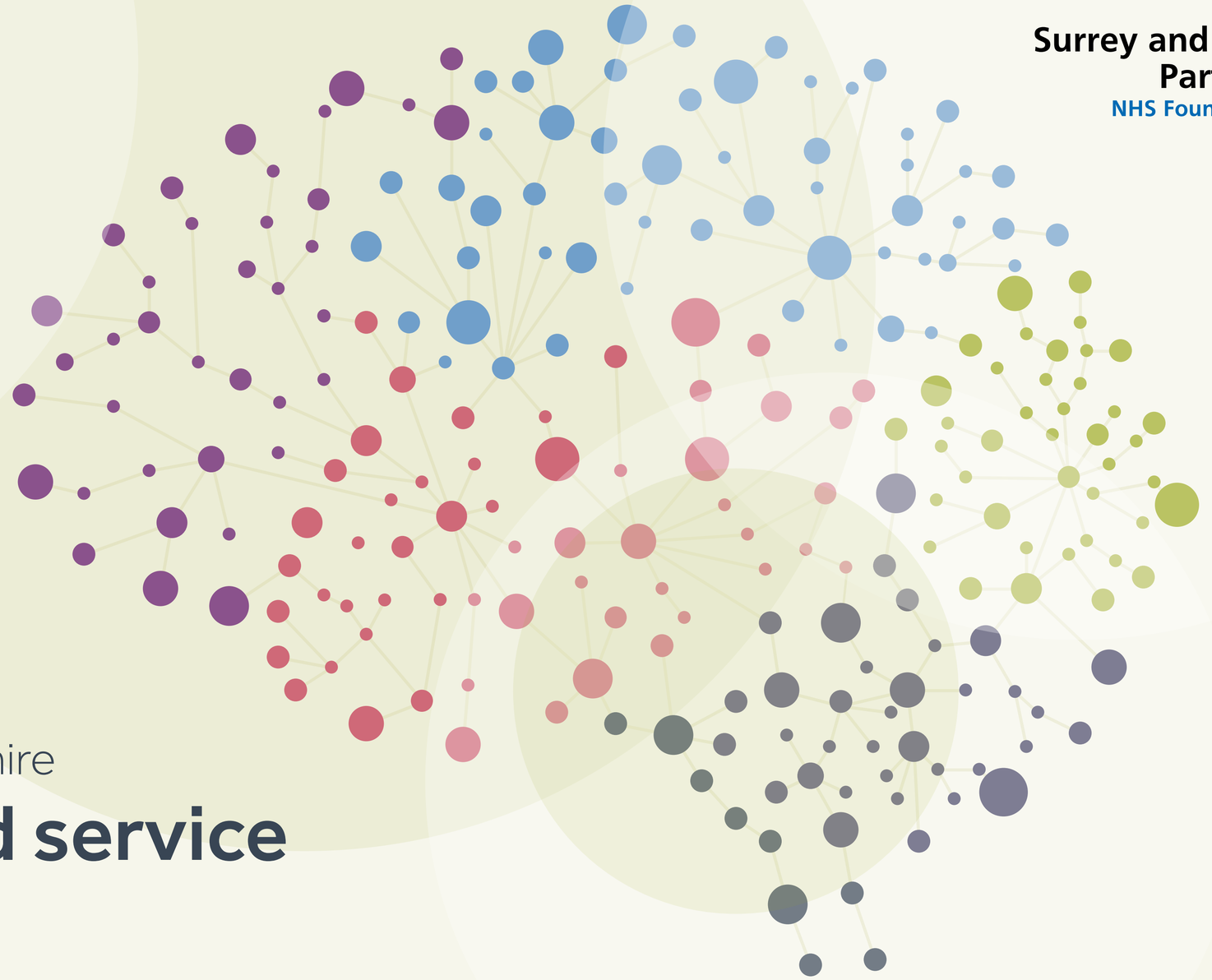
Health Innovation
Oxford & Thames Valley

NHS
Surrey and Borders Partnership
NHS Foundation Trust



Surrey and Northeast Hampshire

Trauma-informed service

Training report

End of year two 2024

Glossary and Accompanying Information

Module – term used for a training course.

Workshop – term used to describe an individual session run of a module.

Self-reported sign-up fields - Participants were asked for information about their roles and employment when signing up for training. These questions were self-reported and the questions were mostly formatted as free text boxes. Where possible for this report these fields have been verified and checked for aggregation of data and specific analysis.

- **Organisation** – the organisation which participants are employed by, e.g. Surrey and Borders Partnership NHS Foundation Trust.
- **Sector** – the sector to which the employing organisation belongs, e.g. NHS.
- **Job title** – participants reported job title, e.g. Residential Support Worker.
- **Team** – participants who reported Surrey and Borders Partnership NHS Foundation Trust as their employing organisation when signing up for training were asked to provide which team they work within, e.g. Acute therapy team.

Appendices

Appendices have been used to provide full breakdowns of analysis where there are a large number of categories. Breakdowns have been provided at the levels of:

Appendix 1 – Full list of Surrey Changing Futures organisations.

Appendix 2 - Full list of employing organisations and number of individuals who attended training.

Appendix 3 – Surrey and Borders Partnership NHS Foundation Trust participant reported team.

Appendix 4 - Professional qualifications reported by participants.

Appendix 5 - Participant reported job title.

Appendix 6 - Feedback forms by organisation.

Appendix 7 - Follow-up questionnaire responses by organisation.

Appendix 8 - Full examples of participant behaviour changes through how they have applied the training in practice.

Overview

This report forms part of a series, evaluating the implementation of the trauma-informed programme offered by the Surrey and Northeast (NE) Hampshire trauma-informed service. The service vision is to drive trauma-informed system-wide change through co-produced training and consultation.

Health Innovation Oxford and Thames Valley began the process of designing and implementing an independent evaluation in March 2023. This report provides evaluation of the second year* of trauma-informed training which ran from April 2023 to March 2024.

Previous reports in this series can be found here.

*The service started in 2020 and pilot training was delivered to a limited number of services until March 2022. Year one of training was the period of April 2022 to March 2023 as the first year where the service was formally established. Year two of training refers to the period of April 2023 to March 2024.

Changes made to training from year one feedback

The content and delivery method of the training modules was reviewed in line with feedback from year one training attendees and an updated evidence base. Small changes were made to accommodate the change in primary sectors attending the training, for example, using statistics and videos relevant to crisis services.

The individual modules and frequency of delivery were scheduled in line with resource and demand. 11 of the modules which were delivered in year one were also offered in year two. Two modules did not run in year two: Trauma-Informed Care in Primary Care and Trauma-Informed Supervision.

Training eligibility

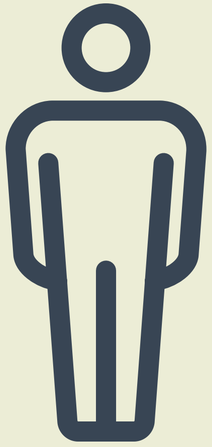
Access to the trauma-informed approaches training modules continued to be freely available to staff working in Surrey and NE Hampshire who were clinical staff working in a frontline role predominantly supporting people in a mental health crisis within a crisis service. This included the police and accident and emergency (A&E) departments. In addition, organisations in the Surrey Changing Futures programme were also funded and therefore continued to be able to access the training. These are local organisations in the voluntary, community and social enterprises (VCSE) sector including housing, substance use and domestic violence. A full list of Surrey Changing Futures organisations can be found in Appendix 1.

Paid training places were available for staff working in Surrey and NE Hampshire who were not eligible for a funded place. These included the local, district and borough councils, VCSE organisations not included in Surrey Changing Futures, and NHS services not offering mental health crisis support. Staff could pay per module and paid places were limited to a set number per module, with priority going to staff in eligible organisations.

Attendance

The second year of trauma-informed training began in June 2023 and ran until the end of March 2024. A total of 59 workshops were run across 11 modules, with 510 workshop spaces attended.

59
Workshops



510
Workshop spaces attended

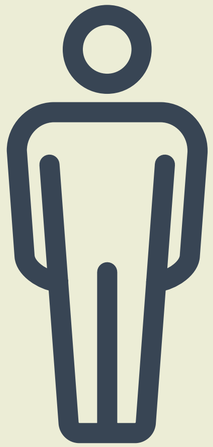
Modules
11

Attendance

A total of 331 individuals attended training workshops.

Overall uptake of workshop spaces was 50%, and overall attendance of workshop spaces was 37% (510 spaces attended of 1385 spaces available). Of the 1385 workshop spaces available, 1335 spaces were offered as free spaces and 50 spaces were offered as paid-for spaces. 36% of free spaces were attended and 54% of paid-for spaces were attended.

All workshop spaces where individuals did not attend (DNA) or cancelled at short notice (SNC) (13%) were for free spaces.



331

Individuals attended

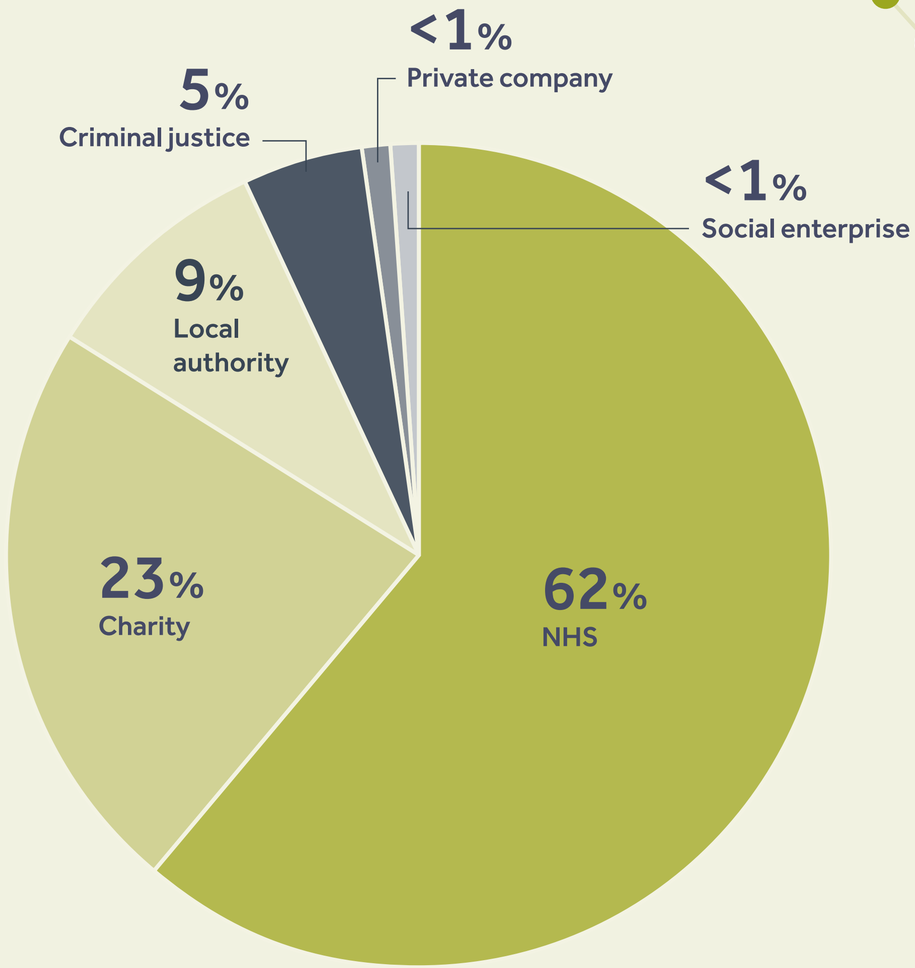
One module ran face to face and provided two workshops on the same day: Understanding Trauma and a Trauma-Informed Approach, all other workshops were delivered online.

