GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Straen Trawmatig Cymru
Traumatic Stress Wales

Trauma-enhanced safety and stabilisation training for frontline staff

Lucie James and Clare Crole-Rees

Aims for session

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- The context for the training
- How the training was developed
- Overview of the training
- Outcomes of the pilot
- Next steps
- Self care

What is Traumatic Stress Wales?

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- National quality improvement initiative
- Aims to improve the health and wellbeing of people affected by traumatic events
- Person-centred trauma pathways
- Joined-up and integrated across services
- Evidence-based

Integrated trauma pathways

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- Are joined up across social care, voluntary organisations and health services to ensure that social and psychological needs met
- Offer a consistency of approach – ‘no wrong door’
- Evidence-based psychological therapies embedded within trauma-informed systems and organisations
- Understanding the practice level and training needs of everyone within the workforce
- More effective whole-system approach

Supporting people who have experienced traumatic events

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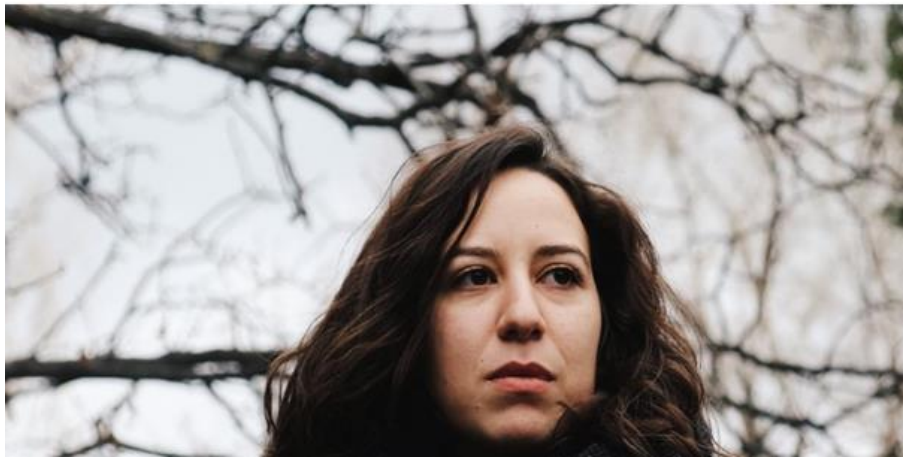
- A resource developed for frontline staff
- Focus on refugees and asylum seekers
- Practical ideas on how to help people cope with emotional, physical and relational impacts of trauma:
  - Relaxed breathing
  - Grounding
  - Improving sleep
  - Coping with nightmares and flashbacks
  - Coping with low mood and anger
  - Understanding difficulties with trust and relationships

Supporting people who have experienced traumatic events

NCMH National Centre for Mental Health



Scottish Trauma Framework

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TRAUMA INFORMED PRACTICE LEVEL

Knowledge and skills required for all members of the Scottish Workforce.

TRAUMA SKILLED PRACTICE LEVEL

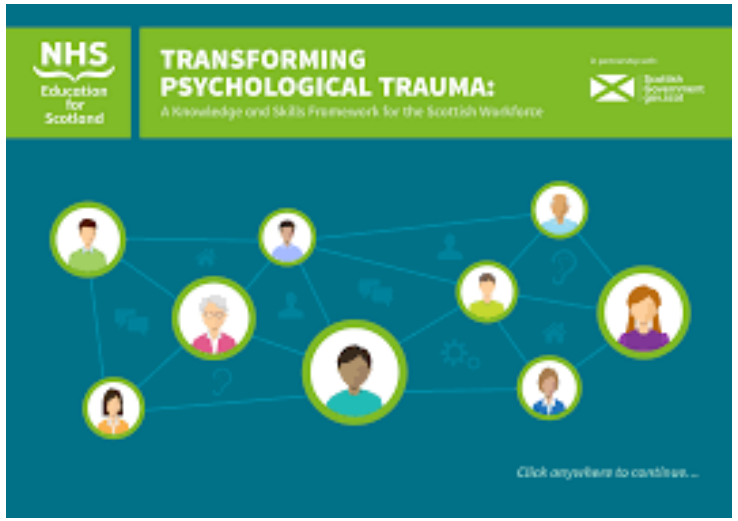
Knowledge and skills required for workers with direct and frequent contact with people who may be affected by trauma

TRAUMA ENHANCED PRACTICE LEVEL

Knowledge and skills for staff with regular and intense contact with people affected by trauma and who have a specific remit to respond by providing support, advocacy or specific psychological interventions to protocol, and/or staff with responsibility for directly managing care and/or services for those affected by trauma.

TRAUMA SPECIALIST PRACTICE LEVEL

Knowledge and skills for staff who have a remit to provide evidence based interventions and treatment for those affected by trauma with complex needs.



