Exploration of The Salvation Army's Trauma-Informed Journey, and Identification of Facilitators and Barriers in the Creation of a Service Environment and Culture that Enables Optimal Wellbeing for both Staff and Service Users.

"we would like to acknowledge that reports of this nature only exist because of collaboration across a whole community - sincere thanks is therefore due to all who contributed to the report and focus groups. To bring your authentic self to reflective spaces takes courage, an open heart and thrives in kindness - qualities we saw in abundance - thank you"

(the steering group)

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Foreword

We are proud of The Salvation Army's 157-year history of coming alongside people; offering safe spaces to reduce harm, to build strong and supportive relationships, to ignite a sense of purpose and build hope, connection for opportunities for transformation - at the heart of all we have done and continue to do is to offer people 'life in all its fullness with Jesus'.

We have undertaken many journeys of growth and development across all expressions of our ministry and mission and our determination to deliver services and interactions that are Trauma Informed is part of our desire to meet people where they are at, without condition, trauma reducing not inducing!

We are aware that the environments, communities, and systems we are all a part of have the potential to either promote or impede the trauma recovery process and we would like to thank our partners within The Safeguarding Board in Northern Ireland for collaborating with us to deliver this pilot report.

There is a wealth of research that indicates that most individuals in the general population experience some form of trauma[1] and that strongly aligns to people experiencing homelessness which then places individuals at higher risk of experiencing traumatic events[2]. A Trauma Informed Approach is conducive to creating environments that are not focussed on *'what's wrong with you'* but seeks to understand that *things 'have happened to you'* and with this in mind, we can work together to focus on *'what's strong with you'.*

A Trauma Informed Approach is about the whole community, the research tells us that Trauma Informed Care has positive outcomes for clients and staff [3]. If we want to offer spaces for reparation, for healing and growth, we must support our staff to be able to support others, safely, respectfully and always without causing harm to body, mind and soul.

This pilot represents the first of many more steps to come in our journey to deliver Trauma-Informed Practices and Programmes intended to help create a culture of trauma awareness and responsiveness across all expressions of our ministry and aligns naturally to the values of The Salvation Army, as well as the five mission priorities.

Mitch Menagh
Assistant Secretary for Mission
The Salvation Army, United Kingdom and Ireland

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1 Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. Journal of Traumatic Stress, 26(5), 537-547. doi:10.1002/jts.21848

2 Deck, S. M., & Platt, P. A. (2015). Homelessness is traumatic: Abuse, victimization, and trauma histories of homeless men. Journal of Aggression, Maltreatment & Trauma, 24(9), 1022-1043. doi:10.1080/10926771.2015.1074134
Ellsworth, J.T. (2019). Street crime victimization among homeless adults: A review of the literature. Victims & Offenders, 14(1), 96-118. doi:10.1080/15564886.2018.1547997
Kushel, M. B., Evans, J. L., Perry, S., Robertson, M. J., & Moss, A. R. (2003). No door to lock: Victimization among homeless and marginally housed persons. Archives Of Internal Medicine, 163, 2492-2499. doi:10.1001/archinte.163.20.2492

3 Damian, A. J., Mendelson, T., Bowie, J., & Gallo, J. J. (2018). A mixed methods exploratory assessment of the usefulness of Baltimore City Health Department's trauma-informed care training intervention. American Journal of Orthopsychiatry, 89(2), 228-236. doi: http://dx.doi.org/10.1037/ort0000357
Hales, T. W., Green, S. A., Bissonette, S., Warden, A., Diebold, J., Koury, S. P., & Nochajski, T. H. (2018). Trauma-informed care outcome study. Research on Social Work Practice, 1-11. doi:10.1177/1049731518766618

Dawn Richardson (lead author)
Lee Ball
Dr Claire Luscombe
Sheila Rigg (SBNI)

Introduction

Trauma-informed environments can support the building of relationships that are more open and trustworthy between providers of services and users of services, whether they be 'clients' or 'staff members'. A trauma-informed workforce (across roles, services, programmes, organisations and sectors) using a trauma 'lens' can lead to improved understanding of why some individuals might be presenting in certain ways, or with different responses to supports and services being offered. Resilience can be built, and adversity mitigated against, but a systemic approach, both internally and externally, is required (SBNI, 2020).

The Salvation Army Journey Thus Far

To date, The Salvation Army has demonstrated a commitment to developing enabling organisational environments, supporting staff wellbeing, enhancing evidence-based service provision and ultimately improving outcomes for individuals and families. Whilst this is all indicative of progress, there is organisational awareness and acknowledgement that there remains significant distance to travel along the trauma-informed journey.

Becoming a trauma-informed organisation and workplace is a lengthy, ongoing process, and any lasting change requires intentional effort to create congruency between awareness and meaningful action. Key to this process is focusing upon existing strengths in order to build upon areas where already there is success, to reinforce the good parts of our trauma responsiveness, and to also target and improve the more vulnerable areas (Trauma-Informed Oregon, 2018).

By being intentional about shifting our attitudes and bringing curious empathy to all our interactions, workplaces can begin to take the necessary steps to avoid re-traumatisation and create environments that enable flourishing and promote wellbeing for all. This requires organisational, systemic and cultural change within our organisation - and everyone has a role to play in that.

The development of this work is deeply rooted within The Salvation Army's Homelessness Services Unit (HSU) strategy, specifically the drive to develop a resilient workforce and improve the wellbeing of staff. As this work develops, the benefits will align with the strategic goals.

Background / Context to this Pilot Project

During 2019/20 The Salvation Army participated in the Safeguarding Board Northern Ireland's (SBNI) Trauma-Informed Practice Project (TIP) 'Be The Change' Leadership Programme, which was to support leaders to explore organisational change and consider future strategic direction.

The SBNI TIP workforce development project had initially been funded through the cross departmental Early Intervention Transformation Programme (EITP), but since 2021 has been funded by the DoJ led 'Tackling Paramilitarism Programme'. Initially launched in 2018, the project focused upon widespread training of the workforce to increase awareness and knowledge of Adverse Childhood Experiences (ACEs), (Bellis et al, 2015), and to support system change to adopt and apply trauma-informed principles and concepts, and support the application of these in practice.

Currently in Year 4 of the programme, the project team continue to work strategically across the

systems to ensure that SBNI member and associate agencies – including The Salvation Army - are supported to develop policies and practices to embed trauma-informed practice in their work. This is delivered through the following objectives:-

- Deepen Collaboration: The SBNI will support cross-sectional collaborative working and coordination to generate TI systemic approaches for those impacted by childhood adversity through the application of the Sequential Intercept Model (SIM) and the Universal Service Delivery process (USD).
- Embed ACEs / TI Knowledge: Organisations will embed knowledge about Adverse Childhood Experiences (ACEs) and Trauma-Informed Practice (TIP) across the system to improve outcomes for children, families, and adults who have been impacted by adversity.
- Develop Organisational Practice: SBNI will work alongside organisations to translate knowledge and learning into strategic planning and governance for organisations and the system.
- Sustain Workforce Development: SBNI will assist organisations and government departments to continue to develop their workforce to raise awareness of childhood adversity and trauma sensitive approaches to practice through promoting awareness and understanding of the SIM and USD process methodology.