Attendance by sector and organisation

Individuals who attended trauma-informed training represented a wide-ranging workforce from six sectors, employed by 33 organisations. A full breakdown of organisations can be found in Appendix 2. The largest numbers of individuals who attended workshops were from the NHS, charity or local authority sectors.

Organisations with the highest number of individuals who attended training workshops were:

187 18 16



Individuals who selected their employing organisation as Surrey and Borders Partnership NHS Foundation Trust (SABP) when signing up for training were asked which team they worked within. The most frequently reported teams were Community Mental Health Recovery Service (CMHRS) (n=44), Community Mental Health Teams for Older People (CMHT OP) (n=36) and Children and Adolescent Mental Health Service (CAMHS) – Crisis only (n=33), a full list of SABP participant reported teams can be found in Appendix 3.

Participant job role

298 individuals, of the 331 who attended training, provided a response to the question about their role requiring a professional qualification, of those 57% of individuals reported yes and 43% reported no. 60 different professional qualifications were given in the self-reported sign-up field ‘If yes – what is the qualification?’, the most frequently reported were nursing qualifications, followed by medical and psychology. See Appendix 4 for a full breakdown of participant reported qualifications.

292 individuals of the 331 who attended training, provided a response regarding if their role was patient/client/service user facing. Of those 84% reported ‘yes’, 5% reported ‘no’ and 11% reported ‘sometimes’. Examples of job roles of those who reported ‘yes’ included assistant psychologists, outreach workers, nurses, psychiatrists, support workers and key workers. Examples of job roles of those who reported ‘no’ included clinical safety manager, public health lead and senior employee experience consultant. Examples of job roles of those who reported ‘sometimes’ included service managers, clinical leads, independent chair, and specialist nurse in child death reviews.

A full list of participant job titles from the self-reported sign-up field ‘job title’ can be found in Appendix 5.

Workshops attended

Most participants attended a single workshop (n=222), however 109 individuals attended multiple workshops across modules, with three individuals attending six or seven workshops each.

Organisations whose participants attended the largest number of workshops matched those with the overall highest number of individual participants, with the addition of South West Domestic Abuse Outreach Service.

Workshops attended by sector

Individual workshops attendance

Module	Number of Workshops	Uptake of spaces (%)	Spaces Attended	DNA and SNC (%)
Understanding a Trauma-Informed Approach	8	59%	47% (n=85)	12%
Trauma-Informed Approaches for Supporting Autistic People	8	57%	45% (n=83)	12%
Applying Trauma-Informed Principles to Ourselves and Our Teams	2	74%	40% (n=20)	34%
Understanding Trauma and a Trauma-Informed Approach (in person)	7	53%	39% (n=61)	14%
Understanding Trauma	10	43%	36% (n=83)	7%
A Trauma-Informed Approach with Refugees and Asylum Seekers	4	47%	33% (n=30)	15%
Trauma-Informed Approaches to Risk Assessment and Management	3	60%	33% (n=26)	28%
All Interactions Matter	3	53%	32% (n=24)	21%
Responding to Trauma and Resisting Re-traumatisation	4	43%	30% (n=30)	13%
A Trauma-Informed Approach with Carers	3	36%	30% (n=21)	6%
Leading and Influencing Trauma-Informed Change	7	41%	28% (n=45)	13%

(n=individuals attended)

Workshops with the highest attendance rates

- Understanding a Trauma-Informed Approach (47%)
- Trauma-Informed Approaches for Supporting Autistic People (45%)

- All Interactions Matter (32%)
- Responding to Trauma and Resisting Re-traumatisation (30%)

Workshops with the lowest attendance rates

Module Attendance by Sector

NHS

There was attendance at all eleven modules from individuals from the NHS sector. The highest attended modules by NHS staff were Understanding a Trauma-Informed Approach (n=51), Understanding Trauma (n=51), Trauma-Informed Approaches for Supporting Autistic People (n=50), and Understanding Trauma and a Trauma-Informed Approach (in person) (n=46).

Charity sector

There was attendance at nine out of eleven modules from individuals from the charity sector. The highest attended modules by charity sector workers were Understanding a Trauma-Informed Approach (n=23), Trauma-Informed Approaches for Supporting Autistic People (n=20), Understanding Trauma (n=19) and Leading and Influencing Trauma-Informed Change (n=18).

Local authority sector

There was attendance at ten out of eleven modules from individuals from the local authority sector. The highest attended modules by local authority staff were Understanding Trauma (n=11), Understanding a Trauma-Informed Approach (n=7) and A Trauma-Informed Approach with Refugees and Asylum Seekers (n=7).

Criminal justice sector

There was attendance at eight out of eleven modules from individuals from the criminal justice sector. The highest attended modules by this group were Trauma-Informed Approaches for Supporting Autistic People (n=8), and Understanding Trauma (n=4).

Private company sector

All three individuals from the private company sector attended one module, Understanding a Trauma-Informed Approach.

Social enterprise sector

The individual from the social enterprise sector attended one module, Leading and Influencing Trauma-Informed Change.

Module Attendance by Sector

Course	Charity	Criminal justice	Local authority	NHS	Private company	Social enterprise
A Trauma-Informed Approach with Carers		1	1	19		
A Trauma-Informed Approach with Refugees and Asylum Seekers	9	1	7	13		
All Interactions Matter	5		1	18		
Applying Trauma-Informed Principles to Ourselves and Our Teams	3	1		16		
Leading and Influencing Trauma-Informed Change	18	2	3	21		1
Trauma Informed Approaches for Supporting Autistic People	20	8	5	50		
Responding to Trauma and Resisting Re-traumatisation	8		5	17		
Trauma-Informed Approaches to Risk Assessment and Management	5	2	2	17		
Understanding a Trauma-Informed Approach	23	1	7	51	3	
Understanding Trauma	19	4	11	51		
Understanding Trauma and a Trauma-Informed Approach (in person)	11	3	1	46		

Evaluation

Evaluation methodology

The New World Kirkpatrick Model

The New World Kirkpatrick Model (Kirkpatrick and Kirkpatrick, 2021) was used as a framework for this evaluation. As seen in Figure 1, the model provides a framework for evaluating training across four levels: reaction, learning, behaviour and results.

Evaluation of the trauma-informed informed training consisted of an online feedback form shared with training participants immediately after each workshop. A follow-up questionnaire was sent in June 2024 (3-12 months post training) to all those who attended training and was open for responses for two months.

The feedback form contained both free-text questions and rated questions using a 5 point Likert scale, from strongly disagree to strongly agree for all modules and additional Likert items related to individual modules for eight modules, as reported within the results section.

The follow-up questionnaire contained both free-text questions and rated questions using a 5 point Likert scale, from strongly disagree to strongly agree. The questionnaire included a final question where participants could share their contact details with the evaluation team to arrange a short online interview to provide further details of the impact of working in a trauma-informed way.

Figure 1. The New World Kirkpatrick Model (Kirkpatrick and Kirkpatrick, 2021)

Data

The feedback form and follow-up questionnaire were sent out to all training participants after each workshop (a total of 510 workshop places attended) via an online link by email from the Surrey and NE Hampshire trauma-informed service team administrator. Responses were analysed using Microsoft Excel. Responses to each of the free text feedback questions have been coded and themed, Likert item responses have been treated as quantitative data. The online interview was conducted via Microsoft Teams, this was recorded and transcribed before anonymising through allocation of a participant number and the recording was deleted. All quotes from participants are reported anonymously.

Findings from the feedback forms have been used to address levels one and two of the Kirkpatrick Model, findings from the follow-up questionnaire and interview have been used to address levels three and four of the Kirkpatrick Model.

Changes were made to the training feedback forms for the year two evaluation. Individual module specific questions were added to eight module feedback forms that related directly to the content of the module taught. The follow-up questionnaire was also changed for the year two evaluation. Two new questions were added that asked participants about further trauma-informed resources they have accessed since the training and what other topics or content of training around trauma-informed approaches they would like to attend.

Feedback forms

223 feedback forms were completed (a 43% response rate), of those, 15 individuals did not consent to their information being used as part of the evaluation reporting and were removed. A further 39 forms were removed as only one or two fields had been completed (consent and organisation) and one form was removed as it referred to a pre-recorded maternity session not included in this evaluation. This resulted in **168 feedback forms included in the evaluation, completed by individuals from 24 organisations** (Appendix 6).

Module	Number of feedback forms received
Understanding a Trauma-Informed Approach	40
Trauma-Informed Approaches for Supporting Autistic People	32
Understanding Trauma	25
Understanding Trauma and a Trauma-Informed Approach (in person)	14
All Interactions Matter	11
Responding to Trauma and Resisting Re-traumatisation	11
Leading and Influencing Trauma-Informed Change	10
A Trauma-Informed Approach with Carers	9
A Trauma-Informed Approach with Refugees and Asylum Seekers	5
Applying Trauma-Informed Principles to Ourselves and Our Teams	4
Trauma-Informed Approaches to Risk Assessment and Management	4

Follow-up questionnaire and interviews

There were **28 responses** in total to the follow-up questionnaire. Three participants provided their contact details to arrange an online interview, all were contacted by the evaluation team, one participant responded and took part in an interview.

Responses to the follow-up questionnaire came from seven different organisations, of which Surrey and Borders Partnership NHS Foundation Trust (SABP) was the most frequently reported (n=14). A full breakdown of reported organisations can be seen in Appendix 7. Responses to the follow-up questionnaire spanned a range of services including a variety of mental health services (including services for children and young people, adults and older adults), domestic abuse support, learning disability, policing, refugee settlement and administration.

Over half of follow-up questionnaire participants reported mainly working with people who use services (n=15), 11 participants reported working with both people who use services and staff, and 2 people reported working mainly with staff. The most frequently reported population to work with was adults (n=12). Six people reported working with older adults. The remaining participants reported working with a mixture of children and young people, adults, and people with learning disabilities.

Responses to the follow-up questionnaire included participants from 10 of 11 modules there were no follow-up responses for the module Leading and Influencing Trauma-Informed Change. Participants selected the modules they had attended, 15 participants reported attending one module, 7 participants reported attending two to four modules and three people reported attending five modules. The most frequently attended modules by those who completed the follow-up questionnaire was Understanding a Trauma-Informed Approach (n= 12) and Understanding Trauma (n= 8).

