paths. The change appeared to have contributed in them feeling more valued as staff members and had given them a sense of achievement. Moreover, participants talked about how the increased awareness of the impact of trauma had resulted in increased self-awareness around their own personal struggles and how these can impact their work and their personal lives. Finally, participants described how the introduction to trauma informed care had validated their own experience of distress and vicarious traumatisation when participating in restrictive practices or witnessing behaviours that challenge.

3.2.1 Unlearning past attitudes for self and others

Participants talked a lot about how the process of transitioning to a trauma informed forensic unit appeared to have initiated a parallel process of unpicking and unlearning well ingrained attitudes they used to hold towards service users. They identified the roots of these attitudes in the underlying culture of working in inpatient mental health units. Participants described what they used to think and subsequently feel, and how these thoughts and feelings were impacting the way they were responding to service users in the unit. Participants were open in sharing their feelings of frustration which they were experiencing very often in the past. They recognised how unhelpful it was to find themselves within this difficult pattern of thoughts and behaviours. This pattern was frequently compared to how these views had been evolving since the process of transitioning has started.

> *I mentioned earlier on, I am honest about it myself,* ***I felt that I wasn't as frustrated*** *(following the transition) ….* ***the negative thing I used to think about them*** *sometimes ….* ***was not there*** *as much… I have been like 'you will be alright', 'we can do this', whereas before I would be like 'oh Not again' you know what I mean? I hope that's not awful… (Group 1, Participant 7)*

> *We always sort* ***of think of trauma as one-select patient*** *or that's how I felt before about patients. (Group 2, Participant 13)*

> *I think for the full staff team to see other patients who have suffered trauma* ***definitely changed how people were around them****… I don't think It was more compassion because there was compassion anyway, I think there was a little bit more empathy … (Group 4, Participant 20)*

Some participants also shared how these internalised attitudes had perhaps affected the way they viewed the transition to a trauma informed care model at the beginning and how they observed increased fear and anxiety within the team. This was identified particularly around the principles of co-production with service users, giving back some control and increasing choice. This could potentially be coming from a perspective that forensic services have traditionally emphasised the need for restricting practices and managing risks as priorities therefore it would appear to be difficult for staff to steer away from this perspective.

> *I do think potentially at the beginning* ***there has been a fear*** *around kinda… and this sounds absolutely awful…****' let the lunatics, release them out'****…, I think like there was some of that (Group 2, Participant 12)*

Participants also talked about the impact of the model on the attitudes around working particularly in female forensic services and the stigma that female service users have to deal with in comparison to male forensic service users.

> *I have worked for 4 years now in forensic male... and I think, I feel the model of trauma stuff , it's…I don't know how to put it , it's ..**the ladies needed a lot more support** and they go to a crisis point a lot faster I am new to female services and it helped me in a way like 'oh but actually… took a step back think about what they have done… how we got to this point. (Group 1, Participant 2)*

Participants across the focus groups articulated how the changing attitudes towards service users was an ongoing process which would take time for them to fully adopt. Perhaps this reflects how the nature of the job which involves dealing with behaviours that challenge and managing high risk situations is both physically and emotionally demanding and they can very easily revert back to negative patterns of thinking about service users. At the same time, participants reflected that overall, they viewed the changing mindset as a positive experience.

> *I think when you see something repetitively and some of the behaviours that we are dealing with like ...it's **easy to just sort of forget** where they came from… (Group 3, Participant 17)*

> *yeah and sometimes, I don't mean to sound awful **but the empathy sort of fizzles** when… you know **it is a hard job to do**, it is hard to see …… (Group 1, Participant 3)*

> *but I feel **like our mindsets have changed** to be a lot more positive (Group 2, Participant 11)*

Participants also talked a lot about changing attitudes towards what was expected from them as forensic staff. They described how the underlying culture of being a staff member in a forensic unit seemed to have led into internalised attitudes of thinking that you had to appear strong at all times. Moreover, there was what appeared to be a widespread belief that they had to be able to recover immediately after incidents that they have been involved with or that they have witnessed and return to work. Participants seemed to attribute the high levels of burn out that they used to experience to that strong belief.

Coming from this perspective, participants appeared to view the change within the organisation as giving them permission to admit that they too struggled at times.

> *I think historically what I've always felt about forensic populations of staff is that* ***there is this idea that you've got to be tough****, you* ***never ask for help****, you've just* ***got to get on with it*** *, this kind of idea , nurses particularly prevalent with that because we all think it is part of our role to kind of crack on but what I've realised from this is that it's becoming ok for staff not to be ok…(Group 2, Participant 12)*

> *You* ***were expected to bounce back*** *from it and you* ***wouldn't talk about it*** *and it was just like expected it or myself and the staff team to just move on and we have all these other ladies to look after…(Group 1, Participant 6)*

> *You are coming in because* ***you are expected to do it*** *and with your colleagues you just assume, I am alright, everyone is alright will get on with it that's happened and you just rolling off… rolling off (Group 3, Participant 15)*

Participants across the focus groups talked extensively about a previously held assumption within the service which was that the focus should be solely on the service users and that their wellbeing did not really matter either to them personally or to the systems around them. Participants articulated how this attitude seemed to be linked to the attitude of being strong and in a way celebrated for its thoughtful nature. However, perhaps the transition to a trauma informed care model, which advocates for an equal focus on staff and service users, has somehow contributed to the dismantling of such a notion. It would appear that participants had found themselves in a process of getting used to having their wellbeing centred as much as the wellbeing of the service users. In this way, they seemed to feel more listened to and supported in their work.

> *I feel like she (the ward manager) kind of see it from our perspective as well, because* ***previously I did genuinely feel it was all about the patients*** *previously (Group 1, Participant 4)*

> *You might recall historically we've always been focused on the patient changing to see them but it's* ***looking at both staff and patients equally*** *so looking at how staff feel before and then after and during the changes which I feel we've never focused on staff before (Group 2, Participant 8)*

> *it was just given that staff wellbeing it is what it is …things in place to support should you need it formally. I think in everyday practice from a trauma perspective* ***we do as much with staff as we do with patients****. And from that staff morale has increased they feel more supported they feel more listened to, more involved stuff like that they haven't felt for a while (Group 2, Participant 12)*

3.2.2 Reconnecting with job satisfaction

Staff spoke about when they first started their roles, they were feeling a sense of purpose and had expectations of a rewarding job. However, participants claimed that these expectations were lost as the years went by due to the challenges faced by cuts in resources and lack of support and guidance. It would appear that the shared focus that staff had been describing as something they have been enjoying since the implementation of trauma informed care, had potentially led to also staff rediscovering what it felt like to consider their job as rewarding. Participants across the focus groups, seemed to conceptualise job satisfaction as a general increase in morale and feeling happier and more comfortable at work. Participants also expressed hope that the model would continue to contribute towards maintaining the sense of satisfaction in the future.

> *Just* ***be more happy at work*** *and work with people and deal with incidents, even not just incidents just deal with the day better like with a better outlook and mindset (Group 1, Participant 7)*

> *I would say **it gives you more satisfaction** and suppose it is early to say isn't cause … you can see lots of changes and I've worked here a long time and if this is gonna be a consistent change, so I think like… (Group 2, Participant 11)*

> *I am hoping **it's gonna make my job more rewarding** cause I hope that we'll see some more benefits and improvement with patients and the staff alike there will be just nicer coming to work (Group 3, participant 17)*

Participants also talked about the burn out they have experienced in the past and how feeling burnt out was almost ingrained in their identity as professionals. It would appear that they do not identify with that notion since the implementation of the model. This could potentially be linked to the changing misconceptions around having to be tough and move on from difficult situations and at the same time having the focus of the systems around them, turned on to their wellbeing as well.

> *Now **I am being somebody that isn't burnt out** and always the one that's saying we are a team, we can do it, we are here for a reason (Group 1, Participant 7)*

> *I think we got to be **feeling a little less burnt out** which is great (Group 4, Participant 20)*

Participants across the focus groups spoke extensively about the sense of pride and the sense of achievement they had been feeling about the process of implementation of the trauma informed care model. Participants seemed to be linking this to the positive feedback and recognition they had been receiving from external sources as well as with managing to get people on board, apply the principles of the model and getting a sense of actually helping the service users in the unit. Perhaps this reflects the challenging context within which participants used to practice that led to feelings of burn out instead of viewing the work environment as a rewarding place to be which seems to be more the case now.

> *Probably **quite proud** because we are doing a lot of hard work and there is recognition that all this that is going on that it is working, and we have done some things I suppose to be proud (Group 1, Participant 4)*

> ***That I am proud** as well like I think at first we had there some issues with getting staff on board with the change and there were people who worked in the service for a long time and used to the ways things always been so it's been a work in progress and we are sort of in a place now people have all agreed in …we change as we go along (Group 3, Participant 16)*

> *I feel It's **a great sense of achievement** for when we implemented it and I think what we have achieved as a staff team and where the staff are and doing the measures pre and then probably where we will be now it's **a massive sense of achievement** from implementing it for us as a staff team to get cohesion with the patients but also for staff morale to be better for us to have some consistency and some structure it's been a really positive change for us (Group 2, Participant 12)*

> *I do agree with what number 11 was saying about **the sense of achievement** and everybody sort of working together and the positive that it's actually had on the ward and the work the team have actually sort of continue to implement it as well …erm actually the top benefit is like to amongst themselves …conversations (Group 2, Participant 10)*

> *and you feel like **we all feel a sense of achievement** that actually yeah, I helped someone today because these small things are big things for them, that we do but we didn't even realise that we did before (Group 4, participant 19)*

3.2.3 An evolving self-awareness

In this context of changing attitudes towards work and increasing job satisfaction, participants also reflected on how much more aware they felt they had become because of the impact of both personal traumas and vicarious traumatisation on themselves.

Perhaps coming to understand more about the impact of trauma on them, participants talked about the ways they attempted to manage the impact of the work in the past by, for example going on long-term sick leave. At the same time, they appeared to observe differences in the way that the impact of the work is understood and responded to in other wards which have not yet transitioned to a trauma informed care model.

> *I've noticed about implementing trauma informed care how it's affected our ward is that with staff I think* ***they are more mindful now*** *about* ***how trauma affects the staff*** *as well (Group 1, Participant 5)*

> *when you go* ***to other wards*** *that haven't implemented trauma informed care* ***I don't know if they are as aware of the impact*** *that these incidents have on the staff as well as the patients (Group 2, Participant 12)*

> *you do forget when you've been off the wards for so long just how … how much… constant self-harming constant aggression and constant behaviours can* ***really impact on a member of staff's wellbeing*** *(Group 2, Participant 11)*

> *the* ***impact of that sort of witnessing trauma or aggression*** *from patients and staff was a lot more long lasting it could* ***potentially gone on for sickness for weeks*** *or months (Group 3, Participant 16)*

Speaking out of the framework of increased awareness of the impact of trauma on their wellbeing, participants appeared to have been going through a process of changing the meaning of what they had been witnessing at work such as self-harming behaviours and violence. Participants appeared to be considering that it was 'not normal' to be exposed to violence and that it should not be expected. It would appear that some of them had also been reaching a conclusion that the normalisation of experiencing violence at work was mainly due to a context which did not provide as much support in the aftermath of incidents.

> ***it's not normal*** *(witnessing self-harming) and it's not kind of don't just kind of get on with the job, we saw that, let's crack on like it's not …(Group 1, Participant 2)*

> *so, I think staff it's particularly on (name of ward) when I took over the ward* ***it was just acceptable to witness you know*** *ligatures really severe ligatures four five times a day and it's just not acceptable (Group 2, participant 9)*

> *You were (thinking that you were) lucky if you were going out and not getting attacked (Group 1, Participant 7)*

> *on the ward you have a lot of situations where you are* ***seeing things that aren't normal***
> *and sometimes it's not that you get used to it but you are doing it, where I think by doing this* ***you realise that these things aren't normal*** *and you haven't been offered support (Group 3, Participant 17)*

Perhaps the changing meaning of these experiences and the changing expectations from the work environment allude to a changing culture of moving from seeing resilience as an individual's responsibility to considering it the responsibility of the system around the individual. This may mean that the system would need to both introduce ways to prevent violence and to contain staff members' distress and allow recovery to happen within it, when it is necessary.

3.3 Redefining group dynamics

Apart from the impact on an individual level, participants also discussed the impact of implementing trauma informed care in the unit at a group level. Participants spoke about the sense of togetherness that they had been experiencing both with colleagues and service users. On one hand they noticed that members of the multidisciplinary team spent more time on the ground with the rest of the team and on the other hand participants described how they had a sense that service users wanted to spend more time with them instead of being in their rooms. Being involved in group support practices such as reflective groups and

group supervision had been a new experience for a lot of staff members of the unit. Participants talked about their experience of these platforms being available to them and how recovering after incidents is now a team process and not an individual's responsibility to "put themselves together" before returning to work.

3.3.1 Sense of togetherness

Participants across the focus groups spoke a lot about the impact of the organisational change on both how they worked and collaborated as a team and on how they felt closer to colleagues they worked alongside with and across disciplines and levels of seniority. In particular, participants in the focus groups involving staff who mainly worked on the ground such as HCAs and nurses, described having experienced a lack of involvement in decision making processes and not being heard by senior level staff in the past. It would appear though that since the implementation of the trauma-informed model this gap is starting to be bridged.

> *I have experienced that **as a massive disparity between what's actually happening** and **what is understood at senior level (in the past)** …I agree with that erm one of the biggest challenges coming on to work in here was that **staff didn't feel like they had a voice** on the ward and not necessarily to their immediate managers (Group 2, participant 12)*

> *I think **it changes relationships** from ward to senior levels like people were talking in more positive ways about some of the areas that trauma informed care is implemented (Group 4, Participant 19)*

> *I have to say in my opinion like it's more about the staff team and I think **like it stops being a hierarchy as well** like I think sometimes… I feel like they like **working with each other more equally** than we have previously I feel like there's more cohesion now than what it was previously (Group 1, Participant 4)*

Maybe this is because non-managerial staff feel they play a more active role in developing plans for service users or taking more of a lead in organising sessions in accordance with the model and in this way, they seemed to enjoy this more collaborative way of working. Perhaps this also reflects that participants often felt like they used to work very separately in smaller groups in the past in comparison to now. This sense of working closer as a bigger team could potentially also contribute towards the sense of greater job satisfaction as it was described earlier.

> *so that's like nice when **everybody bands together** on the ward already, we do a lot of trauma like EMDR and stuff, so we already **work a lot with psychology** in doing like intervention plans as I suppose that's the major changes, there's been **a lot of input from everybody** like people offering different ideas and taking charge of different session to do (Group 3, Participant 15)*

> *it is really good, and I also think there's as well been **a lot more collaboration within the team** not everybody some people have … but a lot of us, it's like asking everyone at every level what do you think asking and getting that more wider team input and that I think is good collaboration (Group 2, Participant 8)*

> ***the whole team is more involved** with the treatment I think rather than sort of everything being separately I don't know how to explain it really (Group 4, Participant 20)*

At the same time, there were participants who seemed to think that there was further scope for the team to improve even more on working together on the ward and articulated a wish for a more united ward environment as the process of implementation moves forward.

> *Not saying everybody but it is the majority who does stay in the office and I know they've got a lot of work to do totally understand that, so* ***it gets them involved as well*** *and* ***make everyone like one big team*** *(Group 1, Participant 3)*

> *Hopefully it* ***will put the team more together*** *and… and maybe unite us a bit as a full ward staff and patients (Group 3, Participant 15)*

The sense of togetherness described by the participants seemed to also be extended to involve the service users in the unit. This observation may be unique to inpatient units in relation to implementing a trauma informed care model, since by default staff and service users find themselves in closer proximity than in other services. Participants seemed to hold a belief that this close proximity created the environment of a family for service users which in the past may have been dysfunctional due to the restrictive practices in place. Speaking out of this belief, participants reflected that the relationships with service users had become more cohesive and more collaborative than before leading to staff and service users feeling more comfortable in each other's presence.

> *we become their family* ***we built a relationship with them*** *you know that they really … they really are the best relationships they ever had (Group 1, Participant 4)*

> *patients with the staff* ***they get along more*** *than they did before (Group 3, Participant 16)*

> *I think it is easier for us to work with them because we now we are not telling them… you know… I think quite often previously it was this, this and this… I think now they've got …* ***makes our relationship better*** *(Group 4, Participant 19)*

Participants reflected that this may be because they actively spend more time doing activities and sessions with the service users as it would be required by the model.

