Trauma-Informed Substance Use Pathfinders

Learning Report

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Trauma-Informed Substance Use Pathfinders – Learning Report

Supported by the National Trauma Transformation Programme

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National Trauma Transformation Programme
Responding to Psychological Trauma in Scotland

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Executive Summary

Background

Commissioned as part of the National Trauma Transformation Programme (NTTP), the Scottish Government funded four pathfinder projects with a focus on two priority sectors: maternity and substance use services. This report presents a summary of learning from the two substance use pathfinders which were based in Dumfries and Galloway and Orkney. The pathfinders took place over a 15-month period from January 2022 to March 2023.

These highlights are intended to support services across Scotland to consider the opportunities and challenges of planning for, developing and implementing sustainable trauma-informed (TI) practice, care and systems. A key aim of the pathfinders was to share learning which would further support substance use services in particular to implement and embed the Medication Assisted Treatment (MAT) Standards, and in particular, MAT Standard 10 (Trauma-Informed Care) as well as supporting the Scottish Government and Convention of Scottish Local Authorities (COSLA) shared ambition for a trauma-informed and responsive workforce and services across Scotland.

Approach

The two substance use pathfinder areas were provided with approximately 40 days of dedicated support across the two areas from a specialist in TI Practice (who was also a Clinical Psychologist), as well as support from a Monitoring and Evaluation specialist. The substance use pathfinders followed three phases:

1. Understanding service context and readiness for TI Practice.
2. Improvement planning, informed by Phase 1.
3. Implementation of agreed priority areas.

Summary of Key Learning

From the outset of the pathfinders, it was recognised that services were already progressing many aspects of trauma-informed work, often without realising it. It is important that these actions are explicitly recognised as positive progress on an organisation's journey to becoming trauma-informed and responsive. The pathfinders also supported the development of a number of practical recommendations in relation to embedding the core components of a trauma-informed approach, including:

Organisational Culture: Each organisation's culture will look and feel different, but it is important to consider how TI principles, values and ways of working are embedded within the culture of an organisation. Practical approaches such as completing an organisational assessment tool and service-specific lens walkthrough, using supporting resources provided through the NTTP, can support teams/ services

and organisations to reflect on strengths, challenges and opportunities across strategic and operational aspects.

Leadership: Visible and transparent support from leaders for TI Practice implementation is important for staff motivation and buy in, for example the production of a TI Practice mission statement can reinforce this as a long-term priority for the service. Attendance at Scottish Trauma Informed Leaders Training (STILT), provided through the NTTP is beneficial in helping everyone at all levels of an organisation to understand what TI Practice requires and the importance of trauma-informed leadership.

Workforce Care, Support and Wellbeing: Any assessment of readiness for TI Practice should ensure that staff wellbeing is recognised as a priority issue and is being supported. Consideration should be given to investigating suitable evaluation measures of staff wellbeing, which can then be fed into a wider system of tailored actions for improvement. Services should also have access to clinical supervision where required and/or reflective practice groups facilitated by someone with the appropriate level of knowledge, skills and experience.

Power-Sharing with Experts by Experience of Trauma: Planning for power sharing with people with lived experience should happen in the early stages of implementation of TI Practice to ensure people who use the services are included in the process from beginning to end in a meaningful way. This may include setting up a service user group, or an advisory group from people further along in their recovery journey, or potentially engaging with people with lived experience from existing psychosocial groups run either within the service or with third sector colleagues.

Workforce Knowledge, Skills and Confidence: Consideration should be given by services as to how to incorporate the NTTP resources into their own tailored training plans, which can be particularly useful for induction of new staff and ensures the training plan becomes sustainable and integrated into training provision. Scaffolding or coaching post training, where capacity allows can support staff to implement knowledge and skills.

Data, Feedback Loops and Continuous Improvement: Developing a longer-term implementation plan (longer than 1 year) is likely useful for services, so staff understand all that is involved in implementing TI Practice and have a clear plan (with accountability) as to how actions can be taken forward.

Policies and Processes: Human Resources (HR) staff play a key role managing NHS wide policies. Consideration should be given to providing trauma training for HR staff alongside senior managers to ensure HR have the knowledge and support to apply a TI lens when reviewing policies. Creating working groups to review existing service documentation and guidance appears to be a sensible way forward for progressing the organisational capacity and catalyst necessary to facilitate change.

Budgets: Budget needs to be considered and reviewed when drafting a TI implementation plan to identify in/direct costs and resources required to implement

and sustain these changes. This is a further reason for ensuring senior management are involved in the drafting and progress on implementation plans.

Service Design and Delivery: Where possible, whoever is leading the implementation of TI Practice should have a good knowledge of the team, to facilitate some of the potentially difficult conversations and reflections which may need to happen to implement TI Practice. This will support implementation planning with sufficient depth and specificity.

Introduction

Commissioned as part of the National Trauma Transformation Programme (NTTP), the Scottish Government funded four trauma-informed pathfinder projects with a focus on two priority sectors: substance use services and maternity services. This report presents a summary of learning from the two substance use pathfinders which were based in Dumfries and Galloway and Orkney. The pathfinders took place over a 15-month period from January 2022 to March 2023. These highlights are intended to support substance use services across Scotland to consider the opportunities and challenges of planning for, developing and implementing sustainable trauma-informed (TI) practice. The learning is also intended to be useful and replicable for other frontline services.

Context

Medication Assisted Treatment (MAT) Standards

Prior to the start of the Pathfinders, the Scottish Drugs Deaths Taskforce and Public Health Scotland (PHS) developed and published evidence-based Medication Assisted Treatment (MAT) standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. They were developed by a diverse group, including those who will deliver care and those who will benefit from that care with input from individuals and families with experience of harmful drug use.

The MAT standards have been a priority focus of substance use services throughout Scotland and are a key part of the context within which the substance use trauma-informed pathfinders have been delivered. There are 10 MAT standards, two of which directly overlap with trauma-informed care:

- Standard 6: the system that provides MAT is psychologically and trauma-informed (Tier 1); routinely delivers evidence based low intensity psychosocial interventions (Tier 2) and supports the development of social networks; and
- Standard 10: All people receive Trauma-Informed Care.

It is important to highlight that the remaining standards, whilst some are more medically oriented, are still influenced by, or relevant to TI Practice, such as treatment choice, mental health, shared care, and primary care. The MAT Standards are available here.

PHS published a National benchmarking report in June 2023 which shows progress towards implementing the standards. PHS has recommended that all 10 standards should be fully implemented by April 2025.

National Trauma Transformation Programme

The Scottish Government and COSLA have a shared ambition for a trauma-informed and trauma-responsive workforce and services across all sectors of the workforce in Scotland. Since 2018, the Scottish Government has invested over £9.6 million in a National Trauma Transformation Programme (NTTP). This includes a total of £1.6 million each year since 2021/22 shared equally across all 32 local authorities to work with community planning partners to further progress trauma-informed services, systems and workforces.