Module	Follow-up questionnaire reported module attendance
Understanding Trauma and a Trauma-Informed Approach (in person)	5
Understanding Trauma	8
Understanding a Trauma-Informed Approach	12
A Trauma-Informed Approach with Refugees and Asylum Seekers	4
Trauma-Informed Approaches to Risk Assessment and Management	2
Trauma-Informed Approaches for Supporting Autistic People	5
Responding to Trauma and Resisting Re-traumatisation	5
Applying Trauma-Informed Principles to Ourselves and Our Teams	2
All Interactions Matter	3
A Trauma-Informed Approach with Carers	2

Reaction (level one)

Relevance and Satisfaction

Level one of the evaluation sought to determine participants' satisfaction and engagement with the training and its relevance to their roles. Participants found the training highly relevant to their roles and that they were highly satisfied with the training. Relevance and satisfaction scores across all 11 modules were consistently over 95%.

% of participants who agreed or strongly agreed

Relevance and Satisfaction

Where participants were asked to leave any general comments about the training, these were overwhelmingly positive in nature and frequently thanked facilitators for providing helpful and relevant training. Many of the positive comments highlighted the relevance of the training, the way in which training was delivered and that the training should be delivered on a wider scale.

This training was one of the best trainings I've ever done - it was so informative, engaging and I enjoyed the discussions and almost feeling as though everyone was having a 'lived-in experience' of working for the NHS.

I really appreciated this course and how it built on the previous sessions I have done. **This felt really relevant to me.**

These trainings are helping everyone and should be spread out more to every professional linked to care and support.

I thought this was really useful. **I needed this and the reminder to bring my smile first and foremost.** I have been forgetting.

I thought the training was excellent, **really thought provoking** and the pace was lovely as it really enabled some wider reflections.

It is concise and well-delivered training. **It should be mandatory for all professionals** that are involved with people suffering with mental health conditions.

Engagement

Engagement scores were also consistently high across modules. The item regarding the facilitator with clinical experience received 100% agreement in nine modules and 99% agreement in two modules.

For the item regarding the facilitator with lived experience there was variation across the modules. The modules Applying Trauma-Informed Principles to Ourselves and Our Teams, A Trauma-Informed Approach with Carers, A Trauma-Informed Approach with Refugees and Asylum Seekers and Understanding a Trauma-Informed Approach all received 95-100% agreement that the facilitator with lived experience was engaging as a facilitator and helped their understanding of the material. The remaining modules received agreement ranging from 78% for Trauma-Informed Approaches for Supporting Autistic People to 36% for All Interactions Matter. However, as reported by participants in their free text comments, in a number of workshops the lived experience facilitator was not able to attend and therefore this may have highly influenced the results of this item.

Methods of delivery

Participants most frequently reported that the videos and sharing of lived experiences were the methods of delivery that most engaged them and helped their learning. A full breakdown of the methods of delivery is shown below.

What methods of delivery used by the facilitators most engaged you and helped your learning?

% of participants who agreed or strongly agreed

Learning (level two)

Level two of the evaluation sought to determine participants' knowledge, skill, attitude, confidence, and commitment as a result of the training. To ascertain this specific Likert items pertaining to the content of the training were included in the feedback form for participants to rate for eight out of the eleven modules. The free text question 'Please provide an example of how you plan to apply what you have learnt from this training?' was included in the feedback form for all modules.

Learning is therefore reported by individual module feedback. Where module specific Likert items were asked (for eight modules) these are provided supported by participants free text responses about how they planned to apply the training in practice.

Understanding Trauma

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

Understanding the impact of trauma and how to mitigate responses to trauma, changing discourse.

Being able to explain to my colleagues my understanding of trauma from this training. **Better understanding what trauma responses are.** Being able to identify the responses from someone's ACE's [Adverse Childhood Experiences] perspective in order to better communicate with them during a distressed episode to ensure collaborative work.

I work with clients every day that are all unique in their own way. I plan on applying what I have learnt from the training by looking at the physical and mental impact of ACE's [Adverse Childhood Experiences] in an individual and **being able to now understand that they are a physical and mental health impact of ACE [Adverse Childhood Experiences] rather than just a behaviour that has no meaning.**

Understanding a Trauma-Informed Approach

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

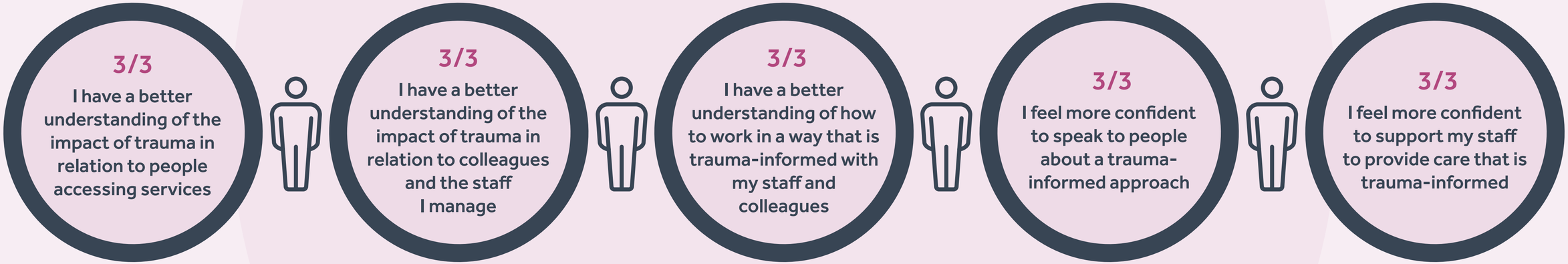
To really consider the issue of **intersectionality** with a client and **look at practical ways to overcome the barriers** to improving one's situation. To start by **considering my own background** and privileges and how I fit into society in the UK and reflect on how my clients fit in.

I feel **more confident** in the way in which I am speaking about trauma and in a classroom with those who have experienced trauma.

Be more mindful of properly explaining my role and what I can and can't do at first meeting in order to build trust. Trying to **empower people in the decision-making process** rather than imposing what's 'best' on them.

Understanding a Trauma-Informed Approach for Managers

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.



Having reflective practice, CPD [continuing professional development] and MDT [multidisciplinary team] meetings.

Sign posting more.

Use principles and PV [Polyvagal] Theory.

Understanding Trauma and a Trauma-Informed Approach (in person)

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

14/14
I have a better understanding of what trauma is

14/14
I have a better understanding of the impact of trauma

14/14
I understand the six principles of a trauma-informed approach

14/14
I have a better understanding of how to provide care that is trauma-informed

13/14
I feel more confident to speak to people about a trauma-informed approach

I will be more mindful when discussing things with colleagues and patients as **we all experience trauma differently.**

Awareness and understanding e.g. focus on **what happened to you** rather than what is wrong with you.

I am going to be more mindful in my day-to-day work, especially 1:1 with clients, ensuring they feel **heard, empowered and supported.**

Trauma-Informed Approaches for Supporting Autistic People

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

31/32
I understand the ways in which autistic people are at increased risk of being exposed to trauma

31/32
I understand the impact of trauma for autistic people

32/32
I understand the six principles of a trauma-informed approach

31/32
I have a better understanding of how to work with autistic people in a trauma-informed way

I would implement the new skills learnt in care coordinating service users who are autistic in my case load. I will put into consideration the **uniqueness of each autistic person's response to traumatic experiences** and support them as an individual person in need without assumption or generalisation.

I will order ear loops and not rely on people bringing in their own, I will use the **Double Empathy**- all of it was really useful.

Offering different communication, assessment tools, being more mindful of **the impact of autism within psychosis** and how the person may respond differently and require a different strategy and support plan.

Leading and Influencing Trauma-Informed Change

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

7/10
I have a better understanding of who my stakeholders are

9/10
I have a better understanding of why implementing change can be challenging

9/10
I feel more confident that I can lead trauma-informed change

10/10
I feel more confident that I can influence trauma-informed change

9/14
I have a better understanding of how to make service changes in a way that is trauma-informed

To think about where the team are and **how to encourage collaboration** to move forwards.

Using the stakeholder map in creative ways, both to hear about the stakeholders' for each people we are supporting and for us as a service overall. **Involving the voice of LE [Lived Experience]** in trying to have powerful stories held with senior management.

Better engaging with my stakeholders to **build more trauma-informed relationships** in view of hopefully allowing them to be more trauma-informed.

A Trauma-Informed Approach with Refugees and Asylum Seekers

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

5/5

I understand the six principles of a trauma-informed approach

5/5

I understand the impact of trauma for asylum seekers and refugees

5/5

I have a better understanding of how to work with refugee and asylum seekers in a trauma-informed way

Wider understanding of the **impact of trauma for refugees and asylum seekers** (pre and post migration).

Keeping in mind the traumas that may have occurred, particularly in the pre-migration phase.

In my engagement with both host and guests under the Homes for Ukraine. **To add the 6 principles to our case records.**

Trauma-Informed Approaches to Risk Assessment and Management

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

4/4
I have a better understanding of how risk assessment and management can unintentionally re-traumatise individuals

4/4
I have a better understanding of how to apply a trauma-informed approach to risk assessment

4/4
I have a better understanding of how to apply a trauma-informed approach to risk management

4/4
I feel more confident that I can work with people in a way that is trauma-informed

More awareness of how Risk assessment & Management may **trigger** previous trauma memories.

More careful of the **language** I use in documentation.

I will be more mindful of using **transparency** while conducting a risk assessment during a new patient assessment.

Applying Trauma-Informed Principles to Ourselves and Our Teams

Number of participants who agreed or strongly agreed / number of feedback forms received for individual module.

4/4
I understand the risk and signs of vicarious trauma, compassion fatigue and burnout

4/4
I understand the six principles of a trauma-informed approach and why they are relevant to staff

3/4
I understand how to apply the six principles of a trauma-informed approach to myself

4/4
I understand how to apply the six principles of a trauma-informed approach to others

3/4
I have a better understanding of the impact that our work can have on myself and others

4/4
I feel more confident to have open conversations with my colleagues/ manager about how I am feeling

To be **aware of my own difficulties** and those of other people in the team.

Consideration of how we can **increase psychological safety** within the team, supporting team members and bearing in mind likelihood of lived experiences.

All Interactions Matter

Eleven feedback forms were received for the module All Interactions Matter. There were no module specific learning items for this module in the feedback form, however participants' learning from the module was reflected in their responses when asked how they planned to apply the training in practice.

I will remember to allow myself **time to decompress and reset.** Giving myself grace will encourage me to have patience, understanding and compassion in my interactions.

I plan to consider how even the **smallest interactions can have an impact**, and tailoring my approach accordingly.

Being more **mindful during brief encounters** in corridors etc.

Responding to Trauma and Resisting Re-traumatisation

Eleven feedback forms were received for the module Responding to Trauma and Resisting Re-traumatisation. There were no module specific learning items for this module in the feedback form, however participants' learning from the module was reflected in their responses when asked how they planned to apply the training in practice.

By reflecting on aims of the Changing Future programmes in resisting re-traumatisation with regard to **the importance of listening to what the person wants rather than assuming** referrals to other services are what they need and ensuring we adhere to this.

Thinks more about the person, **listen, validate, not fix, explore with the client** what would be helpful, share skills they could use if they wanted to.

I will **be clearer in initial assessments why we have to ask** the information we do, when it may not seem relevant to being housed (e.g. about substance misuse, DA [Domestic Abuse] etc).