> *It's a chance for **all the staff team and all the ladies to all sort of group together** so we are more together so cause we are doing it twice a day (Core sessions) so we do it before dinner and we take it off the ward so it's a different environment for them as well (Group 1, Participant 5)*

> *If anything, **it has made us more a bit tighter at the seams**, because we got a bit more structure like with the ladies and we get the ladies … we get together… what to do with the Core sessions and we are all filling our days (Group 3, Participant 16)*

On the other hand, participants spoke about observing that the service users chose to spend more time with them even outside of structured session or activity time and reflected on the difference they observed when working or visiting wards which did not follow the same model of working. In this way, they seemed to believe that spending more time with service users contributed towards the cohesiveness of the group as a whole and somehow bridged the 'us and them' boundary between them.

> *I do not say that's across the site, but I do feel that our **patients spent a lot more time** in the day room **with the staff team.** (Group 1, participant 7)*

> *What you notice is on the wards where there is trauma informed care that's where you will see the **majority of the staff and patients sat together** in the day room… you generally find on the wards that don't have trauma informed care that a lot of the staff are being in the office and a lot of the patients are being in their own areas like you've said that might not be a bad thing but it just feels more cohesive (Group 2, Participant 12)*

> *I think that there is **more of a dialogue** and there is more of… you've always got staff of the shop floor which is literally out… where **you have that interaction all the time between the staff and patients** , it **creates cohesion** I think and stops the*

> *disparity between service users and staff, I feel like working on the other wards when you go on to them compared to ours I feel our ward is sort of we are working a lot closer to the patients (Group 4, Participant 18)*

3.3.2 Building shared support

Participants reflected on how since the implementation of the model they had observed an increase in the available platforms for talking through the impact of the work including reflective practices, debrief sessions and longer nursing handover meetings. This observation by participants seems in line with the model requiring organisations to put in place structures of practical support for staff in order to ensure their wellbeing. This could also potentially link back to staff becoming more aware that trauma informed care as a service model requires a shared focus on both staff and service users.

> *It is the type of reflection though, **we do reflections**, don't we? 24 hours after an incident (Group 3, Participant 16)*

> *I mean I **never done the incident reflection sheets before** until I come to the females …so that was a big change, but they **helped me immensely** (Group 1, Participant 1)*

This increase in the number of platforms to deal with the impact of the work may also reflect an increase of opportunities for staff to spend more time together and process a lot of shared experiences. This might contribute towards an increased awareness of staff openly caring for each other and may lead towards what has been described so far as a sense of togetherness on the ward since the implementation of the model.

> *I think **being supportive of each other more** and like I mentioned previously the debrief and things **we now debrief** where…. and it is documented in …more formally than previously so it's about support, more support …I feel (Group 1, Participant 7)*

> *In the pilot **we do a 24-hour staff debrief** and we've never done that previously ermmm so we ring staff if they are not at work to see if they are alright (Group 2, Participant 11)*

> *You know **we are doing more debriefs on the ward**...at 7 o'clock where the staff debrief so the nurse checks on every staff member just to make sure that you know is everyone fine so it's **more like checking on staff** … to make sure that staff are managing and coping with things they have seen on the ward (Group 4, Participant 20)*

Additionally, it would appear that participants previously held on to a belief that recovering after incidents was an individual responsibility and had to be dealt with separately from the rest of the team and the service users. This could potentially link back to the long-held attitudes about forensic staff presenting as tough and strong and not being as affected by what is happening on the ward.

> *I was involved in an incident and I feel like I didn't get like a great more support like I **felt like I dealt with it a lot on my own** (Group 1, Participant 2)*

> *before the nature of the ward it was very kind of reactive, there was an incident and then **staff would go one way and patients the other** to try like manage it and then come back and brew again and it would go and brew again and it just it feels a bit more I mean it still happens sometimes-but **it feels a bit more fluid now** where it's more kind of blended (Group 2, Participant 12)*

At the same time, participants reflected on how the processes which followed incidents were focusing only on the assessment of risks rather than focusing on the recovery of the staff member. It would appear that participants often felt blamed which may have

potentially evoked feelings of shame and wanting to retreat away from the team in order to recover rather than openly sharing thoughts and feelings.

> *before all the trauma informed care went in the place staff felt I don't know like … a **blame game** sometimes like when an incident happened … (Group 1, Participant 7)*

> *I don't know the right support wasn't all in place I think people found like but **previously it was just all about checks** like why this went wrong…checks … risks … (Group 3, Participant 17)*

Participants reflected on how these processes had been changing and how recovering after incidents was becoming a team effort. Participants seemed to link this change to the increased awareness of trauma and how much it affected staff members. Perhaps for some, witnessing these efforts and providing this active support for each other may have somehow brought them closer feeling like the dynamics of shame and blame are being resolved within the team and may have led into staff supporting each other beyond their professional roles.

> *So after incidents I've noticed **we make a solid effort to the staff** that was in the incident are you alright? is everything …differently? Like you can follow with me if you need support later (Group 2, Participant 9)*

> *So much is going on it's hard I don't know people just forget to ask and after maybe I forgot to ask if everyone is alright, something so stressful, l I think **we make more of a conscious effort to do it**, cause we understand a lot more about it than other places (Group 1, Participant 7)*

> *I think **we all support each other** …with our own traumas (Group 1, Participant 2)*

3.3.3 Establishing openness through trust

Participants talked about how transitioning to a trauma informed care model had started establishing a culture of openness in the unit and therefore potentially leading to better relationships within the group. This was described during the focus groups in regard to staff feeling comfortable sharing their own experiences with colleagues and with service users. This could potentially be the result of the increasing self-awareness around the impact of their own personal traumas and vicarious work-related traumas on them and the normalising of their reactions to them. Coming to understand that may have allowed them to link the personal to the work environment. Additionally, perhaps the increasing number of opportunities for sharing such as trauma-focused supervision, reflective groups etc. may have also contributed to the normalising of talking about the impact of the work.

> *To **raise the issues** and come and talk about things that are bothering them and to **talk about their own traumas**… I had several staff come to me and **talk about trauma quite openly** and not just their own stuff but also **how that might be affecting** what is happening on the ward and being triggered and things like that, I just think in general it is kind of **took the lead off the secrecy around trauma** with both staff and patients **it's becoming everybody's business now** and I think that can only ever be a good thing (Group 2, Participant 12)*

> *They are **more willing to sort of open up and say I was impacted** and talk through that in supervision which previously they just kept it completely separate which you do anyway but if it's gonna impact on your work life they are more willing to talk about it now (Group 4, Participant 19)*

> *Staff are **a lot more open to talk to you** about even how they are interacting with patients on the ward (Group 2, Participant 13)*

> *I think the benefits have been probably the staff feel maybe hopefully a little bit more acknowledged and **a little bit more able to talk about their own experiences** that would be the most important thing I think for me (Group 3, Participant 15)*

Participants also reflected on the open sharing of information within the team and the difference that this has made to their practice. Participants described how traditionally the information regarding service users' background history or even intervention plans would never reach the staff working on the ground leaving them wondering about the actions they needed to take or about the best ways to respond. However, participants claimed that now and in accordance with the model, information was openly shared within the team in order to ensure that the environment on the ward does not re-traumatise the service users. This could potentially also link to the shared training the teams received regardless of job title or grade and perhaps it had added to ground staff feeling more valued and respected as team members.

> *Nursing assistants do the tasks on the ward or whatever and **it was not level** … **everyone now got the same knowledge** so everyone will be leading on the same thing (Group 2, Participant 12)*

> *But there are other times that is really positive we did a ... which they all seem to like and do more interacting and getting to know each other, **staff know exactly what is going on at all times** (Group 4, Participant 18)*

Moreover, some participants talked about feeling more comfortable sharing personal information, within limits, with service users which is something they wouldn't have done previously. This could possibly be coming from the changing paradigm of understanding service users' life stories and experiences. Maybe participants are coming to understand more about how trauma works within their own selves and how it has operated in service users' lives and perhaps this has allowed them to reach the realisation that both they and the service users share the same needs for physical and relational safety within the unit. This context may have highlighted their common humanity and allowed them to overcome

some of the communication barriers placed between them by a system which used to prioritise risk over relationships.

> *We do , I think I've here 8/9 years I think now and I think we really… things have changed because when I first started* ***it was all about security*** *and you couldn't mention your family, you couldn't do it this* ***now you can sit and talk to them*** *obviously you know where to draw the line … but they know you got family and you can talk about where you have been and you think you have built such a good relationship (Group 1, Participant 5)*

Some also described how they had been observing more open communication between service users in the unit. Participants shared how service users used to be very suspicious of each other and of staff members. Perhaps this reflects an increasing sense of safety within the unit but also increasing opportunities for service users to spend more time together such as the timetabled sessions and activities as well as feeling more comfortable spending more time in the day areas of the wards rather than in their rooms. These opportunities may have contributed towards service users identifying common experiences with each other therefore bringing them closer as a group and increasing the trust and support between them.

> *For patients because they've been* ***more open with each other,*** *because we've had little groups about the trauma informed care presentation and the staff training and the patients had an input in that, they sat together and talked about that together and then today they had quite* ***an open conversation****, appropriate conversation* ***about self-harming*** *in the day area (Group 4, Participant 19)*

3.4 Navigating new practices

Participants shared how the most obvious and direct impact had been on their everyday clinical practices on the wards. Participants talked about adopting the 'trauma lens' in their

everyday practice which for most of them was a new way of making sense of service users' distress. This new way of understanding had been moving them away from using diagnostic labels and bringing them closer to wanting to know the stories behind them. However, the adoption of this paradigm by ward staff had also created conflicts regarding the management of service users, with professionals who abided to a medical view of mental health. Participants discussed how the working day looked very different than it used to, mainly due to the introduction of structure in the form of timetables and scheduled activities. Participants highlighted that they were developing and using competencies such as skills teaching which previously was considered a 'psychology thing'. However, since the transition, these skills were transferred across the team regardless of role. Additionally, participants talked about the re-negotiation of control, risk and boundaries between them and the service users. This was particularly prevalent within the conversation when referring to the management of incidents on the wards and the access of service users to preferred activities, items and ways of engaging with them. Finally, participants talked about how they viewed consistency of approach as very important for the successful implementation of the model and how it could be very easily broken. The reliance on agency staff who were not trained on the model to cover shifts could hinder the consistency of trauma informed ways of managing the environment putting everyone at risk of escalating incidents. Finally, participants talked about the inconsistency found between what they practiced since the implementation of the model and the systems they needed to use in order to record or assess new service users. This inconsistency hindered the full implementation of the model as it did not make the work of staff visible across the local organisation as well as within the wider NHS.

3.4.1 Adapting to a new paradigm

Participants across the focus groups discussed about how trauma informed care which was had introduced them to a new way of viewing service users' presentations called the trauma lens. Participants spoke about how previously they would mainly focus on the behaviours in the 'here and now' without making links with service users' backgrounds. Maybe this was because of the context through which the majority of participants was coming from in terms of having had nursing training for their roles. Traditionally, this context of professional

training prioritises an understanding of mental health distress through set diagnostic criteria. Additionally, maybe participants were not used to make these links between behaviours and background because it would appear that the information was not readily available to them. It seems that since the implementation of the model which involved training on the relationship between trauma and severe and enduring mental health distress, participants had been making efforts to view past behaviours that challenge or diagnosis and reframe what they saw as the result of a very traumatic past.

> *You do forget, and **you just see the behaviours** but there is obviously **a reason behind** so if you, if you sort of help with the main problem and then the behaviours will be less …sort of (Group 1, participant 7)*

> *She went back through everything didn't she? all of the histories and then you do start to think 'oh I did forget that, that's how **trauma of a lifetime** can …**maybe that's why she does the things that she does'** so I think it was almost like **refresh yourself** and get **a new set of eyes** through the formulation (Group 1, Participant 6)*

> *it'd give us a bit more **in depth knowledge about the patients** you've got the paperwork there and you know their past histories it supported us to get a bit more of **an understanding around them** and look into it a bit **further other than just a diagnosis** or symptoms (Group 2, Participant 9)*

> *I totally agree like when we've done the trauma lens and **read the script some of our ladies anonymised** so what it do… I **didn't even recognise** the script of **the storyline behind it** like literally didn't know it was them at all and I didn't even hear some of the information previously (Group 3, Participant 16)*

> *so **the information is not as available** like to plough through it was quite eee alarming some of them were really bad you know **you were just not aware of some of the stuff** cause the ladies on the ward … high risk sometimes, you know…but when*

> *you hear the sort of trauma lens stories it just drives it more,… what they might need (Group 4, Participant 18)*

It would also appear that apart from an increased understanding of the impact of trauma on people's lives, participants talked about how previously most of them were also unaware of how experiences of trauma were quite widespread, especially within the population they had been working with. Perhaps, as a result, participants had previously viewed trauma as affecting a very small amount of service users, if any. Possibly, this could also have contributed towards a culture within the unit which focused on managing risk and behaviours rather than understanding these through the context of trauma.

> *we always sort of think of trauma **as one select patient** or that's how I felt before about patients I just feel like now I see it from all patients' perspectives cause **they've all had traumas** in their lives it could be something quite mad about the impact on their lives historically which sort of they haven't dealt with yet **it's opened my eyes to see a totally different perspective** (Group 1, Participant 7)*

> *I think **looking from a trauma perspective** it's totally puts things in a perspective that's probably the reason why we are getting all the challenging times quite often, I think we've never seen that… there was **only one patient** whose been suffering with trauma when that actually wasn't true (Group 3, Participant 17)*

It would seem that the training the participants received, which potentially started a process of changing their viewpoints on the mental health of service users, also had an impact on their behaviour towards them. Participants discussed how they noticed they had been moving from feelings of compassion to feelings of empathy for the people they had been working with. Potentially, this may link to the increasing understanding that participants claimed that they had gained in regards to their own stories of adversity and trauma. Perhaps, by being able to identify the impact of trauma on themselves, they felt they had more in common with the service users than they initially thought. Coming from

this understanding, maybe the implementation of the model facilitated the discovery of the shared humanity between them and people who had been traditionally framed, in the context of mental health services, as the 'other'. Moreover, it would appear that some participants have been reaching a realisation that working outside of the framework of trauma, could have potentially resulted in an environment which triggered survival responses in service users and possibly re-traumatised them.

> *I think for the full staff team to see other patients who have suffered trauma definitely* ***changed how people were around*** *them and I don't think It was more compassion because there was compassion anyway, I think there was a little bit more empathy* …(Group 1, Participant 6)

> *Looking at the patient from a trauma lens* ***totally changed how you were with all of the patients that's been really good for our staff team*** *in particular things around patients we as I say we just see the behaviour, now we've seen the historical information that you don't see (Group 2, Participant 8)*

> *It's not justifiable and the behaviours in my eyes but* ***it gives you a bit more of a reason as to say that's why,*** *that's why if they think that that was changing you know how we worked to manage them without realising the traumas that people …****it could be setting them off all of the time*** *… (Group 1, Participant 4)*

Participants also discussed how this new framework of understanding the service users' presentations had been changing the way in which information about incidents in the unit was being shared within the team. Participants talked about narratives being shared which involved potential explanations incidents, rather than just descriptions of behaviours that challenge. It may be that the increasing understanding of trauma has allowed participants to have a clearer view of what might be triggering an incident. Subsequently, they may feel that if they were more able to know the concrete reasons behind it, it would allow them to prevent it from being repeated. Perhaps, these efforts to prevent rather than just deal with

incidents, also demonstrate to service users that there is a process in place which validates their experiences and increases their sense of safety.

> *It was fedback to me that she's been involved in an incident, but as it was fedback with the incident (sheet)* ***so was the information about the reason why*** *she thought she ended up in that incident, because somebody had done something which had actually* ***triggered a flashback*** *for her and that thing was* ***spotted and noted*** *so that information didn't just come to me in 'this patient did A, B and C and ended up in restraint and then seclusion' it was like this happened , then they did this , they reacted like,* ***the narrative went beyond the behaviour*** *which makes it more manageable because you then go to the peer and say don't do that anymore cause … (Group 2, Participant 12)*

> *I've noticed the* ***information is different*** *of what we are getting so I think probably* ***patients feel more understood*** *and they realise you are not just looking at them for what they are at the moment but looking beyond it really (Group 4, Participant 19)*

Apart from describing the course of adopting the trauma lens through increasing knowledge of trauma and changing behaviours and processes of risk management, participants also highlighted that conflicts had arisen within the team due to this change. Participants talked about how even though the unit had been undergoing the official process of transitioning to a trauma informed care service model, the previous way of working under the medical model was still being used to create plans for service users. It would appear, that this had put participants in a position where they felt like they had to fight between two conflicting views, which maybe left them feeling tense and not heard within the wider context of the unit. Participants seemed to recognise that these conflicts within the team may had a negative effect on service users as well and they could maintain a re-traumatising environment.

