Trauma Informed

Communication Skills Training

Report of a pilot project

July 2020

Author John Conolly

Summary of training sessions

- The pilot trauma informed communications skills training sessions established that there is demand for this type of training for frontline health and social care workers.

- Most frontline health and social care workers had never had this type of training before, even though they regularly dealt with challenging patients or clients.

- The vast majority of those who completed the training felt more confident going forward to deal with agitated patients or clients.

Recommendations

- Anyone likely to work with agitated, aggressive patients or clients should have trauma informed communications skills training: it will produce better outcomes for staff and clients - building better relationships and lowering emotional stress.

- Pathway should explore how best to roll-out this kind of training to frontline workers and evaluate its impact on outcomes for patients and staff.

- Pathway should design and develop additional, targeted trauma-informed training modules.

- Pathway should work with key NHS agencies to promote awareness of the value of trauma informed communications skills training so that it is included in the training offered to all public facing staff working in the NHS.

Background

In early 2019 following a successful funding bid, Pathway was awarded a grant from the Grocers' Company to explore the usefulness and viability of a short training module to help frontline staff better understand and respond to some of the challenging behaviours they often face at work.

The idea for the project emerged from the clinical practice of leading homeless and inclusion health psychotherapist John Conolly. Through many years of counselling practice in specialist homelessness services he had noted how often his patients reported difficult or confrontational interactions with mainstream services: in housing departments, in hospitals, with the police and so on. These interactions very often seemed to 're-trigger' trauma based reactions in the moment and, because of the negative outcomes, contributed to increasing his patient's feelings of profound exclusion and marginalisation.

John wanted to explore whether it would be possible to train mainstream frontline staff to better understand what might be happening in these interactions and to have the confidence and skills to respond in a more appropriate, 'trauma informed' manner.

Once Pathway had secured the funding for this project, John's employer, Central London Community Healthcare NHS Trust, agreed to release him to lead the work for one day a week for six months. His task was to design and test a practical short course in trauma informed communications skills.

We are grateful to both the Grocers' Company and Central London Community Healthcare NHS Trust for their support for this work and to the five organisations that released their staff to test out the training.

The training sessions took place in the second half of 2019. A key objective of the project was to gather, analyse and share evidence of the impact of providing this training.

Introduction

The Trauma Informed Communication Skills Training was a half day two module course**.** It was specifically designed for frontline workers to learn how to recognize and sensitively respond to people who have experienced trauma**.**

The aim of the course was to equip participants with an understanding of how to de-escalate high conflict situations and to practice skills described through role-playing exercises.

The training stressed the importance of body language and the C.A.R.S (connecting, analysing, responding, setting limits) approach (1) to de-escalating and managing high conflict situations.

It was not intended to be a replacement for local safety procedures and protocols, but rather it sought to offer staff other tools to consider or ways to respond before activating more formal procedures. The hope was that it might reduce the number of times frontline staff felt the need to call security.

Why trauma training?

A high number of homeless people have experienced physical and psychological trauma at some point in their lives.

Physical and sexual abuse, neglect, domestic violence and other traumatic experiences, especially in childhood can have a devastating and long-lasting impact on a person's life.

Other life experiences are likely to have further compounded these traumatic experiences - for example, previously being in care, time spent in prison, experience of violent crime, illness, loss/grief, addiction, gambling, work related trauma or poverty.

Frontline workers, who regularly come into contact with people who have experienced trauma, must be able to respond confidently, with compassion and care.

Homelessness and Trauma

It is now well documented that 'Complex Trauma', a reaction to ongoing and sustained traumatic experiences in childhood to early adulthood is very prevalent and can be as high as 69% in single homeless people (2).

This kind of trauma, with its associated communication, emotional and behavioural difficulties undermines the building and maintaining of relationships, including healthcare ones.

Attachment and Bonding

''A great proportion of the misery that wanders, in hideous forms, around the world, is allowed to rise from the negligence of parents'' (3).

A baby's developing brain is directly impacted on by the quality of care and communication it is exposed to (4).
Stress or even fear experienced as a result of carers failing to be sources of safety and calm causes stress hormones like cortisol to be regularly released, and natural opiate releasing calming mechanisms to become inhibited.

Over time this can lead to 'anxious solitude', and to attention deficit, peer exclusion, or conduct disorder in childhood, and antisocial behaviour and self-medication to calm down as an adult. (5). People may be labelled as having some degree of personality disorder.

The individual's capacity for 'mentalization', the prerequisite to psychological resilience, communication, social skills and self-control will be significantly impaired (6).

Trauma Informed Communications Skills Modules

With weakened internal mentalization, and particularly in situations that may be very likely to trigger a stress response, communications can be so significantly impaired as to become behaviourally challenging.

This is the basis for thinking about enhanced trauma informed communication skills, including the setting of behavioural limits, whilst at the same time avoiding escalation.

The pilot training sessions

The training sessions were piloted on **57** individuals from five different NHS and non-NHS services.

Those who took part were frontline workers in health, housing, social work, addiction, counselling, justice, education, and customer services.

The training was open to anyone who had contact with vulnerable people in community-based settings, to enable them to benefit from having a better understanding of trauma.

The primary aim was to equip participants with the skills and the confidence to respond in line with the principles of trauma informed practice.

Training consisted of: -

Module One explained the 'High Cycle of Conflict', including the 'Mistaken Assessment of Danger', 'Blame Speak' and 'Behaviour that is aggressive/defensive'.

It also demonstrated how not to take it personally but to apply the C.A.R.S. (connecting, analysing, responding, setting limits) approach or 'Compassionate Self-Assertion'.