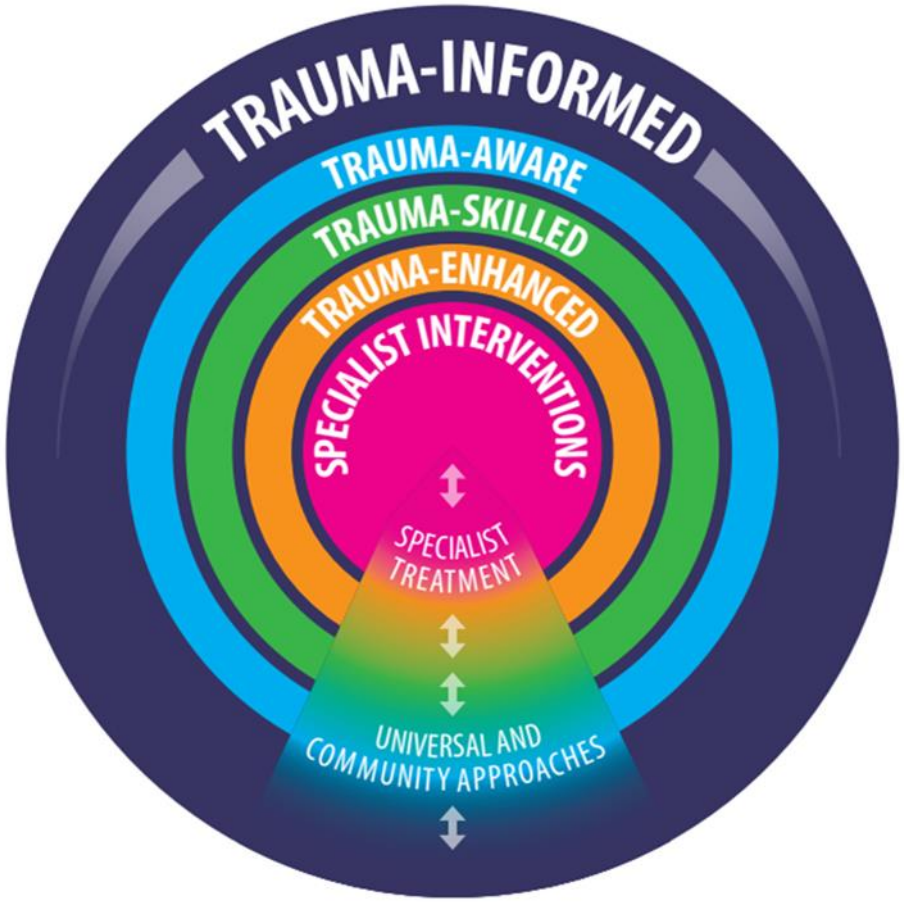
Trauma-informed framework for Wales

Trauma-aware: Everyone in society understands our universal needs for compassionate and supportive relationships

Trauma-skilled: People who have contact with people who may have experienced trauma, whether or not it is known about. Focus is on providing safety, promoting trust and preventing re-traumatisation

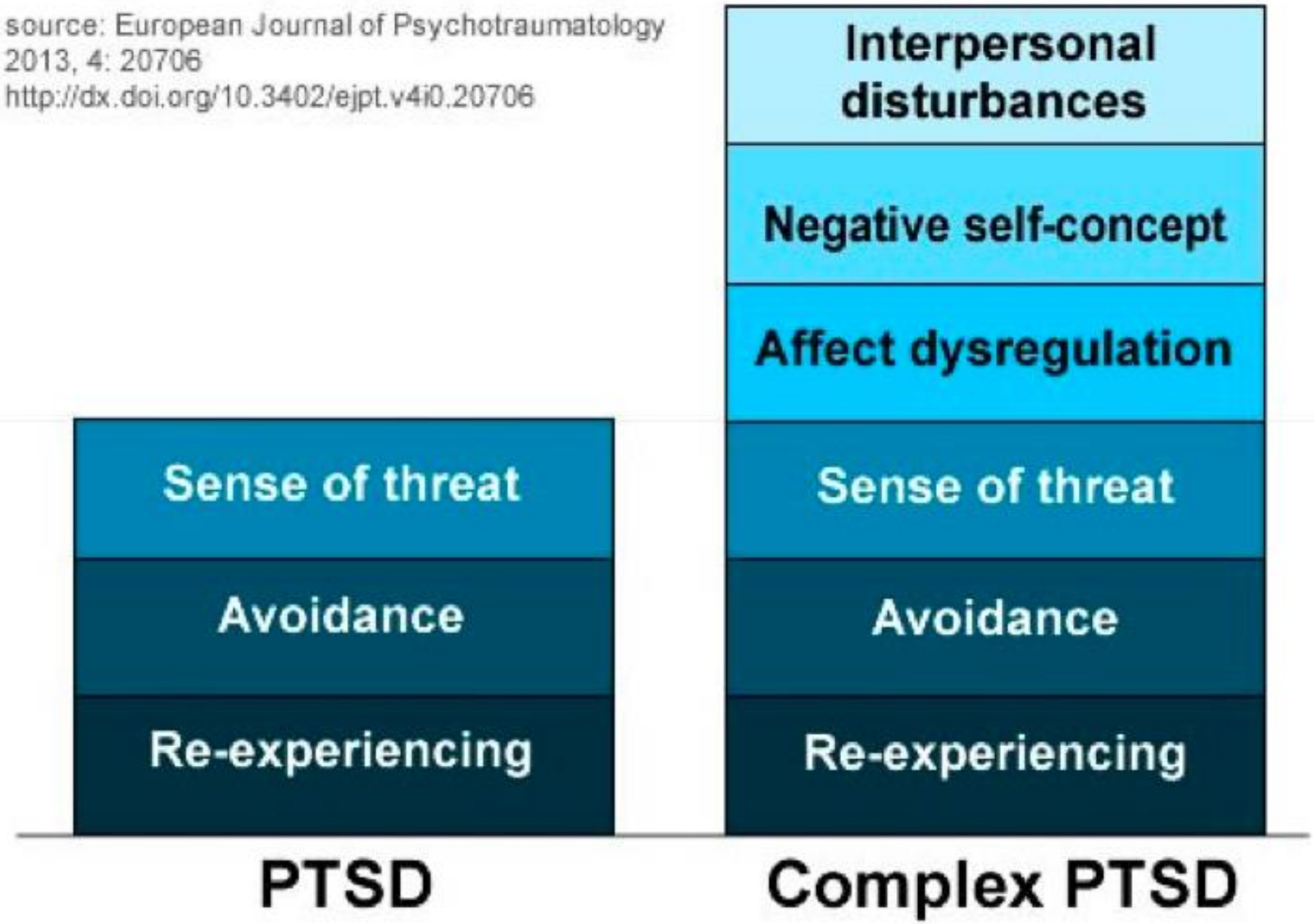
Trauma-enhanced: workers and carers who have regular and intensive interactions with people known to have been affected by adversity/traumatic experiences, and who provide specific supports or interventions

Specialist interventions: Practitioners/Services who provide low or high intensity, formal evidence-based or evidence-informed interventions for people impacted by traumatic events.