> *I think that kind* ***the medical model we've all followed for so long*** *I think* ***it will take a while to unpick*** *that, even today when we had the ward round, just even debates with the doctors from the ward, like decisions that are being made,* ***still we have to***

> ***sit there and be like 'well no, this doesn't make any sense'*** *and not even from a trauma point view, just from the patients' point of view (Group 4, Participant 19)*

> *Cause once a* ***week there is a battle*** *sometimes to be able to implement the trauma informed care from the medics' point of view. I think, following from some drama this morning, you get sort of a* ***treatment plan in regards from a medical point of view*** *and then a* ***treatment plan from a psychological point of view*** *and* ***it doesn't meet*** *and then as a team, we have to try and* ***implement both somehow*** *and sometimes with your opinion lost …(Group 4, Participant 18)*

> *I think there still seems to be a bit of 'No, no they'll have this medication everything will be swimming' and* ***they still deal with the diagnosis*** *rather than what the patients experience every day* ***and what we do to retraumatise them****, they just* ***don't take that into account*** *(Group 2, Participant 11)*

3.4.2 An evolving working day

Participants across focus groups talked extensively about the introduction of daily structure on the wards since transitioning to a trauma informed care model. The groups conceptualised structure as the introduction of scheduled activities and timetables that staff and service users followed during the day. Participants described how it felt to work without structure and the effect it had on them. It would appear that participants experienced the lack of structure as also the lack of purpose and guidance in their job role. It would also appear that the lack of structure was also leading to them feeling unsafe and experiencing the job environment as un-containing. At the same time, it seemed that there was recognition by the participants of the impact of an unstructured day on service users' opportunities to make the best use of their time on the ward.

> *They felt like they* ***didn't have any structure****, they felt like they* ***didn't have any guidance*** *when they came on shift,* ***they didn't know what they will be doing****,*

> *patients didn't really know what they would be doing half of the time unless they had set activities (Group 2, Participant 9)*

> *So, there was basically no routine, no structure, no nothing, you just felt at the time that you were just **a glorified baby sitter** and if you got out without getting attacked you were lucky because I would say …but we just had to undo it because that's their chance (Group 1, Participant 4)*

> ***We lost our way** because **there was no structure**, people just staying in bed and they did like missing meals and that meant they would get hungry like… (Group 1, Participant 3)*

Participants compared the time before the introduction of structured timetables and activities to how things were now on the wards and how much their working day had changed because of that. It would appear that participants placed a lot of focus on the importance of offering service users' opportunities for occupying themselves. Speaking from this context, it would appear that participants linked the introduction of structure with increasing motivation, feelings of safeness and trust in their abilities to manage the ward environment better than before.

> *I think **It is structured better**, I am only part time, but they are doing more things, **they are more occupied**, all the time, it seems to be working better rather than having …how it used to be (Group 1, Participant 6)*

> *Doing something like that and come back about seven o'clock that gives the chance to get on with their jobs and they are enjoying themselves and **we can get on** with our stuff **we are not frantic** are people gonna go out on time and stuff (Group 2, Participant 13)*

> ***It keeps themselves safe as well****, it gives some things to look forward to than lying in bed, you know, you just need to involve them to do things because they would just quite happily stay in bed all day (Group 3, Participant 17)*

> *It's not good for them not doing anything so now they have these Core sessions in place and the incentives I think it is really…* ***I think it is getting back on track****, you know, and keeping people more busy and less time to…. (Group 4, Participant 20)*

Additionally, participants talked about the impact of this new-found structure on their sense of purpose as professionals. It would appear that previously participants felt uncertain about what they actually had to offer to service users and how they practically contributed to service users leaving the ward more skilled in order to manage everyday life better than before. Perhaps the scheduled activities such as the skills teaching sessions and timetables offered participants a more tangible frame of reference when they talk about what they were able to offer to service users. Possibly, being able to make specific links between their role and how it translated in practice has allowed participants to rediscover the purposefulness of their jobs.

> *It's about structure of the day which I think it's gonna be like a massive thing for a lot of staff cause erm… I think it will make us feel like we are doing something so one of the big things is '****oh what we are doing for them'*** *like I think* ***we will have more of a clear goal****, of an understanding of what session we are doing, why we are doing it…(Group 2, Participant 9)*

Participants discussed how their everyday practice had changed due to learning new skills which they felt they could implement with service users in order to better manage their distress on the ward. They also talked about the possibility of these skills being transferred beyond the ward and service users using them in their lives in the community after discharge.

> *Even I think and it sounds bad from the way that we've always worked, this is across the wards not just this one,* ***it gets to the point where it's like patients just lie in bed*** *all day and they get some leave and there is nothing but I think TIC helps immediately any future planning 'cause eventually* ***gives them some structure and skills it gives them*** *loads of other* ***stuff to do and some purpose*** *(Group 1, Participant 5)*

Participants across the focus groups and regardless of job role referred to using skills stemming from DBT and mindfulness practices. Perhaps this demonstrates that apart from the unlearning of attitudes and learning to understand service users' stories from a different framework there is an extra layer of learning taking place. This could potentially be the more practical layer of learning which seemed to be taking place and a likely sign that the knowledge of therapeutic skills was being de-centralised from psychology and transferred throughout the unit. It would appear that in line with the trauma informed care model participants viewed that all interactions could be considered therapeutic.

> *And* ***learning new skills*** *so that* ***we can teach the girls the skills*** *and the benefit long term is seeing them move on from the ward, that's amazing 'cause the girls that we have with personality disorders have been charged because of …(Group 1, Participant 4)*

> *I try and sort of* ***implement the mindfulness with patients*** *as well sort of you know getting things wrong and getting very angry and so I say to them use your mindfulness go think about things and come back and then we will talk again and try and do it in that sense obviously it doesn't work all the time … a bit more mindful (Group 3, participant 16)*

> *I have always done* ***DBT*** *for about two or three years but* ***I have implemented it a lot more with the women*** *especially since more this transforming care… giving more understanding of emotional regulation and stuff… and like now I talk to the lasses even the ones who haven't done DBT treatment and I just say look …****actually it's***

> ***alright to feel like this, it's alright to be angry, it's alright to be upset. I implement it a lot more purely because of the trauma stuff****… (Group 1, Participant 7)*

Participants also referred very frequently to skills they felt they have developed specifically in relation to trauma such as being able to recognise what might be a trigger for a service user. There was a sense that they also thought that due to the development of these skills they were more efficient in not allowing certain situations to escalate into unmanageable incidents. Possibly this sense of efficiency in managing difficult situations better, could contribute towards them feeling more confident in their abilities which subsequently could contribute towards the unit being experienced as safer than before.

> *I feel like we do sort of I am not saying all the time but regularly* ***we do pick up on triggers a lot quicker*** *(Group 1, Participant 2)*

> *I feel like we are sort of there,* ***a lot more attune to some of the earlier signs*** *of like no 13 said we* ***pick up on things a lot quicker*** *(Group 2, Participant 9)*

> *It feels a lot* ***more containing and safe,*** *incidents* ***don't get the chance to escalate*** *to you know monumental proportions 'cause* ***you are kind of on it*** *(Group 4, Participant 19)*

Apart from discussing how the therapeutic skills had been affecting their interactions with service users, participants reflected on how what they had been learning through the sessions they run had been affecting how they manage their own distress. Maybe the increased self-awareness of how they were impacted by trauma, has led the participants in being more pro-active in using everything that was available to them, including the skills they teach service users, in order to regulate their emotions in and out of work.

> *Core skills sessions that we run I think they are fantastic for the patients with the things they do, perhaps a bit of a reflection* ***they've been working for the staff as well*** *and I think* ***it gives them the skills whether at work or at home*** *or whatever if*

> *they have trauma to kind of deal with things … some of my family helping themselves and things like that (Group 2, Participant 12)*

Following on from discussing the changes they had observed in terms of their own competencies, participants reflected considerably on how their working day looked different in regard to how trauma informed care had been inviting them to renegotiate the concept of control in the unit. The notion of control was operationalised by the groups as both the level of involvement of service users in their care and how participants, as staff members, maintained control of high-risk situations. Initially, participants talked about the fears emerging in terms of sharing control of decisions with service users. It seems that some participants made links between the concept of control and the concept of power. Speaking from that perspective, it appeared that they had been reaching an understanding that the sharing of control potentially evoked feelings of powerlessness in staff members who had traditionally seen their work in an inpatient forensic unit as requiring them to be in control at all times. At the same time, it seemed that participants had become more aware of how by holding the control of all decisions, they became responsible of evoking feelings of powerlessness in the service users. Perhaps, the increased understanding of trauma as a loss of power, has steered participants towards seeing that an environment which enforces powerlessness because of its design can potentially become re-traumatising for service users and hinders the initial purpose which is to be aid healing.

> *but there's been always* ***the odd person, they don't want to let go of that control,*** *they don't want to pass over that control because* ***maybe because they feel powerless****… (Group 2, Participant 8)*

> ***We are evoking a sense of powerlessness in our patients*** *and most of them are traumatised so most of them have* ***come from powerless positions****, so it's triggering, so that dynamic in that relationship of power and control becomes the be all and end all, and there is absolutely* ***no room for any kind of healing*** *relationship or collaboration…(Group 4, Participant 18)*

> *I think it's more **about people's fears about what will happen** if we do co-produce and we do work more on things like that … (Group 1, Participant 7)*

Participants then reflected on how they had been observing increasing efforts of collaboration between them and the service users since the implementation of trauma informed care in the unit. It would seem that participants understood these efforts as mainly efforts to share control and to give the power of decision-making back to service users. At the same time, it seemed that participants recognised that there were limits on how much power they could actually share since the risks to their safety are not completely eliminated after the introduction of trauma informed care.

> *I think **the main difference** is about like **working more collaboratively with patients** rather than feeling like you are more in control like with it being forensic, it's still kind of feels sometimes like a pr…like rather than caring does (Group 1, Participant 6)*

> *like **working a lot more collaboratively** and getting like people's opinions and things and like **trying not to enforce** things on them … I think. (Group 4, Participant 17)*

> *I think it's a good idea … if the patients are **more involved in it**, it makes … so **they've got a bit of control** as well (Group 1, Participant 3)*

> *recently I think that's been massive, even to the point where the staff have been like I am **not making this decision for you** like this is your plan what do you want to do? (Group 4, Participant 18)*

> *It has **given a lot more empowerment** and independence like I can give you some choices about what we can do, you know, cause **there are limitations** about certain things or we can do this or we can do that or you can do it this way or we can do it that way **but I am not deciding, you decide** (Group 2, Participant 12)*

> *I think you **cannot put your barriers down** when it comes **to safety and risk**, you always have to be aware risk and your own safety (Group 1, Participant 2)*

Participants also talked about their use of restrictive practices in order to control high risk situations such as severe self-harm by service users and how differently they had been trying to manage these in accordance with trauma informed care principles.

Participants reflected on approaching situations by attempting to be more mindful of their own initial reactions which could potentially lead to an escalation of risk and subsequently to the need to use restrictive measures such as restraints. The risks, which continue to be present, seemed to be reducing since participants had been approaching them in a different way.

> *that first happened cause at first like this time of year it's* ***high medication and seclusion*** *for the entire period like what's going on,* ***whereas this time it's been 'what are you doing****?'* ***'what shall we do?*** *I think that's totally changed hopefully the longer-term outcome for her… (Group 2, Participant 13)*

> *whereas now it's like 'alright* ***I know you've got a ligature*** *on your hand but* ***let's just talk*** *about it rather than WE NEED TO GET IT OFF' (Group 4, Participant 19)*

> *Yeah that happened a few times on the ward where* ***we've had attempted ligatures*** *and* ***instead of running in to pull it*** *from the hands and be hands on,* ***we actually stepped back*** *and be like 'you are breathing, you are talking to me what are we gonna do? And we've actually talked and* ***the number of incidents, alarms that we haven't pulled over the last six weeks has come down significantly,*** *it's like being on a different ward (Group 2, Participant 14)*

> *Cause* ***at first*** *some people said 'What?* ***Aren't you gonna do anything****?* ***No, you are in charge****,* ***it's your decision*** *and they don't want to do it, it works, it's like, it's brilliant actually, isn't it? Obviously, we assess risk all the time (Group 1, Participant 7)*

3.4.3 Navigating consistency

Participants appeared to be concerned about the consistency of the approach across the team in the unit. This strong concern may have stemmed from previous experiences of inconsistencies in delivering interventions or managing the ward which had resulted in low staff morale and increased the number of adverse incidents involving service users.

> ***Low morale before the trauma informed care was related to inconsistency*** *like other people said about eerm* ***not sort of following the same*** *…sheet, different nurses coming on doing different things, someone sort of* ***causing incidents*** *because previous nurse was doing something completely different (Group 2, Participant 8)*

Participants talked about the importance of having regular staff who had been trained on the model in order to be able to maintain consistent responses towards the service users. Perhaps, allowing new staff to work in the unit without training posed a significant risk to the consistency of the approach resulting in miscommunication within the team or increased incidents. There seemed to be a particular challenge towards getting new staff up to speed which was recognised by the participants as one of the complexities of implementation. This complexity may also be coming from a organisational system which does not seem to allocate enough time and money for efficient service development projects.

> *The fact that they* ***aren't getting regular staff*** *they won't be able to …. The core sessions …****nothing will be consistent*** *(Group 2, Participant 11)*

> *On ours we've had a lot of* ***newly qualified nurses who haven't been there*** *that long, and* ***nothing was being fed back to the team****, so it was like two separate things (Group 4, Participant 19)*

> *I've said this once before like* ***not training new starters*** *and (name of ward) has gone through a lot of changes this year so it's been* ***very difficult keeping everybody***

> ***embedded within*** *and continuing picking* ***new people who have started*** *on the ward and* ***never have done it before*** *(Group 2, Participant 12)*

> *Never done anything on trauma informed care and trying to keep going on the ward like implementing it but with* ***new starters that's one of the complexities*** *(Group 1, Participant 6)*

Participants also articulated concerns about inconsistency within the team. They reflected on how the fear of change could have resulted in not everyone being on board with the approach. It may be that this could potentially further hinder the implementation of the model and may be highlights what is outlined within the model as the importance of all staff regardless of role to adhere to the same principles.

> *My biggest concern is people …* ***people are scared of change*** *always, myself included, hate it but this particular sort of change that we are having now like I am super excited about... I am … I think it's gonna be like a massive difference… but my concern is that* ***not everyone is gonna be on board*** *cause there are still some people where they are like of that will never … and I just think* ***if we have that attitude then it won't****… we've got a think that will work, that we want it to work yeah (Group 4, Participant 18)*

> *Think* ***the most difficult bit it will be about everyone****, like every discipline involved on the ward,* ***trying to apply*** *and making sure* ***that regardless of what is going on****, the* ***sessions are the priority*** *and* ***not missing the staff supervision****, not missing the patients' reflection group … (Group 2, Participant 10)*

Finally, participants reflected on their observation that the systems they used for recording their clinical practice were not in line with the requirement of the model which was to prioritise information about trauma and to make it easily accessible. This could potentially pose another threat to the consistency of the model since it could prevent staff teams from accessing important information about service users but could also prevent them from

accurately recording the work they do. Therefore, it would appear that the use of recording systems tailored to trauma informed care principles is another new challenge emerging from the implementation of the model within an NHS context which favours the use of similar recording systems regardless of type of service.

> *I think that even still apparent that even though there is four wards that have implemented the TIC* ***there is still nowhere that documents that on the computer system*** *that everybody still uses… so our massive risk assessment is all about risk and history and* ***a tiny little bit about trauma*** *… like the tiniest bit and like no easy way to access that on PARIS or any external assessments whether doctors go and see people in prison or high secure to bring people here …* ***they don't ask any trauma question*** *so…(Group 4, Participant 18)*

> *Yeah, I looked on PARIS and* ***the trauma is what … three lines long*** *when that would* ***probably be the root of … everything you need to learn*** *about somebody (Group 3, Participant 17)*

3.5 Managing longer term challenges of trauma-informed change

Participants talked about how the implementation of trauma informed care had highlighted and introduced challenges for them to manage. They identified that trauma informed care is a resource-heavy way of running a unit which required constant update of practices and environments. Participants discussed how this can be quite draining to keep up with.

As time goes by, participants had been questioning the sustainability of the model while they felt like they are falling short of what is required from them. In addition, the requirement for availability of human and tangible resources in order to fully transition into a trauma informed and responsive organisation, has made the lack of these resources even more visible. Participants talked about strong feelings of uncertainty which followed the introduction of trauma informed care in the unit, which left them wondering a lot of time if their practice was in line with the principles of the model. Moreover, they shared that they found themselves still needing to fight the expectation that trauma informed care will be the answer to every difficulty they encountered as a team on the ward and in their relationships with the service users.