Development of this Pilot Project

An organisation's trauma-informed journey can be complex and it can be challenging to know what to do or where to start. In these situations, it has been found that the assistance of a framework can be useful to support an organisation to measure the extent to which their work and practice is already trauma-informed, to identify strengths and needs, to guide implementation efforts, and then assist with the development of a clear action plan to monitor progress toward improvement and transformation of organisational culture.

The Ireland Region of The Salvation Army subsequently commenced a pilot project and collaborative partnership with the SBNI. The aim of the project was to begin to gain a more accurate understanding of how to respond more effectively to the needs of service users and staff, with particular focus upon identification of enablers and barriers in our responses to trauma and adverse childhood experiences. Drawing on the work of the SBNI and their adaption of the Sequential Intercept Model (SIM), (Policy Research Associates, 2018), and the Universal Services Delivery (USD) Process, (ISO 9001, 2015), this pilot study within Belfast Salvation Army services, made use of these frameworks to apply a trauma lens to consider the journeys of both service users and staff members through all parts of the service system.

The SBNI suggested that using both, provided a framework to guide the organisation's journey to becoming more trauma-informed through:-

- Identifying both the strengths and the gaps
- Considering how each interaction addressed vulnerability
- Considering the intercept of services
- Applying the 6 key principles of trauma informed practice
- Looking at the 10 management domains as suggested by SAMHSA and asking reflective questions

The improvement of outcomes for service users remained a central goal, alongside the creation of sensitive, safe and welcoming living and working environments which are conducive to everyone's wellbeing.

Consideration was given to what service users need from the services and staff team, but also crucially what the staff members need from the workplace and the organisation in order to deliver the required support. This greater insight and understanding would then enable the organisation to map service provision and workplace support in an honest and transparent way in order to understand how trauma-informed the programmes, practices, services and systems are. Given that staff members are the ones delivering trauma-informed services to vulnerable service users at times within very complex situations and services, it is vital to understand how they themselves experience the factors of trauma-informed care within the work and service delivery environment. Only with this deeper level of understanding and appreciation, can attention then be focused upon promoting better outcomes for service users, embedding a culture of trauma-informed care which supports staff health and wellbeing at work, and delivering safe, high quality, continually improving, compassionate care, support and leadership for all who live or work within Salvation Army centres and services.

A steering group and two separate focus groups were set up to coordinate, consider and undertake this mapping process. The steering group comprised of representatives from senior management roles within homelessness services and other operations across the Salvation Army, regional management, specialist teams and front-line service managers. The pilot sites and subsequent focus groups were selected as Centenary House and Thorndale Parenting Service, to enable the study to consider both a single homeless service and a family service so that potential similarities or indeed differences could be explored. It was envisaged that this would enable a more accurate assessment of the needs of a greater range of service users and staff members within Salvation Army services in Northern Ireland, whilst also providing group members with the opportunity to learn from each other, share experiences, ideas and innovative best practice, with a clear focus upon openness, transparency and lived experience. Focus groups comprised of a range of roles including specialist support workers, social workers, administrators, assistant support workers, managers, and a Salvation Army chaplain.

The format and process of the steering group, focus groups and the regular review meetings were a strength and essential component of this pilot project. They provided accountability and governance, enabled different opinions, views and knowledge to be shared both locally and organisationally, and created a safe space for people to share stories, learning and reflections on any developments, challenges or struggles. The expertise in different areas and the collaborative approach contributed to the smooth running and development of the project, whilst the regular meetings with support from the external SBNI advisor kept a developmental focus with accountability for any agreed actions.

> ***"I enjoyed the openness of the groups and found that it felt like a safe space to really honestly explore the subject. I feel it opened up discussion and allowed people to feel that they were heard"***
>
> (comment from a focus group member)

Application of the Models and Frameworks

Being mindful that 'every moment and every interaction is an intervention' (Treisman, 2018), the frameworks assisted reflection upon how effective organisational systems and practices are in addressing needs and vulnerability at every stage of the journey, and to explore whether this intervention and support is sufficient to prevent individuals getting stuck or indeed lost in the system. The SIM model particularly assisted with reflections about collaboration and identifying the right

people and agencies to provide the right support at the right time, while the USD then mapped the experiences from entry to exit of services.

Using both approaches within the focus groups provided a robust framework to guide the organisation's trauma-informed inquiry approach and exploration of the journey to becoming more trauma-informed. This mapping process enabled the focus groups to funnel their extensive considerations and reflections, maintain a focus, and ensure that all trauma-informed principles and implementations domains were being considered.

In addition to assisting with reflective questioning and identifying internal service strengths, gaps and opportunities for further development, making use of the SIM model and underpinning USD process assisted with a deeper understanding of how both service users and staff 'enter' services and workplaces and what they 'bring with them'; enhancing curiosity about their experiences of the environments and interactions during their time within those settings, consideration of what was happening at each interaction and intercept to address vulnerability; and then how they 'exit', and ultimately whether anyone is any better off.

> ***"I really love the reflections around 'noticing' and having increased 'curiosity' and the reminder of the need to view things differently sometimes....to show that we care enough to consider things through various lens and from different perspectives".***
>
> (comment from a focus group member)

A reflective practice and trauma-informed inquiry approach was taken by the facilitator to assist group members to consider more deeply and bring curiosity to their thoughts, with the 6 Trauma-Informed Principles and 10 Domains (SAMHSA, 2014) being used to consider what these might mean for each service and workplace at each intercept of the journey from entry to exit, and reflection upon the areas of both strength and challenge, how things could be improved, and what impact this could have upon service users and staff members. An inquiry-based approach was felt appropriate given its focus upon active dialogue and open-ended questions (Lewis-O'Connor, 2015), and with the focus being upon creating a safe environment in which participants can share as much or as little of their experiences as they choose.

Whilst the 6 TI principles were used to guide reflections, along with consideration of the SIM and USD when exploring an individual's journey and experience, the discussions remained flexible with the reflections and emerging themes themselves guiding subsequent focus groups. This resulted in the services resonating more with the issues being raised, as they were real and meaningful for the staff involved. This approach created greater ownership, inclusivity and meaningful engagement in the sessions, rather than staff being passive recipients of training being delivered 'to' or indeed 'at' them.

"I have worked here for a long time and seen many highs and lows, and engaged in all sorts of training and programmes.....but in all honesty I think this is the first time that I have ever sat back and been properly helped to think – really think about this stuff.....This really feels like we are doing the right thing, in the right way, for the right reasons.....Let's have more of this please".

(Comment from a focus group member)

During some of the concluding focus groups, the project was further supported by local artist Beth McComish who listened to the considerations and findings from the focus groups, and then produced a number of illustrations which captured the essence of the reflections from the focus group members. These will be included throughout the report and highlight main emerging themes.

