Academic Health Science Network
North East and North Cumbria

NHS
Northern England
Clinical Networks

A Commissioning Framework for the Delivery of Trauma- Informed Care in Women's Prisons.

TICA
Trauma Informed Community of Action

The North of England Women's Prisons Health Partnership Board commissioned the national Trauma Informed Community of Action (TICA) to undertake this project, which had three aims:

- Identify and evaluate evidence-based practice within this context, through a review of the literature.
- Identify gaps and suitable models with on-site leads, outline what good might look like and how they can work towards that.
- Produce a report outlining the potential delivery of trauma-informed models care within the female prison estate in this region.

Methodology

The Trauma Informed Community of Action is a network of clinicians, system changers, people with lived experience, directors, researchers etc who are engaged in considering new ways of delivering health and care that addresses harm, whether historical, current or inadvertent, through an understanding of the interplay between an individual's context and experiences and their mental health or behaviour. The network was used to source key people with the expertise to complete the evidence review, run the focus groups and consult on the process and findings. All of this was truly co-produced with experts by experience bringing their lens and equality of contribution to each of the tasks. Two main sources of evidence was sought.

1. A rapid review of the published evidence on this topic
2. Focus groups with key staff from each of the four sites, another for people with lived experience and one for a charity for staff working psychotherapeutically in prisons.

Governance of the project was assured by a diverse panel of experts from across the UK.

A regional Health and Justice stakeholder group allowed time for this project at their meetings and contributed to the development of the key lines of enquiry through those discussions.

task	Jan	Feb	March	April	May	June
Scoping/ Planning						
Evidence Review						
Governance Meetings						
Stakeholder Engagement						

Focus Groups						
Expert Reference Group						
Collating Report						
Final Debrief with Experts by Experience Group						
Final report submitted						

Recommendations

1. Peers

Develop and commission an independent peer support and peer trainer organisation to provide inreach to women in the prison. Create a robust co-produced governance structure with clear and transparent expectations and remit. Engage an independent lived experience consultant as mentor/ coach at a senior level to support this inreach.

Principles of peer support and training in this context would be demonstrated by:

- Visible people with lived experience of having been in a women's prison are accessible to the women for support and hope.
- These peer supporters have training and supervision in how to use their lived experience in a supportive way.
- Appropriate support structures and reflective spaces put in place to contain the emotional impact of the peer support role.
- Specific peer advocates should be included in the remit.
- The principle of peer mutuality requires some adaptations to usual prison protocol around confidentiality, interventions and risk management.
- The governance for this should be coproduced in advance.
- Training is always codesigned and co-delivered.
- Training needs and plans are led from those with lived experience.
- Those with lived experience must be paid at an equal rate to non-lived experienced trainers.

2. Staff support

Review the acceptability and scope of current Staff support offers within the estates. If appropriate, commission an independent staff wellbeing service with confidential space to discuss work related stress based on need rather than purely diagnosis.

Principles of staff support that would enhance the culture would be demonstrated by:

- There is clear information about factors in staff health and wellbeing that is accessible.
- Staff know where they can access support that is separate from occupational health or HR.
- Staff do not need to be off sick or have a diagnosis to access support.
- Senior staff model positive wellbeing care and are open about accessing support.
- Access to team support for postvention after serious incidents, coaching of staff to consider their work performance in a confidential arena, preventative wellbeing offers relating to physical and mental health.
- Access to specialist therapy for MH conditions relating to work e.g. PTSD.
- Staff feel able to approach each other for peer support, know how to support each other with mental health conversations, and know how to recognise signs of dissociation, distress or burnout in each other sufficient to warrant an intervention. A formal peer support model could be considered.
- Schwartz rounds could be an acceptable way of bringing staff to gather to consider the impact of their work (More Information on Schwartz Rounds).

3. Managing disclosures of trauma and abuse

Sensitively screening for trauma related symptoms could be done on admission using the Trauma screening Questionnaire and the new dissociation screening tool (in prep) or alternative.

Routine enquiry of trauma histories of all women is not recommended. However women should be able to give consent for some historical information to be shared and follow them into the prison. Population level stats on trauma histories should be collated so a truer estimate of local need can be established.

Officers should be supported to manage disclosures according to best practice guidance. See attached. This may require core training and opportunities to share or reflect on the impact of this on staff and inmates.