3.5.1 A fragile sustainability

Participants talked extensively about the challenges they faced in terms of the sustainability of the model in the unit. They described their efforts to keep providing new material for replenishing the content of the sessions they provide to service users and how draining this process felt for them. Perhaps this reflects two things. On one hand, it may be confirming trauma informed care as a service model which requires the provision of multiple resources in order to maintain its efficacy. This may be particularly challenging for services trying to implement it given the current context of the NHS. On the other hand, it appeared that the responsibility of constantly updating materials and content had fallen on nursing staff. This may have led participants into feeling disproportionally responsible for the overall sustainability of the model while also trying to manage the everyday running of the wards. Speaking out of this framework, participants reflected on how much they felt they struggle to keep it going. Perhaps, this could potentially be hindering the sense of satisfaction they have been getting from other aspects of the model such as the increased support with the impact of the work or the reduction of restrictive practices.

> *but I think it is quite **hard thinking about different things** to do all the time. Like I struggle …. (Group 1, Participant 2)*

> *Staff team said they feel obviously a lot better; the patients are happy doing it, the only concern that it is sort of, **the level of keeping the Core sessions going** and the concerns around incentives (Group 1, Participant 7)*

> *I think it's **trying to create new ideas** and new focuses **for every session** without being too much of a drain but to also be important for the patients, so we are **constantly thinking of new stuff and that's a challenge** (Group 2, Participant 13)*

> *to try and **think of new ideas** and keeping the file up to date and I think it's been **a massive challenge** for our ward, it's just been **a massive challenge to maintain t**he core sessions (Group 3, Participant 15)*

Participants talked about how they had been identifying less engagement from service users. It appeared that participants had been observing less attendance and maybe signs of boredom by the service users. They tried to make sense of that by attributing it to the repetitive nature of the sessions they had been offering. This maybe confirmed that the constant updating of the content would be necessary in order to maintain service users' engagement with the ward activities and to subsequently maintain the benefits of these sessions in the long term.

> ***less patients are attending*** *now because they are not as good, they are not as meaningful they are* ***quite repetitive*** *with what they are offering so I think that's why we are getting less probably patients attending them (Group 1, Participant 7)*

> *it's quite often the* ***patients are getting a bit bored now doing the same all the time*** *so* ***trying to be innovative all of the time*** *it's that constant trying to improve constant****, constant trying to think of new things which is draining*** *(Group 3, Participant 17)*

Apart from the difficulties with sustaining the variety and quality of the activities and clinical interventions on offer in the unit, participants also reflected on the wider systemic factors which they felt were impeding the future sustainability of the model. It appears that participants had been observing recurrent issues with the staffing levels in the wards. They discussed how low staffing levels had been affecting the delivery of interventions by decreasing their frequency and the length of time spent on them. Perhaps for some, this could potentially mean an increase in difficulties with managing risks on the ward and needing to resort to more restrictive practices due to lack of adequate human resources. In this context, the danger of the ward environment becoming re-traumatising for both staff and service users can possibly be quite high.

> *I think it's been really good; I mean at the moment what's sort of affecting us and the girls is that* ***we haven't got staff*** *to like to facilitate very long sessions (Group 1, Participant 7)*

> *This week there was **no staff on the floor** because they were all (service users) one-to-one and we ended up saying look I am sorry, but we will need to cut this one short (Group 2, Participant 14)*

> ***Obviously, staffing** is an issue I don't know how they are going to change that 'cause you cannot predict for like sickness if you can't cover shifts then you can't do anything with that, can you? (Group 1, Participant 6)*

The difficulties regarding the number of available staff members on the ward may had been reflective of wider issues around allocation of budgets and the necessary financial resources which the participants also discussed. They talked about the challenges they had been facing in trying to secure resources in terms of allocated time and money in order to be able to continue with the implementation of the model. It would appear that participants had been finding themselves in a position to have to keep the faith in the effectiveness of the model and wanting to continue with implementing it, but at the same time realising that in order to do that they need to keep asking for resources which may not be available to them. This may be quite frustrating for them and potentially further hindering the future sustainability of the model.

> *I think managing the ward and doing the trauma informed care it's what that results looks like and **where that money is coming from** and of replenishing resources **those above don't allocate money** for that pot, so that's where you are coming back from, **it's a constant challenge looking for resources** (Group 2, Participant 12)*

> *That is **a main challenge** I think when it comes to **money** and continuing going on and keeping it embedded (Group 3, Participant 16)*

> *There **is no budget for trauma informed care in forensic services** that's not something that I need to probably discuss, because it seems like services often introduce these things **without any substantive time** within your own day and **without any funding to do that as well**…(Group 2, Participant 11)*

Maybe this speaks to the complexity of the implementation of trauma informed care within an NHS context which has been hit by funding cuts in recent years. Even though participants had been positioning themselves as active agents in delivering the direct work required such as sessions, interactions and interventions, at the same time it seems that they feel that they cannot control the wider influences affecting the successful implementation of the model. This is a conflict which arises irrespective of their individual efforts to keep the model going in the unit. Participants reflected on how the initial successful implementation gave them the sense of achievement while identifying that the sustainability of the model was the next big hurdle on the way to transitioning to a trauma informed forensic unit.

> *Along with the patients feeling being validated and understood a bit more in my opinion the thing that we need to do* ***putting all of the sustainability in place securing a budget so that we've got money*** *to keep this going and* ***securing some time for me to support the staff with what they are doing*** *(Group 2, Participant 12)*

> *I think if we were to go forward to make it meaningful, we would probably* ***need to invest*** *something more in it so that's definitely something that I wanna take forward (Group 4, Participant 19)*

> ***so last year was all about getting up*** *and starting it* ***and implementing it*** *and making sure that people knew what it was and doing the pilot …****now more about sustaining trauma informed care*** *(Group 2, Participant 11)*

> *that's my main concern, even though we are all really excited, the majority, about TIC* ***external things that we can't control are going to dictate how well*** *that goes and* ***that's quite frustrating*** *(Group 3, Participant 15)*

Even though the staffing and financial challenges were there long before the introduction of trauma informed care, by changing the organisation towards a model which required a lot of resources and at the same time empowered staff to be open about their struggles, these challenges can become more visible than ever before. Coming to this understanding,

participants may have felt particularly affected by both the new challenges associated with the clinical application of the model and the old challenges embedded within an NHS context which requires services to develop with limited resources.

3.5.2 Managing expectations

Participants talked about the initial stages of implementation of the trauma informed protocol following the training they received. It seems that participants felt quite unsure about what was expected from them at the beginning. It would appear that a lot of them felt thrown into this new way of working. Perhaps, the experience of the change as something sudden rather than something that happened in stages, evoked feelings of confusion about their practice. Subsequently, they may have felt overwhelmed about the amount of information they needed to absorb in order to deliver what was anticipated. Potentially, this may have led to feelings of low confidence in themselves as professionals and the need for constant reassurance about what they were doing. Participants, reflected on how this uncertainty impacted on them at the beginning, however as the transition progressed, they claimed that they were able to see the benefits of the approach and embrace it.

> *Yeah, I do, I do think like it does work better but I think as well we stopping with the same, the least restrictive practice so I think sometime* ***we get confused*** *and…****with different ways of working*** *(Group 1, Participant 1)*

> *For me* ***it was about not feeling confident in your job role*** *and* ***you are sort of thrown in*** *especially because the patients rely on you to guide them, we were shook by it and* ***we were not sure where to go what to do with it****, it was that things …all at once wasn't it? it wasn't one thing at a time, it was you need to cover this, you need to cover that and make sure this it was a bit full on to be fair (Group 1, Participant 6)*

> *It* ***knocked the staff self-confidence*** *you have to keep going and asking and getting reassurance yourself for the answer that you are given because* ***you are not sure if you are right or wrong and initially*** *we were a bit … , it has gotten a lot better, but*

> *at the beginning **we had a few teething problems** not knowing where to go with things (Group 3, Participant 16)*

> *You **felt like you weren't good enough** to deal with…. **Because you didn't know** …. Be wrong all the time and yeah (Group 3, Participant 17)*

Participants also reflected on how the transition to a trauma informed unit had been a continuous learning process. Participants in the more senior positions talked about how difficult it was to predict any outcomes at the beginning. It appeared that the knowledge acquired during the first ward transitioning, informed the process which was followed by subsequent wards in the unit. Perhaps, having the responsibility to translate a general framework of practice into everyday concrete operational principles for a specific context and environment, may have resulted in the participants in the more senior positions to feel particular pressures to make it work despite the uncertainty.

> *I think in terms of (name of ward) it **was very much like a pilot site**, so **we learnt as we went along**, and I said this to the (name of ward) training and (name of ward) you learn as you go along, and it was **very much like suck it and see** if …(Group 2, Participant 10)*

> *I think (name of ward) was the original fight and the difficulties for me I guess with that we **didn't know what the outcomes were gonna be** whereas with (name of ward) I could wholeheartedly say what worked and what didn't (Group 2, Participant 8)*

Coming from the perspective, that the trauma informed care model provides the framework but does not dictate specific actions, participants talked about the process of managing high expectations about its efficacy in the unit. Participants described how recurrent challenges such as increasing risks and incidents may have hindered their faith in the model and may have also impacted negatively on their morale. Participants coming from more leadership positions talked about how they were making efforts to remind their teams that due to the context of working in forensic mental health services, risks could not be entirely eliminated.

Perhaps, when being compared to the previous ways of working and particularly the more restrictive practices such as restraints and the use of medication, trauma informed care did not seem to provide the same immediate results. Consequently, it would appear that participants were trying to manage these perspectives in the team by pointing out the long-term benefits of the approach and by being honest about what could be achieved and not presenting it as the solution to every issue.

> *I think if it is a particular patient, day to day same behaviours and sometimes the staff feel like '**ouff this trauma informed care has done nothing'** … trying to remind them of the bigger picture …they have progressed, and they have come back to us and we have to help them go forward as well (Group 2, Participant 14)*

> *I feel like sort of staff because we had an escalation of risks on the ward within the past few weeks **my fear is that they will get demoralised** and think of '**what is the point'** sort of thing so I think I feel like **they will say it's not working which is not the case** actually (Group 2, Participant 13)*

> *To remind people that it is not actually like a treatment as such **it is not like a medication** and **it's not gonna fix things** yeah and it's not working **it's not actually a treatment, it's an approach** to actually but to try and make things easier and better (Group 4, Participant 18)*

> *I mean by sort of it **not being a treatment** and separating it if you want still doing the principles of it everybody is still doing it but the time that patients are going through the wrong things guess we can kind of help with but **it's not an answer to everything** (Group 3, Participant 15)*

CHAPTER 4: Discussion

4.1 Chapter Overview

In this chapter, I will begin with presenting a summary of the findings while revisiting the aims of this project as they were set out in the introductory chapter. I will then attempt to explore and link these and current research. Following this, I will discuss the unique contributions of this project and how they could be applied to clinical practice and policy. Consequently, I will reflect on its strengths and limitations and I will suggest implications for future research. Finally, I will briefly present the dissemination that this project has already had and will end with my concluding remarks.

4.2 Summary of findings

This project aimed to explore how staff members perceived the transition to a trauma informed forensic unit. Four themes were developed: Reconstructing your professional identity; Redefining group dynamics; Navigating new practices; and Longer-term challenges of trauma informed change.

The first theme of 'Reconstructing professional identity' captures the perceived changes of transitioning to a trauma informed unit on an individual level for staff members. Initially, it seems that participants had been engaging in a process of unlearning personal attitudes on both how they viewed service users and themselves as professionals. This may have led to them reconnecting with the job satisfaction which seemed to have been lost since they started their professional paths. It appeared that participants felt valued and derived a sense of achievement by the process of implementing a new service model. Finally, there seemed to be an evolving appreciation and focus on staff wellbeing. This appeared to evolve by an increasing self-awareness around understanding someone's boundaries and validating their own experiences of personal adversity and trauma but also experiences of vicarious trauma.

The second theme of 'Redefining group relationships' highlights the observed changes of transitioning to a trauma informed unit on the relational and group dynamics level. There was a sense of connectedness within the team of professionals and between professionals and residents. Participants talked about the increasing shared time and shared spaces with service users and colleagues and how this may have led to building a culture of shared learning. This appeared to happen via the increasing use of talking platforms such as reflecting groups and by introducing recovery processes after incidents which engage the whole group and don't consider recovery as an individual responsibility. At the same time, there seemed to be another process of establishing openness through trusting each other more by sharing their experiences and by sharing information about service users throughout the team.

The third theme of 'Navigating new practices' speaks to perceptions of changing clinical practices. The transition to a trauma informed care unit introduced participants to a new paradigm of understanding mental health distress which moves away from psychiatric diagnosis as the sole explanation. By adopting the trauma lens, participants got the chance to delve into service users' life stories and make links between service users' backgrounds and how they present on the ward. This has led participants in adopting a much more empathetic stance towards service users' behaviours which were considered challenging. Moving towards a framework which prioritises trauma in formulations and interventions seems to have had a positive impact on the unit. However, it also seems that it has put participants in a position of needing to manage several conflicting views within the team and more specifically with medical staff. This may be affecting the consistency of both the responses towards service users and the consistency of assessments and recording systems therefore hindering the full implementation of the model. Discovering new ways to manage risk has been one of the practices that participants seem to directly link to the reduction of incidents in the unit while there seems to be a deep appreciation for the introduction of structure in the working day.

The fourth theme of 'Longer-term challenges of trauma informed change' captures the participants' perceived concerns over the sustainability of the model and the management of expectations within the team. In terms of sustainability, it would seem that there is a realisation within the team, that trauma informed change requires a lot of resources therefore keeping it up would be mean a constant effort to innovate and produce materials. Perhaps the danger inherent in that, according to the participants is that it could be draining in the long term whilst they also find themselves fighting to secure the already limited resources available. In terms of managing expectations, it would appear that participants perceived the initial implementation of the model as creating a lot of uncertainty within the team about their practice but also came with a lot of promise which they had to learn how manage over time.

Overall, it would seem that following the transition to a trauma informed forensic unit, participants have observed changes on an individual level, a group level and a clinical practice level. At the same time, concerns over sustainability and expectations about its efficacy seem to challenge the full implementation of the model within the NHS context.

4.3 Links to theory and research

4.3.1 The science of implementation

Trauma informed care as an organisational change model, when implemented, aims to improve the organisational culture of a service. Organisational culture is defined as the values, beliefs and behaviours that contribute towards the social and psychological environment of a service (Ravasi & Schultz, 2006). The results of this project highlighted the change processes that participants have been experiencing since the trauma informed protocol was implemented within the organisation. Participants talked at length about their attitudes and behaviours towards service users and themselves as professionals as well as the environment in the unit. It would appear that these have been gaining new more positive meanings since the introduction of the new framework of understanding and practicing which prioritises trauma and adversity as the roots of distress.

In line with literature from the systematic review on implementation of trauma informed care within inpatient forensic units, staff members discussed the improvements they had observed in their physical and psychological safety, their morale, and in their relationships with residents and colleagues (Elwyn et al. 2017; Kramer, M.G. 2016; Olafson et al. 2018). Consistent as well with the systematic review were the themes around reduction of restrictive practices and finding new ways to manage risk which may be contributing to the increase of physical and psychological safety for participants (Olafson et al. 2018; Elwyn et al. 2015; Kubiak et al. 2014; Kramer, M.G. 2016; Elwyn et al. 2017).

Some of the themes of this project, are also corroborating the results of the service evaluation (Robinson et al. 2018, unpublished report) which took place in one of the wards six months after the implementation of the model. The quantitative data of the evaluation showed increased job satisfaction for staff and a better environment on the ward. In this project, participants seemed to associate the increased job satisfaction with feeling more valued due to the focus on their wellbeing and the sense of achievement and purpose they have been experiencing. In a study which looked particularly into the link between trauma informed care and staff satisfaction (Hales et al. 2017), it was reported that there was an increase in staff satisfaction, with the most notable differences in staff satisfaction with their ability to do the job, their relationship to management and their connection to the workplace. Even though this study (Hales et al. 2017) focused on agency staff in outpatient settings in the USA, it would appear that a similar impact could be potentially observed in a forensic inpatient environment within an NHS context as well.

Participants talked about the difficulty of fully implementing the model in the unit due to medical staff not aligning their practice with the new focus on trauma rather than on medical diagnosis. This had created some tension within the team and at times left participants unsure about which model they needed to follow. According to Kotter's eight step model of organisational and transformational change creating a guiding coalition and getting the group to work together as a team with a common goal is the second most important step in any effort made by organisations that want to introduce new ways of working and change their culture. When the coalition is not cohesive enough then change

cannot be fully implemented. Therefore, it would seem that the full implementation of trauma informed care in the unit could be hindered by the resistance of medical staff to fully adopt the new model. This difficulty may be of particular relevance not just to this unit but to the wider system around it given that the structure of the NHS is organised through the medical model of mental health.