"working at this together, with everyone playing their part...a different part....we can get there"

(comment from a focus group member)

Current Situation

The findings from this pilot project have been disseminated to senior management and the organisation is currently considering further roll out of the project across the Ireland region and then into other UK regions of Salvation Army Homelessness services. Senior leaders are currently consulting on pathways into other organisational streams - Wellbeing for All, People's Strategy, and HR.

A full organisational report has been produced containing the breadth of findings and reflections. This summary report will provide an overarching account of the process undertaken, highlights of the emerging themes, and an indication of some of the subsequent recommendations and organisational action to date.

Details of the focus group reflections and findings and mapping to the SIM model can be found in the appendices of this report.

Key Findings / Themes

The SIM and USD Models are excellent frameworks that facilitated the exploration through a trauma lens of both service user and staff experiences through all parts of the 'service' and 'system'.

It was felt throughout the pilot and within the focus groups that there is not only a strong evidence base for using both the method and model, but there is also a feeling that this process strengthened the 'connective tissues' between workers, workers to service users, workers to services and workers to the wider organisation.

Through discussion and reflection, it was felt that this 'Trauma Informed Inquiry' approach, although still in its infancy, could be grown organically through the various regions of Homelessness Services Unit, but wider still throughout other units and all expressions of The Salvation Army. A phased approach could be taken where relevant stakeholders held the place of the critical friend/observer as the pilot was widened. This reflective facilitation not only fostered rich discussion (and hence data), it also showed how this approach might be beneficial to other 'training' pathways.

> ***"What stuck out for me the most from the group was how using the model enabled us to think in a different way and be curious. I find myself stepping back and asking 'why is he behaving like that?' 'why won't he speak with me?' ' why is he avoiding his meetings with staff?' After doing the job for so long and working in such a chaotic and emotionally tough environment, we can become a little robotic and complacent. So taking part in this TIC group has taken us back to why we wanted to work in homelessness in the first place. Now we can see beyond the behaviours again and see the real issues".***
>
> (comment from a focus group member)

Safety is key to everything! - This needs to be the foundation block to the continued work.

> ***"I LOVED staying there and in all honesty there is a part of me that misses it....the chats, the laughs, the conversations, the caring..... and maybe most of all knowing that someone always had my back no matter what, was always there for me regardless. I really did feel very safe there and as if I belonged and mattered"***
>
> (comment from a previous service user)

Within trauma-informed care, the centrality of safety for all is clear. This pilot has revealed that for staff members working within such emotionally demanding and psychologically distressing environments, and for service users living within our service environments and receiving our support and interventions, safety is created where there are positive connections, and where there have been intentional efforts to explore, and understand, consider and reconsider. In this way, it is imperative that the organisation more greatly appreciates that safety is not simply the absence of threat, but the presence of connection where people feel seen, heard and accepted without judgement (Porges, 2014). Organisational responses to safety must focus upon both physical and psychological safety, and all dimensions of the organisations provisions must be considered - environments, structures, systems, practices and relationships - in order to create an environment and culture that enables optimal wellbeing for both staff and service users.

> ***"When I just arrived, my worker took the time out to sit and she explained her role to me and how she could support me. Staff went over everything with me, again and again, taking time and making sure that I understood everything."***
>
> (comment from service user)

> ***"Because of my trust issues I didn't want to tell someone all about me at the initial interview. I didn't want to drag up all my past and be judged. I just told them what I had to, and kept stuff to myself that I wasn't ready to share or have talked about at this stage"***
>
> (Comment from service user)

Connection is central to success and a clear tenet running throughout all discussions and reflections.

A number of factors were revealed as having the potential to significantly influence employees' sense of connection to their team, to the services users, and to the organisation. The centrality of connection (or disconnection) largely appears to be the driving force behind the experiences of any individual - staff or service user.

> ***"people here 'get me'. They are genuinely interested in me and that matters - a lot"***
>
> (comment from service user)

The extent to which an organisation is trauma-informed depends somewhat on the day to day behaviours of its staff (Metz, et al., 2007), yet it is also evident that staff conduct and wellbeing are also somewhat reliant upon the overarching support and facilitation of the organisation they are working within (Baker, et al., 2016). As the organisation strives to better understand the needs and experiences of staff within the implementation of trauma-informed care, it is essential that consideration is given beyond day-to-day practices, to a deeper examination of organisational behaviours and culture.

However, a disconnection was felt between frontline staff and senior managers.

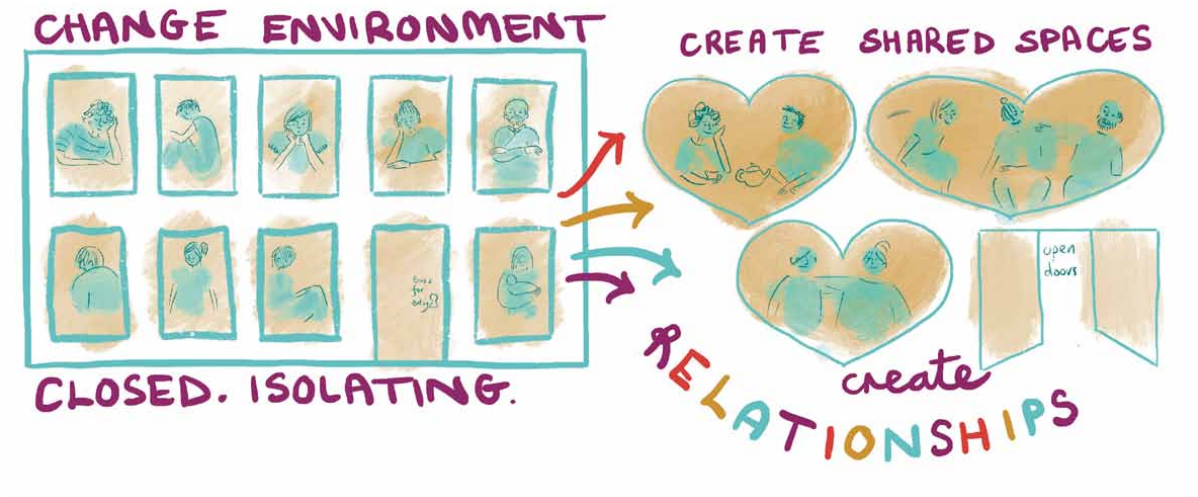
Group members appeared to feel a strong connection with and loyalty to their immediate service, but somewhat less of a 'belonging to' the overall organisation. This lack of connection was clearly leading to a sense of 'othering', a 'them' and 'us' with collective terminology being used such as 'senior leadership', 'The Salvation Army', 'they' etc.

It appeared that an element of a managerialist culture had developed, with priorities of efficiency, targets and performance indicators, rather than a focus maintained upon relationship skills and ethical values.

Group members acknowledged the challenges and complexities of everyone's role throughout the organisation and recognised that senior leaders had major issues to deal with on a daily basis. At times however it was felt that not enough recognition was placed on the importance and value of each individual staff member, what they did, what they brought, what they offered to the service and organisation, but ultimately their uniqueness. Staff spoke of needing to be seen, be heard, and to feel more like individuals with their own needs and finite capacities, rather than just a 'cog in the wheel' of the organisational machine.