Good practice in managing disclosures would be demonstrated by:

- Not routinely asking specific questions about this history whilst on remand or at reception but being open if this is voluntarily shared. Asking about trauma history is relevant info to custody and divergence programs and possible once a relationship has built up with a worker in the prison and such a question may be relevant to the distress or coping. If a disclosure has been made prior to prison, having that info be available (if the person consents) alongside a robust plan for managing the consequences would be recommended.
- Screening for trauma related MH symptoms may be useful, eg dissociation and PTSD.
- Recording any disclosures in the persons own words in the records (for use in any potential legal case against alleged perpetrators). Do not push for details or gather a 'statement' unless this enters a formal process, as this can destabilise the person.
- Following any disclosure of abuse careful support should be offered to consider whether the woman wants to report any potential crime to the police and safeguarding practices should also be followed in case there are any other parties at potential ongoing risk

- Whether is appropriate and/or safe to gather further details from the woman, this should be discussed with her so collaborative ,shared choices can be made about information gathering taking into accounted own well being

- Demonstrate good listening skills and emotional containment during any disclosure.
- Provide appropriate monitoring, care and support following a disclosure.
- Some women may find the prison experience traumatising and this should be compassionately acknowledged with some prevention possible e.g. for those separated from children or giving birth in prison. Prevention of traumatisation by these events would be better.
- Women should be offered an assessment of their trauma related needs after release and given appropriate support.
- Training and guidance for officers should be given on disclosures and such information should be passed on to health team.

4. Interventions

Whole system commissioning is a key facilitator of adequate trauma informed services. For the prison estate to be more trauma informed, high level healing Interventions need commissioned that aim to keep women from entering the prison in the first place, ie liaison and diversion. Therapeutic work that is started in the prison should be able to continue once released with an adequate handover. This can only be done if the prison mental health service is commissioned as part of a whole system pathway for women entering the criminal justice system, including arrested, bailed, sentenced or remanded women?

For those women with sentences over 5 years, (who are assessed as having enough time on their sentence to engage safely and meaningfully with a therapy that aims to resolve the impact of trauma), there should be access to specific trauma specialists who can properly resolve the mental health sequelae of past traumas or those resulting from the prison experience.

For other women, interventions should be flexible according to need and not based on a threshold for access where only those that demonstrate deterioration and risk can access the service as this disincentives wellness. Interventions must not be coercive or taken up as part of the requirements of a sentence plan.

Interventions should be delivered by qualified therapists or those in training (under supervision).

A range of psychological, physical and body therapies should be available, which are properly reviewed for effectiveness and acceptability. Choice is essential for empowerment and recovery. The non psychological interventions will offer other routes to healing via the body and functioning that may be more effective for some individuals. Strengths based and preventative wellbeing offers should be in place e.g. work, learning new skills, opportunities for academic advancement, enrichment activities.

Competencies of therapists should be focused on:

- Use of non-stigmatising and non-pathologising language.
- Capability for shared decisions.
- Able to be transparent and acknowledge power differentials.

- Skills of use within the first stage of the trauma recovery model focusing on stabilisation of self, mood and perception.
- Knowledge of attachment difficulties and know how to work with this.
- Knowledge of the role dissociation plays in self concept and risk.
- Knowledge of the neurobiology of trauma and separation.
- Ability to communicate and use all of the above in individualised ways.

In summary, interventions will be observed as trauma informed if they can demonstrate:

- They are needs led rather than pathway driven.
- Dropping any reference to the term 'personality disorder' if a presentation has developed as a result of abuse and trauma or neurodiversity. If the person wants and values this diagnosis then it won't be removed from them but the words used to describe people will rarely be in this lens or language.
- They offer choice about the type of intervention.
- They are open access.
- They are based on a genuinely co-produced formulation that explains how the current problems have emerged and what needs to be done to heal this, including what responses are needed from others to prevent escalation.
- They keep an emphasis on individual survivor-defined goals and demonstrate significant outcomes without unintended consequences.
- Interventions are not just intrapersonal but social too. For example advice and support around debt, housing, and safeguarding once out of prison.
- That interventions whilst in prison focus on the skills and relationships essential to surviving the prison experience with an explicit acknowledgement that trauma informed care will be aiming to prevent problems from imprisonment. That is, a focus on prevention of iatrogenic harm.
- Interventions acknowledge that offences are always relational, often linked to managing emotions and relationships in ways that have been heavily influenced by past trauma and adversities.
- Interventions acknowledge that prison can be experienced as a place of relative safety by some women and address this.
- They include access to non-psychological therapies.
- They are delivered within a phased recovery framework with an emphasis being on safety and stabilisation.
- Therapies aimed at resolving trauma beyond stabilisation should be available for those with longer term sentences. For others, this work should be done before or after prison in most cases.
- They are well governed and delivered by competent therapists from a range of backgrounds (not just psychologists) with adequate supervision.
- Consider developing posts for some of the new therapy roles that are developing. The service may have to train and develop their own staff in order to get the staff they need and this may take some years.
- To commission a service that has sufficient staff to deliver good quality care that does not put some women at a disadvantage. (refer to other sites for comparable staffing levels).

