Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

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Commissioned by Dr Emilie Smithson (Clinical Psychologist) and Dr Kevin Wright (Consultant Clinical Psychologist) on behalf of the forensic care group.

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1. Introduction

Wakefield's forensic care group is implementing a trauma informed care (TIC) pathway. The implementation of the TIC pathway is hoped to embed trauma informed care into everyday practice and thus improve the service user experience. As part of this, the South West Yorkshire Partnership NHS Foundation Trust (SWYT) Clinical and Forensic Psychologists devised an in-house TIC training package to support staff in the transformation. The package was devised by with consideration of the developmental needs of existing and new forensic staff, inclusive of discipline and employment band, to emphasise the values in line with TIC.

Here, an evaluation of the TIC training is presented. It is hoped that the results of this SEP, together with results of other ongoing evaluations within the service, will enable the service to determine which areas of the TIC pathway are developing well and which may require further attention.

2. Literature review and background

2.1 Service evaluation context

This service evaluation project (SEP) was commissioned by Dr Emilie Smithson (Clinical Psychologist) and Dr Kevin Wright (Lead Consultant Clinical Psychologist in the Forensic service; see Appendix A). The evaluation aimed to explore forensic staff's knowledge of, and confidence in using TIC and how training in TIC impacted levels of knowledge and confidence. This evaluation forms part of a wider evaluation of the implementation of a trauma-informed pathway within the forensic service.

2.2 Approvals

The evaluation was discussed with the Research and Development Team at SWYT (reference number 2021/22SE40). Ethical approval was sought from the University of Leeds Research Ethics Committee, and approved by the School of Medicine's Ethics Committee, the DClin sub-REC, on 1st March 2022 (reference number DClinREC 21-009).

2.3 Trauma

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) define trauma as something which can occur due to emotionally harmful events such as abuse, neglect, violence, loss and disaster. It is well established that experiencing trauma is linked with both poor mental and physical health. Mood and anxiety problems have been associated with physical abuse, sexual abuse, and neglect, while personality disorders and schizophrenia

have been linked with emotional abuse (Carr et al., 2013; de Aquino Ferreira et al., 2018). Research suggests that the risks associated with traumatic events increase with the number of traumatic experiences (Muenzenmaier et al., 2014).

Available studies suggest that there is a higher prevalence of traumatic experiences among forensic inpatient populations compared to the general population (Macinnes et al., 2016; Sarkar et al., 2005; Spitzer et al., 2006; Spitzer et al., 2001; Stinson et al., 2016), with some studies reporting that 100% of their participants within inpatient forensic services had experienced traumatic events (Garieballa et al., 2006; Gosein et al., 2016). A recent audit found that almost all service users (SUs) of the Wakefield service had experienced traumatic events (Bagnall, 2022).

2.4 Trauma Informed Care

TIC arose in the 1990's (Becker-Blease, 2017; Harris & Fallot, 2001). TIC acknowledges that traditional service delivery can be re-traumatising for SUs (Conners-Burrow et al., 2013) and aims to reduce the impacts of trauma within service delivery (Harris & Fallot, 2001; SAMHSA, 2014). TIC is a whole system approach based on how trauma impact peoples' physical, psychological and social development across the lifespan (Hodas, 2006; Paterson, 2014). Currently, there is no universal definition of TIC (Branson et al., 2017; Hanson & Lang, 2014; Marsac et al., 2016), but principles such as safety, trustworthiness, transparency, collaboration and mutuality are proposed to embody TIC (SAMHSA, 2014).

When SU's reasons for challenging behaviour can be understood in the context of trauma, difficulties are less likely to be pathologized, and clinicians can understand behaviour as a normal reaction to an abnormal experience (Johnstone & Boyle, 2018, p. 18; Leitch, 2017; Van der Kolk, 2014).

Research suggests that SUs within TIC systems can have a decrease in symptoms, reduced treatment times, greater discharge rates to lower-level care services, lower levels of substance misuse, improved mental health (Greenwald et al., 2012; Hodgdon et al., 2013; Morrissey et al., 2005), and that TIC systems can lead to reductions in the use of restraint and seclusion (Azeem et al., 2011; Chandler, 2008; Dike et al., 2021; Hodgdon et al., 2013). However, the design of these studies did not control other factors which may have contributed to these changes, meaning that causal conclusions were drawn.

Despite its rising popularity (Becker-Blease, 2017), little is known about how to best create effective organisational change for TIC (Hanson & Lang, 2014). Purtle (2020) systematically

reviewed organisational interventions for TIC and created a narrative synthesis of study findings but results did not indicate which interventions may be most effective.

Staff training has been deemed an essential first step in creating TIC (Hanson & Lang, 2016; Purtle, 2020; SAMHSA, 2014). Training can focus on the prevalence and effects of trauma, and the principles of TIC, with the goal of increasing staff knowledge and changing practice. The TIC model and principles can be viewed as an underpinning framework for TIC training and the practicalities of its structure and content. However, individual providers may choose to emphasise different aspects.

2.5 Impacts of TIC training

Purtle (2020) systematically reviewed organisational interventions for TIC, some of which evaluated staff training but few of these directly measured the impacts of training for staff. The studies included utilised staff working in a variety of healthcare settings. Several studies including training which was not explicitly about TIC and which made tenuous links between training and outcomes, such as linking training to rates of seclusion with no statistical consideration confounding factors (e.g. Azeem et al., 2011; Blair et al., 2017; Borckardt et al., 2011). Therefore, a meta-analysis of available studies would be helpful to create a more rigorous evaluation.