Our welcome needs work! - welcome is so important and we aren't placing enough importance on it for service users or for staff.

Group reflections identified an understanding of the priority of safety for both service users, but also for staff. If individuals didn't feel safe, then any subsequent interventions would be superficial. There was an acknowledgement that for the most part, our physical environments did not promote the best sense of welcome or safety, and that there was considerable work to do in this area. Reflections identified that many of these areas for change and improvement could be easily achieved with a greater focus, application of a trauma 'lens', and some intentionality to create a welcoming, inclusive, and regulating environment and atmosphere.



Some focus group members undertook 'trauma-informed walk throughs' of the premises and processes, created photo journals, and identified that some of the arrival, waiting, interview, and living areas were somewhat clinical, cold, drab, and not lending themselves to creating a sense of safety or regulation. Reflections included entrances, signage, fences, gates, security systems, buzzers, locked doors, keys, staff uniform, first point of contact (phone/reception), welcome provision, waiting areas, interview rooms, interview and data collection processes, lack of privacy, inclusivity of information, and many other areas. Overall there was a sense that environments were not sufficiently welcoming, calming or regulating, and in some areas could be potentially retraumatising for individuals. Attention and action was required to address this.

It was also acknowledged however that a balance had to be struck between attempts to create an atmosphere of domesticity and the need for appropriate safety / security measures perhaps such as door buzzers and secure entry systems to help keep service users and staff feel safe. It was also important that assumptions were not made about how certain aspects of the service set up would make individuals feel.

> ***"I felt very safe knowing that there were gates and security cameras and staff available 24/7. I knew my ex-partner couldn't get near me or my son"***
>
> (comment from service user

There was acknowledgement that with the Covid pandemic then the clinical look and feel of some spaces was even greater - with plastic screens or tape marking out areas for social distancing etc, and even less of an inclusive feel. The teams noted however that safety for all was essential, but their reflections were simply how this could be making service users feel or exacerbating feelings already present. Creating even more physical and emotional barriers between staff and service users, a 'them' and 'us' feeling, a computer in the way, and a list of questions to be answered.

> ***"at times the paperwork was too much....I remember not even focusing at the start...just agreeing to anything and everything"***
>
> (comment from service user regarding the admission / induction)

Staff also reflected on their own induction and recruitment to the organisation and the need for the organisation to look at not only how it equips staff with the skills and importance of working in a trauma informed way but also is mindful of how the various processes and systems 'model the model'. Partnering with HR in this next phase and building upon the work already being undertaken, will assist HSU (Homeless Services Unit) to develop this work further with even greater collaboration.

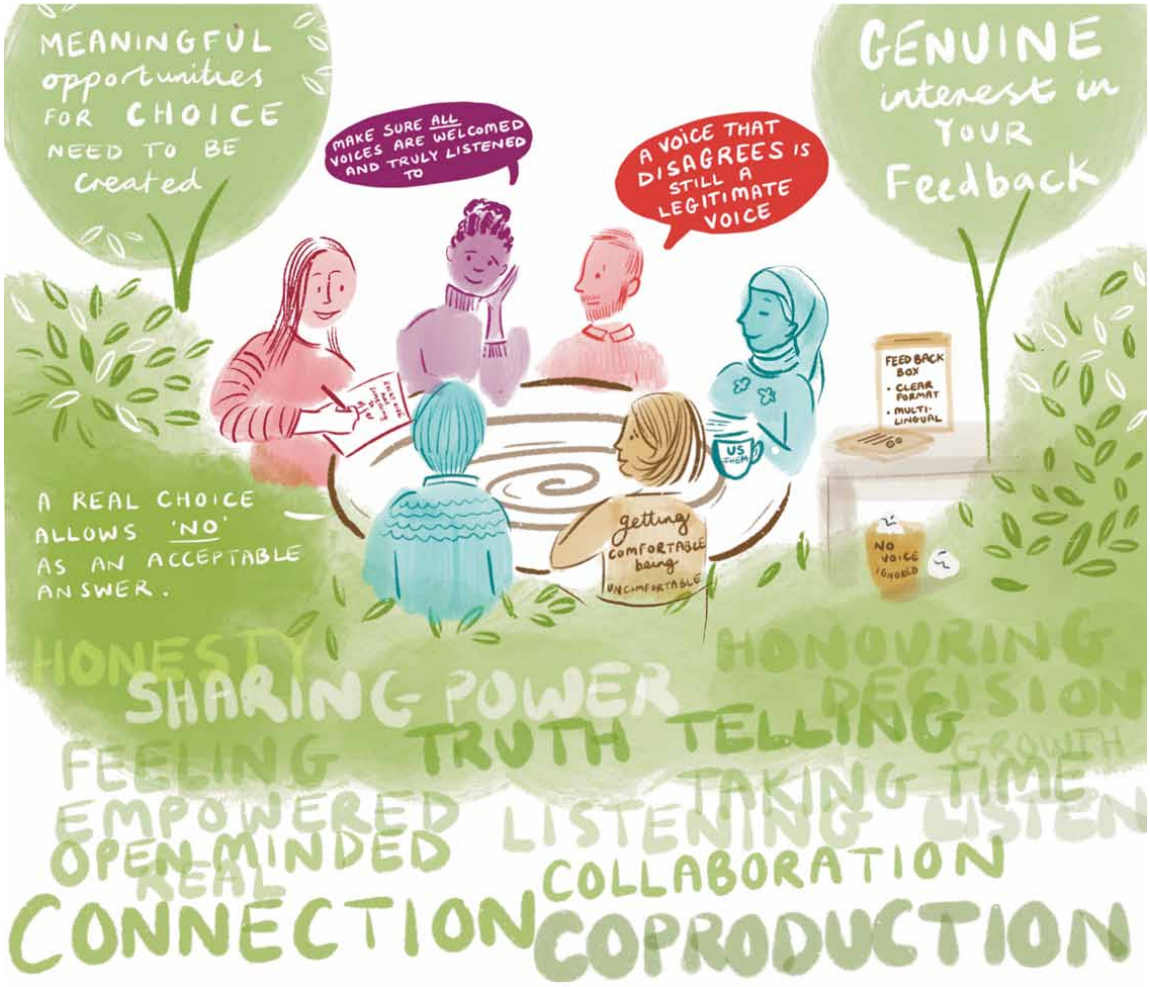
We need more genuine intentional service user involvement and space to work through the tensions between the assumption of need versus meeting service users where they are at.

When considering the principle of true voice and choice and collaboration, there was acknowledgement that whilst staff teams meant well and genuinely tried at times to include and engage service users in projects, events, discussions etc, that this was somewhat superficial, almost tokenistic at times and not in any way embedded enough.

At times the intention was genuine desire to involve, whereas at other times it was more to meet the needs of the service or commissioners or inspectors or funding bodies who liked to see 'evidence' of client involvement. There was acknowledgement that staff and services needed to further consider and develop the willingness and ability to really listen, rather than only listen to that which was easier to hear or to obtain, and to work much harder with greater intentionality to ensure genuine inclusivity with a focus upon 'power with' rather than 'power over'.