Overall, previous research on organisational change due to the implementation of trauma informed care (Chandler, 2008) and the themes of this project, both support the notion that cultural change requires both individual commitment and structural supports regardless of the setting and population.

4.3.2 The psychological contract

Another concept which seems to be relevant to this study is the concept of the psychological contract. The psychological contract is "the exchange relationship between employee and organisation, concerning mutual obligations in the employment relationship as perceived by the employee" (Rousseau, 1995).

They are usually viewed as serving two functions: they outline the employment relationship and create mutual expectations that shape behaviour (Hiltrop, 1995). Context has been found to play a significant role in both these functions (Chaudhry et al. 2009). As a result, these functions impact on attitudes and behaviours around trust and subsequently on commitment and cooperation (Malhotra and Murnighan, 2002). It has been demonstrated that psychological contracts are being affected during organisational change processes (Kickul et al. 2002) because the changes are likely to impact what the organisation and employees offer and expect to receive (Freese et al. 20). In this study, participants spoke about what they used to expect from the organisation and how these expectations have been changing in particular around the offering of more support structures than before. This seemed to have an impact on how participants viewed their work environment as more rewarding which subsequently seemed to be affecting their behaviours and attitudes towards themselves and others.

Schalk et al. (1998) suggested that going through an implementation process has particular consequences on the psychological contract. They located these more specific consequences in the way that the organisation manages the change processes, which information needs to be shared and what kind of support is required. Participants in this study reflected on the beginning of the implementation process and the uncertainty about what was expected from them and how less confident they felt in delivering the requirements of the model. This could potentially signify these specific challenges in the changing of the psychological contract and how these have been managed at the time. Trauma informed care may be an interesting service model to view under the framework of psychological contracts, because research so far has mainly focused on looking at the relationship between employee and organisation and not as much between service users and organisations in the context of mental health. With a trauma-informed care model, service users are not there to be "managed" but to be active participants in the designing and delivering of services through co-production. Therefore, as it has been observed in this study the relationships between service users, employees and the wider organisation is changing in terms of expectations and what is being offered. We may be observing new psychological contracts not just between staff and the organisation but also between service users, employees of the unit and the wider trust.

4.3.3 The role of leadership

Some participants in this project, talked about how they have observed more collaborative relationships among staff at all different levels, how senior staff spend more time on the ground with them and how more open they can be about their own distress with managers and supervisors.

Similarly, during the focus groups with more senior staff it seemed that participants felt that their role was to keep modelling good practice, to keep supporting staff and to manage expectations about the efficacy of the model. These themes are consistent with the role of leadership in fostering organisational change which includes practices such as role modelling and inspiring others (Kouzes & Posner, 1995). In particular, about the successful implementation of trauma informed care, Elwyn et al. (2017) indicated that even though the

model itself is an important component, it would not be sufficient to bring about the changes reported within the organisation. It would appear that changes in the leadership style of the unit, which is probably closing the gap of the previous hierarchies by prioritising relationships and sharing of information, has been seen favourably by the participants. A leadership style which seems to be more attune to what is happening at the ground level and which focuses on staff wellbeing may be contributing towards increased staff engagement and investment in the successful implementation of the model (Elwyn et al. 2017).

At the same time, apart from appearing to have confidence in this leadership style, participants talked about how they have been learning and implementing new skills, being in charge of organising sessions and generally being more in charge of their practice. By giving staff the opportunity to develop these leadership skills, the implementation process seems to be making visible to them that trauma informed care has added value and motivation in their working day (Sweeney et al. 2016). Maybe we are also observing a parallel process between staff and service users in the unit, whereby the sharing of power and control via active involvement in decision making, staff can position themselves as active agents of change which may be leading in further investment in the success of the change.

4.3.4 Compassion as resistance to burnout[1]

In February 2019, the NHS published the results of the NHS staff survey (2018) which revealed that 39.8% of staff were feeling unwell as a result of work-related stress. This was the highest figure in five years. Unfortunately, the results highlighted a significant downturn in staff wellbeing. Another finding of the survey was that fewer than three in ten staff felt their trust takes positive action to improve their wellbeing. In a study by Elliot et al. (2013) which looked into the stress, coping and psychological wellbeing among forensic health care professionals, the results seemed to support a commonly held assumption that forensic

[1]While writing this chapter, it was announced by the World Health Organisation that burnout is included in the 11th revision on the ICD in a more detailed way and is defined as: "a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It refers to phenomena in the occupational context"

services are intrinsically stressful and dangerous environments which may cause forensic staff to experience increased levels of psychological distress and burnout. Burnout can include emotional exhaustion, depersonalisation and reduced sense of personal accomplishment (Newel & MacNeil, 2010).

Participants in this study described how they had experienced burnout in the past which was manifested by feeling very disconnected from themselves and service users, by needing to take long periods off work in order to recover and by feeling like they had nothing to offer to service users. It appeared that the focus of the unit was on risk management and as one participant said, '*you were lucky if you were going out and not getting attacked'.* Participants said that the environment felt unsafe and uncontaining of their anxiety. From an evolutionary perspective, if someone feels under threat, especially over a prolonged period of time, the compassionate and self-soothing systems of the mind shut down and survival mechanisms such as avoidance and numbing of emotions take over (Lee, 2012). For forensic staff this is particularly relevant since it could explain their experiences of burnout. The way out of trauma usually involves understanding its impact, learning adaptive coping mechanisms including increasing compassion and reconnecting to ourselves and others (Herman, 1992). Compassion can be defined as 'feeling with' and 'feeling for' a person which includes learning to feel kind towards yourself (Lee, 2012). In this way the sense of threat reduces and the sense of safety increases. Within an organisation, creating a compassionate culture which leads to psychological safety in order to tackle staff burnout, is not the responsibility of its individual professional but rather needs a systemic approach (Camping, 2015). During the focus groups participants used the word compassion mainly when referring to their relationship with service users in the unit. Compassion towards others is one aspect of compassion which when it gets increased by a safer environment it then facilitates the flow of other aspects which are the increase in self-compassion and receiving compassion from others (Gilbert, 2010).

It would seem from the themes of this study that trauma informed care as a service model could potentially provide this systemic approach in increasing compassion and subsequently contributing towards psychological safety for staff and service users. Participants highlighted how they have been in a process of unlearning self-critical attitudes and

normalising their experiences of trauma while being given the opportunity to access support via training, reflective groups and supervision. They talked about how they have reconnected to the values that first brought them into this line of work. For the participants, the ripple effect of that has been their improved relationships with colleagues and service users which are characterised by openness and more trust.

With these themes in mind, it would seem that trauma informed care is very close to the concept of 'Intelligent Kindness' as proposed by Campling (2015). 'Intelligent kindness' as a concept proposes that there is a sophisticated way to think about compassion and kindness at a collective level and that leadership and organisational skills and systems can purposively promote compassionate care for both staff and service users. It is directing the attentions and efforts of people and organisations towards relationship building, recognising needs and meeting them accordingly (Campling, 2015).

In order to illustrate how these behaviours are nurtured within the wider system a virtuous cycle is proposed; staff attentiveness enables attunement which builds trust and generates therapeutic alliances which in turn leads to better outcomes. This whole process reinforces the conditions for the development of kinship which promotes compassion and kindness (Campling, 2015). The sense of kinship is understood as seeing oneself in the service user and breaks down the 'us and them' paradigm which can be particularly strong in forensic mental health services. In this study, the increased awareness of the impact of trauma on both participants and the people they serve was seen as making trauma everybody's business. Seeing trauma as a shared event within a unit, can make recovering a shared event too and a way to discover the common humanity of staff and service users. Trauma informed care seems to be rooted in the concept of collective compassion embedded in kinship.

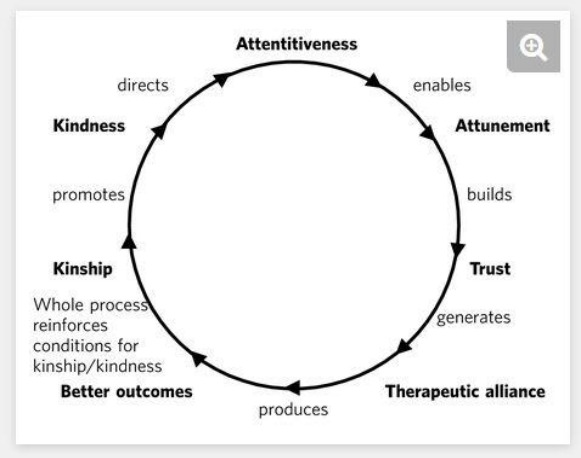


Figure 3: Intelligent kindness virtuous cycle

4.3.5 Trauma informed care as justice-doing

Adopting the 'trauma lens' is one of the first principles of trauma informed care which invites services to place behaviours and distress within cultural, historical and gender contexts through training staff on the impact of trauma in people's lives. Therefore, by promoting an intersectional view of distress, it is prioritising people's stories and seems to move away from a positivist view of mental health. Participants in this study talked extensively about adopting the trauma lens as a new framework of understanding in their everyday practice. This seemed to affect the way they manage risk, the way the create intervention plans and the way they relate to service users. At the same time, the changing paradigm of the unit seems to be coming in contrast to an NHS context which is diagnosis driven. This appeared to be leaving staff confused and frustrated a lot of the time about what approach they need to be following on the ward. Participants located this tension particularly in relation to medical doctors and articulated the wish for them to get on board in order to ensure the successful implementation of the model. It is after all a requirement of the model that all systems within a service are in line with the model's principles.

The Division of Clinical Psychology (DCP) has developed several publications the last few years advocating for a paradigm shift in mental health services with professionals' guidelines on language and formulation and a Position Statement on psychiatric diagnosis (DCP, 2013). Additionally, the DCP launched the Power-Threat-Meaning framework which is

a conceptual meta-framework that is being proposed as an alternative to diagnosis (Johnstone & Boyle, 2018).

Long before these efforts though, there has been the rise of a strong movement led by survivors of the psychiatric system. The survivor-led movement has not been restricted in providing evidence about what it is like to use mental health services in order to bring the restrictive and re-traumatising practices into the public's awareness, but it has also been advocating for a change in how we conceptualise mental distress (Campbell, 2013) by challenging professional understandings of it. The debates and activism around different model of distress have been long-standing and ongoing. For a lot of the participants of this study, it could potentially be something new to engage with which may have emerged from the implementation of trauma informed care in the unit.

Changing the culture of an NHS organisation towards an understanding of mental distress which moves beyond diagnosis can be very challenging and the study results highlight as well how deeply political this kind of changes really are. At the core of the trauma informed care model, we find the recognition that systems can be re-traumatising and as professionals we are asked to resist that. In order to resist re-traumatising, we need to address power dynamics, abuses of power and replication of acts of oppression (Reynolds, 2012). Therefore, trauma informed care, on one hand is about opening up to accountability as professionals and on the other is about taking an anti-oppressive position. It has been argued (Sweeney and Taggart, 2018) that any development of trauma-informed approaches should include a social justice element because 'trauma' is not just a diagnostic category, but it is also a concept with political and social implications for survivors. Therefore, the centrality of survivors' voice in any attempt of implementation of trauma-informed care is considered a key element of the model (Sweeney and Taggart, 2018).

Participants talked about how they have been actively involving service users in decision making regarding the running of the wards, giving them back control and choice over their possessions, activities and environment, and how they have been making efforts to limit the use of restraints and seclusion by managing risk in a different way. These may be some

examples of how they have been showing more consideration of power dynamics in their practice. At the same time, the themes around the changing relationships between colleagues of different rankings and the focus on staff wellbeing could potentially be seen as the organisational culture transitioning to a more anti-oppressive stance towards staff too.

Overall, it has been well documented that the healthcare system can be replicating oppressive systems found in society. As helping professionals, taking an anti-oppressive stance demands from us to reflect on our own relationship to power, privilege and our relationship to social control and change (Reynolds, 2012). Accepting accountability and recognising the impact of trauma could be the first steps in making the transformation of re-traumatising structures our duty and part of our everyday practice.

4.4 Implications

4.4.1 Overall implications

The study results could indicate that trauma informed care when implemented has a profound effect on an organisation, which goes beyond the everyday practice elements of what a service does. The themes point to both an ongoing individual and group level transformation which starts taking place. Parallel processes of unlearning and learning start emerging for individuals and groups, whilst everyone becomes aware and navigates old and new challenges which come with change.

The study also highlights the considerable investment needed by leaders and teams and the big amount of resources required to successfully implement and maintain the model within a service over time. In particular, there is an implication about the allocation of money and resources on both staffing levels in each ward but also in the provision of appropriate materials in order to maintain the running of the daily activities.

Most importantly, the research demonstrates the value in seeking the views of people directly involved with service users and how much they can contribute to the body of knowledge in the field of trauma informed care.

4.4.2 Clinical Implications

4.4.2.1 The NHS Long term plan: Dissemination of Trauma Informed care in AMH

The NHS Long Term Plan (2019) which was published earlier this year postulates that trauma-informed care will be central to NHS England's adult mental health services particularly for services for people with a diagnosis of a 'personality disorder' and services for young people in the youth justice system.

The plan said that the NHS wants to ensure that people with lived experience are at the heart of designing, developing and implementing these plans. In order to achieve that NHS England (2019) aims to deliver training on trauma informed care across the adult mental health workforce. Results from this study, which is one of the first to look at the implementation of trauma informed care within an NHS context, could potentially inform the planning and training stages of implementation. It may as well inform teams on what to expect following implementation including potential challenges. Hopefully, it could also make the case for NHS England to not just disseminate trauma informed care in community services but also to inpatient and forensic inpatient.

On the 28th of March 2019, The Academic Health Science Network for the North East and North Cumbria and the North of England Mental Health Clinical Network hosted an event entitled 'Creating a Narrative for Trauma Informed Service Transformation'. The purpose of the event was to use narrative good practice examples to draw out some themes that could be useful in designing and organising services. I was invited to this event and this study was offered as one of the narratives of practice used on the day. The ultimate goal of the day is to inform the development of a Trauma Informed Care framework that might be useful for commissioners wishing to develop their services.

4.4.2.2 The NHS Long term plan: Staff wellbeing

The NHS Long term plan (2019) also included plans for improving staff wellbeing. The Health Education England draft health and care workforce strategy; 'Facing the facts, Shaping the future' indicated recruitment and retention of staff as key issues linked with the recognition that insufficient attention has been paid to the impact of poor psychological wellbeing and stress of staff on organisational success. It is also recognised in the same draft report that the wellbeing of staff affects patient care, staff retention and navigating the challenges facing the NHS. Results of this study highlighted the benefits of the focus being on staff wellbeing within an organisation especially when the service is undergoing a change which can increase anxiety and uncertainty. Participants talked about how they have been experiencing less burnout which they seemed to link to the changing culture, they feel more supported and motivated and the sickness levels have dropped within the unit. These themes could inform efforts of NHS trusts on improving staff wellbeing. Additionally, participants talked about personal accountability and realising their own role in potentially re-traumatising practices which were taking place in the unit as well as learning about the service users' traumatic histories. Given that health care professionals experience vicarious trauma (Sage et al. 2017) the challenge for any organisation considering implementing trauma informed care would be to negotiate complex interpersonal dynamics arising from these realisations and trauma histories (Sweeney and Taggart, 2018).

The National Workforce Skills Development Unit (2109) commissioned by the Mental Health Foundation developed a framework called 'Workforce Stress and the Supportive organisation' which aims to invite organisations to improve staff wellbeing via reflection, curiosity and change. This is a systemic framework which invites organisations to think about the elements that can support of hinder the people it comprises. It explicitly indicates that traditionally the individual was responsible of their resilience and how much they can take at work therefore organisations being absolved of responsibility for supporting them. However, the framework states that:

"*Organisations and indeed the wider system have a duty to support people who are doing difficult jobs in challenging circumstances. In short, an organisation should maintain a culture and operate in such a way that the need for personal resilience in minimised as much as possible, allowing people to maintain the compassion and empathy that led them to choose careers in the health service"*

The framework suggests five pillars of equal importance: 1) Leadership and management 2) Behaviours, attitudes, and beliefs, 3) The nature of the work 4) Structures and processes 5) psychological safety. This is particularly relevant to staff working in forensic inpatient settings given the very challenging environment they find themselves in and to the results of this study. Some of the themes of this study map onto these five pillars. Results have indicated how attitudes are changing, how psychological safety is being promoted, the processes that have been changing and the role of leadership in these since the implementation of trauma informed care. Results have also highlighted how wellbeing and recovery became a group responsibility and process since the implementation of trauma informed care. Therefore, it could be argued that trauma informed care as a service model already involves this framework of thinking in its principles. Furthermore, the results of this study could inform efforts of other NHS organisations which would like to use either the Model of supportive organisations or to reflect on the principles of trauma informed care when thinking about improving staff wellbeing.