- There needs to be time allowed for good quality, co-produced, peer reviewed research to be published to ensure a lived-experience-informed learning culture.

5. Managing distress in the moment

In addition to any timetabled interventions, there needs to be a culture of responding to distress in the moment that is helpful and timely that does not require escalation to crisis point, but focuses on much earlier support and response to needs. This relational, systemic context will mitigate risks much more effectively and directly.

The following factors will be observable.

- Attention is paid to requests from people, especially if these requests have been repeated. Attention is paid to any building sense of frustration and hopelessness in order to predict and prevent a crisis.
- Attention is paid to neurodiversity and conditions that change the baseline for distress e.g. banging doors will be more unmanageable for some people and therefore environments that mitigate this should be incorporated.
- Attention is paid to the immediate emotional impact of separation from family, witnessing directly or indirectly assault in prison, anniversaries of events, the distress of witnessing self harm etc and opportunity for preventative support given.
- Self harm and other overt acts of distress are to be seen as attempts to manage internal trauma experiences, meaning equal attention needs to be paid to understanding and meeting underlying emotional needs as a form of risk management, as well as the general traumatic environment of the prison structure.
- Personalised understandings of self-harm and suicidality and shared plans should be established to collaboratively find other ways of containment before crises escalate.
- That felt sense of safety is foremost and action taken to ensure issues such as bullying etc are addressed.
- Immediate action is taken to any disruption or prevention of someone's ability to sleep or rest. This may include loud cellmates or trauma-related night terrors, etc.
- All staff to have basic competencies in the impact of trauma on self, relationships and biology and the power of their relational encounters in healing or hindering wellbeing.

6. Environment

The entry process should be reviewed for its potential therapeutic value and mitigate against the distress that may become traumatising.

Intensive therapeutic support and a plan of increased supported positive risk taking to be offered to women in segregation for prolonged periods of time.

Therapeutic spaces are needed for support to work and action taken to invest in space that facilitates emotional regulation, as far as is possible given the threat and isolation and separation that the women experience. This should include those therapy rooms used by staff to deliver interventions and also those spaces where prisoners can use themselves to calm down.

The opportunity for co-commissioning with the Ministry of Justice could be explored with an emphasis on equity across the estates elsewhere.

Safer staffing standards should be adhered to enable the above to happen. Staff to prioritise enabling therapeutic groups and interventions to occur in a reliable and consistent way.

A healthier environment could be demonstrated by;

- Quiet, confidential rooms for any therapeutic work were to be carried out.
- Sufficient senior clinical leadership in recommending intervention plans, given the potential for de-stabilisation or exacerbation of traumatisation from overly manualised or 'process-driven' approaches.
- During the entry process, a phone call home, a quiet zone/time out/low stimulus capacity that is therapeutic in design and function
- Reflective meetings are built into the everyday structure of the wing, e.g. morning meetings to discuss ongoing issues, come together to highlight problems and demonstrate a culture of enquiry and discussion.
- Working with a designer or architect on projects relating to the physical space (Healthy Happy Places).
- A culture of vulnerability, emotional expression and transparency led and modelled by senior management.
- Environmental amendments to take into account neurosensory needs, e.g. make relaxation rooms/decompression rooms better suited for neurosensory disruptions that women might experience due to their trauma.
- Better shared IT systems that allow liaising of information between courts, staff and link workers.
- Lived experience roles integrated throughout the prison structure at every level.
- Adequate staffing that is in line with other sites.
- Exploration of the range of new roles that are emerging in mental health. PPN - New Roles in the Psychological Professions: Q&A
- Significant clinical leadership positions.

Acknowledgements

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Supplementary reports

TRAUMA INFORMED H AND J SERVICES IN WOMENS PRISON FOCUS GROUPS REPORT

Trauma-Informed Care in Women's Prisons - Rapid Review