> ***"we need to stop making assumptions about what is needed, or what someone needs to do or achieve, and what they need to have in their support plan and goals.....we need to start doing more asking rather than talking.....asking them what they want, what they need, how they feel...."***

(comment from focus group member)



Staff wellbeing needs to be more integral. Support needs to be intentional, genuine, and available and accessible when needed.

Wider organisational support and connection is essential for improved staff wellbeing, and a consistent approach across all services, streams and departments .

As participants continue to work within challenging services and strive to deliver trauma-informed care to service users with high support needs, they are reporting a need for a greater sense of psychological safety that compassion can create - a culture of reflection, accountability and learning, where risk taking with safe boundaries is encouraged, and an acceptance that some mistakes will be made and learnt from. This would steer away from any perceived developed culture characterised by fear or blame, and where staff can begin to feel more confident to engage, to speak out and speak up.

Within the organisation, a culture of strength and resilience is aspired to. However what this really meant for staff on the front line was that they felt as though they are expected to be continuously "tough" and "strong" and "made of steel" in order to deal with and cope with some of the issues they came across, situations they had to try to manage, decisions they had to make and stand over, overdoses, fatalities, near misses, children being removed, allegations against them, amongst many others.

Despite this clear complexity and significant level of responsibility and accountability, the general feeling was 'this is the work we do', 'toughen up', 'get on with it' with staff feeling therefore a sense of weakness and in fact inadequacy if they did not seem as able to deal with things as well perhaps as some of their colleagues. Staff felt at times that they were expected to be some sort of super hero, when really, they actually need to be more like turtles (hard on the outside, soft on the inside but willing to stick your neck out a little!). This highlights the importance of the centrality of wellbeing support and resources for staff as integral to the work and not a 'luxury add-on' which it can sometimes be seen to be. This needs to be reframed with wellbeing not only made a central theme, but appropriately resourced too. This means giving time and space to staff to participate.


While women weep, as they do now,
I'll fight; while children go hungry,
as they do now I'll fight;
while men go to prison,
in and out, in and out,
as they do now,
I'll fight...
Hope will FLOURISH here
TRUST, FAITH and HOPE. YOU HAVE MADE ME FEEL SAFE
SUPPORTING EACH OTHER UNDERSTANDING ONE ANOTHER
I KEPT GOING, BUT THEN YOU ASKED ME, "ARE YOU EASY?" THANK-YOU I WASN'T.
TOGETHER WE CAN DO IT
...while there is a poor lost girl upon the streets, while there remains one dark soul without the light of God, I'll fight, I'll fight to the very end!
THE SALVATION ARMY

Concluding Remarks

The journey towards becoming a more trauma-informed organisation is not an easy, quick or straightforward one. It will require sustained commitment, attention, effort and resources, and enhanced internal and external collaboration. Even this small scale study has highlighted the need to move beyond previous and traditional models of practice and service delivery, towards re-evaluation of all organisational structures, systems, practices and policies through a trauma-lens. The organisation will be required to prioritise wellbeing for all, and the building of safety, connection and trusting collaborative relationships above all else, and a move from 'fear to safety, control to empowerment, and power to accountability and transparency' (Concetta, 2018).

Partnering with HR in this next phase, and building further upon work already being undertaken, will assist HSU to develop this work further with even greater collaboration.

This study has used the unifying process of the 6 Trauma-Informed principles and 10 implementation domains (SAMHSA,2014), alongside the Sequential Intercept (SIM) model and USD framework to assist focus group exploration of the service user journey from 'entry' to 'exit'. The rich reflections and subsequent findings have provided an extremely useful initial insight into service user and staff views of what trauma-informed practice and responses look and feel like in a real life setting in front line services.

Lessons Learnt

This was a small-scale study focusing upon the experiences and needs of staff within two services in one of eight regions within the organisation. Future work could therefore expand the breadth of the research to the full range of services within a region, or indeed the inclusion of a number of additional regions across the United Kingdom and Republic of Ireland structure.

Whilst the steering group had planned the initial stages and sequencing of the project; selection of focus groups, provision of foundational training, and then commencement of focus groups, and relevant timings of this - there was clearly an underestimation of how much time would be necessary to organise the setting up and facilitation of focus group members.

There needs to be significant line management support, forward planning and commitment to ensure staff are 'freed up' to attend and to enable successful participation. Improved planning and organisation with the focus groups would also potentially lead to more effective group size. In this study there were 7 participants in one group, but only 5 in the other. Whilst attendance and commitment was high, there were a few occasions when these numbers dropped slightly as a result of absence from work or work and rota pressures. The group discussions and reflections were still rich with full participation, but it would be felt that a group size of 8-10 could be more beneficial to allow for an element of drop out or non-attendance. If any future groups were going to be held virtually then this number of participants would better enable smaller break out room activities.

Selection of focus group members could also be further improved to gain representation from a wider range of roles, levels and length of experience. Careful consideration of this is however required. Whilst it is acknowledged that it is crucial to have representation from different roles and levels of authority in the organisation (Guarino et al., 2009), consideration must be given to the likelihood of power and relationships coming into play. This is more inevitable if members of management are present alongside staff they manage or have responsibility for. Whilst there may be some resistance to having senior managers present as a result of possible trust issues, there is the counter argument that having senior leaders present is a clear message that TIC is valued at the highest level. Managerial presence can also enable changes to happen more readily, rather than this 'permission' having to be then sought outside of the focus group. This should however be considered on an individual service / regional basis, and group members asked for their honest views and preferences.

In this initial pilot there were dates set for the foundational Level 1 ACEs and Level 2 TI training, and then planning worked 'backwards' from this resulting in timings being too tight with last minute rota organisation. What would have been preferable would have been to focus on selecting the focus groups, sorting rota provision and only then trying to secure dates for the training.

Next Steps

1. **TESTING ASSUMPTIONS:** The (full) report has produced many rich and insightful reflections, findings and potential solutions from frontline staff and service users. Due to the geographical spread of The SA's services, across borders, cultures and expressions of work, it is recommended that there is a continuation of the pilot not only across the Region of Ireland, but also into the various regions and devolved nations of the United Kingdom. It is hoped that the next regions to be involved in this rollout will be services within Scotland and Wales.

2. **GOVERNANCE AND LEADERSHIP:** If The SA/HSU was to embrace the widening of the pilot across the regions of HSU, not only is the support of investment in the implementation of the approach needed, but vital to this is the investment in the sustainment of a trauma-informed approach. In order to do this, to ensure quality assurance, consistency and capacity, it is recommended that there should be an identified point of responsibility within the organisation to lead and oversee this work (SAMHSA 2014). A champion of this approach is often needed to initiate a system change process, and it is the proposal that this be the Trauma Informed Enquiry Lead.

3. **CONSISTENCY AND SKILL:** It is recommended that there needs to be a particular skill set in any Trauma Informed Enquiry Facilitator. This must not only include a deep understanding of trauma-informed practice and the appropriate models but also the use of reflective facilitation. The skilled use of regular collaborative reflection between a staff team, focus group facilitators (and supervisor) develops and deepens the understanding of a Trauma Informed Approach.