PTSD and complex PTSD symptoms

source: European Journal of Psychotraumatology
2013, 4: 20706
http://dx.doi.org/10.3402/ejpt.v4i0.20706



http://traumadissociation.com/complexptsd

What is emotional safety and stabilisation? (Herman, 1992)

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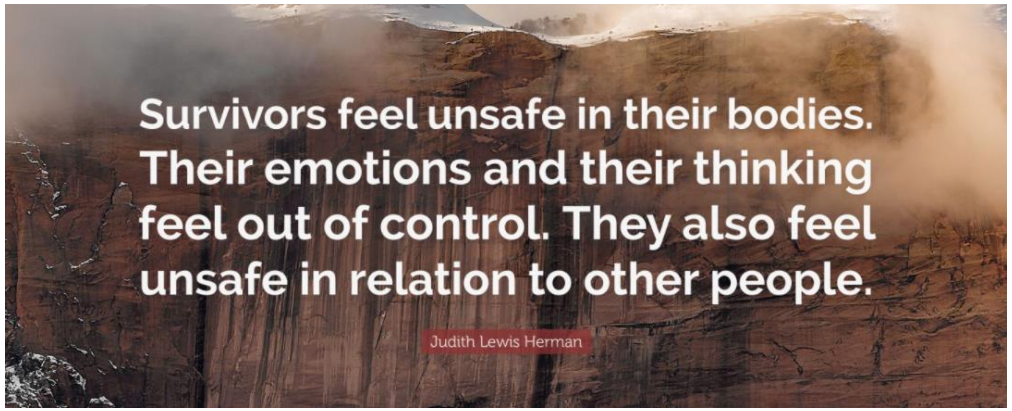

What is stabilisation?

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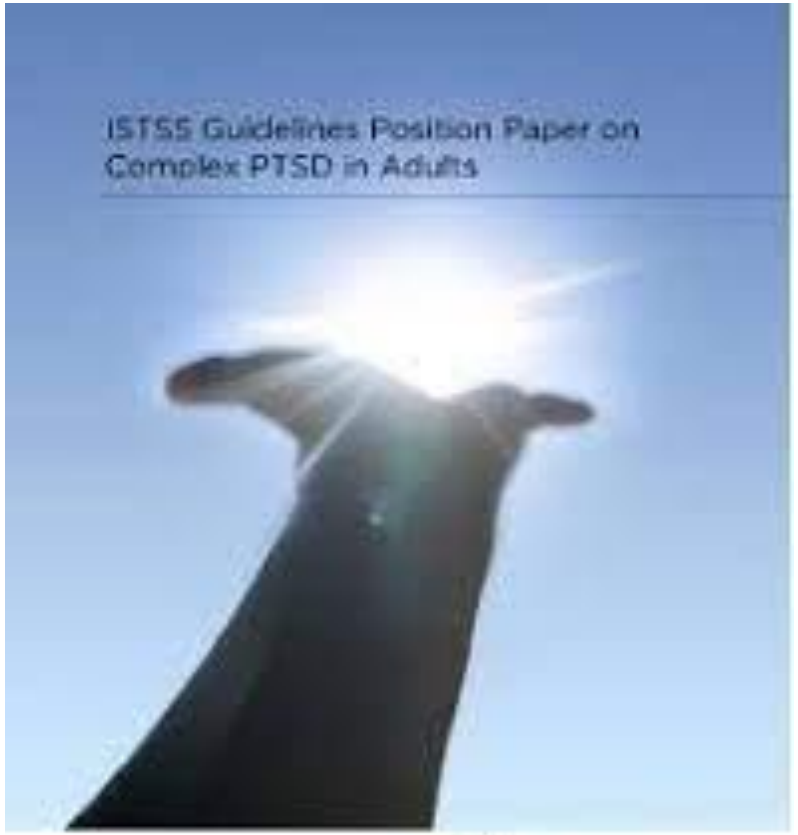
- Part of a phase-based/sequenced approach to therapy (e.g. Cloitre et al, 2019)
- Modular multi-component approach to therapy (e.g. Karatzias et al, 2020)
- Integrated skills-based approach for PTSD and substance misuse (Schafer et al. 2019)
- Stabilisation groups (e.g. Baekellund et al. 2021)
- ISTSS guidelines (2012) recommended
- De Jongh et al. (2016) – no robust evidence for stabilisation component of trauma-focussed therapies
- Further research is needed (ISTSS, 2018)



Trauma-informed practice

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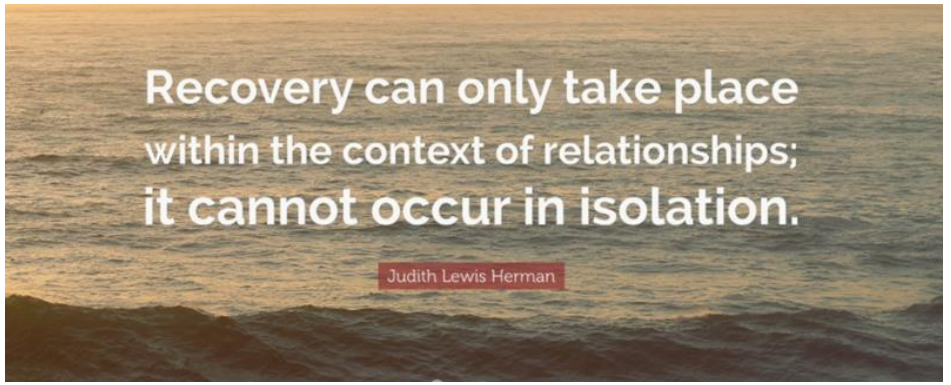
- Recognition of the historical, environmental, social, and relational determinants of trauma
- Implicit/explicit power structures related to authority, class, gender, wealth and health etc. etc.
- Trauma is caused by people using their power over us to harm us (Johnstone and Boyle, 2019).
- Trauma-informed organisations consider the impact of their environments, policies, leadership on the people that work in the organisations and people that seek help from the services
- Resist re-traumatisation, recognise widespread impact of trauma, provide empowering relationships and safe environments (SAMHSA, 2014)



Trauma-enhanced training pilot

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- Principles of trauma-informed practice and emotional safety and stabilisation
- Evidence-informed and theory-based techniques
- Enhancing routine practice of frontline staff rather than being delivered within a phase-based trauma therapy
- Building the trauma pathway within community services
- Integrating social, relational and and psychological needs
- May help to improve transitions into formal psychological therapies and increase effectiveness/retention

Development of the training

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A semi-structured questionnaire developed and sent out widely to range of stakeholders

Multi-agency focus group to give views on content, delivery method and optimal implementation process

Focus group comprised of experts with lived experience

A workgroup of experts by experience and professional training led on the development of the training.