A Trauma-Informed Approach with Carers

Nine feedback forms were received for the module A Trauma-Informed Approach with Carers. There were no module specific learning items for this module in the feedback form, however participants' learning from the module was reflected in their responses when asked how they planned to apply the training in practice.

> Being more aware of, and hopefully spotting the more subtle **signs of a carer experiencing trauma.** I also think having an increased awareness of employee carers and the demands they are faced with and some ideas about how employers can support their staff who have additional caring roles.

> I have learnt to **involve carers whenever possible** to ensure a robust safety plan and support is in place for each patient, these actions will ensure better patient journey.

Cross-cutting themes of how participants will apply their training

Changes to individual approaches and day to day interactions

A number of cross-cutting themes were found within participant responses regarding how they planned to apply the training across the modules.

Take the time to **understand why someone is responding in a particular way.** Listen to their experiences.

To not make assumptions of what someone experience may have been.

I will plan differently my contact with the patients, I will make sure the patients will feel safe, comfortable and will **reassure them that they have a voice.**

Being more considerate of this approach and it's benefits e.g., being **more open in communication** with service users.

To ensure I am asking relevant questions around what might make our interactions more positive.

Try more to understand the trauma that people experience and how it affect them. This can lead to a better **therapeutic relationship and co-production** of solutions.

Recognising trauma and understanding the impact

Enhanced my understanding of Trauma and to **recognise the symptoms/signs of Trauma and how it impacts on others**, which will help in my face to face work with young people and their families.

I will be mindful of the **effects of trauma** covered in the session and of how they are **not always obvious** to others. I will take this forward in my clinical and managerial practice.

More consideration of TIA [trauma-informed approaches] in meetings with staff :When debriefing with my students: Having reflective practice, CPD [continuing professional development] and MDT [multidisciplinary team] meetings: Helping staff during traumatic periods/ staffing issues.

Increased confidence of working in a trauma-informed way

I was pleased to see that my service is already embedding a lot of these principles in practice, but I didn't realise previously that this would be considered a trauma-informed approach. Even just by having this awareness, **I feel much more equipped to confidently and competently engage with the people I am supporting.**

We already use these approaches in our work which is reassuring. Feel more confident to encourage others that we may come into contact with.

Sharing learning

Plan to share with **new volunteers** on induction to share how they can interact with service users.

To share my insights and learning with **Organisational Development colleagues** who work more on the Change Management side (i.e. project planning and implementation).

Spend time trying to implement this approach within our ways of working by sharing knowledge with **GPIMHS [GP Integrated Mental Health Service], Catalyst and Surrey Autism Board.** Better services, more understanding, more time and increase awareness within our teams and in 1:1 with patients.

A reminder to the team that **every interaction with our clients can be a positive intervention**, reflecting on intersectionality and the wheel of privilege.

Taking it to my colleagues to see options and ways to **incorporate within daily routines.**

Adapting the physical environment

Behaviour (level three)

Level three of the Kirkpatrick model seeks to determine the behavioural changes that result from training. These are demonstrated through critical behaviours and required drivers.

Critical behaviours are specific actions, which, if performed consistently in practice will have the biggest impact on results after training. Required drivers are described as the processes and systems that reinforce, monitor, encourage, and reward performance of critical behaviours (Kirkpatrick and Kirkpatrick, 2021).

In the context of evaluating the trauma-informed training, critical behaviours are the reported individual changes in behaviour made by staff, such as application of the concepts taught in day-to-day work and changes in thinking and approach to people who use services, colleagues and themselves.

Required drivers in the context of evaluating the trauma-informed training are the changes made as a team that act to reinforce and encourage the training such as meeting as a team, and revisiting training in conversation.

Behavioural changes were evaluated within the follow-up questionnaire through participant responses of agreement to the following two statements using the 5-point Likert scale:

- **I feel more confident about working in a trauma-informed way since attending the training**
- **I have been able to apply the training to my work**

And through participant responses to two free text questions:

- **What (if anything) have you been able to apply from the training in your day-to-day work?**
- **If you can, please give an example of how you have applied the training with a person who uses services, patient/client or staff member (please do not use names or other identifiable details)**

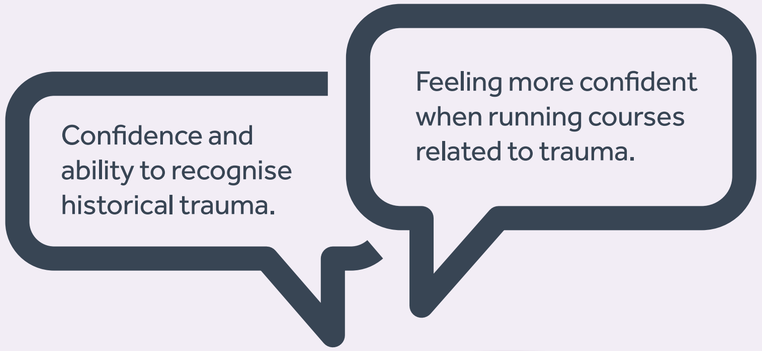
20 out of 28 participants provided examples of how they have been able to apply the training with a person who uses services or staff member.

Appendix 8 provides full examples of participant behaviour changes through how they have applied the training in practice.

Confidence to work in a trauma-informed way

93% of participants agreed or strongly agreed that since attending the training they feel more confident about working in a trauma-informed way (n= 26).

Two participants neither agreed nor disagreed that since the training they feel more confident about working in a trauma-informed way.



Applying the training

93% of participants agreed or strongly agreed that since attending the training they have been able to apply the training to their work (n= 26).

Two participants neither agreed nor disagreed that they have been able to apply the training to their work.

Responses detailing how training has been applied to day-to-day work were grouped into changes made on an individual and team level.

Individual level behaviour change

- Creating a safe space
- Changes in language
- Communication about trauma
- Using the trauma-informed principles

Team level behaviour change

- Materials to support people who use services
- Discussing the impact of trauma

Individual level behaviour change

Creating a safe space

Multiple participants described examples of creating safe, open and trusting spaces, acknowledging that this may look different for different people, and using skills from the training to help people who use services feel able to talk, feel heard and feel responded to.

I listened to my client and heard what was important to him. I then applied this and made this happen for him. eg he wanted to sign on with a dentist to sort his teeth out. He is now waiting for his dentures to be made and has reached the final hurdle.

I often recall the phrase **'every interaction can be therapeutic or it can be re-traumatising'** and I often remind myself of this when interacting with service users or staff.

Given time to open up, become trusted person. Patient was able to open up about SA [Sexual Abuse] for the first time, **didn't panic at hearing this** or ask loads of questions.

A client who has been under my case for 4 years just recently disclosed historical sexual abuse during recent relapse. This is the first time in 20 yrs that this was mentioned. I was able to understand reasons it never was mentioned but also show more **understanding and acknowledgement of the persons strengths and abilities** to be ready to have the support at this time.

Making sure that **my team feel heard and understood** - I love the phase: 'People will often resist change (even if they agree with it) if they don't feel heard and understood'.

By being cautious when conducting Pre-Counselling Assessment with clients, when asking about historic abuse/DV [domestic violence]. **I make sure the client knows they don't need to answer or give detail**, so as not to risk retraumatising client by bringing memories to the surface during interview.

Individual level behaviour change

Changes in language

Participants across a variety of settings were able to describe specific ways they have adapted or changed their language, both verbally and in written materials when interacting with people who use their services.

I have made it normal in my approach with all clients, thinking what happened as opposed to 'what's wrong with you'.

Training has been used with a staff member who is neurodiverse and helped me to manage/supervise that person in a more empathic way. I **consider the language I use** more and ensure I listen properly and ask open questions.

With one person who has come to frequent police attention, with the guidance from the training I was able **to adapt my approach and documentation** to best suit their educational needs and took in to account their trauma to deliver a holistic approach to prevent the offending in the community.

Change how I ask people about what happened, I now focus more on the impact it is having and how it makes them feel.

In terms of the groups I deliver, I explain the courses have been designed to be trauma-informed... experiences are always referred to as what happened to you and education around their **responses being a normal reaction to trauma**, rather than the medicalised version of what is wrong with you.

Individual level behaviour change

Communicating about trauma

Participants reported examples of applying the training in their interactions with other people by helping them to explore how trauma has impacted on their lives, share knowledge and consider adaptations to care.

Patient A experienced childhood trauma which was potentially impacting on their older adult behaviour when washing and dressing. I was able to support and **advise staff how to support when providing personal care.**

Cascade knowledge to clients (about how past experience and systemic variables may have impacted them). Sign post them to reading around trauma (such as Power Threat Meaning Framework, Compassion focussed therapy).

Explained to a patient how her previous trauma is affecting how she is today. when she was younger, she suffered horrific domestic abuse and had not linked it to how she was feeling today. She was able to talk about it and agreed to be referred to Psychology.

Using the principles

One participant cited how they continue to utilise the trauma-informed principles, in particular ‘Empowerment, voice and choice’, in their work with people who have forensic histories.

I am aware previously how trauma can lead to risk especially with people with forensic history and I have continued to utilise the **principles of empowering and promoting support** in the community for our service users.

Team level behaviour change

Materials to support people who use services

One participant reported their team have created new materials to share with people who use their services because of attending the training.

> We are also putting together a short webinar on trauma and its effects so that clients can access this information easily and hopefully better understand what is happening in their brains and bodies and how this is a normal reaction and not something that is “wrong” with them.

Discussing the impact of trauma

Another participant stated that their team prioritise more discussion about trauma and its impact.

> ...discussing trauma as a team and the things that we as professionals face and being mindful of this when in supervision etc.

Impact (level four)

The intended purpose of level four evaluation within the New World Kirkpatrick Model is to measure one singular outcome, that pertains to the purpose of the organisation undertaking training. However, it is acknowledged that relating a single training session to a high-level organisational outcome can be problematic, and so results may be measured through leading indicators. **"Leading indicators are defined as short-term observations and measurements that suggest that critical behaviours are on track to create a positive impact on the desired results"** (Kirkpatrick and Kirkpatrick, 2021). Leading indicators are closely linked to behavioural changes described in the previous section, however, focus on the impact of learning and behavioural changes in practice.

This section of the report will discuss findings in relation to the following leading indicators that have evidenced the impact of participants' learning and utilisation of trauma-informed approaches in practice:

- Improved relationships with people who use services
- Sustained awareness of trauma and using a trauma-informed approach

Appendix 8 provides full examples of participants' perceived benefits and impacts to making changes as a result of trauma-informed training.

Improved relationships with people who use services

Participants spoke more broadly of how the training helped them to improve relationships. Many people reported that an improved understanding of trauma and its impact, helped to improve empathy, communication and collaboration with people who use services, supporting them to feel more empowered.

> Start to understand the reasons for distress and to promote recovery. **They feel more empowered and there is less internalisation of their difficulties.**

> More empathic and understanding approach, which makes them more likely to feel able/willing to disclose past trauma. Understanding the experiences of trauma better helps with developing and maintaining a non-judgemental approach.

> I am more confident. Was able to utilise the **principle of collaboration and sharing power** and decision making.

> It helps you to think about what you are saying or writing and how it may affect the other person.