   The Facilitator allows this *reflection on* to become *reflection in* the moment, enabling staff to embed their understanding and response to thoughts shaping feelings, and feelings instructing behaviour. A quality reflective facilitator complements the goals and practices of a Trauma Informed Approach.

4. **CONNECTION AND BUY IN:** The use of a focus group, to offer an additional space for reflection and introspection was vital to bring not only a sense of objectivity in a field that can produce very subjective emotion, but it also fostered a strong sense of buy in and connection.

   The ability to offer reflection, to test the assumptions and findings, to involve and connect with the wider service of HSU will support staff to feel that this is not just another approach, that they are expected to implement, but instead facilitates staff to connect the dots, and integrates theory into evidence-based practice.

   It is recommended that the focus groups continue but also welcome colleagues from across other units/departments of The SA. Allowing the membership to be wider will allow the work to permeate deeper, into the very structures and systems that we work within. Within the next phase of the rollout it seems appropriate that HR colleagues be a key partner.

References

1. Baker, C. N. et al., 2016. Development and Psychometric Evaluation of the Attitudes Related to Trauma-Informed Care (ARTIC) Scale. *School Mental Health,* Volume 8, pp. 61-76.

2. Concetta, P. (2018). Survivors voices, personal communication, in Sweeney, A & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental heatlh. *Journal of Mental Health*, 27(5), 383-87.

3. DoH (2019) Social Work and Homelessness: Reflections on Homelessness https://www.health-ni.gov.uk/sites/default/files/publications/health/refelections-homelessness.pdf

4. Fallot, R. D. & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Washington, DC: Community Connections. Retrieved from https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelfAssessmentandPlanningProtocol0709.pdf

5. Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. Retrieved from http://www.air.org/resource/trauma-informed-organizational-toolkit

6. Harris, M., & Fallot, R. D. (Eds). (2001). *Using Trauma Theory to Design Service Systems*. San Francisco, CA: Jossey-Bass.

7. Hooper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Service Settings. *The Open Health Services and Policy Journal, 3, 80-100*

8. Jennings, A. (2004). Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services

9. Lankelly Chase Foundation (2015). *Hard Edges: Mapping Severe and Multiple Disadvantage, England.* Available at: http://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

10. Lewis-O'Connor, A., Warren, A., Lee, J.V., Levy-Carrick, N., Grossman, S., Chadwick, M., Stoklosa, H., Rittenberg, E. (2019). The state of the science on trauma inquiry. *Journal of Women's Health 15, 1-17*

11. Mate, G. (2003) *When the Body Says No: The Cost of Hidden Stress*. Toronto: Vintage Canada

12. Metz, A. J., Blase, K. & Bowie, L., 2007. *Implementing evidence based practices: Six "drivers" of success.* Washington DC: The Atlantic Philanthropies.

13. Munetz & Griffin. (2006). Use of the Sequential Intercept Model as an approach to decriminalisation of people with Serious mental Health illness. *Psychiatric Services 57(4): 544—549*

14. Perry, BD. (2007) *The Boy Who Was Raised as a Dog: and Other Stories from a Child Psychiatrist's Notebook : What Traumatised Children can Teach Us About Love, Loss and Healing.* Basic Books : USA

15. Porges, S. (2014). *The Pocket Guide to The Polyvagal Theory: The Transformative Power of Feeling Safe*. New York: WW Norton & Co.

16. Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. SMA 14-4884). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

17. Sundin, E. & Baguely, T. (2015). Prevalence of childhood abuse among people who are homeless in Western countries: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology,* 50, 183-194

18. Thomas, J. (2016). Adverse Childhood Experiences among MSW students. *Journal of Teaching in Social Work, 36, 235-255*

19. Trauma Informed Oregon. (2018). Standards of practice for trauma informed care. Retrieved from http://traumainformedoregon.org/standards-practice-traumainformed-care/

20. Trauma Informed Oregon. (2016a). Roadmap to Trauma Informed Care. Retrieved from https://traumainformedoregon.org/roadmap-trauma-informed-care/

21. Trauma Informed Oregon. (2016b). Trauma Informed Care Workgroup Meeting Guidelines. Retrieved from https://traumainformedoregon.org/wpcontent/uploads/2016/01/Trauma-Informed-Care-Workgroup-MeetingGuidelines.pdf

22. Trauma Informed Oregon. (2020). Behaviours and actions of trauma informed leaders. Trauma Informed Oregon Research Notes. Retrieved from traumainformedoregon.org

23. Treisman, K. (2021). A Treasure Box for Creating Trauma-Informed Organizations: A Ready-to-Use Resource for Trauma, Adversity, and Culturally Informed, Infused and Responsive Systems. Jessica Kingsley Publishers.

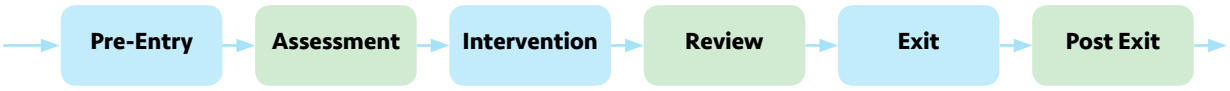
24. Treisman, K. (2018). *Working with Relational and Developmental Trauma in Children and Adolescents.* Routledge.

25. Trevithick, P. (2003). Effective Relationship-Based Practice: A Theoretical Exploration. *Journal of Social Work Practice, 17, 2.*

APPENDIX 1.0

Summary of Reflections from Focus Group Discussions ('from Entry to Exit' USD process)

Pre-Entry & Entry



1) Referrals

- Difficulties experienced at times with discussions and collaborations with referrers and other agencies and how transparent these discussions may be if there was concern that additional information might lead to a referral not being accepted.
- Acknowledgement that enhanced and more transparent communication between agencies could lead to smoother transitions for service users; need to get back to more regular multi-agency meetings and networking.
- Challenges of GDPR and barriers in sharing of important information between agencies - leading to the need for duplication of documents, requesting more information directly from service user and therefore increased risk of re-traumatisation - could we not have greater access to shared information between key agencies which could be accessed when needed (CH).
- Challenges experienced by services when referring agencies responses or engagement is less trauma-informed, and service users not given every support at the stage of referral (pre-entry) to succeed.
- Realistic or unrealistic expectations from referring agencies?
- Acknowledgement of the benefits of planned moves, enabling provision of information to be sent to prospective client in advance, and arrangement for worker to be allocated even prior to the point of arrival (early intervention worker)

2a) Pre-arrival (TH)

- Meetings and visits prior to admission help create foundational connections and beginning of safety
- When admission is planned, family feel expected; personal touches added.
- Background reports and information pre-populated into Salvation Army documents. Team have undertaken 'tuning -in' process to new family arriving and considered required approach and adaptations.
- Awareness of impact of possible 'stories' prospective families may have heard.

2b) Pre-arrival (CH)

- Consideration of whether the service user may have previous experiences of other service providers or indeed The Salvation Army.