Some studies explored the impact of training on attitudes towards TIC and found that engaging in training led to more positive attitudes towards TIC (Niimura et al., 2019; Ramadurai et al., 2022; Wagner et al., 2021; Weiss et al., 2017; Williams & Smith, 2017). However, it is unclear whether more positive attitudes to TIC lead to increases in TIC practice, as practice was not measured (Wagner et al., 2021; Williams & Smith, 2017). Staff must be trained in TIC to provide it; participants of the study by Niimura et al. (2019) identified that a lack of confidence in practising TIC was a barrier to them developing their practice.

Research has indicated that engaging in TIC training leads to increased knowledge of trauma and TIC (Buxton et al., 2022; Evans et al., 2019; Goldstein et al., 2018; Im & Swan, 2020; Kenny et al., 2017; Lotzin et al., 2018; Marsac et al., 2020; Ramadurai et al., 2022; Williams & Smith, 2017; Zordan et al., 2022) although one study reported no changes in knowledge (Crable et al., 2013). Few studies explicitly described the content of TIC training, meaning that is unclear which aspects of training may be most helpful to participants.

Some studies suggest that engaging in TIC training leads to greater TIC practice (Brown et al., 2012; Choi & Seng, 2015; Conners-Burrow et al., 2013; Greenwald et al., 2012; Kramer et al., 2013; Lotzin et al., 2018; Raja et al., 2015), but in these TIC practice was often measured using self-reported data, which may not reflect practical changes in day-to-day practice (Brown et al., 2012; Choi & Seng, 2015). Capturing such changes would be difficult and require long-term follow-up, which many studies did not have.

Zordan et al. (2022) utilised a simulation-based TIC training for Australian graduate nurses working in inpatient environments and found that engagement led to more TIC behaviours in a simulation. Unfortunately, the TIC behaviours were self-reported, so may have been influenced by social desirability, and practice in clinical practice was not measured. Williams and Smith (2017) evaluated the impacts of TIC training on practice and found that one year later, clinicians reported training having a moderate impact on their practice. However, this is based on self-reports on an unvalidated questionnaire and would be best supported by objective measurable outcomes such as observable behaviours.

Having knowledge about TIC may help clinicians to practice TIC but other factors may influence clinicians' ability to practice TIC. For example, perceiving talking about trauma to be outside of their role (Palfrey et al., 2019), time constraints in clinical roles, having little confidence in practising TIC (Niimura et al., 2019).

Marsac et al. (2020) provided TIC training to clinicians and measured their confidence in providing TIC. Marsac et al. reported that participants' confidence in providing TIC statistically significantly increased following training, and that this change was maintained at both one- and six-month follow-ups. It is noteworthy that training was accompanied by weekly tips for practicing TIC, which may have influenced increases in participants' knowledge. It would be helpful for this study to be formally published to facilitate further evaluation of findings, as so far it has only been shared at a conference. Other studies have found that engaging in training led to greater confidence in providing TIC, but more studies with greater scientific rigour are needed (Buxton et al., 2022; Kelton et al., 2022).

Despite the high prevalence of trauma within forensic inpatient services, no research has yet evaluated the impact of TIC training for forensic inpatient staff. Therefore, an evaluation of a training programme was needed to ensure that it benefits those who receive it. In line with previous research, benefits may include increased TIC knowledge or increased confidence.

2.6 Aims

This service evaluation aimed to evaluate the impact of a TIC training on forensic mental health staff's understanding of trauma and TIC, along with staff confidence in implementing TIC. This will be achieved by:

1. Assessing staff's existing understanding of trauma and confidence in implementing TIC before receiving training
2. To assess the impact of training on staff's understanding of trauma and confidence in implementing TIC
3. To explore staff perceptions of what will be helpful to implement TIC in their practice

3. Method

3.1 Design

This SEP was pragmatically designed to assess the short-term impacts of TIC training for staff in relation to knowledge and confidence; other service evaluations are measuring outcomes for both SUs and staff in the long-term.

This SEP was designed to collect baseline data about staff's knowledge of TIC and confidence in providing TIC; henceforth referred to as pre-training data. Staff were asked to complete a pre-training questionnaire via a service-wide email and before engaging in TIC training. A pre-post design was used to evaluate the impact of TIC training by comparing questionnaire scores before and after completing training. A longitudinal evaluation of training would have been ideal, but due to time constraints and uncertainties as to when training would be delivered, this was not possible.

3.2 Training

The TIC training consisted of four modules, each lasting three hours. Training sessions addressed staff's experiences (vicarious trauma, resilience) and how trauma can manifest in later life, as shown in Table one.

Table 1

TIC training agenda

Day one	Module one	Understanding trauma
	Module two	The principles of trauma informed care
Day two	Module three	Vicarious trauma
	Module four	Compassionate organisations

3.3 Sample

All participants were SWYT forensic inpatient staff.