> More person-centred approach to caring, and service users and their **carers feel more empowered.**

> ...there's always a big urge or I have a real urge to find the answer, to find out why has this happened, what's what, what's led to this? How do I explain it, you know, which we never know the answer to actually. But, you know, unlocking what could have led to it, what the story is, I just found that really fascinating and satisfying.

Experiences raised at interview

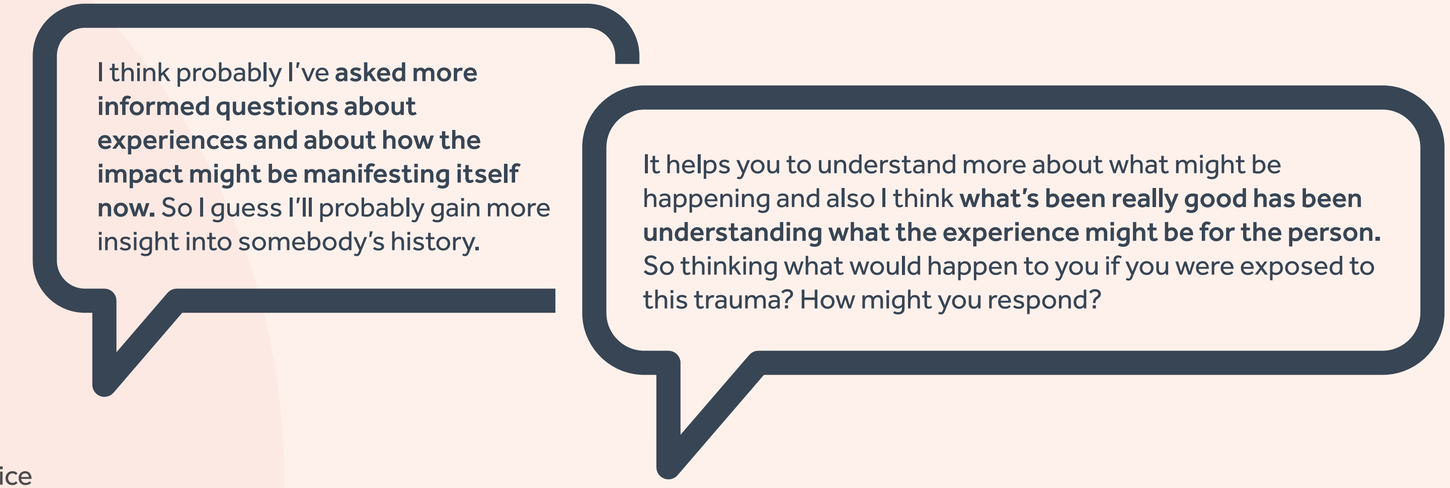
At follow-up interview the participants reported feeling more satisfied in their role and interacting with people who use services by knowing they don't need to try and find answers to why people have had certain experiences, and that understanding a person's story can be enough.

Sustained awareness of trauma and using a trauma-informed approach

Participants highlighted a continued awareness and understanding of trauma when working with people who use services and confidence in their own ability to recognise this.

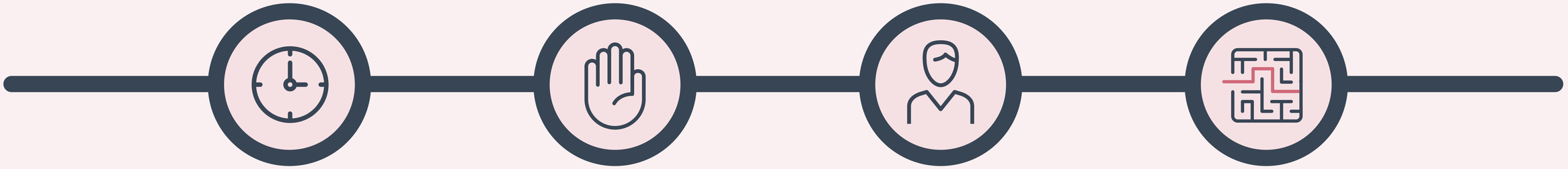
Experiences raised at interview

At follow-up interview, the participants reported continuing to be mindful of trauma in their conversations with people who use services, considering how trauma might impact their interactions and how they can adapt their way of working.



Barriers to implementing learning

Participants were asked what the barriers may be to implementing their learning from the trauma-informed training modules. 151 participants provided a response to this question, of those, six participants reported that there were no barriers they could think of to implementing the training. The barriers identified were similar across all 11 modules and have therefore been themed together and were reflective of those identified in the previous year's training report.



Time and resources

Resistance and culture

Lack of awareness and training

Personal barriers

Time and resources

The most frequently referenced barriers to implementing learning were time and resources. Participants highlighted time constraints for both themselves and the people they are working with as a barrier. A lack of service resources including short staffing, resulting in longer waiting times, and the inability to provide longer term support were also identified as barriers, alongside inflexible service provision and practical resources to access services.

Time of both ourselves and the carers- we do work with many carers who continue to hold down a job and care for someone so sometimes arranging a good time and space for both clinician and carer to spend time exploring any needs can be tricky.

Lack of resources to provide longer period of care which is much needed to establish trusting relationship.

Services offering further trauma psychological work, **long waiting list** to begin intervention.

Limited resources or certain aspects can't change (e.g., transportation links/building layout etc.).

NHS **financial restraints,** colleagues that don't want to listen because they are overworked and overwhelmed.

The conundrum of people needing support from specialist services but **the way this support is offered needs to flex** and the other systems are not always able to do this.

Resistance and culture

Resistance from staff and culture at both a team and organisational level was frequently cited as a potential barrier to implementing learning. Participants referred to a lack of recognition of experienced trauma and potential stigma, and particular challenges around working with staff in a trauma-informed way. Other barriers included a potential lack of trust in services by those who access them and openness of other services to work differently.

Resistance from team this is not how we do things. Services that are **systems led rather than people led.**

Pressure to get people housed as soon as possible in any way possible i.e. **just get it done.**

My clients are a staff group. Therapeutic approach can be sabotaged by others (often non-clinical staff) who have different opinions and therefore encourage conflicts.

Some of the people I work with do not think it is a trauma they have experienced and would rather forget about it.

Stigma around being open about challenging areas of our work.

Distrust of services by service users and getting clients to open up about their background, struggles and needs and wants.

Working in schools varies as to how receptive they are to thinking differently or making significant adjustments.

Lack of awareness and training

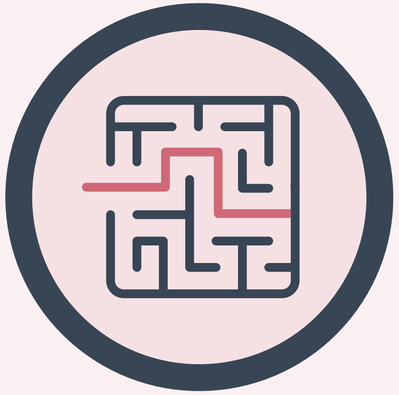
Many participant responses included lack of awareness and training as a barrier to implementing their learning. This was emphasised across all levels including individual, team, organisational and system wide.

> Lack of awareness of trauma-informed care in the wider system.

> It still feel as if decisions by management in my organisation are being made **without consulting staff** or thinking about any trauma-informed practice.

> As a new service our team is still building our best practice working model. Implementation should be fairly easy. It might be that other **services we work alongside may not have done training.**

> When risks are shared or held by different people and services, **not all professionals are trauma-informed** so depending on the service user and their complexity, I tend to worry.



Personal barriers

Participants identified a number of individual level barriers that related to remembering what they had learnt and the impact of their own emotions on applying a trauma-informed approach to themselves.

> Being able to consistently remember the 6 principles.

> Stopping myself wanting to do more for my clients than required.

> My own stress and need to give time for this.

> Feeling like I should be working instead of taking a break.

Overcoming barriers

Participants were asked what would help them to overcome the barriers they identified to implementing their learning. 148 participants provided a response to this question. Responses to overcoming barriers were reflective of the themes of the barriers themselves.

Training

System level changes

Time and resources

Individual actions within practice

Training

Training was the most frequently given response by participants as to what would help them overcome barriers. Participants referred to wanting trauma-informed training to be mandatory and emphasised the need for training to be available system wide and across different services to ensure continuity of care and for teams to work in the same way. Specific training around improving physical environments was also a theme within responses.

For trauma-informed trainings to become **mandatory** to all services.

Wider system training, with services such as probation, leaving care, i-access.

Upskilling all of the staff that we have to ensure everyone receives TIC [trauma-informed care] training so that everyone has more of an opportunity to respond to the trauma needs of our clients and their carers.

More training for practitioner so we understand trauma and **share a common goal in treatment** and outcomes for our patients.

Further education for hospitals in how to improve the physical environment.

I will be encouraging all members of my team to sign up to these training courses.

Making individuals from organisation more aware of what TIP [trauma-informed practice] is and how it is changing so much - need to keep up with the times.

System level changes

Developing a trauma-informed approach at a system level through raising awareness at a strategic level and developing relationships within organisations and with other services was highlighted by participants as a way to overcome barriers.

Keeping TIA [trauma-informed approach] at the heart of service development.

Working with ICS [Integrated Care System] Surrey Heartlands, to **commission services that support the TIA** [trauma-informed approach] for HIU [High Intensity User] patients.

I will also be **referring to the new published framework** when having conversations with colleagues from other teams around trauma-informed approaches.

Utilise formulation and a TI [trauma-informed] language to continue to seek the reasonable adjustments and continue to **raise at a strategic level how existing pathways inherently exclude some people** from accessing the support and interventions they need.

Building relationships with senior mental health leads in schools, and perhaps translating some of what is learnt today in training material we deliver to school staff.

Developing deeper ties with other professionals who are also trauma-informed so **effective wrap-around care** can be offered and implemented successfully.

Time and resources

Many participants highlighted that more time and resources would help overcome barriers. This included time to plan and reflect, better staffed services, better funded services and specific resources such as access to interpreters and more rooms being available to meet with people.

If we were allowed more time for carers and this was a recognised and reflected in our time on our caseload.

Friendly and supportive work environment, clinicians' are given **appropriate time to complete work with patients** to ensure carers are well informed in all areas of patient care.

Sadly, as always with charities, more staff and more funding.

Quiet rooms being made available.

Ensure access to both **interpreters and access to appropriate courses** for increased learning of relevant coping strategies.

Individual actions within practice

Participants highlighted ways in which they could overcome barriers through individual actions within their practice. This included continuing to remind themselves of the six principles and working in a trauma-informed way.

Continue to be **transparent,** patient and demonstrate a caring nature.

I will be printing them [the six principles of a trauma-informed approach] out and keeping them pinned up at my desk.

To **validate** how traumatic things are for patients and to work with them in a **compassionate** manner.

Helping patients feel included, building support network and community connections, stabilisation work and healthy coping skills.

Finding creative ways to work with people in a less restricted way.

Ensure that people's needs are met, regardless of time-frame, through follow-up and **good communication.**

Good time management and **ensuring I am supported by senior leadership.**

Suggestions for improvement of trauma-informed training programme

84 participants stated there was nothing to improve the training.

18 participants made reference to the lived experience trainer being unavailable for their workshop and that this would have improved the training for them.