Scotland was one of the first countries in the world to publish a knowledge and skills framework for psychological trauma, developed by NHS Education for Scotland (NES). This framework sets out the knowledge and skills needed by everyone in the Scottish workforce to be able to recognise where an individual may be affected by trauma and to adapt their practice accordingly in order to minimise distress and support recovery through a safe and compassionate response.

The NTTP provides accessible, evidence-based trauma training resources developed by NES and informed by experts by experience, including a trauma-informed leaders component. Support for training and implementation, across all sectors of the workforce, is provided by a team of Transforming Psychological Trauma Implementation Co-Ordinators (TPTICs) based in every Health Board in Scotland. A network of 'Trauma Champions' has also been established. Supported by the Improvement Service, this network includes senior leaders from across local authorities, health boards and key community planning partners who work collaboratively to influence change across local areas.

A 'Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland' has been developed by the Improvement Service in collaboration with partners and will be available on the NTTP website. This resource is designed to help services and organisations identify and reflect on progress, strengths and opportunities for embedding a trauma-informed and responsive approach across policy and practice.

Trauma-Informed Practice

Being 'trauma-informed' means being able to recognise when someone may be affected by trauma, collaboratively adjusting ways of working to take this into account and responding in ways that support recovery, does no harm and recognises and supports people's resilience. A trauma-informed organisation will reduce barriers to accessing services, recognising that experiences of trauma can create barriers to engagement in services.

Being 'trauma-informed' involves:

- **R**ealising how common experiences of trauma, adversity and adverse childhood experiences (ACEs) are
- **R**ecognising the different ways that trauma can affect people
- **R**esponding to support recovery

- **R**esisting re-traumatisation
- Recognising the central importance of **R**elationships

The evidence is growing that TI Practice can both improve outcomes for people using services and support the wellbeing of the workforce. Five key principles underlie TI Practice: safety, trust, choice, collaboration, and empowerment. The development of TI Practice requires services, organisations and systems to be aligned with these five principles. implementation of TI Practice is often described as an 'ongoing process of change' or a 'continuum of implementation'. This requires us to take a whole system approach, moving beyond a sole focus on staff training to allow for a wider understanding of all aspects of an organisation's culture and practice delivery, viewed through a trauma-informed lens.

The importance of involving people with experience of trauma and adversity is essential in developing trauma-informed approaches. It is also acknowledged that members of the workforce can also be affected by trauma, through their own personal experience and, in many cases, 'vicariously' in the course of their work. Workforce wellbeing is therefore fundamental to a trauma-informed approach.

Being trauma-informed is not about providing treatment for trauma related difficulties, although some people may benefit from specialist evidence based psychological treatment options. It is about enabling the workforce to address barriers that people affected by trauma can experience when accessing the care, support and treatment they require. It also involves preventing trauma related distress that can be triggered for service users when in contact with staff and services (i.e., re-traumatisation[1]).

[1] https://www.cambridge.org/core/services/aop-cambridge-core/content/view/B364B885715D321AF76C932F6B9D7BD0/S2056467818000294a.pdf/div-class-title-a-paradigm-shift-relationships-in-trauma-informed-mental-health-services-div.pdf

Approach to Pathfinders

The pathfinder areas were each provided with approximately 40 days of dedicated support across the two areas from a specialist in TI Practice (who was also a Clinical Psychologist), as well as support from a monitoring and evaluation specialist. The pathfinders followed three key phases:

Phase 1: Understanding service context and readiness for TI Practice.
Phase 2: Improvement planning, informed by phase 1 learning.
Phase 3: Implementation of agreed priority areas.

Key learning from each of these phases is outlined below.

Phase One: Understanding service context and readiness

It is recognised from the outset that each organisation's culture will look and feel different, but it is important to consider how trauma-informed principles, values and ways of working are embedded in the DNA of an organisation; how the key principles of safety, trust, choice, collaboration and empowerment are hardwired into day-to-day work, decision making, policies and practice; and how a trauma-informed approach in our daily work can become second nature to everyone in the organisation. To help develop an understanding of where the pathfinders services were, on this particular journey, the pathfinder leads began with a familiarisation phase to build relationships between the pathfinder specialists and the service teams and to understand the services and their contexts (e.g., design and delivery, current culture, relationships, perspectives on Trauma-Informed Practice (TIP)) and the extent to which these acted as facilitators or barriers[2].

To achieve this the pathfinder team undertook an initial phase of online meetings with individuals or groups of staff. These meetings were also used to access service documents, policies, and pathways, where available. The team met with a wide range of staff from the services and completed online group and individual interviews via MS Teams. Some partner organisations were also interviewed. The familiarisation phase discussion guide is included in Annex A.

Phase Two: Improvement Planning

Approaches to improvement planning were informed by the familiarisation phase and included the use/development of the following tools and processes:

Trauma-informed (TI) lens event(s). A half day event was held in both pathfinder locations and a facilitation plan was made based on the TI lens recording available

[2] Support for how to self-assess organisational readiness is provided through the 'Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland'

through the NTTP website on vimeo[3]. Attendees were also given a visual representation of the service pathway drafted from their own service documentation to aid journey mapping.

As a service user's journey throughout the service was determined by their alcohol and/ or drug use, as well as their vulnerability and risk, attendees were assigned to three groups each using vignettes of two different fictitious service users to help participants draft hypothetical but specific journeys through the service (See Annex B for example vignette). The journey maps drafted at the start of the TI lens event were used as a reflection tool for the remainder of the event. This process allowed service staff, partners, and people who use the services to review service pathways and support through a trauma lens, helping to identify positive practice, potential service barriers and agree prioritised areas for improvement.

Planning for the engagement of people with experience of trauma. Representatives from existing local support networks for people with experience of trauma were invited to participate in the TI lens events. The pathfinder lead met with the support network lead and potential participants prior to the event and ensured emotional support spaces and activities were provided at the TI lens events in case needed by those with experience of trauma. People with experience of trauma supported the development of outputs to address the issues they identified (e.g., a 'This is me' document and a service communication leaflet).

Establishing a Trauma-informed Practice Implementation Group (TIPIG) from service staff. Following the TI lens events a small group of staff were recruited/volunteered in each site to take the learning from the events forward and to identify solutions to issues raised. The staff met monthly with support from the pathfinder lead and the evaluation specialist. The group agreed a TIPIG charter detailing their purpose and role.

Organisational assessment. The TIPIGs assessed where their service currently was using a trauma-informed organisational assessment tool adapted by the pathfinder leads for substance use settings. This process provided a baseline against which to evidence future progress. Resources to support Organisational Assessment are available through the 'Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland'.

TI coaching/support for leaders was provided via the pathfinder lead (a clinical addiction psychologist). Leadership coaching was a valued part of the pathfinder project, giving managers the opportunity to have a reflective space to discuss the challenges they face in a confidential environment, and with the support to apply a trauma-informed lens to their practice. Consideration should be given to the support already available to managers, and if there is a suitable existing person in an addictions service team who could offer this support to leaders.