3.4 Materials

3.4.1 Demographic survey

A demographic survey collected information to contextualise participants and evaluation results (see Appendix B and C). Questions included participants' gender, age, ethnicity, time in job role, time in field and whether they had previously received trained in TIC. Ethnicity was included as Kenny et al. (2017) found that baseline knowledge of TIC was a statistically significant factor associated with existing knowledge in their evaluation of TIC training, with White participants scoring more highly than Black and Hispanic participants, indicating greater TIC knowledge.

3.4.2 TIC Questionnaire

A TIC questionnaire was devised as no relevant and freely available measure was available. The Attitudes Related to Trauma Informed Care Scale (ARTIC; Baker et al., 2016) is a well validated measure (Baker et al., 2021; Baker et al., 2016; Stokes et al., 2020) used in healthcare but considers factors irrelevant to the evaluation of TIC training. For example, system-wide support for TIC (Baker et al., 2016). Furthermore, it does not appear to be validated in forensic services. One study utilised a quantitative measure to assess participants' attitudes towards TIC and confidence in providing following TIC training (Weiss et al., 2017) but this measure could not be accessed with University subscriptions.

A brief questionnaire relating to knowledge of TIC and confidence in implementing TIC was devised by the author and the commissioner. The roles and developmental needs of staff within forensic inpatient services, their interactions with colleagues and service users, and the principles of TIC were considered in the questionnaire's development. As engaging in TIC training is related to increased TIC knowledge (Buxton et al., 2022; Ramadurai et al., 2022; Zordan et al., 2022), only three questions measured knowledge. As less research has addressed confidence, eight questions were devised. Some questions were inspired by previous research (Hall et al., 2016; Hickle, 2017) and related to the TIC evidence-base. For example, both individual and system-wide changes are needed to implement TIC (Kotter & Cohen, 2003), and examples of this can include recognising signs of trauma in both staff and SUs (SAMHSA, 2014).

Most items were quantitative and required participants to respond to statements on a five-point Likert scale (strongly disagree-strongly agree). A score of zero was given for 'strongly disagree' while a score of four was given for 'strongly agree'. To encourage participants to consider their responses, questions three, six, nine and eleven were phrased negatively and reverse scored. The qualitative items were designed to contextualise quantitative responses; the wording of qualitative items was altered slightly to reflect participants experience at that point in time; pre-training (see Appendix D and E) and post-training (see Appendix F).

3.5 Procedure

3.5.1 Recruitment

All SWYT forensic inpatient staff were invited to take in the pre-training questionnaire, and all were eligible to take part in the TIC training. However, opportunities to participate in training may have been dependent upon line manager decisions and the clinical needs of the hospital.

3.5.2 Pre-training

An email was sent to 410 staff (see Appendix G) and a reminder email was sent two weeks later (see Appendix H); pre-training group A. Prospective participants were directed to Jisc, an online questionnaire platform (formerly Bristol online Surveys), where they were presented with the participant information sheet (see Appendix I). Participants consented by continuing to the next page, participants then completed the demographic and TIC questionnaire.

Staff were invited to attend a face-to-face TIC training session. Before training commenced, training facilitators provided attendees with paper copies of an information sheet (see Appendix J) and a consent form (see Appendix K). Those who completed the consent form then completed paper copies of the demographics and pre-training questionnaire; pre-training group B. Participants generated a unique code to allow pairing of pre- and post-training questionnaires.

3.5.3 Post-training

After training, those who consented to participating in the SEP completed paper copies of the post-training TIC questionnaire with their unique code.

3.6 Analysis

Pre-training data was grouped to ensure participants anonymity; as the groups may not have been independent, analysis was conducted separately. Descriptive statistics were calculated using IBM SPSS, version 27.

To understand the impact of TIC training, pre- and post-training confidence and knowledge scores were analysed using IBM SPSS Statistics, version 27. Descriptive statistics were calculated and data exploration revealed that post-training confidence scores had statistically significant kurtosis and skew ($p > .05$); one participants' score was much lower than the others. It was not possible to reliably determine whether this was due to error or if it reflected a difference experience of training. Therefore, the score remained part of the data set and the non-parametric Wilcoxon Signed Rank Test was used.

Qualitative data gathered in free-text responses was analysed using the principles of realist Thematic Analysis (TA); TA extracts meaning and themes from data and can be used flexibly (Braun & Clarke, 2006, 2012). Realist approaches value the concept of validity (Maxwell, 2012), and centre causal explanation as part of predicting observable phenomena (Clark et al., 2007). Codes and themes were discussed with the commissioner to increase validity and reliability of results.

4. Results

Quantitative and qualitative results are interpreted simultaneously to explore the impact of TIC training for staff in relation to their understanding of trauma and confidence in implementing TIC.

4.1 Participants

An email was sent to 410 staff with a link to the pre-training questionnaire; 24 (5.85%) completed this; group A. In total, 29 staff began TIC training and 28 of these completed the pre-training questionnaire; group B. Table two presents demographic information about pre-training participants and participants who completed training. Although 29 staff began TIC, only nine completed the training (all of whom completed the post-training questionnaire).

Table 2

Demographic information of participants.