4.4.2.3 Evaluating the implementation

As it was described in the systematic review of the literature, a decision was made to include the local service evaluation of one of the forensic inpatient wards which was conducted at the six-month point of implementation of trauma informed care. The evaluation involved quantitative measures and indicated that there was a significant reduction of number of incidents, staff were more satisfied at work and the environment felt better. Some of the results of this study support the outcomes of this evaluation. The qualitative nature of this study can inform the quantitative data and provide valuable insights on the process of implementation particularly on how staff have made meaning of it and how they have viewed the whole process. The service evaluation was conducted in only

one of the wards, but further evaluations are currently being done for the rest of the unit. The study involved all four wards in the unit; therefore, it could inform the outcomes of the rest of service evaluations as they happen for each ward. Hopefully, the themes can inform further training events for staff in the unit as well as any future efforts to implement trauma informed care in the rest of the hospital which also comprises of male forensic wards. Both the local evaluation and this project also keep in line with the trauma-informed organisational change model as proposed by Harris and Fallot (2001) which suggests that a short-term follow up and a longer term one in order to identify any barriers in implementation that need to be addressed.

4.5 Methodological Considerations

4.5.1 Strengths of the current project

This is the first known qualitative study to have evaluated the impact of trauma informed care on staff within a forensic inpatient unit within an NHS context in the UK. As it was demonstrated in the introduction and systematic review, trauma informed care is fairly new in the UK and the evidence of its efficacy is mainly coming from a US context.

Due to its qualitative design, the study offers an in-depth description of the impact on the workforce, which offers good insights into the quantitative data gathered in by the service and further makes the case for considering trauma informed care as a feasible alternative to more traditional ways of working in mental health services.

4.5.2 Limitations of the current project

Trauma informed care is a complex organisational change model. It would be difficult to evaluate its full impact on the organisation's culture by only capturing it at one point in time as this study did. Therefore, the results may be relevant only for this initial stage of implementation and may be difficult to generalise them at later stages of implementation.

This study did not involve service users. The impact of trauma informed care on service users was discussed by staff therefore it is based on their assumptions and the meaning

they have given it. Therefore, this study could not account for their experience. In order to capture the complexity and impact of the model service users will have to be included in future projects.

The majority of participants came from mainly the nursing profession or had a nursing background. Consequently, the results may not be representative of all staff. Furthermore, all the participants were female, and the unit includes only forensic female wards. Again, the results may not be representative of efforts to implement trauma informed care in make inpatient units. Finally, the results may be relevant to inpatient units, but they may not be applicable to community setting or primary care settings in the NHS.

4.5.3 Reflections of the research process

This project has been the biggest learning curve for me as researcher. I had conducted research before, but nothing would have adequately prepared me for what was ahead when I first thought of looking into trauma-informed systems change. And even though, I did learn a lot about changes in organisations, I also went through an internal process almost parallel to what has been described in this study, as a re-construction of identity as both a researcher and a clinician. I noticed how I learnt to manage my expectations of the model and face the realities of wider contexts and how to manage my own biases about my participants' political affiliations and the relational risks I needed to take in order to ensure a rewarding research process. If anything, I ended this project feeling a bit more hopeful than when I started despite all the struggles on the way. Feeling a bit more hopeful about the future of the health service and how I would like to position myself within it. It was interesting doing this project while doing a complex trauma specialist placement. Part of the week I am using trauma theory applied on an individual intervention level and the rest of the week using trauma theory applied on a systemic level and realising how these parallel processes can come together. If anything, I would like to continue bringing them together in my practice in the future.

4.6 Areas for future research

4.6.1 Longitudinal study

It would be very valuable for this project to be the beginning of a longitudinal evaluation of the impact of trauma informed care. Since this project tried to capture the first year of implementation, it would be interesting to see if similar or different themes develop at the two- or five-year mark and even later on. As a complex organisational change model, it needs to be captured at different places in time in order to be evaluated in full.

4.6.2 Studies involving service users

In order to further understand the impact of trauma informed care in order so as to inform practice and policy within the NHS, future impact studies will need to involve service users as participants but also in the designing and planning stages of research.

4.6.3 Studies of trauma informed care in different settings

As it was described, trauma informed care as a service model provides a set of principles that need to be followed and which need to be adapted according to the context of a service. Since trauma informed care is in the NHS Long term plan for adult community mental health services, it would be important to conduct research in these settings in order to capture the differences in impact and outcomes between inpatient and community services.

4.6.4 Studies exploring the emotional impact on staff

Exploring the emotional impact on staff after discovering the trauma histories of the service users and their role in restrictive practices was beyond the scope of this particular project. However, exploring this further could offer implications for both staff wellbeing and training and well as staff how staff members implement the model.

4.7 Conclusions

This study aimed to explore the impact on staff of transitioning towards a trauma-informed care model within a female forensic unit in the UK. The results suggested that staff members may be experiencing changes in their professional identity, in their practice and in their relationships with service users, colleagues and senior staff members. The initial change process may have caused some uncertainty around what was expected from staff members while they also had to learn to manage their own expectations of the outcomes. At the same time, an environment of limited resources may be increasing the anxiety around the sustainability of the trauma-informed care model in the long term within the current NHS context. The results highlighted the importance of actively considering and including staff wellbeing and development structures, in any attempt of changing an organisation's culture to become trauma informed. Trauma-saturated organisations can have serious negative consequences on both staff and service users (Sweeney et al. 2016). Thinking about the impact of trauma through an ecological framework we could reach an understanding that trauma and adversity not only overwhelm the individual's adaptive capacities, but also the capacity of communities to foster resilience (Harvey, 1996).

Any difficulties with recovery from trauma would not just signify the perseverance of individual distress, but they could also tell us something about the quality and helpfulness of the relationship between the individual and their social context (Harvey, 1996). Therefore, interventions would be looking for enhancing the person-environment relationship through reducing isolation, fostering competence and promoting belonging (Levine, 1987). We could argue, the trauma-informed care is inviting organisations to re-consider and take action in enhancing the interrelationship between person and environment and to apply that to both staff and service users.

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Appendix 1: Strategy for searching databases

Database	Search Criteria	No of papers found at search	Number of papers after titles screened	Number of papers after abstract screened
SCOPUS	Trauma AND informed AND forensic OR correctional OR prison AND staff OR service* use*	24	11	4
	Trauma AND informed AND correctional AND staff OR service* use*	6	4	2
	Trauma-informed AND correctional OR prison OR low AND secure OR medium AND secure AND staff or service* use*	1	1	1
	Trauma-informed AND forensic OR prison OR correctional AND staff OR service* AND use*	16	12	4
	Trauma AND informed AND forensic	70	7	2
	Sanctuary AND model AND trauma	32	3	3
PubMed	Trauma AND informed AND correctional	28	4	3
	Trauma AND informed AND forensic AND staff	10	2	1
	Sanctuary AND model AND incarcerated	157	5	2
	Trauma AND informed AND offend*	35	6	3
CINAHL Plus	Trauma-informed AND care OR practice AND correctional AND staff	10	4	3
	Trauma AND informed AND care AND offend*	5	2	2
	Sanctuary AND model	19	2	1
	Trauma AND informed AND forensic	8	4	2
Total		421	67	33 After removing duplicates: 22

Appendix 2: Systematic Review Process

	SCOPUS	*PubMed*	*CINAHL Plus*	*Grey literature*	*Total*
Total papers after title screen	38	17	12	1	68
Total Papers after abstract screen	8	9	5	1	23
Total Papers after full texts read	4	2	1	1	8

Total papers after title screen	68		
Total papers after abstract screen	23	<u>Exclusion criteria</u> • Describing outpatient intervention for service users: 1 • Describing direct trauma intervention for service users: 6 • Referring to trauma-informed care as a future implication: 14 • Implications for eliminating restraints and seclusion for nurses: 8 • Trauma informed care in a school environment for forensic patients: 1 • Trauma informed care presented as a framework for practice :3 • Trauma informed care in an emergency department: 1 • Duplicates: 11	<u>Inclusion criteria</u> • Research focusing on service users of forensic units and/or staff members • Research reporting results at an organisational level • Evaluating feasibility of TIC within forensic inpatient • Evaluation of TIC organisational change in the UK
Total papers after full texts read	8	<u>Reasons for exclusion include:</u> • Lack of research design :2 • Focus on manualised intervention within a TIC unit :2 • Focus on psychologically informed environments: 3 • Focus on prevalence of trauma: 4 • Focus on community services: 2 • Focus on relationship with probation officers: 1 • Mental health inpatient unit not forensic: 1	

Appendix 3: Quality assessment of all qualitative studies using the Eight "Big-Tent" Criteria for Excellent Qualitative Research (Tracy, 2011).

Criteria for Quality	Kramer, M.G, 2016	Elwyn et al. 2017	McEvedy et al. 2017
Worthy topic	Yes	Yes	Yes
Rich rigor	Yes, A wide range of data collection tools	Yes	Yes, used a combination of data collection tools
Sincerity	Yes, researcher honest about being known to the agency and being a former employee 15 years ago	Paper transparent about methods and challenges however no account of self-reflexivity from the two researchers.	Yes, open about challenges and role and identity of researchers
Credibility	Yes, copy of open coding themes was sent to members in order to co-construct results	Yes	Yes clearly demonstrates triangulation
Resonance	Yes	Yes	Yes
Significant contribution	Yes,	Yes	Yes
Ethical	Yes, detailed ethical procedures described	Yes	Yes, ethics procedure clearly stated
Meaningful coherence	Yes	Yes	Yes

Appendix 4: Quality assessment of the quantitative studies using the Critical Appraisal Skills Programme (CASP, 2018).

CASP Criteria for a Cohort study	Did the study address a clearly focused issue?	Was the cohort recruited in an acceptable way	Was the exposure measured accurately to minimise bias?	Was the outcome measured accurately to minimise bias?	Have the authors identified all important confounding factors?	Have confounding factors been considered in the design and analysis?	Was the follow up on subjects complete enough?	Was the follow up of subjects long enough?	How precise are the results?	Do you believe the results?	Will the results help locally?
Olafson et al. 2018	Yes	No (participants not randomly selected therefore may not representative of population)	Yes (measures administered across six facilities of both male and female residents)	Yes	No	No	Pilot project Unclear if there was a follow up but measures routinely administered at facility	Unclear if there was a follow up	Clearly described.	Yes	Yes -implications for implementation of TIC and training needed
Messina et al. 2014	Yes	Yes	Yes	Yes	Yes	Yes clearly indicated	Yes	Not clearly stated how long it was	Clearly described	Yes	Yes -implications for gender responsive treatments at the facility
Elwyn et al. 2015	Yes	Yes	Yes, measures for both staff and residents	Yes	Yes	Mainly in analysis	Study used measures routinely administered in the facility	Same measures continue to be administered after end of study	Clearly described	Yes	Yes

Appendix 5: Quality assessment of the mixed-methods study (Ferris et al, 2016) using the Mixed-Methods Appraisal Tool (Pluye et al, 2011).

PART I. MMAT criteria & one-page template (to be included in appraisal forms)

Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?	X			
	• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	X			
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	X			
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?	X			
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	X			
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?		X		
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?	X			
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?			X	
	2.3. Are there complete outcome data (80% or above)?	X			
	2.4. Is there low withdrawal/drop-out (below 20%)?	X			
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?	X			
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?	X			
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?		X		
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?		X		
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	X			
	4.2. Is the sample representative of the population understudy?	X			
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?	X			
	4.4. Is there an acceptable response rate (60% or above)?	X			
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	X			
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	X			
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	X			
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

2

Appendix 6: UH, HRA, R&D Approval Documents

University of Hertfordshire UH

HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Vasiliki Stamatopoulou

CC Dr Keith Sullivan

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.

DATE 23/08/18

Protocol number: LMS/PGR/UH/03414

Title of study: Transitioning to a trauma informed forensic unit: Exploring staff perceptions of a shift in organisational culture.

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: 01/09/18

To: 01/05/19

Additional workers:

Dr Angela Kennedy, Consultant Clinical Psychologist & Trauma Informed Care lead [redacted]

Please note:

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page http://www.studynet1.herts.ac.uk/ptl/common/ethics.nsf/Teaching+Documents?Openview&count=9999&restricttocategory=Application+Forms

Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval (if you are a student) and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

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Dr K Sullivan
Ms V Stamatopoulou
Department of Psychology and Sport Science
School of Life and Medical Sciences

11 December 2018

Dear Dr Sullivan and Ms Stamatopoulou

Re: **UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:**
RESEARCH STUDY TITLE: Transitioning to a trauma informed forensic unit: Exploring staff perceptions of a shift in organisational culture
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Keith Sullivan
NAME OF INVESTIGATOR (Student): Vasiliki Stamatopoulou
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGR/UH/03414

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission and notification to the Health Research Authority or University of Hertfordshire Ethics Committee with Delegated Authority (ECDA) as relevant, and I must also be notified of the outcome. It is essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as they are received. Copies of annual reports and the end of study report as submitted to the HRA also need to be provided. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Keith Sullivan
University of Hertfodshire
College Lane
AL10 9AB

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

08 November 2018

Dear Dr Sullivan

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Transitioning to a trauma-informed forensic unit: Exploring staff perceptions of a shift in organisational culture.**
IRAS project ID:	**249401**
Protocol number:	**LMS/PGR/UH/03414**
REC reference:	**19/HRA/0452**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be

IRAS 249401: Confirming Capacity and Capability within [redacted]

Researchanddevelopment [redacted]t>

Fri 07/12/2018 14:18

To: Vasiliki Stamatopoulou [Student HMS] <vs1[redacted]
[illegible]@nhs.net>;

Cc: [illegible] (TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST) <[illegible]@nhs.net>; Researchanddevelopment (TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST) <TEWV.ResearchAndDevelopment@nhs.net>;

3 attachments (305 KB)

SOP Contents Page V5.pdf; LTEWV Start-up Report.docx; 249401 HRA statement activities v2 26112018.docx;

Dear Dr. Keith Sullivan and Ms. Vasiliki Stamatopoulou,

Title: Transitioning to a trauma-informed forensic unit: Exploring staff perceptions of a shift in organisational culture
IRAS number: 249401
R&D reference: 0559/18

This email confirms [redacted]ed study. Please find attached our Statement of Activities as confirmation. We agree to start this study **10th December 2018**.

The research m[redacted]res, which are available to you on request (see attached index of SOPs) or through InTouch for Trust employees.

We require you to let us know when you recruit the first participant and to complete a start up report within the first three months of the study gaining confirmation, a progress report (if required depending on study duration), and on the completion of the study which will outline the key findings for dissemination to clinicians, service users and carers as appropriate. We also encourage you to inform us of any publications which results from the project.

The Trusts R&D office also conducts a yearly audit of 10% of the research studies set up within the Trust, and you will be informed in advance if this study is due to be audited.

I would like to take this opportunity to wish you every success with your research. If there is any way that we can assist you in the future please do not hesitate to contact us.

Best wishes,

Marinder Kaur
Research & Development Facilitator
Research an[redacted]
Tel. 01642 283501
E-mail: marinder.kaur@nhs.net
[redacted]

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Appendix 7: Content of training received by all staff at the beginning of the implementation process

- Why do we need trauma-informed care, what do we mean by it and what does it look like?
- Vicarious trauma and staff wellbeing-why are we all burnt out?
- Understanding why the ward can trigger someone's trauma
- Attachment theory and links with abuse and violence
- Insecure Attachment styles
- Relationship difficulties-Patient-Nurse interpersonal complexities
- The importance of reflecting on these relationships
- Implications for clinical work
- What is trauma and acute stress reactions-How do people become traumatised?
- PTSD and Complex PSTD
- Diagnosis vs formulation
- Developing compassion
- The effect on our emotions
- Trauma informed interventions
- Overview of processing therapies: EMDR, CAT, NARRATIVE, SCHEMA, CBT, DBT
- 7 Domains of skill development: mindfulness, multi-sensory grounding, emotional regulation, distress tolerance, interpersonal effectiveness, meaningful activity, positive action/connection/recovery
- Opportunity for everyone to discuss the roll out of TIC in the unit, fears and expectations
- Next steps, what now, how do we get this off the ground, ideas, what support do you need?
- Review of pilot

Appendix 8: Participant Information sheet

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

IRAS: 249401

PARTICIPANT INFORMATION SHEET

Title of study

Transitioning to a trauma-informed forensic unit: Exploring staff perceptions of a shift in organisational culture.

Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulations governing the conduct of studies involving human participants can be accessed via this link:

http://sitem.herts.ac.uk/secreg/upr/RE01.htm

Thank you for reading this.

What is the purpose of this study?

The aim of this study is to provide an in depth description of the perceptions of staff working in an inpatient forensic unit of transitioning from traditional care to a trauma-informed service and the factors that influence the progress of this transition.

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect your employment with the TEWV NHS Foundation trust.

Are there any restrictions that may prevent me from participating?

You will need to be a TEWV NHS Foundation trust employee working on one of the four inpatient forensic units. You will have worked in one of the units prior to transitioning to a trauma informed care model and after its implementation.

What will be involved?

You will be asked to participate in a focus group with the researcher.

The focus group will last for approximately an hour and a half and it will be audio taped. The researcher will also take handwritten notes in order to facilitate discussion.

The researcher will also ask you to complete some information on yourself.

Information collected will include sex, age, ethnicity and occupation. Any of this information collected will not be matched to individual comments or discussions when reported and only used to describe the overall sample.

The researcher may use some direct quotations from the discussion during the write up of the study and in publications. The quotes will not include any identifiable information. Thus confidentiality will be upheld and no individual will be identifiable in any subsequent write up or publication.

How will my taking part in this study be kept confidential?

The equipment used for recording and storage of data will be encrypted and password protected. Only the research team will have access to the data.

The data collected will be anonymised and will not be matched to individual responses.

You will be asked not to say your name or names of other participants in your group, or the names of the forensic unit that you are employed by, when on tape.

What will happen to the data collected within this study?

The consent forms will be kept in a locked cupboard in the office of Dr Angela Kennedy at the TEWV NHS Foundation trust and will be destroyed via secure NHS shredding services at the end of the study in September 2019.

The recordings will be deleted from the encrypted Dictaphone as soon as they have been transcribed by the researcher. The transcripts will be securely stored in a password protected computer. The transcripts will be deleted permanently at the end of the project in September 2019.

All data will be anonymised prior to storage.

Will the data be required for use in further studies?

The data will not be used in any further studies;

Who has reviewed this study?

This study has been reviewed by the: Health, Science, Engineering and Technology Ethics Committee with Delegated Authority (ECDA).

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me in writing by email: vs16aao@herts.ac.uk.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar.

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this

Your Information, NHS Research, and the General Data Protection Regulation (GDPR)

The University of Hertfordshire is the Sponsor for this study and ……NHS Trust is a collaborator that is organising this research, both organisations are based in the United Kingdom. **The University of Hertfordshire** and the **… NHS Foundation Trust** will be using information from you in order to undertake this study. **The University of Hertfordshire** will act as the data controller for this study, this means that we are responsible for looking after your information and using it properly. **…NHS Foundation Trust** will keep identifiable information about you for no longer than after the study has finished. The study will finish in September 2019.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how the NHS uses personal information at https://www.hra.nhs.uk/information-about-patients/.

… NHS Foundation Trust will use your name and contact details to contact you about the research study, and make sure that relevant information about the study is recorded to oversee the quality of the study. Individuals, the University of Hertfordshire, and …..NHS foundation Trust, and regulatory organisations may look at your research records to check the accuracy of the research study. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Appendix 9 : Participant consent form

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANT
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here*, *in BLOCK CAPITALS]*

……..
of [*please give contact details here, sufficient to enable the investigator to get in touch with you, such as an email address]*

…….
Hereby freely agree to take part in the study entitled

Transitioning to a trauma informed forensic unit: Exploring staff perceptions of a shift in organisational culture.

IRAS: 249401
UH Protocol number ……LMS/PGR/UH/03414

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

Signature of participant……..…Date……

Signature of student researcher……Date……

Name of student researcher Vasiliki Stamatopoulou

Appendix 10: Debrief Info

After you participated in the Focus groups:

- Some of the material we talked about today may be distressing. If you found anything in this process upsetting please speak to the ward manager or one of the Trauma leads. Your current supportive platforms such as supervision and reflective groups will also be appropriate spaces to voice any distress.

- I will remain in the unit today and tomorrow therefore if you would like to talk to me about any part of the focus groups I will be happy to do so. My contact details are on the participant information sheet.

- If you need extra support then please speak to your GP or out of hours call the Samaritans on 116 123 or go to A&E.

Thank you again for participating in this study.

Appendix 11: Interview Schedule for focus groups

Semi-Structured focus group questions

What is your understanding of trauma informed care?

How your experience within a trauma-informed forensic unit compare with your experience within a unit that followed a traditional care model?

What has the process of change been like? What was difficult? What concerns you? What changes have you noticed if any?

How have choice, collaboration, empowerment, safety and trust been integrated into the programme?

Do you think that TIC has had any impact on your relationships with colleagues/managers and service users?

What systems on the unit have needed change?

What skills do you use now that helps with TIC?

Do you behave any differently and if so how?

Do you use any 'products' eg. leaflets, questionnaires, grounding boxes etc that have been helpful?

What do you think the benefits are already? What will be the benefits in the future and what still needs to be done to get there?

Appendix 12: Extract from reflective diary

17th December 2018

07:06 am

On a very early morning train, travelling to … to meet my liaison at the research site. I will also be meeting a research assistant who will bring with her the Dictaphone for me to test. I will probably meet some of my potential participants as well. This is very exciting. It has taken a long time to reach this point. I have felt defeated by the process of acquiring all the approvals necessary on many occasions and the fact that I am now so close in collecting my data is both relieving and very scary. What if something goes wrong? What if the equipment does not work? I guess these are the fears that I am trying to tame with my visit today.

The North of England is an area that I have not explored before. I am really curious about the people I am going to meet. I feel quite biased and expect that most of them will be xenophobic. I am dreading the comments I might hear. My experience so far though has been a very positive one. The people I have liaised with have gone above and beyond to accommodate my project and help me. From ordering new Dictaphones for me to use, to my liaison doing the recruitment on the site and organising the practicalities of the focus groups, to the research assistant who will meet me at the station to take me to the site and show me around I have been left speechless with gratitude. This project couldn't have even started without them. It takes a village!

15:58 pm

On the train back home. The north feels different. It is something about the people that I recognise. It is something familiar to me even though I come from a completely different world. It Is a warmth and a friendliness that makes me feel very comfortable. People say hi even if they don't know you, taxi drivers start great conversations, people introduce themselves, people welcome me with big smiles. There is something about this north industrial town which gave me a glimpse of home today. During a supervision session back in September, my field supervisor said that I was about to find myself doing research with some very rough northern people and asked me how I felt about that. At this very moment I realised that I had not considered the difference in culture at all and maybe I should have had. I do it all the time in my clinical work why I hadn't afforded my research participants and my local contacts the same consideration. And here I am now, having met some of them today that I feel closer to them in mentality than I ever did so grateful that I have them on board this project.

I got the chance to visit the wards and interact with some service users. My liaison has been nominated for clinician of the year. Wherever we go service users greet her with delight.

I felt quite impressed with the support structures they have in place for staff. There is a trauma lead in each of the wards, there is an alternative to debrief, there are therapies offered to staff who have been traumatised by incidents on the ward, there are trauma group formulations taking place. I keep thinking about the complete lack of support for staff, I experienced during my last inpatient placement. When I ask my liaison if she sees mainly staff or service users she says both 50%-50% because if staff is not happy then service users will not be happy. I couldn't agree more but this is so overlooked most of the time.

Everything seems to be organised and ready to go in January. It is going to be a busy month.

I found out that my supervisor has been off sick for a while and will be off sick for a while longer. She has not mentioned anything to me and I wonder why.
Met Greek clinical psychologists in the same office.

Tuesday 16th January 2019 First focus group completed

Just finished the first focus group. So many thoughts!

When I arrived this morning, I was told by Sarah that it might not be able to have just HCAs or nurses in the group today but I might have a mixture of HCAs and more senior staff. This made me feel quite worried about how I am going to handle difficult dynamics within the group and how forthcoming the people will be especially since this is something that I have be adamant about since the beginning to keep ground staff and senior staff separate. Eventually due to staffing issues the focus group was comprised by HCAs and nurses. I felt the participants were overall very open and honest especially about their struggles.

The group started with 7 participants which was more than I expected. Unfortunately, ten minutes in the recording of the conversation the alarm went off and two of the participants had to leave the group in order to respond to an incident on the ward. I did invite them to re-join the group but I felt it would be very difficult. Initially this made me feel quite deflated in terms of having less participants after the initial joy of having seven but now I am able to reframe this and think that this is real world research therefore things like that should be expected. Participants returned after a few minutes.

When I mentioned this to my local collaborator, she was happily surprised to hear it, that I would be describing and defending what happened instead of shying away from it. I said to her that I am not looking for an idealised version of TIC where nothing happens and everyone is happy all the time. I saw a sign of relief on her face. This person is the one who has been instrumental in the implementation of TIC therefore I assume she is quite invested in this research going well or demonstrating good results but on the other hand she may be afraid that she will be judged if things don't seem to be working well.

Moderating the actual group felt easier than I expected. Maybe it was the fact that the participants were talking a lot and did not need any prompts to participate in the conversation. What I found more difficult was focusing the conversation on them, as staff members, as professionals and the impact of TIC on them rather than on service users. The conversations sometimes were quickly escalating towards the "challenging behaviours" of service users and how female forensic service users are "notoriously" difficult to work with. This was difficult for me to hear on two levels. Firstly, because I found myself in a position as a moderator to keep asking them to think about the impact of a changing system on them and them finding it very hard to be self-reflective on their experience. I kept thinking 'Well this does not answer my research question, but I do not want to keep interrupting you because I don't want to scare you'. Secondly, I come from a feminist perspective in my clinical work and have a very soft spot particularly for female offenders who we know 90% of the time have experienced substantive prolonged abuse in their lives. It was very hard hearing some of the biased views towards female service users and had to actively stop myself from being "challenging" of these views during the group. What is it about women's

distress that it is so difficult to grasp? All my participants were also women, but I guess as with other oppressed groups we are born within a patriarchal system which conditions us men and women to think that women should be nice, caring, smiling, good mannered etc. so a female offender , as I read somewhere recently and resonated with me, not only goes against someone or something when she offends but goes against her own gender as well. So how does someone react to that ? What is the right response? It can feel quite confusing. A female going against the expectations not only while in the community where she offends but also in the ward. And even though there is training on trauma and trauma responses there was still a discussion about manners or lack of manners from service users towards staff. A difficulty of understanding "Why since I am caring for you why do you still use abusive language with me? |"

I also sensed a fear of attachment. Of service users attaching too much on staff. This made me think of actual attachment theory and how it explicitly says that secure attachments actually lead to independence and empowerment and probably success in exploring the world on your own. I wonder if this fear of attachment actually leads to recurrent re-admissions. I wonder how counter-productive this could potentially be.

Overall, I am getting a sense of transitioning to a TIC care model is not a single point in time where a service can say we are now TI. It has to be a continuous effort with no ending point. Apart from the process of learning and understanding more about how trauma impacts on people there is also a parallel process of unlearning that needs to take place which is done more unconsciously. I guess this links to any kind of liberation movement which fights oppression either be it about race inequality and how white people need to unlearn and unpick unconscious biases while committing to learn more about the experience of navigating this world as a person of colour and taking action to limit the disparities or similarly as in the feminist movement etc.

TIC as a model requires the sharing of power, requires control to be given back to service users and this is a difficult concept to embrace when you have been working for a long time with a psychiatry diagnosis-led mental health system which has been historically founded on coercion and control. In forensic services, I assume this power dynamic plays out even more because they are specifically designed to control starting from the locked doors, the controlled environment, the practices of restraint and seclusion etc. For a forensic mental health staff member, whatever the job title, I begin to realise, this gives an additional level of complexity when transitioning to TIC model which may need to be taken into account.

Thinking about some of the future implications of this I wonder if the training staff members receive, needs to be tailored to include the intersections of the impact of trauma with gender, race, class etc. while also addressing the fear of attachment more explicitly. Even about oppression and the sharing of power. This makes me think of something I read by Dr. Maria Paredes "Trauma-informed is important but social justice informed is even more important. One cannot do truly trauma informed without understanding the trauma of social injustice" I start to understand even more now what this means.

I have a second focus group tomorrow with mainly clinical leads and trauma champions. It will be interesting to see where the conversation will take us. In terms of my moderation

style I feel that I will instruct people at the beginning of the group and make it very clear that this project is focusing on them and that each question I ask needs to be answered from their own context and perspective as professionals. I hope this will help to keep the conversation focused. To report back here tomorrow.

Some themes I could potentially look for in the analysis:
Process of learning
Process of unlearning

Wednesday 17th January 2019 Second focus group completed

Today I also had 7 participants and they were all able to remain until the end. This is doing wonders for my thesis nerves! It makes me feel quite confident that I can get some really good data out this.

Today's participants comprised mainly by clinical leads and trauma champions. All female as yesterday. My initial fear about this population was that they will try to present a smooth process of transition which may not be really the case. Especially following from yesterday's focus group which was very forthcoming about difficulties and challenges. I am happily proven wrong.

I could feel there was some tension at the beginning when people came in the room. It dawned on me that I am a stranger walking into a well-established group of people asking them to share some quite intimate thought about their job in front of other colleagues. How do I manage that?

I decided to share a few things about myself before we started. I talked about who I am, where I am coming from, what is the personal connection to this, why I am doing it, what is expected of them. I immediately felt this had an impact on the dynamic in the room. I am glad I did it. I will do the same for my next group. And of course, as I thought about it yesterday, I did say that I would like to focus their reflections/thought etc on themselves as professionals going through this transition.

Later today I received a message from Sarah, my local collaborator thanking me for being so warm and personable and that I may have shown nurses how research doesn't have to feel scary. It felt amazing to read that. After the awful, extremely prolonged ethics application process which made me lose sight of why I started all this, I am re-discovering the joy of this project gives me and reading a message like that makes me think how it is all worth it. I want to do it justice.

Despite the difference in grade, I am picking up some underlying common themes with yesterday's group. Especially the process of learning something new and unlearning something well ingrained. There is something transformative about making sense of something rather than explaining something via a diagnostic label. Today's group comes across a lot more positive overall about the process, which is expected but very open about the continuous challenges around the sustainability of the project and what still needs to be done.

For discussion : It will be interesting to discuss how TIC is bringing probably a major change to the psychological contract between staff and the organisation. Two major drives of work engagement are job resources and personal resources and TIC as model promises to increase both.