[3] Taking a trauma-informed lens to your work

A **training needs analysis (TNA)** adapted and tailored from the NTTP workforce survey[4] to include optional questions about staff roles and experience, and was completed with service and close partners' staff to inform a TI Practice training plan. Associated scaffolding around training was proposed to support translating learning into practice. This scaffolding may take the format of staff who complete the training as part of a cohort using an allotted part of team meetings to support each other in this process. For those completing training outside a cohort, alternative peer support will need to be arranged. If future capacity and caseloads allow a more formal coaching process to support training or integrating application of TI Practice with clinical supervision process would help to embed practice. The TI Practice training plan was used by new and existing staff where appropriate and included the NTTP trauma-skilled e-module ' Understanding the use of substances to cope with the impact of trauma'. Further information on all available NTTP trauma training and implementation support resources is available here

A **Theory of Change[5] (ToC) was developed.** This is a visual plan that aligned prioritised activities from the TI lens events and organisational assessment with short, interim, and longer term local and national TI Practice outcomes. The ToC shows the services' long-term TI Practice vision, aids longer term planning and informs a framework for future monitoring and evidencing of progress.

The development of a **three-year TI Practice implementation plan** which expanded on the prioritised activities shown in the ToC. It provided a timeline and identified individuals responsible for taking work forward to aid sustainability of future TI Practice.

Workforce health and wellbeing planning which included provision of short-term clinical supervision by the pathfinder TI Practice specialist with teams due to there being a vacancy in the clinical addictions psychologist post in the pathfinder areas at the time. Support was also given to these teams in using Safety and Stabilisation[6] techniques (for staff and service users). In addition, all staff completed individual wellbeing plans[7] to aid future self-care and emotional safety.

Enhancing documentation, polices and processes. Contact was made with the Pathfinder NHS Boards to initiate reviews of individual policies at a strategic level with a trauma-informed lens to support and embed TI Practice e.g., HR and recruitment policies, wellbeing strategies service plans/changes. The 3 year implementation plan intends to embed the review of all service specific policies over agreed timeframes and in particular address trauma screening and triaging around support and access to emotional or, where necessary, psychological support.

Collaboration with partners. TI Practice implementation involves having successful collaborations with wider partners. Throughout the pathfinder there was evidence of challenges in this collaborative working. Service work with key partners such as the

[4] https://www.gov.scot/publications/national-trauma-training-programme-workforce-survey-2021/
[5] https://www.theoryofchange.org/what-is-theory-of-change/
[6] https://learn.nes.nhs.scot/37900
[7] https://learn.nes.nhs.scot/30741/psychosocial-mental-health-and-wellbeing-support/taking-care-of-myself/wellbeing-planning-tool

Community Mental Health Teams (CMHTs), Prisons, Primary Care/GPs was ongoing parallel to the pathfinder. This work addressed issues such as shared care with GPs, working alongside CMHTs to explore shared mental health and substance use difficulties, including the use of abstinence criteria, Assertive Outreach projects and prison liberation as well as improved data/ information sharing.

Phase Three: Implementation of Priority Areas

The following section provides an overview of the key challenges, enablers and recommendations based on learning from the two substance use pathfinder areas. It focuses on the following key themes:

- Organisational Culture
- Leadership
- Workforce Care, Support and Wellbeing
- Power-sharing with People with Lived Experience of Trauma and Addictions
- Workforce Knowledge, Skills and Confidence
- Data, Feedback Loops and Continuous Improvement
- Policies and Processes
- Budgets
- Service Design and Delivery

Organisational Culture

Culture represents an organisation's fundamental approach to its work. It reflects what is considered important and unimportant, what warrants attention, how it understands the people it serves and the people who support them, and how it puts this understanding into daily practice. In short, culture expresses core values.

Culture extends well beyond the introduction of new services or the training of a particular group of staff members; it is pervasive, and includes all aspects of an organisation's functioning. Leaders within organisations have a key role to play in setting and maintaining a positive and supportive culture and values.

Challenges in the Pathfinder areas

The COVID pandemic and associated working practices placed a tremendous pressure on NHS staff and service leads who continued to offer services as best they could despite increased levels of staff sickness and absence. Viewing this through a trauma-informed lens, there was evidence that both pathfinder areas were working more reactively, with staff and management feeding back feeling that they were constantly 'fighting fires' and only able to deal with immediate challenges and problems (this means they were operating in the 'red zone' of their organisational Window of Tolerance)[8]. This context had an overall impact on trauma-informed organisational culture as it affected relationships within teams, with management, as

[8] Jennie Young - The _Window of tolerance of organisations, services and systems on Vimeo

well as on relationships between staff and the people they support. In both pathfinder services, staff would have benefited from more opportunities to articulate concerns they had about service design, structure, and operation.

Staff health and wellbeing in the pathfinders was an area for concern as a result of the system and staffing pressures, amplified by COVID and the loss of experienced staff. This was evidenced by the high levels of sickness and attrition and was made particularly difficult in the context of a high number of local drugs-related deaths.

Staff in the pathfinder areas faced challenges in their capacity to free up time to undertake training to support them to understand the prevalence and impact of trauma on staff and people coming into contact with the organisation. This impacted on their confidence in how to apply a trauma-lens to their practice and the associated language used when communicating with each other and with people they support.

Enablers in the Pathfinder areas

Positive culture change was apparent in one site in particular, due to multiple factors, including staffing levels becoming more adequate over the course of the pathfinder period which reduced pressure on staff and management. Other factors included the production of a dedicated implementation plan which focussed on staff wellbeing, trauma training and trauma-informed coaching for the service lead.

Working practices were changing to focus more on staff wellbeing, relationships between staff were improving and staff reported thinking more about what had happened to clients and the impact these experiences had on them, rather than what was ‘wrong’ with them. In one area, staff were also more empowered through involvement with the TI lens event, the set up and progress made by the TIPIG and the actions on the implementation plan with some evidence they were feeling more confident to suggest and make changes.

Pathfinder Recommendations relating to Trauma-Informed Culture

- Each organisation’s culture will look and feel different, but it is important to consider how trauma-informed principles, values and ways of working are embedded in an organisation.
- Completing an organisational assessment tool and service-specific lens walkthrough can support teams/ services organisations to reflect on strengths, challenges and opportunities across strategic and operational aspects.
- If substance use services are exploring opportunities for embedding a trauma-informed approach, it is important that they assess their readiness for starting this work. A dedicated implementation plan which includes a focus on staff wellbeing has been found to enable positive culture change.

Leadership

Leadership at all levels is seen as vital for developing and maintaining TI Practice. Leaders support staff in understanding the role of TI Practice for delivering the organisation's purpose as well as individual, team and service outcomes and wider national impacts such as those relating to inequalities and human rights. Leaders help to establish the environment, infrastructure and ways of working which support TI Practice. Leaders can help to manage staff workload and capacity. They can put mechanisms in place to ensure accountability for TI change and to embed it in future processes and services. Leaders can also model trauma-informed approaches in their behaviour and facilitate power sharing with staff and people with lived experience of trauma across the organisation.