		Pre-training		Post-training
		A	B	
	Gender*			
Male		8 (33.33%)	7 (25.00%)	0 (0.00%)
Female		16 (66.66%)	21 (75.00%)	9 (100.00%)
	Age			
Average age (years)		43.74 (15.33)	40.33 (11.96)	41.19 (SD = 13.60)
	Ethnicity **			
Black African		0 (0.00%)	2 (7.14%)	0 (0.00%)
British		3 (12.50%)	0 (0.00%)	0 (0.00%)
Irish		1 (4.17%)	0 (0.00%)	0 (0.00%)
White		4 (16.67%)	0 (0.00%)	0 (0.00%)
White British		15 (62.5%)	26 (92.86%)	9 (100.00%)
Prefer not to disclose		1 (4.17%)	0 (0.00%)	0 (0.00%)
	Staff group			
Management		1 (4.17%)	1 (3.57%)	0 (0.00%)
Medical		3 (12.50%)	0 (0.00%)	0 (0.00%)
Nursing		5 (20.83%)	22 (78.57%)	9 (100.00%)
Occupational Therapy		6 (25.00%)	3 (10.71%)	0 (0.00%)
Psychology		2 (8.33%)	1 (3.57%)	0 (0.00%)
Secretarial / administrative		0 (0.00%)	1 (3.57%)	0 (0.00%)
Social Work		2	0 (0.00%)	0 (0.00%)
	Previous Experience			
Years in job role (*SD*)		12.65 (12.94)	7.83 (8.74)	9.27 (12.62)
Years in field (*SD*)		13.71 (10.37)	11.33 (11.56)	14.98 (16.08)
	Previous Training			
Yes		6 (25.00%)	5 (17.86%)	2 (22.22%)
No		17 (70.83%)	23 (82.14%)	7 (77.78%)
Not sure		1 (4.17%)	0 (0.00%)	0 (0.00%)

Note. The details of those who completed training are included in the pre-training data, as they also completed a pre-training questionnaire. No staff reported being from the staff group 'domestic'.

* Self-identified gender. Other options included 'non-binary' and 'prefer not to disclose'.

** Participants self-defined their ethnicity.

4.2 Pre-training

The pre-training results indicated that most staff who completed the questionnaire had not previously engaged in TIC training (see Table 1). A total score of 12 was possible was knowledge, and a total score of 32 was possible for confidence. Table three presents the pre-training scores for both groups, and Table four shows responses to individual questions for both groups.

Table 3

Questionnaire scores for both pre-training groups

Group	Knowledge score	Confidence score
A	8.33	21.63
	(*SD* = 1.27)	(*SD* = 3.06)
B	7.04	19.57
	(*SD* = 1.82)	(*SD* = 4.05)

Table 4

Quantitative responses to the pre-training questionnaire.

	Question	Strongly disagree		Disagree		Unsure		Agree		Strongly agree	
		Group A	Group B	Group A	Group B	Group A	Group B	Group A	Group B	Group A	Group B
1[C]	I am confident that I can explain what trauma is	0 (0.00%)	0 (0.00%)	1 (4.17%)	0 (0.00%)	4 (4.67%)	11 (39.29%)	17 (70.83%)	14 (50.00%)	2 (8.33%)	3 (10.71%)
2[K]	I understand the impact that trauma can have in people's lives	0 (0.00%)	0 (0.00%)	0 (0.00%)	0 (0.00%)	0 (0.00%)	2 (7.14%)	18 (75.00%)	19 (67.86%)	6 (25.00%)	7 (25.00%)
3[C]	I am not confident in my understanding of 'vicarious trauma'	1 (4.17%)	0 (0.00%)	10 (41.67%)	5 (17.86%)	5 (20.83%)	3 (10.71%)	5 (20.83%)	13 (46.43%)	3 (12.50%)	7 (25.00%)
4[C]	I am confident that I can tell when I might be impacted by vicarious trauma	1 (4.17%)	2 (7.14%)	2 (8.33%)	8 (28.57%)	6 (25.00%)	14 (50.00%)	13 (54.17%)	4 (14.29%)	2 (8.33%)	0 (0.00%)
5[K]	I can spot some of the classic signs and symptoms of vicarious or secondary trauma in my co-workers	1 (4.17%)	1 (3.57%)	1 (4.17%)	12 (42.86%)	10 (41.67%)	11 (39.29%)	11 (45.83%)	3 (10.71%)	1 (4.17%)	1 (3.57%)

6[C]	I am not comfortable asking about others' traumatic experiences and hearing the responses	1 (4.17%)	5 (17.86%)	15 (62.50%)	9 (32.14%)	1 (4.17%)	9 (32.14%)	6 (25.00%)	4 (14.29%)	1 (4.17%)	1 (3.57%)
7[C]	I feel comfortable discussing traumatic experiences with my line manager	0 (0.00%)	0 (0.00%)	0 (0.00%)	0 (0.00%)	5 (20.83%)	10 (35.71%)	16 (66.67%)	14 (50.00%)	3 (12.50%)	4 (14.29%)
8[C]	I feel confident supporting service users should they talk about their previous trauma	0 (0.00%)	1 (3.57%)	1 (4.17%)	0 (0.00%)	3 (12.50%)	5 (17.86%)	14 (58.33%)	18 (64.29%)	6 (25.00%)	4 (14.29%)
9[C]	I do not feel confident talking with patients about their coping strategies to deal with the impact of trauma	2 (8.33%)	3 (10.71%)	15 (62.50%)	14 (50.00%)	3 (12.50%)	6 (21.43%)	3 (12.50%)	5 (17.86%)	1 (4.17%)	0 (0.00%)
10[C]	I am confident in my ability to build trusting relationships with service	0 (0.00%)	0 (0.00%)	1 (4.17%)	0 (0.00%)	0 (0.00%)	0 (0.00%)	14 (58.33%)	20 (71.43%)	9 (37.50%)	8 (28.57%)

	users to enable them to feel safe									
11[K]	I cannot recognise which behaviours may be related to people's previous traumatic experiences	1 (4.17%)	2 (7.14%)	15 (62.50%)	7 (25.00%)	7 (29.17%)	13 (46.43%	1 (4.17%)	6 (21.43%)	0 (0.00%)	0 (0.00%)

Note. C = confidence, K = knowledge.