This module had five components:

1. Communication
2. The Cycle of Protest and the Trauma Response
3. Social Exclusion
4. Cycle of High Conflict Thinking
5. Setting limits skills

Module Two embedded skills learning via role-playing challenging scenarios; and the application of, and the experiencing for oneself, of the C.A.R.S approach.

1. Role Play Guidelines
2. Scripted Role Play
3. Role Play Feedback
4. Communication Skills Checklist

The pilots

The training was piloted on **57** individuals from five different NHS and non-NHS services:

i. CLCH Community Health Care NHS Trust, Community Dental Service (1hr)
ii. The Marylebone Project for Homeless Women (3hrs)
iii. UCLH Find & Treat Team (3hr)
iv. Newham Community Psychiatric Liaison service (1hr)
v. UCLH A&E service (2hrs)

Results

98% (56) of people found that all of the following objectives had been met and they had an increased understanding of:

i. Body Language

ii. Mentalization

iii. Trauma & Exclusion

iv. The C.A.R.S approach to De-escalation and Setting Limits

v. Setting a Limit Skills – The Six Step Assertion Process

85% (51) reported feeling more confident with regard to dealing with an agitated person. Comments included:

- Felt better able to manage expectations
- Better understanding of what was behind behaviour
- Better understanding of Personality Disorder
- Felt more reassured
- Understood the importance of acknowledging patient's feelings
- Had learnt new ideas and useful techniques.
- Felt better able to remain calm and be assertive
- Realised importance of empathy, body language and setting limits in conversation

Conclusion

This small pilot programme of training sessions showed that there is demand for trauma informed communications skills training for frontline health and social care workers.

Most of these frontline workers had never had the kind of combined knowledge and skills based training before, even though they regularly dealt with behaviourally challenging patients or clients.

The value of the role-play exercises in giving participants some idea of how it feels from the client's perspective was crucial.

Participants felt significantly more confident in being able to deal with agitated patients or clients. They also gained a better understanding of the psychological processes involved in trauma responses and what could be behind certain behaviours.

Having shown that there is a real need for more support for staff on this topic, Pathway is keen to explore how to build on the learning generated in this project. We believe that many thousands of staff in public facing roles would benefit from this brief training programme. We will investigate how to scale up and replicate this approach.

There is a parallel demand in specialist homelessness and inclusion health services. While awareness levels of the impact of life-course trauma are higher in this sector, and the 'psychologically informed environments' movement has led to significant improvements in the way staff are trained and supported, we believe more needs to be done to give staff the kinds of skills that will help them manage difficult interactions with more compassion and better outcomes.

Notes

1. Bill Eddy, ' It's All Your Fault!', 2009, HCI press.

2. One of the most influential studies published in England demonstrating the link between homelessness and complex trauma was by:

Maguire, N.J., Johnson,R., Vostanis, P., Keats, H. & Remington,R.E. (2009), 'Homelessness and complex trauma: a review of the literature', Southampton University, http://eprints.soton.ac.uk/69749/, also cited in 'Healthcare for Single Homeless People', (2010), Department of Health, Office of the Chief Analyst, London.

3. By **Mary Wollstonecraft**, author of 'A Vindication of Women's Rights', and mother to Mary Shelley, author of 'Frankenstein', cited in ' Mary's Monster – Love, Madness and How Mary Shelley Created Frankenstein', 2018, Lita Judge, Wren and Rook, an imprint of Hachette.

4. '***Attachment Theory'*** is now very well established, e.g.:

Bowlby, J.: 'Attachment',(1997), Pimlico Edn.

Bowlby, J., 'Separation, Anger and Anxiety',(1998a), Pimlico Edn.

Bowlby, J., 'Loss, Sadness and Depression',(1998b), Pimlico Edn.

Wallin, D. J., ' Attachment in Psychotherapy', (2007),The Guildford Press.

Daniel, S. I. F., 'Adult Attachment Patterns in a Treatment Context – Relationship and Narrative', (2015), Routledge

5. **Bonner, A.,(2018),** ' The Individual; growing into society', Ch One, pps 3-18, in 'Social Determinants of Health', Ed Adrian Bonner, Policy Press, University of Bristol.

6. There is now a vast literature on Mentalization, e.g:

i. Bateman, A., Fonagy, P., , **(2004)**, ' Psychotherapy for Borderline Personality Disorder – mentalisation-based treatment', Oxford University Press.

ii. Bateman, A., Fonagy, P., (2006), 'Mentalization-based Treatment for Borderline Personality Disorder: A Practical Guide', Oxford University Press.

iii. Bateman, A., Fonagy, P., (2006),' Mentalizing and Borderline Personality Disorder', Chapter nine in ' Handbook of Mentalization-Based Treatment', Eds, J.G., Allen and P. Fonagy, John Wiley & Sons ltd.

iv. Bateman, A., Fonagy, P., (2016), ' Mentalization-Based Treatment for Personality Disorders – A Practical Guide', Oxford University Press.

v. Fonagy, P., Gergely, G., Jurist, E. L., Target, M.,(2006), 'Affect Regulation, Mentalisation, and the Development of Self', Karnac.

vi. Hoermann, S., Zupanick, C., E., Dombeck, M., (2013), 'Attachment Theory Expanded: Mentalization', https://www.mentalhelp.net/articles/attachment-theory-expanded-mentalization/, accessed 25th July 2018.

Pathway
4th Floor East, 250 Euston Road
London NW1 2PG
Company no.721079 | Charity no.1138741
www.pathway.org.uk
T: 0203 447 8782
E: info@pathway.org.uk