Training delivery

Training content

Suggestions for further training topics

Training delivery

The main theme drawn from the suggestions for training delivery improvements was more time, with 24 participants responding that this would improve the training. These responses included having generally longer training workshops to allow for more time to engage in group activities, share experiences and transition between activities. Other suggestions around time including spending less time on introductions at the beginning of the session to allow for more time on the training content.

A bit more time in breakout rooms. A bit more time for breaks. As a disabled person it takes me longer to do things.

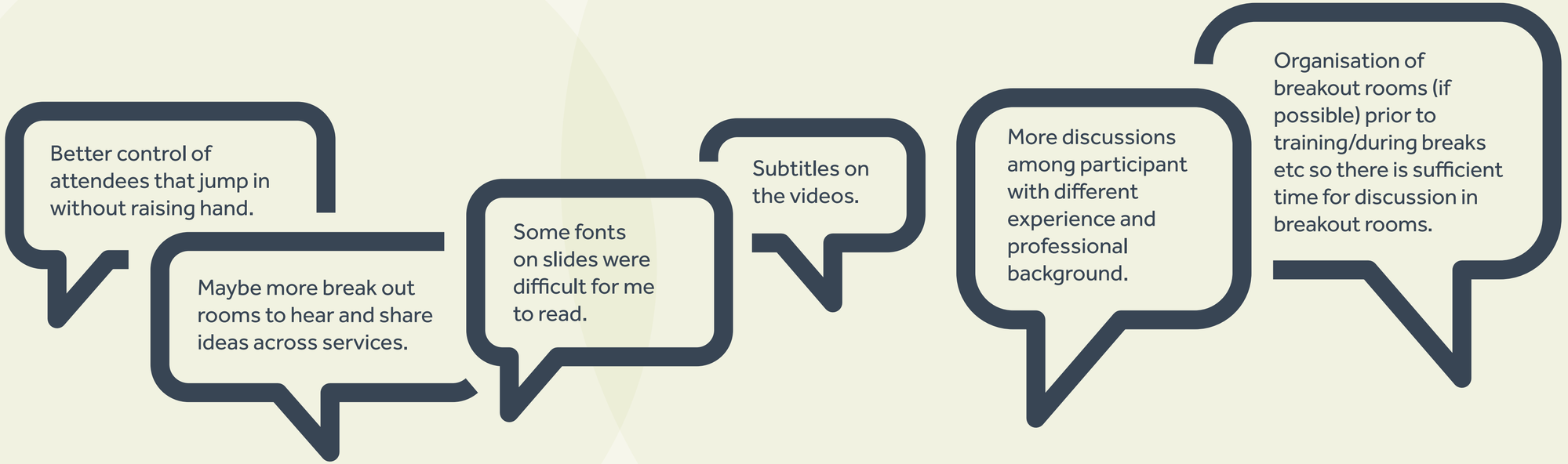
Longer training - to give more space for people to share their experiences.

Group introductions can take a long time meaning less time is available for the content of the training.

Really good training and lived experience input helped to contextualise - but important content at the end felt rushed due to running out of time - can I suggest that 40 minutes at the start for intros / ground rules / grounding exercise felt a little excessive and would have preferred the time spent on content!

Training delivery

Other suggestions for improving training delivery included an in person option for training, having more than one person with lived experience deliver the training, allocating breakout rooms prior to training, more break out rooms or interactive activities, encouraging the use of the ‘raised’ hand function to speak, use of subtitles for videos and consideration of the font on the slides.



Training content

The main themes in participant suggestions for improving the training content were to include more case studies and more content on around re-traumatisation. Other suggestions included more frequently referring to the six principles and the inclusion of more concrete examples of applying a trauma-informed approach.

More information about how change can trigger trauma or re-traumatisation.

A couple of more case examples in different settings and client group, and discuss risk assessment.

Referring back to and bringing in the principles more often.

More about how prevent re traumatisation.

There were three suggestions around training content specific to the module **Trauma-Informed Approaches for Supporting Autistic People.**

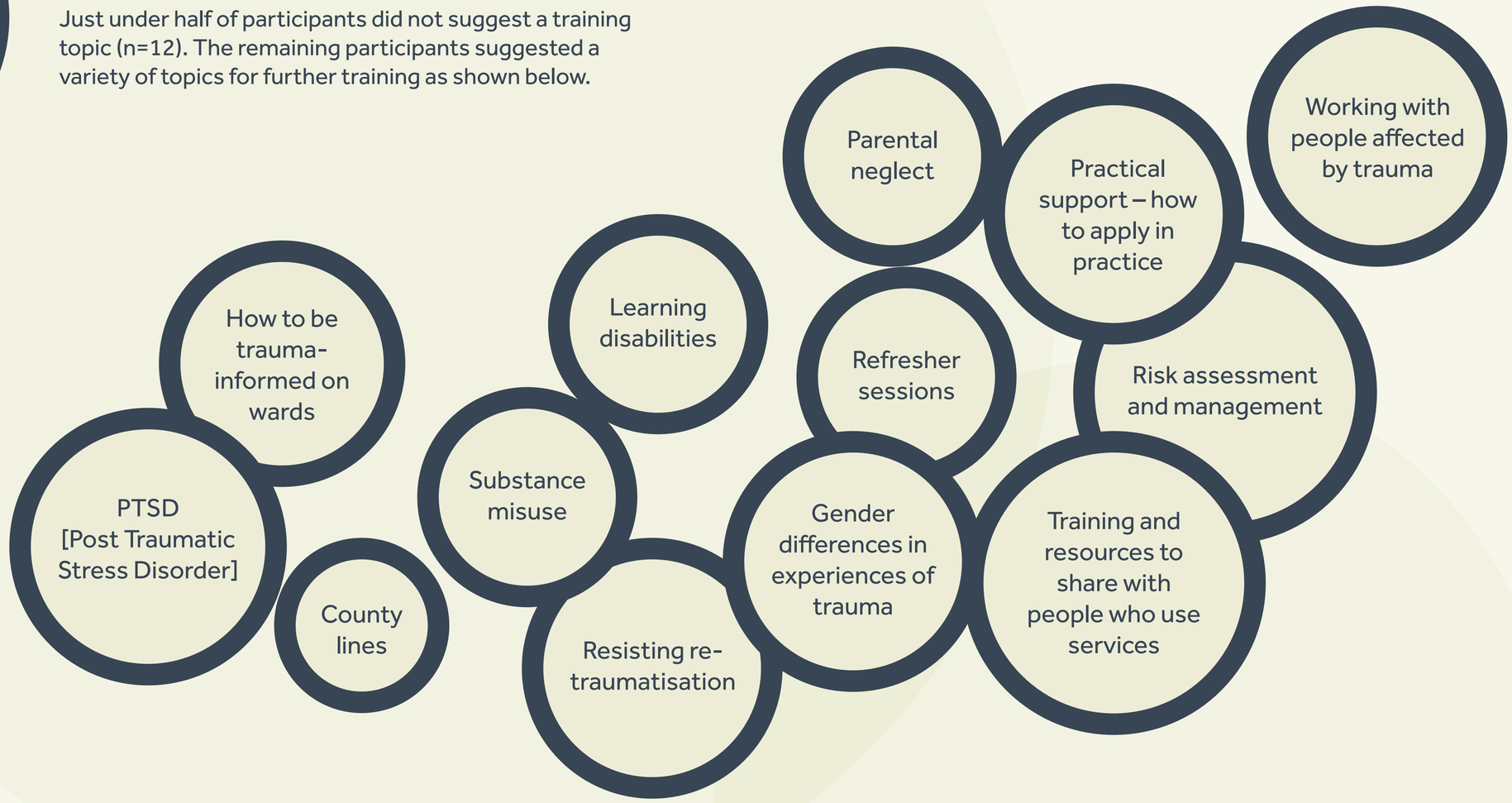
Perhaps split into more than one session? Lots of important information in quite a short space of time. Can be a bit overwhelming especially if you have neurodiversity yourself.

I can't think of anything as thought it was good - maybe some research around gender identity and Autism and also more information such as why would autistic people be at increased risk of diabetes etc - is it the trauma they have encountered?

Less time on education around autism and what their experiences are like in general and more on their experience of additional traumas and what we can do following the trauma.

Suggestions for further training topics

Just under half of participants did not suggest a training topic (n=12). The remaining participants suggested a variety of topics for further training as shown below.



Accessing further resources

Follow-up questionnaire participants were asked what other resources they had accessed to further their knowledge. Just over half (n=16) of participants reported they had not accessed any further materials. Of those who indicated they had explored further reading, the most frequently reported was non-specific, general reading about trauma-informed approaches (n=4).

Three people reported accessing the Trauma-informed Framework and Toolkit, and two people reported reading 'The body keeps the score'. Other resources cited included 'From surviving to thriving' by Pete Walker and materials by Dr Lucy Johnstone.

Changes for year three training

- The introduction section at the beginning of training has been shortened to ensure we move into the content more quickly. For context, the introductions were elongated to see if it facilitated relationships and safety. The feedback suggests that it was not overly helpful. Shortening the introduction section will also enable more time for discussions throughout the training, which people had requested.
- Review of training materials to check for accessibility, inclusivity, case examples, resources and newer literature. This includes inviting people from outside the Surrey and NE Hampshire trauma-informed team to review the training and provide feedback.
- Training session length has not been extended due to equally having feedback that the training is too long/staff resource not enabling time to attend and not wanting to add further barriers to accessing the training.
- Staff and service remit widened: priority and focus remain on staff working in services in urgent and emergency care. However, with an acknowledgement that many services are supporting people in a mental health crisis, an application process has been put in place so all staff wanting to attend the training will be considered.
- Whilst individual applications to attend the training will not automatically be declined, there is an emphasis on teams attending the training who have a plan as to how they will make changes.
- Suggestions for new modules are being taken into consideration and will be implemented in line with system priorities and resource. This includes consideration of a refresher module and modules which are aligned with the ten framework domains.
- Specific training is being co-produced and co-delivered to staff working on mental health inpatient wards.
- Exploration into the feasibility of training in trauma-informed approaches being mandatory. We now ask the question “do you think this training should be mandatory” in the training feedback questionnaire.

Appendix 1

Full list of Surrey Changing Futures organisations.

Organisation
Catalyst
East Surrey Domestic Abuse Service
East Surrey Outreach Service (ESOS)
Guildford Action
Molesey Church Night Shelter
North Surrey Domestic Abuse Service
Oakleaf Enterprise
Renewed Hope
Rentstart - Elmbridge
Richmond Fellowship
South West Domestic Abuse Outreach Service
Surrey Domestic Abuse Partnership
The Hope Hub
York Road Project
Your Sanctuary

Appendix 2

Full list of employing organisations and number of individuals who attended training.