Draft version of the training materials was reviewed and refined before pilot

Cardiff and Vale APB partnered to develop and deliver the pilot to ensure that the project was embedded within local services and supported by commissioners

The train the trainer model

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- Training becomes embedded into a service and builds long-term capacity
- Allows sustainable implementation across a large workforce
- It enables inter-professional learning and consistency in delivering a training curriculum
- It also enables a peer-training model
- Trainers have pre-existing relationships with colleagues and understand the service that they work in, as well as the needs of their clients.
- Consistency of approach
- Viable model for disseminating training
- (Yarber et al. 2015, Pearce et al. 2012, Kienlin et al. 2021).

Trauma and substance misuse

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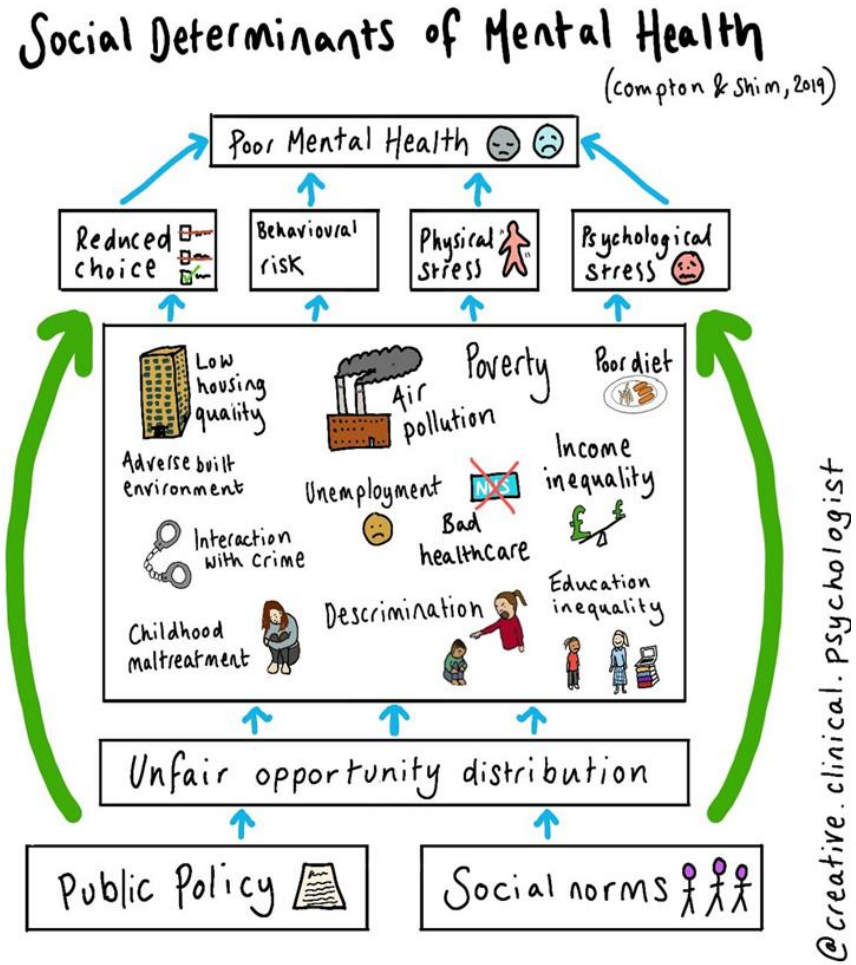
- High rates of ACEs/traumatic experiences
  - 17% of the general population of Welsh adults experience physical abuse. This risk increased to 68% of males and 71 % of females in addiction services
  - 10% of the general population of Welsh adults experience sexual abuse. This risk increased to 52% of males and 61 % of females in addiction services (Liebschutz et al., 2002)
  - Gwent – 100% experienced trauma; 76% in childhood; 60% prior to s.m (Petley & Davies, 2022)
- Poly-traumatisation throughout the life span (Karatzias et al. 2017)
- High rates of PTSD - 36% to 50% (Weathers & Keane, 2007)
- Complex interaction of psychological, social and physical issues
- Likely to experience barriers and have high unmet needs **(Roberts et al. 2015)**
- In need of effective mental health and psychological therapies services



Cardiff and Vale substance misuse services

- Integrated community services, social and health care
- High level of skill across the workforce
- These organisations provide support for finances, housing, employment, mental health and addiction
- APB had identified need for trauma training across the workforce

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Implementation process

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Phase 1 training

- Part 1 'Safety and Stabilisation skills for trauma (7 weekly sessions) plus
- Part 2 'Skills for delivering training and reflective practice' (3 x weekly sessions)
- Reflective Practice (six x monthly sessions)
- Training consultation drop-in sessions (six x monthly sessions)

Phase 2 training (delivered by the cohort of trainers within their own organisations or networks):

- Part 1 'Safety and stabilisation skills for trauma 7 x weekly sessions)
- Reflective practice (six x monthly sessions)

Feed-back and initial evaluation

Phase 3 training (delivered by the cohort of trainers within their own organisations or networks):

- Part 1: 'Safety and stabilisation skills for trauma 6 x weekly sessions'
- Reflective practice (monthly drop-in sessions)