4.3 Post-training

During the data collection period only nine participants completed all four modules of the TIC training, comparison of their pre- and post-training scores using the Wilcoxon Signed Rank test indicated that the pre-training confidence scores (*Mdn* = 21.00, *n* = 9) were statistically significantly less than the post-training confidence scores (*Mdn* = 27.00, *n* = 9), *z* = -2.15, *p* = 0.031, *r* = -0.51; confidence scores increased after training. Similarly, pre-training knowledge scores (*Mdn* = 8.00, *n* = 9) were statistically significantly less than the post-training scores (*Mdn* = 10.00, *n* = 9), z = -2.72, *p* = 0.007, *r* = -0.64. This indicates that knowledge increased after TIC training. Table five details the pre-post scores for each participant.

Table 5

Pre-post scores of the nine participants who completed training.

Pre-training		Post-training	
Knowledge	Confidence	Knowledge	Confidence
7	25	10	26
7	17	10	28
5	13	12	24
9	21	10	27
7	22	8	16
6	19	9	24
8	21	11	27
6	21	10	27
8	20	11	27

Visual analysis of responses to individual questions suggested that the range of post-training scores was highest on questions for three questions, which related to confidence. The reason for these responses in comparison to other participants was unclear.

Table 6

Descriptive statistics for pre-and post-training responses for the nine participants who completed training.

	Question	Pre-training		Post-training	
		Mode	Range	Mode	Range
1[C]	I am confident that I can explain what trauma is	3	2-4	3	3-4
2[K]	I understand the impact that trauma can have in people's lives	3	3-4	3	3-4
3[C]	I am not confident in my understanding of 'vicarious trauma'	3	0 - 3	3	0 - 4
4[C]	I am confident that I can tell when I might be impacted by vicarious trauma	1	1 - 3	3	3 - 4
5[K]	I can spot some of the classic signs and symptoms of vicarious or secondary trauma in my co-workers	1	1 - 3	3	3 - 4
6[C]	I am not comfortable asking about others' traumatic experiences and hearing the responses	3	2 - 3	3	3 - 4
7[C]	I feel comfortable discussing traumatic experiences with my line manager	2	2 - 4	3	3 - 4
8[C]	I feel confident supporting service users should they talk about their previous trauma	3	2 - 4	3	0 - 4
9[C]	I do not feel confident talking with patients about their coping strategies to deal with the impact of trauma	3	1 - 3	3	1 - 4
10[C]	I am confident in my ability to build trusting relationships with service users to enable them to feel safe	3	3 - 4	4	0 - 4
11[K]	I cannot recognise which behaviours may be related to people's previous traumatic experiences	2	1 - 3	3	2 - 4

Note. C = confidence, K = knowledge. 4 = Strongly agree, 3 = Agree, 2 = unsure, 1 = disagree, 0 = strongly disagree. Values were reversed for questions three, six, nine and eleven as these questions were negatively phrased.

4.4 Staff perceptions

Participants described four themes to be important in the provision of TIC: understanding, practical skills, support for staff, personal qualities.

4.4.1 Understanding

Many participants wrote of the importance of understanding SUs by "knowing the service users' past" (2), about their "relationships" (33), and individual factors such as gender and culture. Some participants spoke of the importance of being able to recognise trauma reactions in SUs, as "it may come across as hostile behaviour or something like that" (15). A few wrote that psychological formulations can be helpful, so that they may be more able to "link current behaviours to past trauma and core beliefs" (26).

In relation to future training, participants shared that they would like training to include "theory and models of delivery" (13) of TIC, including what trauma is and understanding power and intersectionality.

4.4.2 Practical skills

Many participants wrote about needing practical skills to provide TIC, such as how to build therapeutic relationships, how "to support someone with trauma" (15), and supporting SUs to practice adaptive coping-strategies. Some participants also highlighted communication skills as a necessary practical skill when providing TIC, primarily to understand what SUs "are trying to communicate when displaying these behaviours [which challenge]" (33). Participants wrote of wishing to develop their skills in understanding "body language […] facial expressions" (40), and emotions.

For future training, participants wrote of valuing opportunities to develop their practical skills during training sessions. For example, by having "more interactive" (27) and practical activities, "examples to aid understanding" (8), which may include recognising trauma reactions in others, learning about adaptive coping-skills and how to support colleagues. Some participants spoke of hoping to have opportunities to engage in formulations, which could be "frequent" (5) and as a "team" (23).