Challenges in the Pathfinder areas

The time-constrained nature of the pathfinders meant that ongoing relationship building and developing senior leadership buy in for the project was limited, although there was some continuity provided through the local Transforming Psychological Trauma Implementation Coordinator (TPTIC) who organised trauma training for senior management staff. Senior managers in the pathfinder areas were often under significant pressure and therefore had limited capacity to focus on the pathfinder work or indeed their own health and wellbeing.

Enablers in the Pathfinder areas

As highlighted previously, service leads were under enormous pressure due to a variety of factors which often meant they were operating out with their Window of Tolerance. STILT[9] training was attended by some pathfinder service leads and team managers, who reported finding it helpful. Individual coaching worked particularly well for one service lead, where a reflective space was provided to apply some of the learning from STILT and from trauma training. Over the course of the pathfinder project, there was evidence of changes such as increased modelling the importance of self-care, likely due to attendance at STILT.

A key part of being a transformational leader is empowering others to share their thoughts and views towards services, and to be able to instil change behaviours. There were emerging findings from the pathfinders to show that staff felt more empowered to make changes as part of the TI Practice implementation.

Pathfinder Recommendations relating to Trauma-Informed Leadership

- Visible and transparent support from leaders for TI Practice implementation is important for staff motivation and buy in, for example the production of a TI Practice mission statement can reinforce this as a long-term priority for the service.

[9] https://transformingpsychologicaltrauma.scot/resources/trauma-informed-organisations/

- Trauma training with senior management is beneficial in helping everyone at all levels of an organisation to understand what TI Practice requires and the importance of trauma-informed leadership.
- HR is key to the implementation of TI Practice as they are often the gatekeepers for crucial policies which impact on culture (for example Staff Mental Health and wellbeing policies), and recruitment (qualities of staff being recruited, and recruitment policies).
- It may be beneficial to put in place pathways for the TIPIG to feedback information on the drafted implementation plan and the progress of this plan to senior management. This ensures actions can be taken at the senior management level to address issues included in the plan, including issues with staffing, wider challenges with service design, development of HR policies, facilities acquisition and wider resourcing issues.
- The management of the pathfinders found STILT valuable. Additional training to further support leaders in transformational change should be considered.
- The qualities needed for trauma-informed leaders should be taken into account when recruiting staff into management roles. HR buy in to implementing a trauma-informed approach can help to ensure necessary amendments are made to recruitment practices, inductions and training.
- Leadership coaching was a valued part of the pathfinder project, giving a manager the opportunity to have a reflective space to discuss the challenges they face in a confidential environment, and with the support to apply a TI lens to their behaviours (as well as those of their staff). Consideration should be given to the support already available to managers, and if there is a suitable existing person (in an addictions service team) who could offer this support to leaders.

Workforce Care, Support and Wellbeing

Workforce wellbeing is critical for TI Practice. Staff cannot deliver trauma-informed services if they themselves do not feel safe, supported and well. It is also important to recognise that staff and volunteers as well as people who use the services, may also have experience of trauma.

Wellbeing is key for any workforce but is even more important where staff are directly supporting others with experience of trauma or are in roles where they themselves may be exposed to traumatic experiences and, or vicarious trauma. Staff in such roles are more likely to experience moral injury or compassion fatigue than others in non-front facing roles. For staff dealing with these circumstances and contexts the provision of both proactive support (e.g., supervision, reflective practice) and reactive support (e.g., action plan for responding to critical events) is vital to prevent staff feeling disconnected from their practice values and suffering burnout.

Challenges in the Pathfinder areas

As outlined previously, staff health and wellbeing in pathfinder services was a concern due to the impact of COVID, staffing pressures and often low staff morale, evidenced by high levels of staff sickness and/or staff attrition. There was no

baseline measure of staff wellbeing currently in place in either pathfinder area and not all staff had access to clinical supervision or reflective practice.

Wider issues relating to staffing levels and service structures at a national level, as well as difficulties in recruiting for posts also substantially impacted on staff wellbeing. This situation was likely amplified in rural and island communities and may act as a barrier to implementing TI Practice. Staffing levels also need to be sufficient to complete the review of policies, guidance, and documents necessary to fully implement TI Practice.

Adequate staff facilities are important for staff wellbeing. In areas where office spaces were overcrowded, with little space for staff to take time to be able to look after themselves, this can also impact on staff wellbeing.

Enablers in the Pathfinder areas

For both pathfinder areas, staff wellbeing was the initial focus on the training plan using existing NTTP resources (which included staff completing an individualised Wellbeing Plan) and discussions began on how wellbeing can be improved in the service. Initiating these discussions helped de-stigmatise the subject of wellbeing.

Staff buy in for TI Practice was improved due to the focus on health and wellbeing. Proactive prevention for staff wellbeing was welcomed by staff, for example soothing boxes for staff to help regulate emotional arousal were provided in one pathfinder area.

It was clear from the pathfinders that having adequate levels of staffing was essential to staff wellbeing, so staff did not feel overloaded and were able to take the time they needed to look after themselves. If caseloads are too high, staff are not able to attend training nor have the time to implement trauma-responsive approaches with people who use the services. This has further impact on staff wellbeing as staff cannot provide the service that they understand the people they are working with need. Skills such as Safety and Stabilisation[10] are likely to have additional importance in the case of supporting people who use Buprenorphine, discussed in the later section on service delivery.

Pathfinder Recommendations relating to Workforce Care, Support and Wellbeing

- Any assessment of readiness for TI Practice should ensure that staff wellbeing is recognised as a priority issue and is being supported.
- Consideration should be given to investigating suitable measures of staff wellbeing, which can then be fed into a wider system of tailored actions for improvement.
- TI leaders need also be aware of the importance of staff wellbeing and the importance of role-modelling positive approaches. Small differences such as

[10] Trauma enhanced | Turas | Learn (nhs.scot)

ensuring managers leave work on time, not sending emails out of working hours, and taking time out for self-care (such as taking a lunch break, or space to regulate their emotions when necessary) can make a difference in service culture.
- Services should have access to clinical supervision and/or Reflective Practice Groups facilitated by someone with the appropriate level of knowledge, skills and experience.
- Staff facilities should be adequate to help staff (and people who use the services) to feel emotionally safe.

Power sharing with people with lived experience of trauma and addictions

The development of trauma-informed service must be done with input and influence from those with lived experience of trauma as they best understand what aspects of services are supportive and which may (re)traumatise them. Involvement should be sought from those who have experience of trauma and more specifically those who have experience of trauma and who have used the service(s) under consideration.

Involvement of people with lived experience should be both safe and meaningful and should happen proactively across all service areas and aspects of delivery. Embedding such engagement and coproduction will help address power differentials and ensure services address needs.

Challenges in the Pathfinder areas

Both pathfinder areas had limited existing structures in place to collaboratively work with people with lived experience of trauma and for them to meaningfully be involved in decision making towards service design and delivery. Prior to COVID, more structures were in place which could have acted as a suitable base for the further development of the relationships needed to engage with people with lived experience.