Methods

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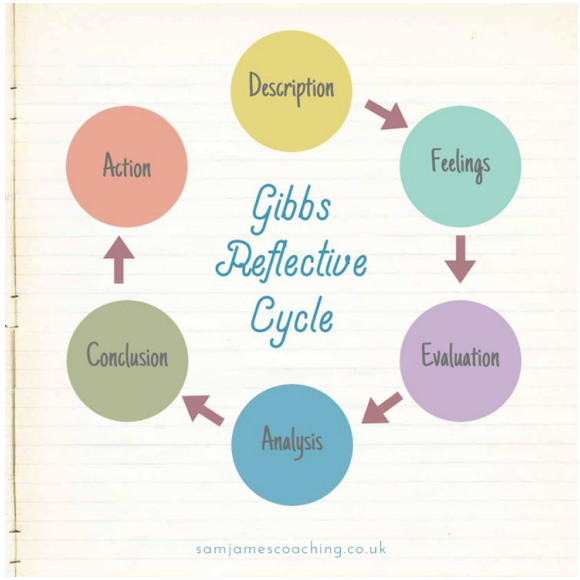
In-session:

- Teaching
- Demonstrations
- Videos
- Role-plays in pairs
- Discussions in small groups

Self-directed learning:

- Self-practice
- Self-reflection

Reflective Practice



Aims of the training

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- Helping staff to make sense of trauma responses (including vicarious trauma)
- To provide individualised, trauma-informed support
- A consistent language and approach to helping.
- Helping to develop emotional safety and stabilisation skills
- It is not a standalone intervention, but is embedded in routine practice
- ‘Normalising’ self-reflection and self-care

Content of training

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- **Module 1**: Introduction to training, self-care and to trauma-informed practice
- **Module 2**: Recognising impact of trauma and talking about ‘what has happened to you?’
- **Module 3:** The window of tolerance and calming your body
- **Module 4:** Grounding and coping with feelings
- **Module 5:** Coping with triggers
- **Module 6:** Putting it all together

Module 1: Introduction and TIP

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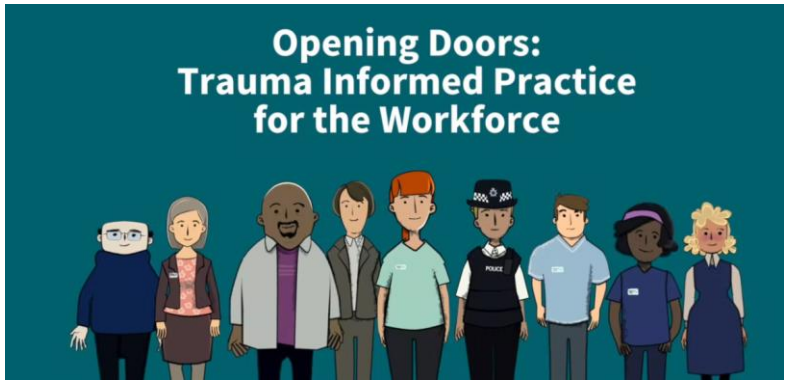
Key aims:

- Impact of trauma on staff and people that use services
- Link between trauma and substance misuse
- Principles of self-care
- Principles of trauma informed practice

https://vimeo.com/274703693



Self directed learning example:

•How can you and your service prevent retraumatisation?
•How can you provide a positive experience of relationships?
•How can you promote choice, collaboration, trust, empowerment and safety?
•What are the barriers to this?
•Can you think of possible ways to overcome some of these barriers?
•What support would you need from colleagues and managers?
•What would you like to be doing differently?

Module 2:
Recognising and asking about trauma

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Key areas:

- Understanding responses to trauma
- Recognising when someone may be impacted by trauma
- Asking about ‘what has happened’
- Understanding barriers to asking
- How to respond helpfully
- Using this conversation as a bridge to collaborative trauma-informed support

Practical example:

In pairs, role-play asking Tom or Anne about what has happened to them, and how this has impacted them.

Afterwards, reflect on how this felt for both of you as the helper and the service user, and what difficulties and opportunities this brought up.

Please then swap roles and practice again

Module 3:
The Window of Tolerance

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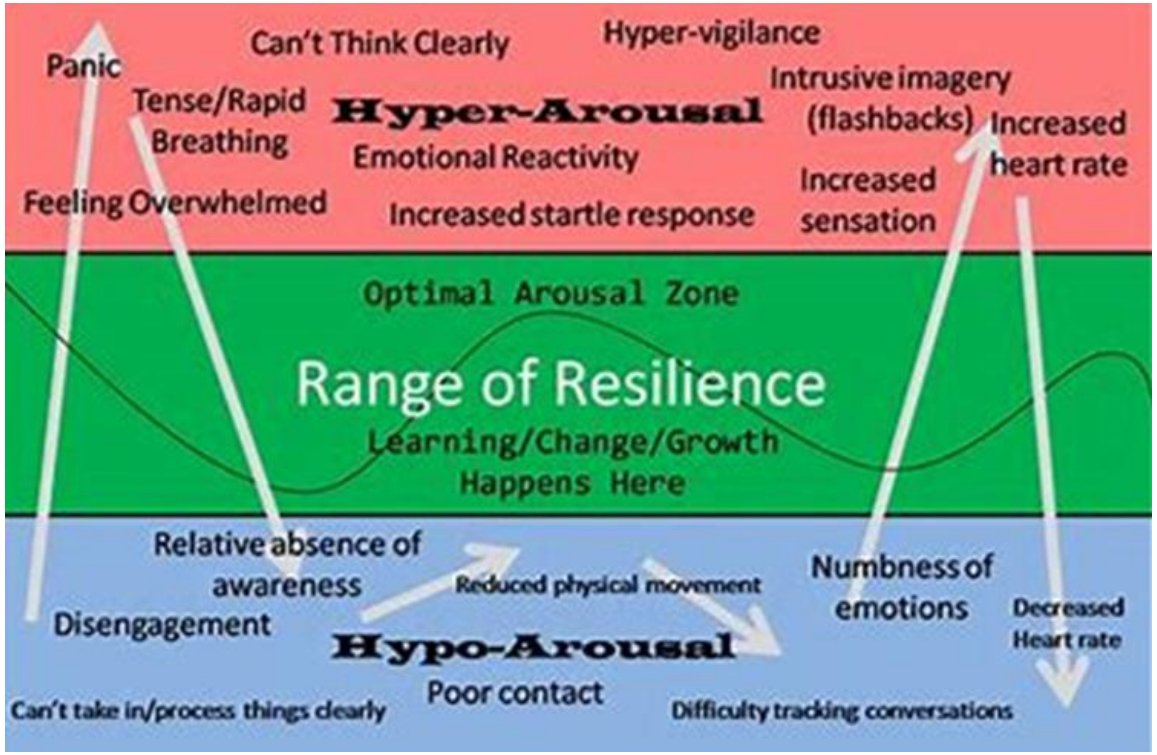
Key aims:

- Impact of trauma on neurodevelopment
- Understanding the window of tolerance
- Impact of substance misuse on the window of tolerance
- Talking to people about their window of tolerance
- Helping them to identify when they are in their green, red and blue zones and the triggers and early warning signs
- Calming their breathing and their bodies



The hand model of the brain: https://www.youtube.com/watch?v=gm9CIJ74Oxw

Module 4:
Grounding and connecting with feelings

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Key aims:

- Recognising when you are in the blue zone
- Different types of numbing and disconnection
- Matching grounding strategies to your needs
- Impact of developmental trauma on coping with feelings
- Ways of helping people identify and express their feelings
- Ways of self-soothing

Discussion-based exercise:

In pairs, please spend ten minutes discussing:

How confident do you feel about recognising and labelling your feelings?
How confident do you feel about communicating feelings?
What are the barriers to this?
What helps?

Why does it matter?
https://www.youtube.com/watch?v=apzXGEbZht0

Module 5:
Coping with triggers

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Key aims:

- The traumatised brain
- Types of re-experiencing
- Sensory and interpersonal triggers
- Strategies for coping with triggers
- Recognising shame and ways of helping with this

Traumatised brain - Brain Model of PTSD - Psychoeducation Video - Bing video

Awareness test - https://www.youtube.com/watch?v=xNSgmm9FX2s

Then and now discrimination

Identify what is the same about a trigger (eg people arguing):

The angry tone

Raised voices

I feel the same – terrified and alone

Then help the person identify all of the differences:

It is Dave and Ben, not my mum and dad

Accents are different

Not beating each other up

There are staff here to sort out the situation, and other people around – I am not alone

I am an adult – not a powerless child

I am in the clinic not my home – lots of differences in the furniture and environment

I can leave the room

I am not in danger

My feelings are understandable, but coming from the past

Module 6:
Putting it all together

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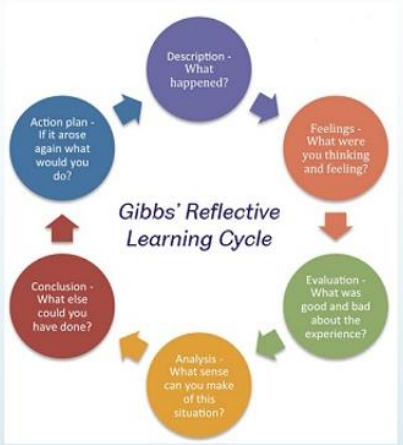
Key aims:

- Recapping the key ideas and techniques
- Using these flexibly in routine practice
- Developing a shared understanding amongst colleagues and people that use services
- Trouble-shooting
- Options for signposting to further support

Taking this forward

Monthly reflective practice groups:

- Sharing expertise and experiences
- Embedding skills into your practice
- Collaboratively explore any difficulties
- Supporting you to develop your self-reflection skills
- These are an important element of your self-care
- Use Gibbs learning cycle model



Training evaluation framework

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WHO guidelines for evaluation of training (2010) (Kirkpatrick model)

- **Reaction:** satisfaction with training
- **Learning:** knowledge and skills
- **Behaviour:** impact on practice
- **Results:** for people that access services and for organisations.

Method: mixed method questionnaires and semi-structured interviews to elicit themes

Who was trained?

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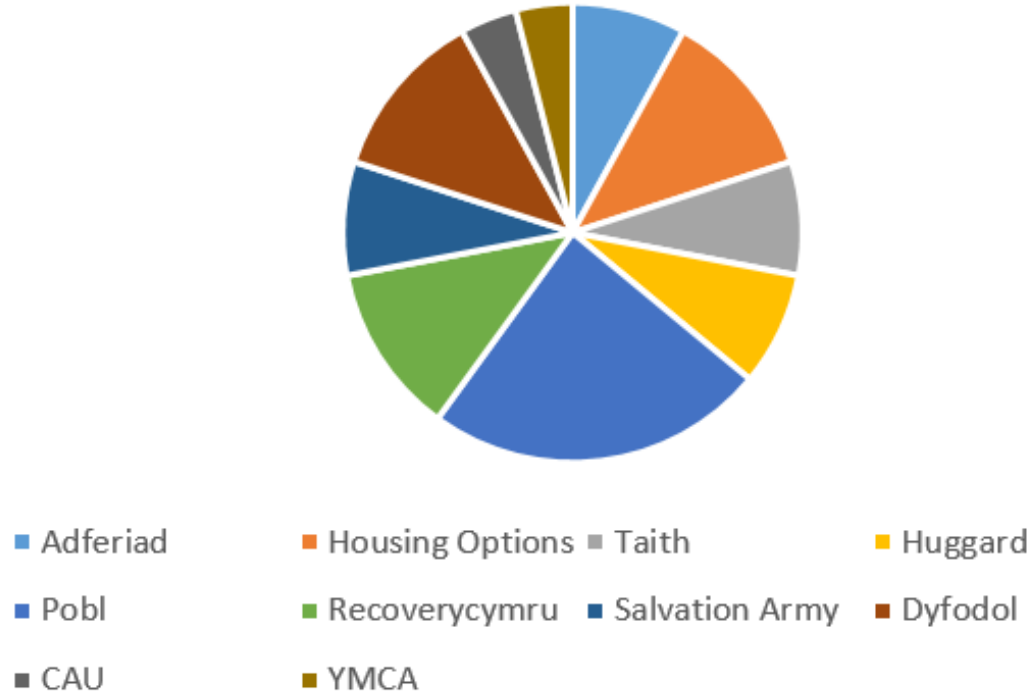
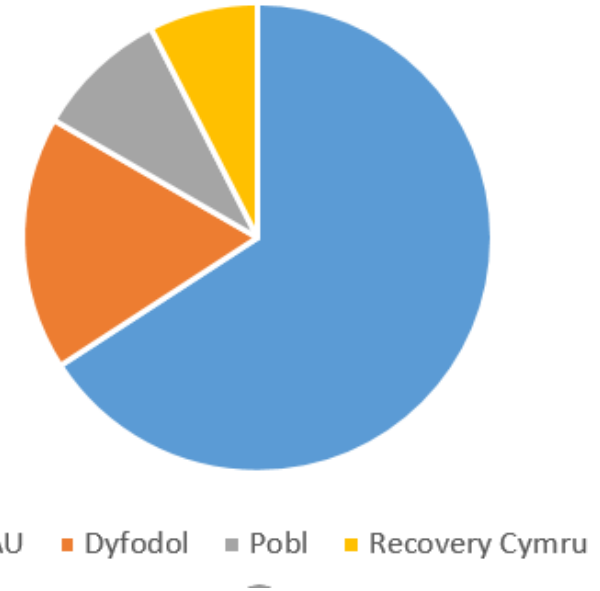
Phase one training by TSW