4.4.3 Support for staff

Many staff wrote of the importance of having appropriate resources and support to provide TIC, such as training in TIC, "time" (44) to invest in and practice TIC, safe and "confidential environments" (13) for learning, opportunities for "good quality reflective practice" (23) and "supervision" (53). Participants wrote of wishing for support to develop their provision of

TIC and that this may be achieved by having "mentors" (49), "support from management and other members of the team" (15), "consistency throughout the team, and then between different teams" (23), and staff [and] service commitment to the model" (23). An example of this included "modelling trauma informed practices at all levels of a system" (4). One participant wrote of the importance of being emotionally contained should they become "emotionally over involved" (11) with a SU.

4.4.4 Personal qualities

Participants identified the personal qualities of both staff and service users as being important factors in the implementation of TIC. Some participants spoke of the importance of staff being "empathetic and respectful" (9), "open minded and non-judgemental" (6). Others wrote of staff having confidence, but it was unclear from the responses given whether this related to confidence in their knowledge and application of TIC, or generally. One participant wrote of "staff motivation and confidence" (20) being important but provided no further context. A few staff wrote about the importance of staff being "aware of [their] own past experience" (36) and trauma to provide TIC.

A few participants wrote of SU qualities which would help in the provision of TIC, such as SU being "ready to receive care" (18) and other personal factors. One participant wrote of "including experts by experience" (44).

5. Discussion

5.1 Key findings

It is noteworthy that results relating to the impact of training are in the context of a very small training sample and therefore should be interpreted cautiously.

- Before TIC training, staff had some knowledge of TIC, and staff had some confidence in implementing TIC
- Engaging in TIC training led to higher knowledge
- Engaging in TIC training led to greater confidence in implanting TIC
- Staff perceived the provision of TIC to be largely related to staff qualities, supported by the provision of adequate resource

5.2 Understanding results

The first aim of this SEP was to assess staff's understanding of TIC and confidence in implementing TIC before receiving TIC training. The pre-training data suggested that most

staff had not previously engaged in TIC training. For the pre-training groups A and, the average score for knowledge was 8.33 and 7.04 respectively, out of a possible 12. Results based on a small sample suggested that staff held some knowledge. Many participants described feeling unsure or not confident in recognising the impacts of trauma in SUs and colleagues, and many felt somewhat confident asking SUs traumatic experiences and hearing the responses. As the service is currently implementing a TIC informed pathway, it may be expected that staff have lower knowledge of TIC and lower confidence in implementing this.

Kenny et al. (2017) found that baseline knowledge of TIC was statistically significantly predicted by participants race, level of education and time in their role. Here, more than 80% of participants explicitly identified as White and the average time working in the field was more than 12 years. Kenny et al. (2017) found that White participants scored higher than Black and Hispanic participants on existing TIC knowledge but, the researchers did not explore the reasons for this difference. It may be important to consider how interlocking systems of power have an impact through privilege and oppression (Barker & Iantaffi, 2019) in relation to race and TIC training. Due to the small pre-training sample and the limited representation of participants who identified as being from racialised groups, the author felt that any exploration of race in the SEP would be potentially unhelpful.

The second aim of this SEP was to assess the impact of training on staff's understanding of trauma and confidence in implementing TIC. Following engagement in TIC training, statistically significantly differences in knowledge and confidence. Although results are supported by previous research (Buxton et al., 2022; Goldstein et al., 2018; Kelton et al., 2022; Marsac et al., 2020), findings here are based on a very small sample size, all of whom worked in nursing and identified as White British, meaning that further evaluation is needed. It is unknown why nurses were the only staff group to complete the TIC training, and it would be helpful for future evaluations to consider this. As the sample only contained nurses, it is possible the findings reflect only nurses, their training or another factor not measured.

Table six reported the pre- and post-training responses. In the small sample, it appeared that participants were more confident in their ability to recognise when they may be impacted by vicarious trauma, and more confident in their ability to build therapeutic relationships with SU to help them feel safe. In relation to knowledge, while participants' understanding of trauma on people's lives was stable, participants became more able to spot signs of vicarious

trauma in colleagues and SU behaviours which may relate to previous trauma experiences. Recognising the impacts of trauma in others' is important within forensic services to maintain physical and relational security.

The third aim of this SEP was to explore staff perceptions of what will be helpful to implement TIC in their practice. Of the 52 participants, only 24 provided responses to qualitative questions, most with little elaboration and several participants simply wrote that they were 'unsure'. All nine participants who completed training provided feedback. Therefore, findings should be interpreted cautiously. Four themes were identified: understanding, practical skills, support for staff and personal qualities. These themes fit with previous research which identified some of the barriers to providing TIC to be time constraints, clinicians feeling that they need further training and having inconsistent information (Bruce et al., 2018).

Participants wrote of desiring practical training sessions and a good example of this is simulation based training (Zordan et al., 2022). Staff described communication as important to provide TIC, suggesting that training in communication skills, such as Motivational Interviewing (Miller & Rollnick, 2013) and Socratic questioning techniques, may be helpful. Such training could be provided by the psychology service.

Some participants wrote of the importance of personal qualities in providing TIC which included being "empathetic" (9) and "non-judgmental" (6). Research by Greenwald et al. (2012) suggests that engaging in trauma-informed case formulation increased staffs' compassion towards SUs; existing weekly formulation sessions may support staff in achieving this.