Barriers to creating power sharing relationships with people with lived experience of trauma and engaging them in the pathfinder project included lack of access to suitable rooms and facilities, the time constraints of the pathfinder project, as well as concerns raised by people with lived experience in relation to confidentiality and anonymity (especially on the islands).

There was some evidence staff members involved in the pathfinder project had started to feel more able to disclose their own personal trauma backgrounds and use their experiences to input to the TI Practice implementation plans. There was also evidence of increased recruitment of people with lived experience into peer support roles over the time period of the pathfinder, however this was limited to Health Care Support Worker roles or similar. There were multiple challenges associated with this recruitment, including having to use existing NHS job descriptions and difficulties with staff retention when in post.

Enablers in the Pathfinder areas

In one pathfinder area, peer support groups run and facilitated by an Alcohol and Drugs Partnership (ADP) peer support co-ordinator were accessed to ensure people with lived experience of trauma were able to attend and partake in the TI lens events, and to be involved in some of the implementation activities drafted into the implementation plan. Due to the limited time of the pathfinder projects, it is hoped these relationships will continue to develop and be further expanded to ensure this co-production becomes more sustainable and integrated into service operation. Parallel work was ongoing within one pathfinder to develop community hubs to extend the psycho-social aspects of services and localised delivery. These hubs will also provide an opportunity to improve mechanisms for feedback and power sharing with those who had experience trauma.

To maximise engagement with the peer support group, the pathfinder lead met the group several times online to build rapport and start to develop a positive working relationship. This included understanding how they wanted to be involved in the process and ensuring any concerns they had were addressed and discussed to maximise the trauma-informed principles in the process. They were also re-imbursed for providing their expert knowledge throughout the process, in the form of voucher incentives to recognise their time, energy and input (to help address this inherent power differential).

The value of contributions from people with lived experience of trauma in the TI lens event (where they could be included) was apparent and led to an improved implementation plan, in comparison with those where engagement had not been possible. In the area where this was feasible, people with lived experience explained they did not feel the service viewed them as people (more for their diagnosis and/or the medical treatment they required). They also did not understand what they should be receiving from services, and the timing of various support. As a result of this, two documents were co-produced with these representatives. The 'This is me' document and a communications leaflet. These are further explained in the service and service design section of this report.

Pathfinder Recommendations relating to power sharing with people with lived experience of trauma and addictions

- Planning for power sharing with people with lived experience should happen in the early stages of implementation to ensure people who use the services are included in the process from beginning to end in a meaningful way.
- Services should consider setting up a service user group, an advisory group from people further along in their recovery journey, or potentially engaging with people with lived experience from existing psychosocial groups run either within the service or with third sector colleagues. It may be helpful if the service drafts guidelines (with input from people with lived experience) on their plan to power share and meaningfully ensure they are included in the process. Service should

also consider whether they have appropriate facilities and spaces that allow engagement of those with lived experience.

- An additional way to facilitate power sharing is ensuring more people with lived experience of trauma are recruited into roles throughout the organisation. Currently the focus tends to be more on recruiting peer supporters than other roles. This is a move forward; however, these positions need to be carefully thought out, planned, use appropriate job descriptions, and put guidance in place about ensuring working environments are sufficiently emotionally safe. Examples might include increased access to areas to regulate emotions; individual health and wellbeing plans; training around wellbeing; and working within a culture which priorities staff health and wellbeing. For the latter, buy in from HR is important.

Workforce Knowledge, Skills and Confidence

To be trauma-informed, a workforce needs to be capable of recognising if, where and how an individual may be affected by trauma. They also need to understand how to work in a way that minimises distress, builds trusting relationships and prevents re-traumatisation. Trauma-informed knowledge and skills can help minimise barriers to service uptake and can sustain service engagement and support people to navigate services. These improvements will in turn support recovery, strengthen resilience and improve outcomes for people who use the service and the workforce. This training should be aligned with the Transforming Psychological Trauma Knowledge and Skills Framework to ensure it is evidence based alongside the Scottish Transforming Psychological Trauma Training Plan which offers organisations guidance on how to assess skills level requirements of staff and commission appropriate training resources.

Challenges in the Pathfinder areas

Challenges to workforce training and development included staff attrition and staff availability to attend training (impacted by staffing levels). There was also a challenge in ensuring people trained to deliver Trauma Enhanced Level Training (eg. Safety and Stabilisation) had the ongoing capacity to deliver training and stayed in post.

Enablers in the Pathfinder areas

Workforce training and development was the area most progressed during the pathfinders. TNAs were completed to tailor training to the needs of staff (although this was challenging due to high levels of turnover and attrition). A training plan was then developed for Trauma-skilled workers in addictions services based on staff wellbeing training resources and the Trauma skilled e learning module for those working in addictions available through the NTTP[11]. Scaffolding was provided for this learning through discussions in individual teams. Staff engaged well with the training

[11] nesd1334-national-trauma-training-programme-online-resources_updated2106.pdf (transformingpsychologicaltrauma.scot)

and reported through clinical supervision, it had improved their confidence in working with people who had experienced trauma.

Enhanced level Safety and Stabilisation training for staff had already been provided in one area due to input from a Transforming Psychological Trauma Implementation Co-ordinator (TPTIC). A plan was in progress as to how to deliver this training to the other pathfinder team as the trainers who had been trained were currently unavailable. In the meantime, a shared file was set up with Safety and Stabilisation resources for staff with scaffolding temporarily provided through clinical supervision from the pathfinder trauma lead specialist.

Managers have been encouraged to embed the training programme within an induction programme for new staff where possible. Additional training, e.g. Psychological First Aid[12] practical session and Lifelines Scotland training[13] has been included within the pathfinders as appropriate. The latter was included due to the existing service design in one area, meaning that staff were operating an Out of Hours Crisis service, and therefore wellbeing training for emergency services staff seemed particularly suitable.

Pathfinder Recommendations relating to Workforce Knowledge, Skills and Confidence

- Consideration should be given by addictions services as to how to incorporate the NTTP resources into their own tailored training plans, which can be useful particularly for induction of new staff. This ensures the training plan becomes sustainable and integrated into training provision.
- Including wider services in TNAs and subsequent training can be beneficial and enhance collaborative relationships, aid understanding and buy in to implementing TI Practice. This can also be beneficial in the use of developing a shared language.
- Scaffolding or coaching post training where capacity allows can support staff to implement knowledge and skills.
- If future capacity and caseloads allow, a more formal coaching process might support training, assist the application of TI Practice or increase embedding TI approaches in practice.