24 people trained across ten organisations

Phase two roll-out of training within organisations



76 people trained by four organisations

Impact on knowledge and skills

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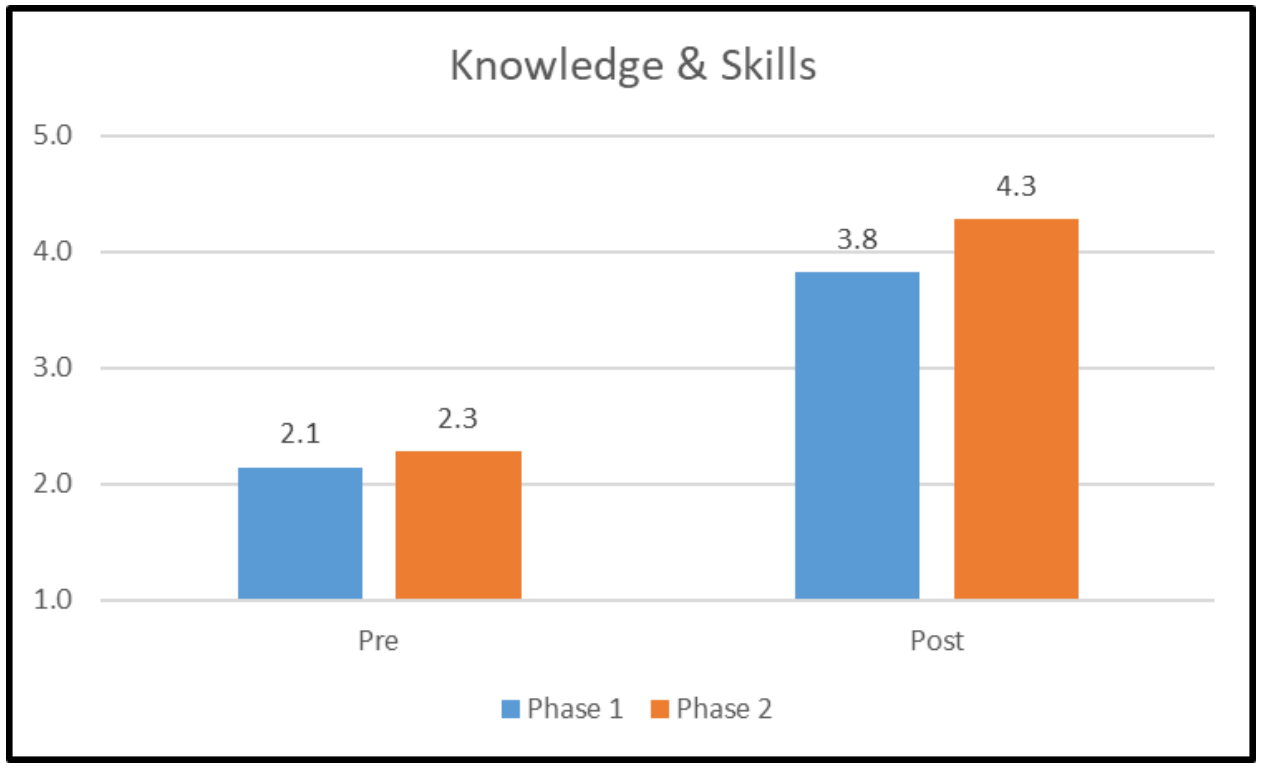
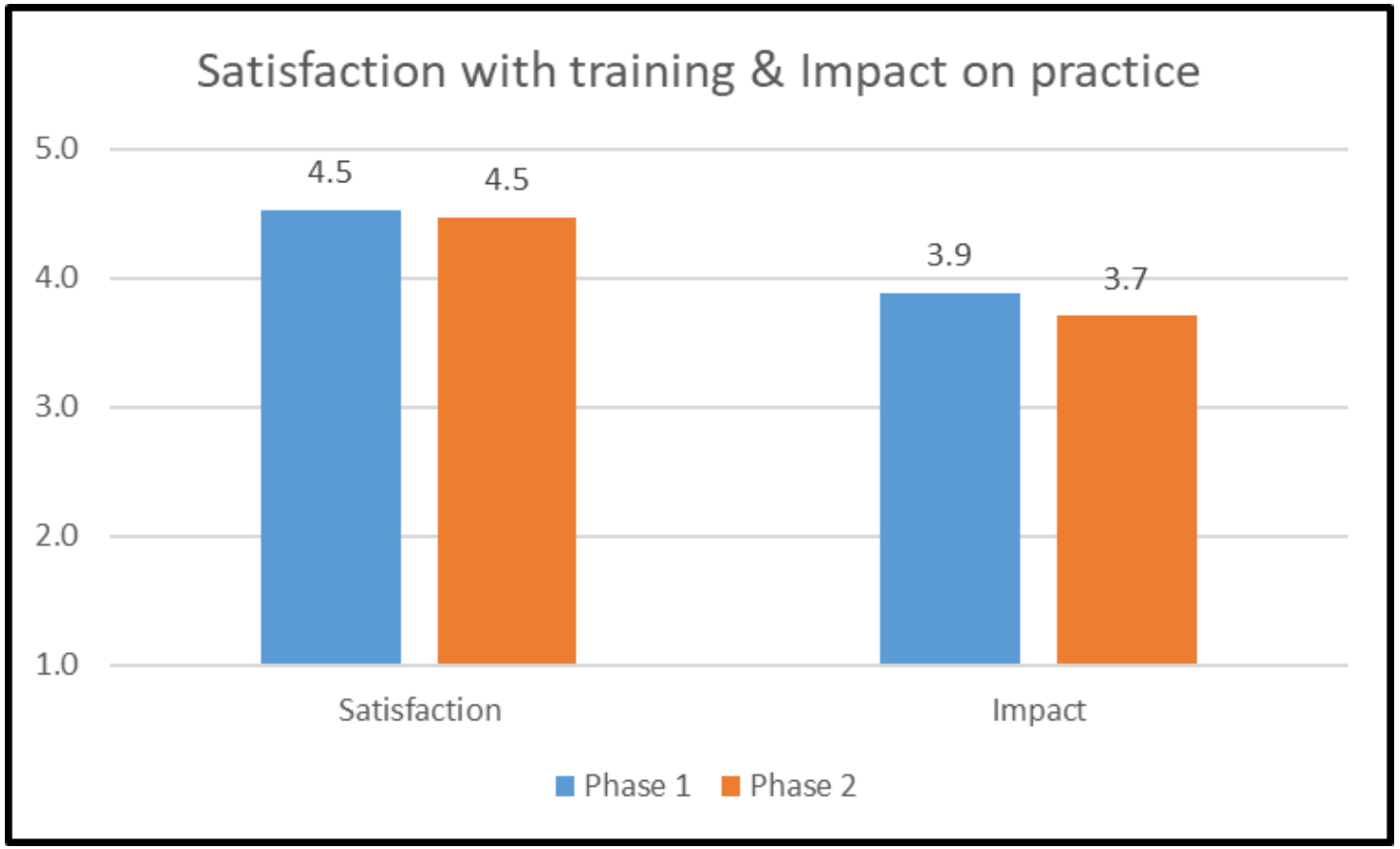