Some participants wrote of their desire to better understand their own trauma to effectively provide TIC. This, together with reference to concerns of being "emotionally over involved" (11) may suggest that training needs to consider interpersonal dynamics that may increase the risk of breaches in relational security or boundary violations.

5.3 Strengths and limitations

While designing this SEP, the impacts of Covid-19 upon training were unclear; three procedures were devised to ensure data collection. These procedures were utilised and led to the pre-training data being gathered from all forensic inpatient staff, providing a tentative baseline of staff's knowledge and confidence in TIC.

This SEP has a small sample. It was hoped that multiple cohorts would complete the TIC training; more participants may have led to normally distributed data, the use of parametric analysis, and analysis exploration of changes to individual questions. The delivery and attendance of training were outside the authors' influence, meaning it was not possible to increase the data set.

The TIC questionnaire was screened by Psychologists but perspectives from other disciplines or SUs would have been valuable. The gender options in the demographic form were limited and did not reflect the diversity of gender; future projects should consider this. During analysis, qualitative data could have been coded by multiple persons, and generated themes compared using a consensus document, to increase the validity and reliability of findings (Wiltshire & Ronkainen, 2021).

This SEP was commissioned with awareness that it would be one aspect of the TIC pathway evaluation, therefore the results should be reinterpreted with other evaluation findings. Changes in staff knowledge and confidence may reflect both the impact of training and wider organisational changes to support the provision of TIC. Organisational measures of TIC consider factors such as general workforce knowledge, workplace culture and relationships within teams, policy and procedures, services (Baker et al., 2016; Bassuk et al., 2017; Chadwick Trauma-Informed Systems Project, 2013; Goodman et al., 2016; Richardson et al., 2012).

5.4 Conclusions

Based on a small sample, this SEP found that forensic inpatient staff had not previously engaged in TIC training but had some existing knowledge of TIC and some confidence in implementing TIC. It is important to acknowledge that findings related to the impacts of training are based on a small number of participants, as only nine participants completed training. When staff engaged in TIC training, their self-reported knowledge and confidence increased. In relation to the provision of TIC, qualitative data provided by 24 participants suggested that they believed staff characteristics and knowledge to be the key factors, and that organisations can support staff by providing access to practical training and protecting time for staff to learn.

5.5 Dissemination

A brief presentation of the findings was delivered by the author at a University of Leeds trainee clinical psychology conference. SEP findings will be presented at a SWYT forensic

psychology business meeting. A copy of the report was also sent to commissioners and senior stakeholders.

6. Recommendations

- To continue to evaluate the effectiveness of TIC training for forensic inpatient staff.
- To consider the use of follow-up questionnaires a set time after completing training. Data could be analysed using a repeated measures ANOVA. If knowledge or confidence decrease in the follow-up period, this may inform how frequently refresher courses may be given to staff to maintain TIC.
- To ensure that future training is as practical, includes real-world examples and practical exercises.
- Participants wrote of the importance of receiving training, having time to learn and to understand SUs. Therefore, future training should be deemed as protected time.
- It would be helpful for future evaluations to consider whether factors such as participants having completed TIC training previously, staff group and participant ethnicity relate to, or influence the impacts of TIC training.

7. References

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8. Appendices

Appendix A

SEP Contract

UNIVERSITY OF LEEDS
Doctor of Clinical Psychology Programme
Service Evaluation Project Contract

UNIVERSITY OF LEEDS

This initial contract is to be completed at a meeting between the trainee and SEP commissioner and outlines expectations and commitments.

Title	Evaluating the Effectiveness of Staff Training in Trauma Informed Care: Confidence in Implementation
Trainee	Stacey Boardman
Commissioner	Dr Emilie Smithson, Clinical Psychologist Psychology Department, Newton Lodge
Field supervisor (if different)	
Agreed aims of project (what will be delivered)	To evaluate the effectiveness of a training programme on trauma-informed care in relation to: staffs' ability to implement trauma-informed ways of working; their confidence in understanding the model; recognising trauma in patients, themselves and others; and, ability to apply learning.
Intended method	Quantitative questionnaire with thematic-analysis informed analysis of free-text responses
Agreed timescale	It is expected that the date of the interim data collection will be 6 months following roll-out – Stacey will have access to a minimum of four groups' data to begin evaluation.
Resources to be provided by commissioners (including amount of field supervision)	Training-facilitators will administer questionnaires to trainees and store these securely. Data entry will be completed by Assistant Psychologists within the service. Field supervision will be provided to discuss ethics applications and design of the SEP. It has been agreed that there will be monthly check-ins by email about the project. Meetings will be arranged as frequently as required as the project progresses. Emilie shared that she is happy to comment on the write-up of the project.

Title	Evaluating the Effectiveness of Staff Training in Trauma Informed Care: Confidence in Implementation		
Publication & presentation plans. (Please provide details)	Stacey will present the findings to the service governance team. It is hoped that the results of this SEP will contribute to a wider service evaluation, with the view to submitting to a peer-reviewed publication.		
Any other comments	The R&D department will be informed about the SEP.		
Date: Signatures	*13.12.2021* *Stacey Boardman* *Trainee*	*13.12.2021* *Department of Psychology* *pp* *Commissioner*	*13.12.2021* *Emilie Smithson* *Field Supervisor*

Please note that final project posters and reports will appear on the Programme website unless requested not to by the trainee or commissioner.