Organisation	Individuals who attended Training	Workshops Attended
Ashford and St. Peter's Hospitals NHS Foundation Trust	4	4
Caprani Care	3	3
Catalyst	12	13
Citizens Advice	2	2
East Surrey Domestic Abuse Service	7	13
East Surrey Outreach Service (ESOS)	6	12
Epsom and Ewell Borough Council	2	2
Epsom and Ewell Refugee Network	5	5
Epsom and St Helier University Hospitals NHS Trust	1	2
Guildford Action	4	5
Hampshire Police	1	2
Mole Valley District Council	2	2
Molesey Church Night Shelter	1	1
North Surrey Domestic Abuse Service	2	4
Oakleaf Enterprise	11	21
Reigate and Banstead Borough Council	4	5
Rentstart - Elmbridge	3	5
Richmond Fellowship	3	5
Royal Surrey County Hospital	1	1
Royal Surrey NHS Foundation Trust	3	4
Runnymede Council	1	1
South East Coast Ambulance Service	5	8
South West Domestic Abuse Outreach Service	11	22
Surrey and Borders Partnership NHS Foundation Trust	187	291
Surrey County Council	18	30
Surrey Domestic Abuse Partnership	1	1
Surrey Heartlands ICB	4	7
Surrey Police	16	22
Tandridge District Council	1	1
The Hope Hub	6	8
Woking Borough Council	1	2
York Road Project	2	2
Your Sanctuary	2	2

Appendix 3

SABP participant reported team.

SABP team	No. of participants
CMHRS	44
OPHMS	36
CAMHS - Crisis only	33
Early Intervention in Psychosis	26
Home treatment team	25
OPHMS	24
Keyworking Service	18
Acute therapy	17
Forensic Outreach & Liaison Service	11
Bridge the Gap	10
Homelessness	10
Inpatient WAA	10
Psychiatric Liaison	9
Mental Health	6
Refugee and Asylum Seeker Support	6
Adult at Risk Team	5
Learning & Development (Education)	5
Liaison and Diversion	5
Older people - inpatient services	5
Ambulance Service	4
Citizens Advice	3
Counselling	3
SHIPP	3
Adult Social Care Epsom & Ewell	2
Changing Futures	2
Child Death Review Team	2
Community Connections	2
Estates Strategy Delivery	2
Family Safeguarding	2
High Intensity Use Service	2
People and Change	2

SABP team	No. of participants
Sexual Abuse	2
Surrey Adults Matter	2
The Hope Service	2
Ukraine Support	2
Ambulance 111 service	1
Anti-social behaviour	1
CAMHS	1
Client services, Oak Leaf Enterprise. Counselling.	1
Clinical Risk Team	1
Clinical Safety Team	1
CMHT for Older People Mid Surrey	1
Community Mental Health Team Older People Runnymede, W Elmbridge	1
Community Support for Ukrainian refugees	1
Drugs, Alcohol, Mental Health, homeless, isolation.	1
Epsom & Ewell hub - Employment Support	1
Epsom and Ewell Borough Council	1
Epsom and Ewell Borough Council - overseeing Homes for Ukraine, Afghan and Syrian Refugee Schemes	1
Epsom Community Mental Health Recovery Service	1
Global resettlement	1
GPIMHS	1
Homeless and Vulnerable adults	1
Hope service	1
HR / Wellbeing	1
CYPS Community Team	1
Integrated Primary Care Team	1
ISS and Deacon Unit	1
LXP	1
Management - night shelter and Bridge the Gap provider	1
Mental Health Integrated Community Service	1
Mental Health Support Teams in Schools	1

SABP team	No. of participants
Mindworks	1
Mindworks AAT	1
NHS Staff Counselling Service	1
nursing directorate	1
Oakleaf jobs advisor	1
OPCC Hampshire and Isle of Wight	1
Operational (also work for refugee/asylum seeker service)	1
Other	1
Outreach	1
Perinatal Mental Health Service	1
Police Service	1
Public Health	1
Reaching Out Service - Transition Pathway	1
Recovery College	1
Recovery College and ECT Clinic	1
Resettlement worker	1
Rough Sleepers Mental Health Outreach Work	1
School based needs CYPS	1
Specialist Nurse Child Death Reviews Surrey Heartlands ICB	1
Supported Living	2
The Children's Crisis Intensive Support Service (CCISS)	1
Ukrainian Resettlement coordinator and interpreter	1
Urgent and Emergency Care HIU lead	1
Voluntary Ukrainian hub Woking	1
Woking BC	1
Work in Partnership with Checkpoint Surrey Police through Guildford Action	1

Appendix 4

Professional qualifications reported by participants.

Professional qualification	No. of participants who reported this qualification
Register Mental Health Nurse (RMN)	40
Nursing qualification	34
Registered Nurse	14
MBBS	9
MRCPsych	8
BSc Psychology	7
DClinPsych	7
Occupational Therapist	7
social work qualification	7
Doctorate in Clinical Psychology	6
Mental Health Nursing Degree	6
BSc (Hons) Registered Mental Health Nurse	5
ForenPsychD	5
Degree	4
HCPC registration	4
BSc Occupational Therapy	3
Doctorate	3
Human Nutrition and Dietetics	3
psychology degree	3
Bachelor's and master's degree	2
Bachelors of Science Degree in Nursing	2
BSc (Hons)	2
BSc Mental Health Nursing	2
Citizens Advice caseworker certificate	2
Diploma in counselling	2
Level 5 Diploma	2
MSc Social Work	2
Registered Nurse Learning Disabilities	2
Accredited mediator.	1
Approved mental health professional	1

Professional qualification	No. of participants who reported this qualification
Architect	1
Art Psychotherapist	1
BSc Hons - RGN, NMP	1
BSc or equivalent	1
BSc Social Work	1
Chartered Architect	1
Chartered Institute Procurement and Supply (MCIPS)	1
CKP In policing	1
Clinical Doctorate in Clinical Psychology	1
Clinical Psychologist	1
CPN	1
Degree in Nursing	1
Diploma healthcare	1
Diploma in Mental Health Nursing	1
Diploma in social work	1
Doctor	1
either RMN,RGN, social worker or OT	1
Ma in Art Psychotherapy	1
MSc	1
MSc OT pre registration	1
NVQ Diploma in policing	1
Pg Dip Counselling	1
PG Diploma in Mental Health Nursing	1
PG sip Education Mental Health practice	1
PhD	1
Prof Diploma in Policing	1
Psychiatrist	1
Psychologist	1
Qualified Counsellor	1

Appendix 5

Participant reported job title.

Job titles of those who responded Yes to "Is your role patient/client/service user facing?"	No. Of participants who provided this job title
Activity coordinator	1
Activity worker	1
Administrator	2
Adult outreach worker	3
Advanced practitioner	3
Advisor	1
Alcohol liaison	1
Alcohol liaison clinical nurse specialist	3
Anti-social behaviour specialist	1
Art psychotherapist	1
Art therapist	1
Assertive outreach worker	3
Assistant psychologist	22
Assistant support worker	1
Associate nurse practitioner	7
Associate practitioner	11
Associate specialist	1
Bridge the Gap Associate/volunteer	1
Bridge the Gap Outreach Worker	7
Camhs specialist nurse	4
CAMHS Clinical practitioner	2
Camhs clinician	3
Case worker	1
CDR nurse	1
Children and Youth Worker	1
Client services manager	4
Clinical safety manager	1
Clinical associate psychologist apprentice	1
Clinical lead	5
Clinical lead nurse	2

Job titles of those who responded Yes to "Is your role patient/client/service user facing?"	No. Of participants who provided this job title
Clinical lead youth justice reaching out service	2
Clinical psychologist	10
Clinical safety manager	3
Clinical team lead	2
Cns	2
Community connector	2
Community link worker	4
Community mental health nurse	7
Community psychiatric nurse	22
Community Support Officer (Homes for Ukraine)	1
Consultant clinical psychologist	2
Consultant psychiatrist	10
Core psychiatry trainee	3
Counselling administrator	1
Crisis clinician	1
Csm	1
Cyps crisis intervention nurse	1
Day service manager	3
Dementia Care home Pathway Practitioner	1
Dementia link practitioner	1
Deputy service manager	1
Detective constable	1
Dietitian	3
Director	1
Disability Advocate & Outreach worker	2
Emhp	1
Emotional and wellbeing specialist nurse	1
Estates strategy delivery manager	2
Family host supervisor	1
Forensic community support worker	1

Job titles of those who responded Yes to "Is your role patient/client/service user facing?"	No. Of participants who provided this job title
Groupwork manager	1
Head of Staff Counselling	1
Hidva	3
High intensity use service lead	2
Homelessness resettlement worker	1
Homes for Ukraine support co-ordinator	1
Htt practitioner	1
Intensive keyworker	9
Interim team manager	1
Jobs advisor	2
Lead community perinatal mental health practitioner	1
Lead nurse- alcohol liaison team	1
Lead practitioner	1
Lead worker	1
Lgbtq+ advocate & da outreach	3
Lxp	1
Manager guildford action	1
Mediator. Drugs, county lines and vulnerable people liason. And related roles.	1
Mental health caseworker	2
Mental health crisis nurse	1
Mental health Link worker	1
Mental health nurse	3
Mental health outreach worker	1
Mental health outreach worker.	1
Mental health practitioner	20
Mental health social worker	2
Mental health specialist practitioner	1
Multi disadvantaged domestic abuse outreach worker	1
Nurse consultant	1

Appendix 5

Participant reported job title.

Job titles of those who responded Yes to "Is your role patient/client/service user facing?"	No. Of participants who provided this job title
Occupational therapist	6
Occupational therapy lead	1
Outreach worker	9
Paramedic practitioner	1
PBS lead	1
Peer support	1
Physiotherapist	2
Pln	2
Police constable	3
Police officer	1
Primary care mental health practitioner	2
Primary mental health worker	1
Principal clinical psychologist	2
Psych liaison nursse	1
Psychiatrist	3
Psychologist	1
Reconnect assertive outreach worker	2
Recovery coach	1
Recovery worker	3
Refugee coordinator	1
Refugee network manager	1
Refugee Support Co-ordinator	1
Registered manager	1
Research Assistant (one day a week in EIIP)	1
Resettlement manager	1
Rough sleeper navigator	1
Senior assertive outreach worker	1
Senior clinical psychologist	3
Senior clinician	2

Job titles of those who responded Yes to "Is your role patient/client/service user facing?"	No. Of participants who provided this job title
Senior Clinician and Education Mental Health Practitioner Supervisor	1
Senior liaison practitioner	1
Senior psychologist	7
Senior social worker	2
Service manager	2
Shipp supervisor	1
Social worker	1
Specialist occupational therapist	1
Specialty doctor	3
Str worker	1
Strategic keyworker	8
Substance misuse specialist	1
Support co-ordinator	1
Support worker	5
Team leader	1
Team manager	1
Therapy assistant	1
Trainee nursing associate	1
Trainee nursing associate / associate practitioner	1
Transition support worker	2
Ukraine hub	1
Ukrainian refugee family coordinator	1
Ukrainian Resettlement coordinator and interpreter	1
Ukrainian support worker	3
Vawg prevention & engagement worker	3
Well-being Activities Co-ordinator	1
Youth engagement Officer	2

Appendix 5

Participant reported job title.