- Consideration of whether referral to CH might be trauma-reducing or trauma-inducing for this individual?
- Referral from prison V referral from last tenancy - would a different response be required?
- What information could help?

3) Physical Entry

- Locating the service - well signposted from transport routes?
- Queuing outside in the cold; hunger, agitation, anxiety, fear (Night Shelter)
- Consideration of physical impact of the environment (sensory and emotional) – first impressions of building, entrance, reception, first point of contact, waiting areas, general 'feel' of the place.
- What helps or hinders the creation of sense of physical and psychological safety?
- Impact of external and reception environment (gates, cctv, barbed wire, signage etc – trauma reducing or trauma inducing?).
- Signage & Noticeboards– need to be clear / helpful / inclusive / representative / motivation, not over-bearing or excessive

4) Admission Process

- Immediate impressions from staff member
- Cumbersome admission process requiring intense engagement from service user, provision of excessive information and same questions asked again and again; documents lengthy, wordy, potentially difficult to understand, and only in English.
- Consideration needs given to overall intake process to enhance sense of physical and psychological safety.
- Regarding re-entry – same questions at times asked again despite being previously recorded
- Acknowledgement that service users may not be truthful with information provided.

Assessment

- Greater focus at times on paperwork rather than 'people-work' and relationship based practice
- Focus on data collection may hinder the development of rapport and connection
- Copious paperwork with unnecessary duplication at times. Needs streamlined and ensure that all documents and assessments are purposeful and their intention fully understood by staff.
- Need to consider rewording, language, terminology used within documentation and assessments (risk assessment, anger management, challenging behaviours) - move away from deficit language to more strength based.
- Acknowledgement of inherent power imbalances - completion of formal paperwork / reports can exacerbate this - consideration of alternative mediums.
- Recognition of the strength of more collaborative, multi-agency assessments

Intervention

- Trauma-inducing or trauma-reducing? / Helping or hindering?
- Acknowledgement of inherent power imbalances and ongoing tendency for focus upon 'rules' and 'behavioural expectations'. Need for move away from command and control and 'othering' to greater efforts at collaborative working with genuine inclusion, voice, choice and empowerment.
- Need for safer spaces for both staff and service users to soothe and regulate (funding applied for).
- Realisation of the centrality of team work and unconditional regard and support for one another (together we can be the change)
- Need for greater focus upon connection and relationship based practice
- Reflections upon: what works? Why do we keep doing this? What would help?
- Greater efforts required to ensure that true voice and choice was promoted with all voices being sought, invited, heard and respected.
- Acknowledgement that despite best intentions, service user involvement was frequently tokenistic and therefore not meaningful - greater intentionality required and willingness to truly proceed down route of collaboration and power sharing.
- Need for more bespoke interventions specific to the needs of individual service users at any given time rather than generic responses.
- Relationship-based practice is core and not 'added-value'.
- Acknowledgement that for our services to truly grow, develop and blossom, and for service users and staff to be enabled to flourish, then real connection, collaborative working and coproduction must be strongly at the foundations.
- Identification of a sense of disconnection between frontline staff and higher management
- Recognition that staff wellbeing needs to be taken more seriously
- Staff needing to feel more as individuals with own needs, strengths and finite capacities, rather than just a 'cog in the wheel' of the organisational machine.
- Need for intentional effort to build stronger relationships and connections characterised by safety and trust
- Staff desire for leadership to 'stop thinking like mechanics and start acting like gardeners'.
- At times staff feeling that their commitment and passion for the work was being taken for granted, and that the more they did and gave, the more that was expected.

- As we strive to provide effective support and innovative services for those in our care, we must ensure that our staff are enabled, that they are provided with supportive foundations, and that a nurturing culture is modelled throughout the whole organisation, as we strive to enhance wellbeing for all.

Review

- Acknowledgement that there were many things that needed reviewed, reconsidered and amended:-
- Who is involved in reviews
- How are service users involved and heard in the review of services
- Is this honest, meaningful, effective
- Review processes needs to be more transparent (with service users and staff)
- Whilst organisational policies regularly being reviewed, this now needs done through a trauma 'lens' and maybe by a trauma-informed focus group of service users and staff
- Acknowledgement that within The Salvation Army there remains a formality that does not sit neatly with trauma-informed working, collaboration and mutuality, and 'power-with' rather than 'power-over'
- Language and terminology needs considered - 'managing challenging behaviour' / 'risk assessment'
- How can we ensure there are systems on the on line client support system (Atlas) to record and evidence relationship based practice and true engagement with service users
- Current systems for establishing feedback need further review - external company commissioned to establish feedback from service users and report on this, however acknowledgement that the guidance about this feedback exercise and the on line document itself is all in English and currently not available in any other languages.
- Staff supervisions need to be more trauma-informed with less of a formal focus upon performance and business processes.

Exit

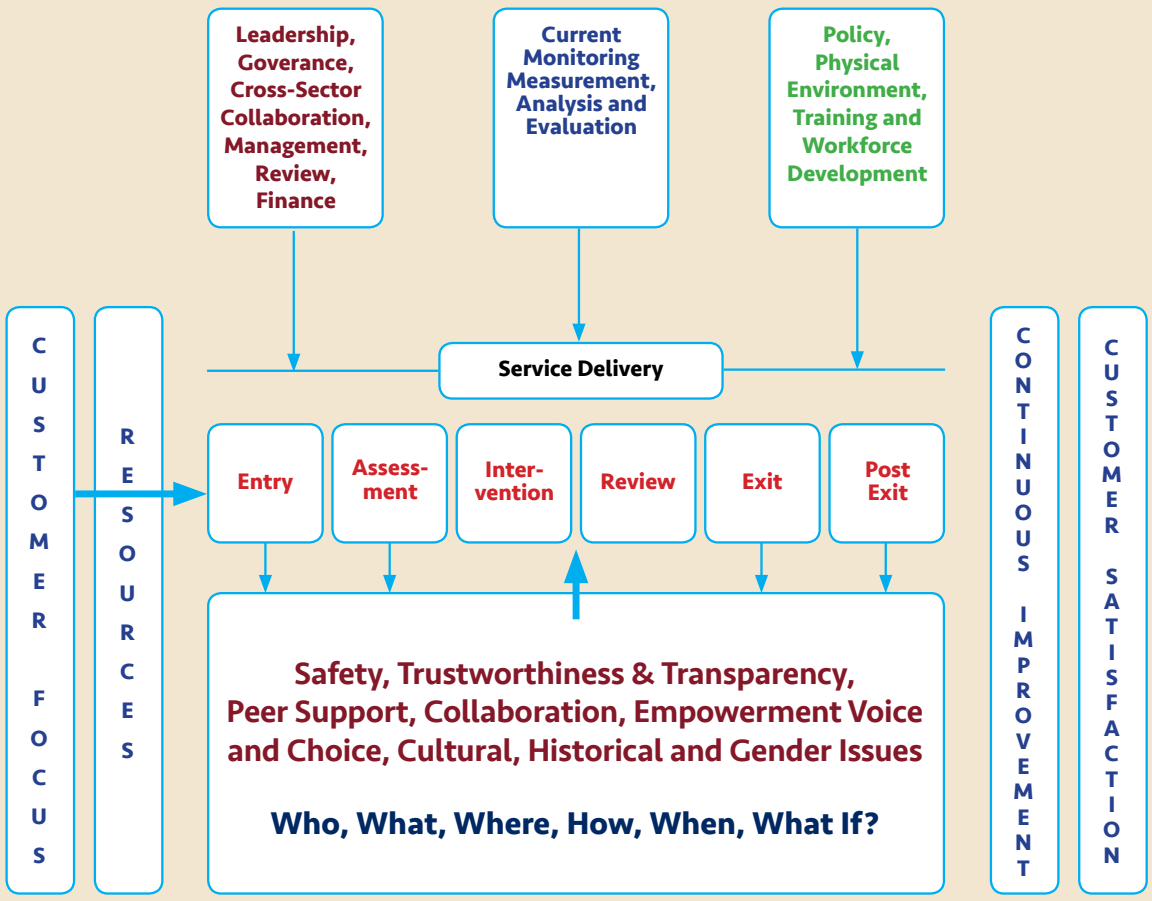
- Acknowledgement that despite many service users having lengthy stays within the services, the discharge and 'exiting' process at times could be very quick and perhaps even without much planning or engagement between the individual and the staff member. This is in contrast to the 'top heavy' admission 'entry' process with its lengthy discussions / interviews and copious amounts of paperwork.
- Staff expressed regret that many 'quality' staff were leaving the organisation without adequate 'exit interviews' or exploration of what (if anything) might have enabled them to remain employed within the organisation.
- Identification that our 'exit' process for both service users and indeed for staff needs to be more robust to ensure that every appropriate support can be offered and implemented and there is adequate planning and consideration of need.