Data, feedback loops and continuous improvement

Service or organisational improvement is dependent on ensuring ongoing discussion and feedback between leaders, staff, partners and people who use the services. All these groups bring varied learning that can be used to enhance service design and delivery. Feedback mechanisms (satisfaction questionnaires, reviews, existing or

[12] https://learn.nes.nhs.scot/28064/coronavirus-covid-19/psychosocial-support-and-wellbeing/psychological-first-aid

[13] https://www.lifelines.scot

routine service data, user groups or carers focus groups/interviews, staff feedback, suggestion boxes, etc.) can be set up proactively and used at routine intervals or as a one-off exercise for a specific purpose. Formal and informal data such as these help organisations to understand how to reduce barriers, increase engagement and enhance TI Practice and other outcomes for service users, staff and the organisation. Acting on feedback is key to building safe, trusting relationships and trauma-informed services.

Challenges in the Pathfinder areas

It is important to note the close relationship between trauma-informed organisational culture and feedback loops. If staff do not feel safe feeding back information on how they feel about an organisation, this will impact on the data collected. Another barrier relates to pre-existing feedback mechanisms and (lack of) perceived action in addressing issues raised via these surveys. If staff do not feel feedback is welcomed, meaningfully analysed and informs decision making, they are less likely to take part in the exercise.

Enablers in the Pathfinder areas

Local ToC models were developed for each pathfinder which offered a strategic view of where current activities contributed to interim and longer-term outcomes locally and nationally. The ToC models were intended as planning tools and the activity lists in the models were expanded upon in the full implementation plans.

The ToC models also inform thinking about future ways in which pathfinders can begin to evidence their progress using tools provided as part of the Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland and other possible validated scales for ongoing monitoring and evaluation.

In one pathfinder area, plans had commenced to start using the new community hub to work with people using the services to gather feedback and feed this into service delivery. This pathfinder also reintroduced the Drug and Alcohol Star[14] within the service, and staff have been trained in its use. This will provide a formal tool to assess service progress for individuals and overall service user progress and provide programme reflection and learning opportunities. The service is reflecting on the future use of a trauma screening questionnaire, which would also provide useful data on trauma experiences of those using the service and may, depending on the measure, support assessment of progress.

Discussion has also taken place about the potential of a 6 month to yearly sample audit of care plans as a means of assessing TI Practice improvement in treatment for example assessing the amount of times ‘trauma’ or ‘Safety and Stabilisation’ are mentioned.

[14] http://www.outcomesstar.org.uk/wp-content/uploads/Drug-and-Alcohol-Organisaiton-Guide-Preview.pdf

Pathfinder Recommendations relating to Data, Feedback Loops and Continuous Improvement

- Developing a longer-term implementation plan (longer than 1 year) is likely to be useful for services, so they understand all that is involved in implementing TI Practice and have a clear plan (with accountability) as to how actions can be taken forward.
- The utility of an implementation plan is dependent on thoroughness of prior activity (e.g., the TI lens event and organisational assessment). The ToCs set these plans out in relation to interim and long-term outcomes and can help guide future evidencing of progress.
- There is value in staff completing a baseline organisational assessment in addition to the TI lens event. This was apparent in the breadth of the implementation plan. It is also a useful exercise in being able to chart and evidence progress on the implementation of TI Practice.
- Further work would be useful at a national and local level to identify and further test possible validated tools for gathering feedback on the impact on people with experience of trauma who use services as well as the impact on staff health and wellbeing.

Polices and Processes

Policies and processes direct how an organisation operates and as such should embody its values and culture. They can support trauma-informed practitioners and make explicit that an organisation is trauma-informed. They can direct and reinforce the application of trauma-informed knowledge, skills and processes, make these consistent and embed them throughout the organisation.

Challenges in the Pathfinder areas

Due to the time constraints of the Pathfinder project, collaborative work with HR to review Staff Health and Wellbeing policies was limited. As a result of capacity pressures there was also a preference from HR colleagues to adopt a TI lens to policies once they were expiring and already scheduled to be redrafted (e.g., existing “Staff Mental Health and Wellbeing” policies). Only HR and senior management are able to review these policies, rather than frontline staff. The latter were only able to review ‘guidance’ documents (documents that were not NHS wide) and this shows the importance of involving HR colleagues as core partners at an early stage of the process.

Language is an important part of everything that is done in an organisation. However, it was not possible within the timeframes of the pathfinder to consider the drafting of a trauma-informed language document, primarily because this policy would have to be NHS wide.

Enablers in the Pathfinder areas

In one area, work was already being completed with HR outwith the pathfinder (with their TPTIC) to produce a policy on supporting staff who have experienced traumatic events in the workplace and the use of debriefing.

A key finding from the TI lens event and the organisational assessment was the frequency people with lived experience of trauma had to recount their trauma histories in assessments and whilst collaborating with other agencies. There was evidence staff were applying a TI lens to these front facing assessment documents and had set up two working groups to start reviewing documents and guidance documents.

As a result of the pathfinder, pathways were being reviewed/ designed to minimise barriers to accessing psychology including reviewing the existing drug and alcohol abstinence criteria in place in both areas. One area had started to discuss how to implement trauma screening guidelines as part of their trauma-informed implementation plan.

Pathfinder Recommendations relating to Polices and Processes

- HR play a key role in drafting and managing NHS wide policies. Consideration should be given to providing trauma training for HR staff alongside senior managers to ensure HR have the knowledge and support to apply a TI lens when reviewing and drafting policies.
- Creating working groups to review existing documentation and guidance appears to be a sensible way forward for progressing the organisational capacity and catalyst necessary to facilitate change.
- Staffing levels need to be sufficient to complete the review of policies, guidance, and documents necessary to fully implement TI Practice.

Budgets

Given the current financial context it is important to consider budget implications of TI Practice. There are many TI Practice changes that can be completed with minimal budgets, such as changes to language and communications. Other areas of change may require some funding, such as ensuring staff capacity to attend training or apply skills, establishing feedback loops or changing aspects of the environment.

It is important to consider available budgets and weigh the costs of various action against the expected benefits. Potential benefits from sustained TI Practice may be evidenced by organisations through improved service uptake and improved outcomes for people who use the services.

Challenges in the Pathfinder areas

Budgeting challenges to consider included allocation of staff time required to attend the TI lens event, TIPIG meetings, staff training as well as staffing associated working groups. Staff also need to be able to work with suitable caseload sizes to work with people to develop Safety and Stabilisation skills. These issues should be considered in staffing allocation.

Enablers in the Pathfinder areas

The pathfinders had additional resources in the form of the specialist support provided through the project. Changes were made that required minimal additional budget, although these still required additional staff time.

Sourcing additional funding from the CORRA foundation proved invaluable in setting up local community hubs in one pathfinder area.

Pathfinder Recommendations relating to Budgets

- Budget needs to be considered and reviewed when drafting the trauma-informed implementation plan to identify the direct and indirect costs and resources required to implement and sustain these changes. This is a further reason for ensuring senior management are involved in the drafting and progress on implementation plans.
- Service leads can explore additional funding opportunities available for services to access additional budget if needed.
- Consideration could be given to exploring cost savings in quality improvement projects. For example, TI Practice may save money in relation to reducing the amount of people not attending their appointments or reducing levels of staff sickness and attrition.

Service Design and Delivery

The way a service is designed and delivered, its processes and pathways and how these interact with other services can all impact on whether a service is trauma-informed and whether it minimises distress, avoids re-traumatisation and supports recovery.