Appendix 13: Example of initial coded transcript

	19: It's about ..I think it's about understanding more about the person and their background and basing their treatment on making it a lot more individual a little more compassionate and generally just understanding from their… like most people they've got some trauma and that way we adapt how we care for people to better fulfil their needs **M**: And what about you as a staff member? What is the impact of that on you? **19:** I am hoping it's gonna make my job more rewarding cause I hope that we'll see some more benefits and improvement with patients and the staff alike and there will be just nicer coming to work and I think the way it's gonna be structured it's gonna bring structure to our days and things won't be as chaotic for us and for them and maybe unite us a bit as a full ward staff and patients **18**: I think it's been said already in a sense of more understanding of the patients group and what their experiences have been but I think just more of an emphasis on caring for the staff in that as well and by the staff having a better understanding of what the patients have been going through and their behaviours and the impact of that there is more support for staff in the TIC with the supervisions and the training and the understanding cause I think it's alight for some members of the team where we can come down and we can leave whereas when you are on a 12 hour shift in and you get behaviours all day and I think sometimes I come from the ward anyway so I got some understanding but then you do forget when you've been off the wards for so long just how … how much… constant self-harming constant aggression and constant behaviours can really impact on a member of staff's wellbeing and then what that results in with regards to simplify small things just the way you can tolerate a patient's behaviour and anything like that and I just think more staff support and input is huge for the TIC I think	Understanding more about the person A compassionate individual approach Normalising trauma Working becoming rewarding Coming to work is nicer Appreciating the structured days A united ward Emphasis on caring for staff Understanding what the patients have been through More staff support Different roles different experience of the ward Forgetting how incidents impact on wellbeing Simplifying your practice More staff support

Listening to these participants talk about the medical model I feel very much aligned with their views on how medics operate in inpatient units. I have worked in inpatients units and have endlessly battled with medical professionals about bringing a psychological understanding to challenging behaviour. I almost feel like I want to stop recording and pour out my soul to these likeminded people but I obviously refrain from doing that and try to keep a level head. My own strong views on the debate between medical model vs formulation will have to wait for now. I feel I have a very good understanding of what they are describing and this would be my personal	yes the emphasis is on patients and having a better understanding of them but the staff support goes with that and I think the fact that both get supported alongside each other it's important and it's not forgotten it's a team everybody **20:** It's about the trauma and understanding patients as individuals and more of the symptoms rather than the diagnosis of like PD or whatever and moving away from that and just treating everyone separate …better together team and a lot more understanding of what some of the patients have been through because there is trauma in their life M: **18**: I think that kind the medical model we've all followed for so long I think it will take a while to unpick that … even today when we had the ward round just even debates with the doctors from the ward like decisions that are being made still we have to sit there and be like 'well no this doesn't make any sense' and not even from a trauma point view just from the patients' point of view. I think it's really hard with the kind of medics that we've got to be even able to slightly impact that would be massive … I think day to day we can make tic amazing on the ward … I think with some long term patients will be more difficult for them to adapt to it and we've got some patients with autism on this ward again I think there will be different impacts there but the difficulty will be about making … we need to put more responsibility on the ward staff and take as much apart of medication and step away from the doctors cause once a week there is a battle sometimes to be able to implement the trauma informed care from the medics point of view I think **19**: I totally agree … following from some drama this morning with the same patient you get sort of a treatment plan in regards from a medical point of view and then a treatment plan from a psychological point of view and it doesn't meet and then as team we have to try and implement both somehow and sometimes with your opinion lost … In particular with the patient we discussed this morning in ward round there was	Supporting staff and patients Focusing on individual not diagnosis Better together Understanding what they've been through Unpicking the medical model B attling with different points of view Impacting on medical point of view paramount Adapting for long term patients more difficult Adapting for patients with LD more difficult Needing to step away from medical model Battling with medical staff to implement TIC Struggling to implement conflicting plans Your opinion lost in the battle

concern about implementing TIC because it is so far removed from the NHS context of how inpatient units operate and which disciplines holds the power to make decisions in them. When I hear that comment I think that finally someone mentions the word re-traumatisation and takes some responsibility in recognising retraumatising practices, there has been a lot of talk about recognising triggers in previous groups but not as much openly recognising responsibility in re-	nothing more clear than how different like … how different both models are … and that's not helpful for the patient either because you gonna get a completely different interaction and response from one side of the team to another … and then the team which is out there doing the work is like I don't know what I am doing just trying to pick up things M: Hoping that TIC will bring these two worlds closer? **19**: I think it's going to be very difficult especially for the consultants with medical background like they think that medication is the fix **18**: And I think… sorry … as well some of that is even apparent with the TIC training for this ward… it has been booked in for three months obviously to be able to release the staff from the ward all at the same time and the doctor didn't come … none of the other disciplines from the ward came and I think it was just apparent that there isn't the importance the staff really want it … the patients really want it but there is no commitment from the medics at all and I think there still seems to be a bit of 'No no they'll have this medication everything will be swimming' and they still deal with the diagnosis rather than what the patients experience every day and what we do to **retraumatise them** ,they just don't take that into account. **20**: I think if before it gets better it will get worse I think there will be a lot of digging into traumas and the patients probably don't wanna talk about it and they haven't talked about it before and we like going to be digging down deep and it's gonna bring a lot of things up that patients don't want to talk about and they haven't talked about **18**: And I think the problem with that it's gonna be that I think like with the patients that we've got at the minute they are quite destabilised but managing alright .. and managing in trauma informed way but then I think with any of them that destabilise the doctors come in and are like 'alright ….	Realising how different TIC is from medical model Conflicting views not beneficial Conflict of views creating uncertainty in the team Difficult to bring conflicting views together Medics not attending training Some disciplines not seeing TIC as important Needing commitment from everyone Sticking with the medication Medical model does not consider retraumatisation Getting worse before it gets better Might be difficult for patients to talk about trauma Talking about trauma might be triggering

traumatisation of service users. It makes me think how validating this comment would be for survivors of the psychiatric system. I drift of in thinking if I have seen anything on PARIS relating specifically to trauma and the risk assessments I have completed as a clinician and I cannot recall anything on the system that would make it easy to access this info for someone. Given that I am doing a complex trauma specialist placement I think that I would have known. It is in this moment that I realise for the first time that I have not considered the need for electronic recording systems to also transition to becoming TI. Again I am faced with my own concerns about transitioning to TIC within the NHS context. I am about	taking away all the work that ward staff have done **M**: **19**: I think as well previously… previous model that we've been using it was more about management and how do we just … how do we manage … how do we sort of stop things and how do we just … just about safety and risk management and TIC it's not about that … **20**: It's taking that risk isn't it and seeing what happens … you get a different result **18**: I think that even still apparent that even though there is four wards that have implemented the TIC there is still nowhere that documents that on the computer system that everybody still uses so our massive risk assessment is all about risk and history and a tiny little bit about trauma … like the tiniest bit and like no easy way to access that on PARIS or any external assessments whether doctors go and see people in prison or high secure to bring people here … they don't ask any trauma question so… **20**: Yeah I looked on PARIS and the trauma is what … three lines long when that would probably be the root of … everything you need to learn about somebody **19**: I think it's even just a tick isn't … **M**: **19:** My biggest concern is people .. people are scared of change always myself included hate it ,but this particular sort of change that we are having now like I am super excited about .. I am … I am really looking forward to it … I think it's gonna be like a massive difference but my concern is that not everyone is gonna be on board cause there are still some people where they are like of that will never … and I just think if we have that attitude then it won't… we've got a think that will work that we want it to work yeah there will be teething problems at the beginning like 20 said it will get worse before it	Previous model all about risk management T Taking safe risks TIC not translated in recording systems Risk assessment not matching TIC principles Assessment need to become TI Concerned about people fearing change Fearing that not everyone will be on board Important for everyone to be on board

to ask what their concerns are. I feel a glimpse of hope thinking that service users have been actively involved in this process. So far this focus group has been triggering all my own concerns so this was great to hear. This is the 4th focus group and staffing issues as a major concern for full implementation is one of the major recurring themes. I think that this aligns with current NHS context and cuts in services and with my own experience as well. TIC requires a lot of resources and can the NHS provide	gets better but eerm I think if we are positive and motivated and support each other to stay positive and motivated because we all like deep me included but I think it can work but my biggest concern is the reluctance .. and not just from staff from patients as well .. all the disciplines and errm people going 'oh all about the trauma again, they want this' ... it's just like … like it's a burden **20**: It's something new isn't it ? … some people are scared trying something new …it's exciting as well cause we haven't tried it before **18**: I think because I did the focus group with the patients last week to talk about the TIC and reflect on the staff training on the day before and look at different things and there was like really positive … more positive than negative coming from all the women on the ward. I think an anxiety of mine is the ward being a lower secure than the other wards is like the drop in for taking staff out first if there is problems elsewhere in the unit so it's kind of like where it should run on six staff it's often three staff or four staff and leads … I think the most difficult bit it will be about everyone like every discipline involved on the ward trying to apply and making sure that regardless of what is going on the sessions are the priority and not missing the staff supervision, not missing the patients reflection group … that's that's my main concern even though we are all really excited, the majority, about TIC ,external things that we can't control are going to dictate how well that goes and that's quite frustrating **19**: I think yeah it requires support from the … our ward and our team, it's support from the … and when other wards come into it ,it's supporting them too ,like if sessions run at different times we can borrow staff to make sure that it happens ,that kind of thing, but it will just be met with so much resistance **M**: **18:** We've done… we've started at the beginning of the year looking at doing the TI … every week so at least to start to pull out what people's histories .. people really didn't	Recognising teething problems at the beginning Staying motivated Concerned about reluctant staff and patients Changed viewed as a burden by some Trying new things scary for some Gathering encouraging views from patients Anxious about staffing issues affecting implementation Challenging getting everyone on board Prioritising TI practices important Relying on external factors for success is frustrating Requiring team support Wards supporting each other May be met with resistance

that ?	know every single patient cause on a shift that's impossible to sit and read every single person's notes so we started doing TI .. fill in a sheet what the triggers were and what the difficulties were for each patient and then also looking at the intervention plans already before the change came in and again that's been met with some kind of resistance from some staff about changing the intervention plans and because it's an endless amount of them but I think that's been a positive thing before we even implemented it so there is chunk of stuff that's already been done so we can hit the ground running when we officially implement it next week **19:** I think that was another thing that was again within the MDT that people said this isn't our place to be doing intervention plans and stuff like that and it's like it is to some … it should be an MDT ,and hopefully the intervention plans ,yes, maybe the response will give the nurses to document it and implement it and plan it as such, but the actual decisions around it like it should be coming from the MDT … but that was a lot that was difficult like 'Oh we don't have time to do this' … trying to think of other things we've done … we've done like a folder for the patients … like a Get to Know me form they've been able to write their own sort of … just trying to keep it quite light hearted and sort of like favourite foods and books and stuff and then a little more in depth of what like kind of things will upset me that you say or do things that I don't like what would help them on a bad day … it's about being able to pick that up and the best way to engage with you and communicate and help you without actually having to tell anyone what happened because I think a big anxiety of the patients is and I hear them saying it quite a lot is that now that TIC is coming in we will have to tell everyone that is coming on the ward all their trauma and so we are trying to reassure them that no it's about … of what that trauma is … I may need to know what that is, but somebody who is covering for a couple of hours doesn't, but they do need to know how to like, you know .. how would you like me to check on you during the night … because if something like that … because if me saying 'oh I am just gonna check on you' and that irritates you every time that I do that you are going to get irritated then by morning you will have a bad day and we could have avoided that if you just tell me just put your head around the door … so	Looking at people's histories Analysing notes in a TI way Meeting resistance in changing intervention plans Doing the groundwork before official implementation Some disciplines feeling it is not their job Decisions should be an MDT responsibility Creating new ways to get to know patients Taking the pressure off patients to tell their stories Reassuring patients about not having to disclose to everyone Informing short term staff about what is necessary Preventing distress by putting patients in control of practice

	it's just simple things like that that helping you lead a better day and if we can help you with it and if we can't then at least be able to say look 'I know that you don't like it when I talk about your dad ' for example but we still need to have little chat so at least you can soften the blow , I suppose	Simple things make a day better
	20: I think it's a good idea … if the patients are more involved in it, it makes … so they've got a bit of control as well	Seeing that Patients having more control is a good idea
	M: What kind of changes have been implemented for staff ?	
	19: I think it's the supervision groups … like I said again it's about structure of the day which I think it's gonna be like a massive thing for a lot of staff cause erm… I think it will make us feel like we are doing something so one of the big things is 'oh what we are doing for them' like I think we will have more of a clear goal of an understanding of what session we are doing why we are doing it and things like the window of tolerance and how it relates to something and how to relate their behaviours to something and you feel like we all feel a sense of achievement that actually yeah I helped someone today because these small things are big things for them, that we do but we didn't even realise that we did before	Structure makes me feel like I am doing something Having a clearer goal Feeling a sense of achievement Realising that small things are big things for them
	18: I think like … forgot my train of thought already …	
	20: I think the patients are getting more involved as well with setting goals at the end of each session … trying to get them off the ward and they are really excited about that, so it gives them something to work towards	Patients excited about being more involved
	M: What does this mean for you as a staff member?	
	20: That they will want to work with us … it's about making that first step and that's only a matter of weeks	Feeling like patients want to work with

	18: I think it just gives all of the staff on the ward just the autonomy to just like lead on someone's care like the old one would have been like nurses … nursing assistants do the tasks on the ward or whatever and it's not level … everyone now got the same knowledge so everyone will be leading on the same thing we just M: **18**: I think specifically with one person it's been slightly less … recently I think that's been massive even to the point where the staff have been like I am not making this decision for you like this is your plan what do you want to do .. and I think to be honest that that person was a bit flawed when all of that first happened cause at first like this time of year it's high medication and seclusion for the entire period like what's going on whereas this time it's been 'what are you doing' ' what shall we do? I think that's totally changed hopefully lthe onger-term outcome for her **19**: I think … it's been… that's the plan with the collaboration I think where it's been it has given a lot more empowerment and independence like I can give you some choices about what we can do you know cause there are limitations about certain things or we can do this or we can do that or you can do it this way or we can do it that way but I am not deciding you decide like and then I think that openness of being like there is a point where I am going to have to make a decision if you don't but let's not get there erm and it is really good and I also think as well there's been a lot more collaboration within the team not everybody some people have … but a lot of us it's like asking everyone at every level what do you think asking and getting that more wider team input and that I think is good collaboration and I think not even with TIC any model I think that's important. I think there are a few people 'It's up to me' but I am hoping that we can break that **18**: That's people's confidence though like if you think you are in control and this is the way that we need to do it that comes with a level of confidence like if the doctor said to	you Shared knowledge shared leadership Not making decisions for patients Changing responses to high risk situations Not making decisions for patients is empowering Observing more collaboration within the team

	do it then that's alright whereas now it's like 'alright I know you've got a ligature on your hand but lets just talk about it rather than WE NEED TO GET IT OFF'	Confidence in changing responses to high risk situations
	20: yeah that happened a few times on the ward where we've had attempted ligatures and instead of running in to pull it from the hands and be hands on, we actually stepped back and be like 'you are breathing, you are talking to me what are we gonna do? And we've actually talked and the number of incidents, alarms that we haven't pulled over the last six weeks has come down significantly, it's like being on a different ward. Cause at first some people said 'What? Aren't you gonna do anything? No, you are in charge, it's your decision and they don't want to do it, it works, it's like it's brilliant actually, isn't it? And a few other patients, actually we've done that, obviously we assess risk all the time, but they are quite happy to do it	Responding differently leading to less incidents
	18: I think the only problem with that that we've got is the consistency because it's some staff that throw themselves in the TIC stuff and there's staff that it's quite hesitant and if you get 2 or 3 on the shift that are more hesitant and TIC shift then there is a different way that the person is managed and you've got the inconsistency the we've got more problems	Being inconsistent hinders progress
	20: Everyone needs to be under the same thing and working together and be like this is the plan this is what we gonna do and that's the patient as well getting them involved cause it works if they have more involvement they have more chances sticking to it they chose to do that	Working consistently with the plan When patients involved they stick with it
	M:	
	20: I think you cannot put your barriers down when it comes to safety and risk, you always have to be aware risk and your own safety	
	18: For patients because they've been more open with each other because we've had	Still needing to be aware of risk and safety

	little groups about the trauma informed care presentation and the staff training and the patients had an input in that they sat together and talked about that together and then today they had quite an open conversation appropriate conversation about self-harming in the day area together so I think things like that like they are more supportive of each other but at the same time if you are having a one to one session with them the patients are like 'oh I don't feel safe enough because well there are all sorts of people in here, isn't there ?we don't know why people are in here but that's few and far between … a lot of the patients had such horrific lives that this is the only place they feel safe so then that's difficult cause sometimes when they make a slight bit of progression then they sabotage that purposefully because… **20**: It scares them… **18**: They think this is the last step before we discharge them so if they are doing too well then … **20:** It's about educating about what is there afterwards and we are not just gonna like go and … so educating them what's on the outside and what's there to support them **18:** Even I think and it sounds bad from the way that we've always worked this is across the wards not just this one it gets to the point where it's like patients just lie in bed all day and they get some leave and there is nothing but I think TIC helps immediately any future planning cause eventually gives them some structure and skills it gives them loads of other stuff to do and some purpose M: 18: I think the TIC stuff immediately makes people more competent in a sense that they feel more supported to make decision and what … I think the weekly supervision for staff as well as they are own clinical management they feel safer and they feel safer now they've seen examples of someone who has tied a ligature but just talking to them	Observing patients being more open with each other Observing patients having more conversations Some patients may feel unsafe around other patients Recognising that Avoiding discharge because ward is safe Giving skills to patients to manage when discharged Preventing patients leaving with nothing TIC making patients more competent

	about that there wasn't a negative outcome at the end of the day whereas if you go and put hands on immediately then you end up in a possible restraint for two hours from that perspective staff have probably felt safer … I think the only downside again as I mentioned before is the staffing and not having enough staff to be able to follow through	Feeling safer due to the support Feeling safer after seeing examples of hands off management of risk Concerned about not enough staff to follow through

Appendix 14: Construction of overarching codes and initial themes

• Realising misconceptions • Sharing the focus	Unlearning past attitudes
• Closer as a team • Closer to service users	Sense of togetherness
• Feeling valued • Sense of achievement	Connecting to job satisfaction
• Using talking platforms • Recovering as team process	Participating in group support
• Knowing your boundaries • Validating own experiences	An evolving self-awareness
• Validating interactions • Information sharing	Introducing a culture of openness
• A much-wanted structure • Negotiating control • New competencies	A new working day
• Keeping it up draining • Struggling with limited resources	A fragile sustainability
• Accepting not a cure for all • Dealing with uncertainty	Managing expectations
• Inconsistent responses • Inconsistent systems	Consistency under threat
• Dealing with conflicting views • Adopting the trauma lens	Adapting to new paradigm

Appendix 15: Initial thematic map with three overarching themes

Appendix 16: Final thematic map following re-grouping of subthemes