Post Exit

- Recognition from staff that better follow up with service users and staff was crucial
- Sense of 'revolving door' for many service users, and team reflections upon what we could do better to prevent this, but then reduce situations which could retraumatise - ie asking same questions all over again and gathering same data.
- Populate data from previous records for any re-entry within or across services.
- Greater interrogation of data – what worked, what didn't and why? Honest review of lessons learnt. Use recordings in system for more careful analysis and to build an evidence base.
- Is anyone truly better off?
- Closer collaborations with partner agencies, particularly those offering follow on / community support. Maintain 'connections'.

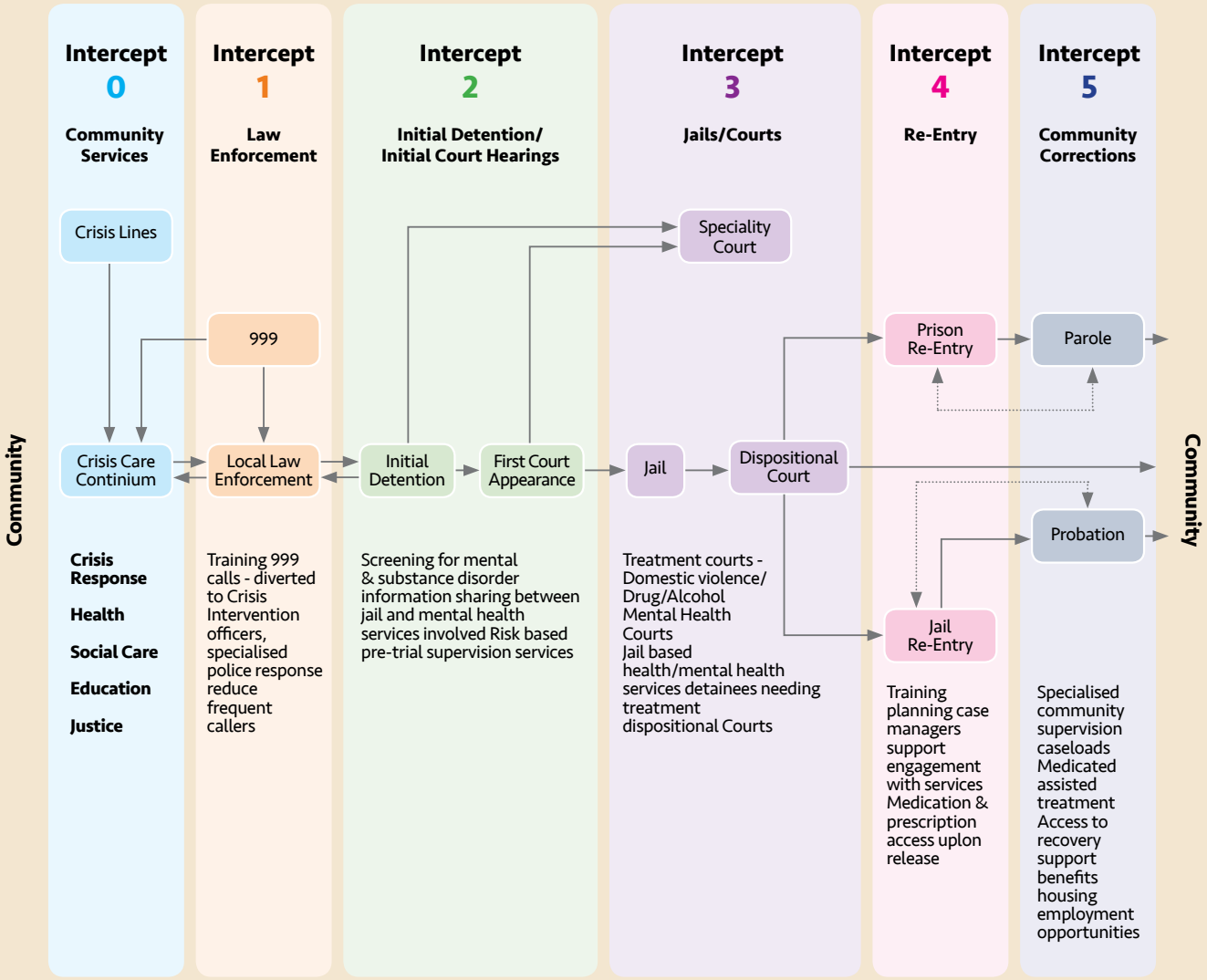
APPENDIX 2.0

Universal Service Delivery Process Reflecting SAMHSA - Domains & Principles



APPENDIX 2B

Sequential Intercept Model - Applying a trauma aware/sensitive approach and response to mitigate the risk of persons with substance use disorder/ mental health problems entering/re-entering the Criminal Justice System - INTERCEPT 0-6 (Policy Research Associates adapted)



APPENDIX 3

SAMHSAs - 6 Principles of Trauma-Informed Care and the 4 Rs

Outline areas an organistaion needs to consider and address in order to support trauma responsive services.

Explicit response to trauma

Trauma Sensitive/Responsive Universal Service Delivery Process

SAMHSA's 10 Implementation Domains

- Goverance and Leadlership
- Policy
- Physical Envoronment
- Engagement and Involvement
- Cross-Sector Colloboration
- Screening, Assessment and Treatment Services
- Training and Workforce Development
- Progress Monitoring and Quality Assurance
- Finance
- Evaluation