The journey of a person who uses a service or organisation can often highlight where they have positive experiences or face barriers or discomfort. These journeys may involve interactions with many staff and systems. Viewing service pathways and journeys in a holistic fashion can highlight experiences with individuals, processes and environments that can be reinforced or improved to address TI Practice.

Challenges in the Pathfinder areas

Physical environment is important in ensuring physical and emotional safety for all people who have experienced trauma (staff and people using the service). In one area, a lack of suitable facilities made it difficult to implement TI Practice. For example the size of available meeting rooms did not allow for enough people to join meetings; staff were located in a small office and there was stigma evidenced in the treatment of people using services. This latter issue highlights the importance of training reception staff and all people coming into contact with people using the services.

In another area where facilities were more appropriate, emotion regulation boxes[15] were made available to support staff and service user wellbeing by giving them space and materials to help keep them in their Window of Tolerance.

In both pathfinder areas, it was apparent there were challenges in accessing Psychological Services for people using the service. This was primarily due to lack of inbuilt psychological input into the drug and alcohol teams, as well as abstinence criteria in place stating people needed to be abstinent from drugs and alcohol for 3 months prior to starting psychological therapy. Services have started to review these abstinence criteria and develop improved pathways to psychology. Over the course of the pathfinder, services had also recognised and had started to embed Safety and Stabilisation skills development in their service provision. These skills are likely to be especially important if someone is using Buprenorphine.

Enablers in the Pathfinder areas

Findings from the TI lens event and the organisational assessment were used to develop an implementation plan alongside management and the TIPIG. Accountability was clear as to who would take the action forward and in what timeframe.

TI Practice implementation was overseen by the Pathfinder TI Practice specialist who was also a Clinical Psychologist. Despite being based remotely and not knowing the teams before the start of the pathfinder, an ‘understanding the service and context’ stage meant they became familiar with service design and pathways, had met staff and spoken to them about their understanding and concerns re implementing TI Practice. This knowledge was then used to tailor the TI lens events for each pathfinder (in relation to the vignettes adopted) and coaching for the team lead. This helped ensure implementation plans were varied and included multiple actions in relation to service design and delivery including changes to physical environments, interactions between staff and people using the service and service pathways.

The TI lens events are also not solely an audit activity but a key mechanism for gaining buy in from staff and those with lived experience of trauma and wider agencies. The events were most successful where sufficient time was given to the exercise; where input was gained from people with lived experience and where other

[15] Covid protocols had previously prevented the use of these

services who regularly collaborated with the drug and alcohol teams were in attendance (for example third sector, Social Work, prisons and GPs). Cross collaboration and opening up the TNA and training plan to these agencies was beneficial and a way of influencing service delivery in other collaborative agencies.

There was evidence of good practice in relation to service delivery in collaborating with GPs and prisons. This included setting up a mailbox for GPs to email queries or concerns; implementing annual reviews by the support team for all patients in shared care; undertaking an initial appointment with practice teams and attending GP cluster meetings to share knowledge about the service and help engage numerous practice teams. The value of attending regular team meetings with prisons was also recognised and working more closely with throughcare teams.

There were examples of joint working between the CMHT and drug and alcohol teams, however this was not always feasible. Improving working collaborations with pharmacy was also identified as an area of priority.

As a result of findings from the TI lens event, two documents were co-produced with people who have lived and living experience of trauma, a 'This is me' document and a communications document. The 'This is Me' document was based on similar documents used for people using dementia services to support person-centred care. This is used to record details about a person who may find it hard to share information about themselves (for whatever reason) and may include a person's cultural and family background; important events/people/places in their life and their challenges and existing coping strategies. If a service chooses, this tool may also be used as a way of recording an individual's trauma and ensuring this is shared with healthcare professionals, so individuals do not have to keep recounting their trauma (if they do not have another document which already meets this need).

The communications document outlined the service pathway, timings, as well as key challenges being faced by the service and how these were being addressed, to help manage expectations of service delivery.

Pathfinder Recommendations relating to Service Design and Delivery

- Wherever possible, whoever is driving the implementation of TI Practice should have knowledge of the team, to facilitate some of the potentially difficult conversations and reflections which may need to happen to implement TI Practice. Without this, the implementation plan may not go into the necessary depth for thorough TI Practice planning. Staff working in collaborative agencies should also be invited to the TI lens event, and to participate in any subsequent TNA and training plans.
- Often facilities management are involved in placing services in suitable buildings. Trauma training should be given to facilities management staff to ensure they understand the importance of physical environment for staff and people using a service.
- Consideration could be given by other addictions services in Scotland as to whether they would find using the 'This is me' document and/or the

communications leaflet produced in this project useful to further implement TI principles.

- The use of abstinence criteria to access psychology for people who use drug and alcohol as a coping strategy for trauma reactions should be reviewed. Information could also be disseminated about Buprenorphine, emotional clarity and trauma symptoms, and the importance of accessing phase 1 Trauma Treatment (Safety and Stabilisation) for these people.
- Specialist knowledge of trauma reactions and TI Practice needs to also be available to addictions teams to help the teams navigate implementation plans in relation to screening for trauma, clinical supervision, implementing Safety and Stabilisation, and assessing the need for further trauma focussed work if necessary.

Progress and Sustainability of the Trauma-Informed Substance Use Pathfinders

The Pathfinder services were already progressing trauma-informed work without always realising it. It is important for staff morale that these actions are recognised as progress on their journey to becoming trauma-informed. By including several smaller actions in implementation plans that do not require a lot of staff time, it can make the journey feel less overwhelming for staff. Examples of this were the co-produced outputs designed with people with lived experience of trauma and adding training plans into induction packs. Small changes can make a big difference.

A lot of progress can be made in a short period of time, for example nurses had already started providing Safety and Stabilisation work (including normalising, psycho-education, Safety and Stabilisation skills). Staff were reporting using more trauma-informed language and asking themselves more about ‘what had happened’ to a person rather than what is ‘wrong’ with them.

A major challenge for the pathfinder areas going forward will be keeping the momentum started through the project. Many of the implementation activities have been started, however clear progress will only be apparent in a year or two, when this is reviewed and continued change is evidenced. The TIPIG implementation groups are scheduled to continue meeting every 6 weeks, and document and guidance working groups have been implemented.

Motivators for sustainability include continued stabilised staffing levels, addressing wider system constraints that are direct barriers to trauma-informed principles, a continued focus on staff wellbeing and the trauma training staff have received (and will continue to receive in induction packs and with Safety and Stabilisation training).

Staff buy in and commitment to the journey will be the determining factor in success, as will an ongoing commitment demonstrated by leaders at all levels of an organisation, to help overcome the challenges outlined above.

Annex A: Familiarisation Discussion Guide

Context setting includes:

- The aims of the Pathfinders and an overview of the National Trauma Transformation Programme; purpose of today's session and interview format; informed consent for interview and permission to record.