For the Phase One cohort of trainees there was an average 78% improvement in knowledge and skills.

For the Phase Two cohort there was an average 88% improvement.

1 is not at all confident, and 5 is fully confident

Satisfaction and impact on practice



Please indicate from 1- 5 your level of agreement. 1 is not at all, and 5 is completely.

Satisfaction:

For the Phase One training cohort, there was an average 91% satisfaction rating.

For the Phase Two cohort there was an average 89% satisfaction rating.

Impact on practice:

For the Phase One training cohort, there was an average 78% rating of the impact on their practice

For the Phase Two training cohort, there was an average 74% rating of the impact on their practice.

Summary of themes

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Experience of training

- Interaction with peers/colleagues
- Working across organisations
- Benefits and challenges of online delivery
- Learning methods

Impact on learning

- Theory-practice links
- Relevance to their own practice
- Confidence in sharing learning
- Coherent framework

Impact on practice:

- Consistency of approach with teams and systems
- Individualised and holistic approach
- Joined-up pathway
- Organisational barriers and supports

What have we found out so far?

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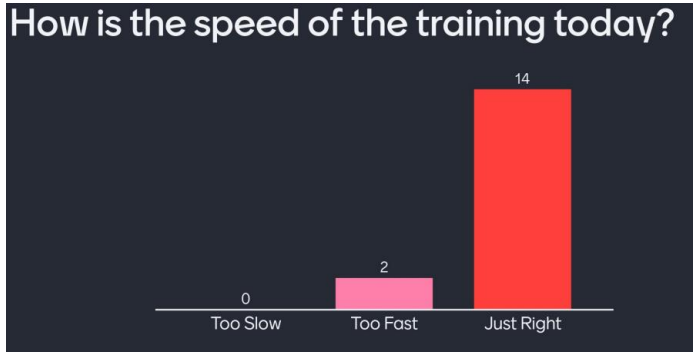
- The training has had a positive impact on knowledge and skills
- High level of satisfaction achieved from the training
- Training has had a positive impact on practice
- Pros and cons of online delivery versus face-to-face
- Train the trainer model is feasible for cascading training



What do we still need to find out?

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- What are the organisational factors that impact on outcomes?
- Does reflective practice increase the effectiveness of the training?
- Is the approach sustainable in the longer term?
- Views of people who use services?
- Impact on staff wellbeing?
- Is the programme feasible and acceptable to managers and commissioners?
- What model of training works best?

'It will be interesting to see this uniformity of language. Some organisations will go back to sitting alone. But we work closely with (another service), it will improve relationships.'"

"We are more confident talking about the person's trauma now. We are more comfortable with talking about the reasons why and how they got to where they were"

Next steps

- High level of interest and demand for training across localities and sectors
- Centralised trainer (trauma-specialist) to deliver training alongside local ‘champions’?

Criminal Justice Pilot:

- Development and evaluation of a clinical pathway for traumatic stress within prisons
- Exploration of managers’ and staff views of barriers and facilitators
- Pilot training within Parc prison – deep-dive into feasibility/acceptability and effectiveness
- Exploration of service user views

Any Questions

- For further information please contact **CTM.TraumaticStress@wales.nhs.uk**