Job titles of those who responded Sometimes to "Is your role patient/client/service user facing?"	No. Of participants who provided this job title
Acute therapy service manager	1
Administrator	1
Assistant psychologist	1
Associate director	2
Clinical psychologist	1
Clinical service manager	1
Community development manager	1
Consultant clinical psychologist	1
Counselling service lead	2
Crisis support worker	2
Director of Safety and Experience/Deputy Chief Nurse	1
General manager- hope service	1
High intensity use service lead	1
Honorary assistant psychologist	1
Independent chair	1
Integrated care service manager (trust wide)	2
Learning disabilities acute liaison nurse	1
Manager	1
Multi disadvantaged domestic abuse outreach worker	1
Operational lead keyworking service	2
Projects team lead	1
Refugee support coordinator	1
Senior assistant psychologist	1
Senior link worker	1
Senior partnership manager	1
Social action director	1
Specialist nurse child death reviews	3
VAWG prevention & engagement worker	7
Volunteer coordinator	1
Wellbeing consultant	1

Job titles of those who responded NO to "Is your role patient/client/service user facing?"	No. Of participants who provided this job title
Cas clinical navigator	2
Clinical advisor	1
Clinical safety manager	2
Clinical team lead	1
Dementia link practitioner	1
Hidva	1
Jsna programme manager	1
Lgbtq+ advocate & da outreach	1
Partnerships lead	1
Public health lead	1
Senior employee experience consultant	1
Shipp supervisor	1
Wellbeing consultant	1

Appendix 6

Feedback forms by organisation.

Organisation	No. of feedback forms
Ashford and St Peter's Hospitals NHS Foundation Trust	4
Catalyst	3
Changing Futures	2
Citizens Advice South West Surrey	1
East Surrey Domestic Abuse Services	4
East Surrey Outreach Service	4
Epsom & St Helier University Hospitals NHS Trust	2
Epsom and Ewell Borough Council	1
Mindworks	1
Myself	1
NHS Farnham Road	1
NHS Surrey Heartlands	2
North Surrey Domestic Abuse Service	1
Oakleaf Enterprise	2
Royal Surrey NHS Foundation Trust	3
SECAMB	3
South West Surrey Domestic Abuse Outreach Service	1
Surrey and Borders Partnership NHS Foundation Trust	103
Surrey and Sussex Healthcare Trust	1
Surrey County Council	20
Surrey Heartlands ICB	1
Surrey Police	2
The Hope Hub	4
The Hope Service	1

Appendix 7

Follow-up questionnaire responses by organisation.

Organisation	Number of participants
Surrey and Borders Partnership NHS Foundation Trust	14
Catalyst	4
East Surrey Domestic Abuse Services	3
Oakleaf Enterprise	2
Surrey County Council	3
Citizens Advice South West Surrey	1
Surrey Police	1

Appendix 8

Full examples of participant behaviour changes through how they have applied the training in practice

What (if anything) have you been able to apply from the training in your day-to-day work?
A better understanding of how trauma is defined and how SABP adapts its services to meet the needs of people who have experienced trauma.
Trauma can affect individuals, groups and communities Understanding the trauma exposure how affect the individuals helps to see the impact different perspective.
Being more mindful of a TIC [trauma-informed care] approach when working with parents and bringing this thinking into MDT [multi-disciplinary team] meetings
To understand that support needs to be tailored and that people present in different ways and respond to trauma differently
Understanding the need to be regulated myself to resist dysregulation for those I am training and to be able to provide support.
Different ways of thinking, asking questions etc. Listening more giving people the space to open up
I am aware previously how trauma can lead to risk especially with people with forensic history and i have continued to utilise the principles of empowering and promoting support in the community for our service users
In terms of the groups I deliver, I explain the courses have been designed to be trauma-informed. We have a clear group agreement at the start and clients are discouraged to go into too much detail about their own experiences in order to avoid re-traumatisation for themselves and others in the group, but to reflect on experiences to aid their learning and understanding. They are encouraged to seek support between sessions as appropriate. Inclusive language is used at all times. Experiences are always referred to as what happened to you and education around their responses being a normal reaction to trauma, rather than the medicalised version of what is wrong with you.
We are also putting together a short webinar on trauma and its effects so that clients can access this information easily and hopefully better understand what is happening in their brains and bodies and how this is a normal reaction and not something that is "wrong" with them.
I think just being aware of how trauma can be different for everyone and what someone finds traumatic another person might not, and not making assumptions either way. But also discussing trauma as a team and the things that we as professionals face and being mindful of this when in supervision etc. Also, approaches to engaging with people with trauma.
Being TI [trauma-informed] in how I liaise with others, including clients, staff and other services
Change how I ask people about what happened, I now focus more on the impact it is having and how it makes them feel.
Training was very informative. I shall be able to use it with most people I interact with. ACEs are a good way of looking at clients (though they may not know the long lasting impact of childhood and how it carries forward).
Cascade knowledge to clients (about how past experience and systemic variables may have impacted them). Sign post them to reading around trauma (such as Power Threat Meaning Framework, Compassion focussed therapy). I am reading more such as Janina Fisher, Judith Herman, Bessel Van Ker Kolk (cascade this info to clients if they are interested)
Just being more aware and conscious of circumstances when having conversations
Change how I ask people about what happened, I now focus more on the impact it is having and how it makes them feel.
Supporting CYPs with ACEs in the diversion from crime through holistic support strategies and resilience frame work workbook.

Appendix 8

Full examples of participant behaviour changes through how they have applied the training in practice

If you can, please give an example of how you have applied the training with a patient/client or staff member.
I often recall the phrase 'every interaction can be therapeutic or it can be re-traumatising' and I often remind myself of this when interacting with service users or staff.
Things taken into consideration that developed good interpersonal relationship made them feel safe to talk about their trauma, choice, empowerment, cultural consideration
Given time to open up, become trusted person. Patient was able to open up about SA [sexual abuse] for the first time, didn't panic at hearing this or ask loads of questions
Encouraging others to think about TIC [trauma-informed care] in relation to parents' perspective, TIC/wellbeing of staff.
Asked more probing and relevant questions and therefore uncovered information about past trauma so as to be in a better position to offer appropriate support.
Shared teaching with colleagues at monthly team-teaching session
Making sure that my team feel heard and understood - I love the phase:
'People will often resist change even if they agree with it if they don't feel heard and understood'
A client who has been under my case for 4 years just recently disclosed historical sexual abuse during recent relapse. This is the first time in 20 yrs that this was mentioned. I was able to understand reasons it never was mentioned but also show more understanding and acknowledgement of the persons strengths and abilities to be ready to have the support at this time
Training has been used with a staff member who is neurodiverse and helped me to manage/supervise that person in a more empathic way. I consider the language I use more and ensure I listen properly and ask open questions.
Help them to understand how current distress may have origins linked to systems around them past and current (past/current abuse, discrimination, poverty etc....)
I have made it normal in my approach with all clients... thinking what happened as opposed to 'what's wrong with you'
Patient A experienced childhood trauma which was potentially impacting on their older adult behaviour when washing and dressing. I was able to support and advise staff how to support when providing personal care.
Explained to a patient how her previous trauma is affecting how she is today. when she was younger she suffered horrific domestic abuse and had not linked it to how she was feeling today. she was able to talk about it and agreed to be referred to psychology.
During my Mental Health First Aid role I focus on how people feel and how they feel they could be supported better.
I assessed a man whose wife was present and she had found his illness and deterioration very traumatising and cited lack of NHS support as one cause of this. I was very transparent with her about what my team can and cannot offer and signposted her to peer support.
With one person who has come to frequent police attention with the guidance from the training I was able to adapt my approach and documentation to best suit their educational needs and took in to account their trauma to deliver a holistic approach to prevent the offending in the community.
I listened to my client and heard what was important to him. I then applied this and made this happen for him. eg he wanted to sign on with a dentist to sort his teeth out.
He is now waiting for his dentures to be made and has reached the final hurdle.
He has the confidence to attend the dentist on his own as I have attended with him since the first appointment.
By being cautious when conducting Pre-Counselling Assessment with clients, when asking about historic abuse/DV [domestic violence]. I make sure the client knows they don't need to answer or give detail, so as not to risk retraumatising client by bringing memories to the surface during interview.

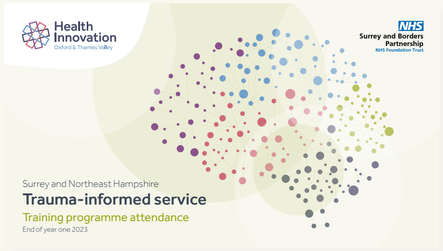
Appendix 8

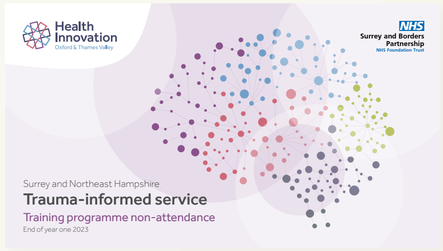
Full examples of participant behaviour changes through how they have applied the training in practice

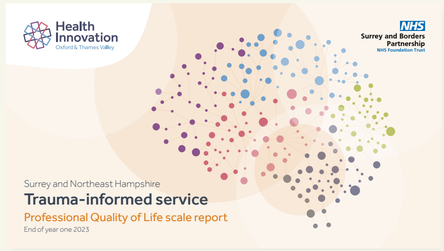
What (if any) have the benefits been to you and your patients/clients, staff or colleagues of working in a trauma-informed way?
Highlighting areas of improvement and best practice for staff to follow.
Increased understanding and empathy, improved provision
Better rapport with clients, able to understand their needs and help them better
Aiding formulation and supporting families.
More empathic and understanding approach, which makes them more likely to feel able/willing to disclose past trauma. Understanding the experiences of trauma better helps with developing and maintaining a non-judgemental approach.
It helps you to think about what you are saying or writing and how it may affect the other person
it means that anyone that is involved with ESDAS [East Surrey Domestic Abuse Service] is treated with respect and an understanding of the ways in which behaviours can be affected by trauma and we can adapt to provide the best support.
I find that people are more open about their feelings and therefore they have a better understanding of what support they require.
I am more confident was able to utilise the principle of collaboration and sharing power and decision making from above case.
Better communication and understanding.
Start to understand the reasons for distress and to promote recovery. They feel more empowered and there is less internalisation of their difficulties.
Better understanding of how trauma from the past affects a person today. also assessed someone who had PTSD [Post Traumatic Stress Disorder] from a job he did when he was young.
The course has benefitted me and the people I support. I have better knowledge on how to support people who experienced trauma in the past.
It improves ability to empathise
More person-centred approach to caring, and service users and their carers feel more empowered.
It has been beneficial for the Recovery College. It would be more beneficial if it were able to reach the wider audience of staff at SABP.
More mindfulness that many of our clients have suffered trauma and may not know it.
I feel fulfilled knowing that I have played a part in changing someone's life for the better.
Enhanced educational inputs

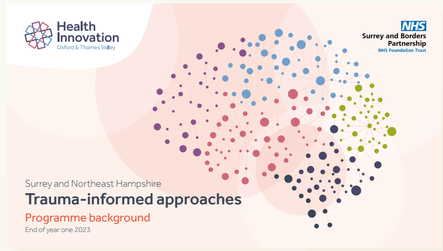
Health Innovation
Oxford & Thames Valley

NHS
Surrey and Borders Partnership
NHS Foundation Trust









Surrey and Northeast Hampshire

Trauma-informed service

Training report

End of year two 2024

SURREY HEARTLANDS Health and Care Partnership

Frimley Health and Care

CHANGING FUTURES

SURREY COUNTY COUNCIL