QUESTION AREAS

1. Respondent's role
   - What is their current role (i.e. job title, what do they do)?
   - How long have you been in a) your current post and b) working in substance use

2. Current service
   - Tell us about your service?
     - Outline key service user groups (approx split alcohol/drug use)
     - Outline Services offered
     - How many staff, type of staff, length of service (latter important as TI Practice likely to be taught on more recent professional courses?), where based
       - How do they all come together as a team? Team meetings? How often? When?
     - Referral pathways into the service and through the service (including to therapeutic input; psychiatry; Occupational Therapy (OT))
     - Outline key partners/stakeholders/ referral routes (other services work alongside, any third sector provision in the team, referral routes in place to third sector services)
     - What is the discharge process? Who is involved? How is this managed?
     - Any lived experience in team as a paid role?
     - How do they currently identify if a service user has experienced trauma? Any trauma pathway?

   - Specific information about Counselling and Trauma Therapy provision?
     - Types of interventions provided
     - When offered, take up?
     - Screening /assessment for service users
     - Safety and risk management processes

   - Other types of specialist input into team – probe for OT, specialist pharmaceutical
     (Ask same questions as above)

   - Key contextual issues challenges/strengths for their service
     - Geographical issues
     - Partner issues
     - Resources/staffing

- Others

Understanding of TI Practice/NTTP

- Understanding IF ANY of TI Practice and the NTTP?
- Has anyone seen any NTTP resources? Which ones?

TI Practice in their service

- Current levels of knowledge/experience [personal/across service]
- Has anyone had existing Trauma training?
  - What level of training
  - Other relevent training e.g. Mental Health or MI?
- Have there been challenges for staff being released to attend training?
- What is the supervision structure in the service? Is this separate to line management? Is trauma raised in supervision and/or team meetings much?
- Are underpinning service values [e.g. choice, trust etc.] made explicit to staff and service users
- Any TNA been done that they are aware of?
- Current policies and activities for wellbeing, supervision, vicarious trauma [more below]
- Any processes for assessing TI Practice current/planned
- Any current priorities [aims/activities /settings/sub geographies] for the pathfinders re TI Practice
- What are people's views and attitudes towards TI Practice? Any concerns?
- What staff feel the aims and objectives of the project should be in relation to implementing trauma-informed practice? How can this project support the local agenda?
- What is already being done well in reation to TI Practice that the pathfinder can build on?

- Are there staff from any other connected services that should be included in this pathfinder or should access the training on offer? (depending on what is feasible)?

4. Current staff health and wellbeing support

- What is the existing provision for supervision – is this enough? Does it need to be improved?
- Is there any existing Reflective Practice Groups? Peer Support groups?
- What are the existing staff health and wellbeing policies? Is there one for vicarious trauma?
- How much emphasis is given on having manageable workloads and/or the importance of self care
- What are the existing Risk Management and safety processes/policies
- What is the current environment like for safety and wellbeing? Are most people in the office/ working from home? Has this impacted on the level of perceived support by a) management and b) your team?
- How emotionally safe do you feel doing the work you do? In your workplace? What could be done to maximise this?

5. Lived Experience
   - How is existing feedback gathered from service users? Service user panel?
   - If not currently, has this been done before?
   - How, if at all, do they include peer support as part of their delivery model?
   - Have any of you worked for services before that do use peer support models?
   - What do you think of including peer support in service delivery models?
   - How could this be done? Do you have any other ideas as to how to get lived experience input into the development of this project and to improve TI Practice in your service?

6. Leaders and management
   - How much contact do you have with a) immediate management and b) senior management?
   - How supportive do you feel senior management will be of developing Trauma-informed Practice?
   - How do you feel they should be involved in the process?

7. Documentation and documentary review
   - Likely documentations needed – Annual reports/ strategies
   - Is it worth speaking to HR re policies (staff wellbeing especially)?
   - Contacts and methods of contact, timescales

8. Issues /concerns
   - Any further questions/concerns
   - Pathfinder generally
   - Their role

9. Next steps
   - Documentary review
   - Support for establishing project and planning
   - Theory of change drafts
   - Second visits
   - ToC refinement workshop

Annex B: Vignettes used as part of the Trauma-Informed Lens Workshop

Team 1 – Lower risk/ more stable

Purpose – to aid discussion on access to psychological care with mental health difficulties but stable drug use.

Ollie (aged 32 years) works in a local shop part time and lives with her partner. She is a regular opiate user. She has decided she doesn't want to continue using opiates and wants things to change. She is anxious about getting out the house with bouts of low mood. She was referred to one of the pathfinder areas through her GP.

Jay (aged 42 years) is a labourer, working on local building sites. He has always been a heavy drinker, and has tried alcohol detox before through his GP. Due to concerns about losing his job as well as having just split up from his wife, he is drinking more heavily. His wife is refusing he has access to his children. He has self-referred to one of the pathfinder areas.

Team 2 – Mid risk – MH and/or physical health difficulties

Purpose – to aid discussion on Buvidal and if it means should access MHT (safety and stabilisation) earlier than other Opioid Substitution Treatment (OST); Skills of pathfinder area staff to handle Mental Health challenges; occasional usage acceptable for CMHT referral/ acceptance; role of Crisis.

Gill (aged 30 years) is well known to one of the pathfinder areas. She was addicted to opiates, but through contact with the service is now on Buvidal. She has started to feel more and remember more as a result of being on Buvidal. She has started to remember more about abuse she experienced as a child, as well as domestic violence by an ex-partner. She is currently on the waitlist for CMHT input, and makes regular Crisis calls. She has previously made several attempts to take her own life.

Bruno (aged 25 years), works in a call centre and lives with his Grandma (he is a carer for her). He started living with his Grandma aged 14 years after it came to light her was being abused by his Mum's boyfriend. He had input from Child and Adolescent Mental Health Services (CAMHS) previously aged 9 years due to "challenging behaviour" at school. He regular drinks at weekends and uses cocaine. He can be up for several days, go missing and not remember much afterwards. He is diabetic, and struggles to keep this under control.

Team 3 – Higher risk, more chaotic

Purpose – to aid discussion on Criminal Justice Social Work (CJSW) involvement and support available post release; Outreach team; Housing; Fatal and non-fatal overdose pathways.

Stuart (aged 25 years) was given a prison sentence after failing a Drug Treatment Testing Order (DTTO). Whilst serving his custodial sentence, he managed to detox,

and engaged well with the education department, however he could still be impulsive and struggle with his emotion regulation (he had reportedly been quite seriously injured in an altercation with another boy in his teens). On release, he was offered housing near where he lived before and his old associates. He started using again, and was found by police having had a fatal overdose.

Lauren (aged 35 years) has a long history of using drugs and alcohol to cope with trauma symptoms she has had all of her life. She struggled with her emotion regulation, interpersonal relationships and has a low sense of self-worth. She has had multiple suicide attempts (usually when she has been drinking beforehand). After a recent overdose she ended up in hospital, and had subsequent involvement with one of the pathfinder areas.

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