A copy of this contract is to be made available to all signatories.

Appendix B

Demographic survey for pre-training measures by email

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS NHS South West Yorkshire Partnership NHS Foundation Trust

Demographic Survey: Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

Please take a moment to answer this demographic survey by selecting the relevant response.

Self-identified gender:

Female	
Male	
Non-binary	
Prefer not to disclose	

Age: _____

Ethnicity: _____

Staff group:

Domestic		Nursing		Secretarial/Administrative	
Management		Occupational Therapy		Social Work	
Medical		Psychology		Other therapy (please indicate):	_____

Time in job role: Years _____ Months _____

Time in field: Years _____ Months _____

Have you previously received trained in Trauma Informed Care:

Yes No Not sure

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Appendix C

Demographic survey for training

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS NHS South West Yorkshire Partnership NHS Foundation Trust

Demographic Survey: Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

To preserve your anonymity, please generate your own six-digit unique ID. The ID should be memorable to you. Please string together: the month of your birth (two digits), the last two letters of your surname and the first two digits of your phone number.

_ _ _ _ _ _

Please take a moment to answer this demographic survey by selecting the relevant response.

Self-identified gender:

Female	
Male	
Non-binary	
Prefer not to disclose	

Age: _____

Ethnicity: _____

Staff group:

Domestic		Nursing		Secretarial/Administrative	
Management		Occupational Therapy		Social Work	
Medical		Psychology		Other therapy (please indicate):	_____

Time in job role: Years _____ Months _____

Time in field: Years _____ Months _____

Have you previously received trained in Trauma Informed Care:

Yes No Not sure

Version 1.0 26.01.2022

Appendix D

TIC questionnaire for pre-training by email

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS

NHS South West Yorkshire Partnership NHS Foundation Trust

Questionnaire: Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

Please tick your response

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
I am confident that I can explain what trauma is					
I understand the impact that trauma can have in people's lives					
I am not confident in my understanding of 'vicarious trauma'					
I am confident that I can tell when I might be impacted by vicarious trauma					
I can spot some of the classic signs and symptoms of vicarious or secondary trauma in my co-workers					
I am not comfortable asking about others' traumatic experiences and hearing the responses					
I feel comfortable discussing traumatic experiences with my line manager					
I feel confident supporting service users should they talk about their previous trauma					
I do not feel confident talking with patients about their coping strategies to deal with the impact of trauma					
I am confident in my ability to build trusting relationships with service users to enable them to feel safe					
I cannot recognise which behaviours may be related to people's previous traumatic experiences					

What factors do you think contribute to delivering trauma-informed care?

_____

_____

_____

_____

PLEASE TURN OVER

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Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS

NHS South West Yorkshire Partnership

Is there anything you think might help in delivering trauma-informed care? If so, please elaborate:

_____

_____

_____

_____

What do you think should be included in future trauma informed care training?

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire

Version 1.0 26.01.2022

Appendix E

TIC questionnaire for pre-training

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS NHS South West Yorkshire Partnership NHS Foundation Trust

Questionnaire: Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

Please tick your response

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
I am confident that I can explain what trauma is					
I understand the impact that trauma can have in people's lives					
I am not confident in my understanding of 'vicarious trauma'					
I am confident that I can tell when I might be impacted by vicarious trauma					
I can spot some of the classic signs and symptoms of vicarious or secondary trauma in my co-workers					
I am not comfortable asking about others' traumatic experiences and hearing the responses					
I feel comfortable discussing traumatic experiences with my line manager					
I feel confident supporting service users should they talk about their previous trauma					
I do not feel confident talking with patients about their coping strategies to deal with the impact of trauma					
I am confident in my ability to build trusting relationships with service users to enable them to feel safe					
I cannot recognise which behaviours may be related to people's previous traumatic experiences					

What factors do you think contribute to delivering trauma-informed care?

_____

_____

_____

_____

PLEASE TURN OVER

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Programme of Clinical Psychology, School of Medicine

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NHS South West Yorkshire Partnership NHS Foundation Trust

Is there anything you think might help in delivering trauma-informed care? If so, please elaborate:

_____

_____

_____

_____

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Appendix F

TIC questionnaire for post-training

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS NHS South West Yorkshire Partnership NHS Foundation Trust

Questionnaire: Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

Please provide the six-digit unique ID you created at the start of training. This was a strong of: the month of your birth (two digits), the last two letters of your surname and the first two digits of your phone number.

_ _ _ _ _ _

Please tick your response

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
I am confident that I can explain what trauma is					
I understand the impact that trauma can have in people's lives					
I am not confident in my understanding of 'vicarious trauma'					
I am confident that I can tell when I might be impacted by vicarious trauma					
I can spot some of the classic signs and symptoms of vicarious or secondary trauma in my co-workers					
I am not comfortable asking about others' traumatic experiences and hearing the responses					
I feel comfortable discussing traumatic experiences with my line manager					
I feel confident supporting service users should they talk about their previous trauma					
I do not feel confident talking with patients about their coping strategies to deal with the impact of trauma					
I am confident in my ability to build trusting relationships with service users to enable them to feel safe					
I cannot recognise which behaviours may be related to people's previous traumatic experiences					

PLEASE TURN OVER

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Programme of Clinical Psychology, School of Medicine

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NHS South West Yorkshire Partnership

What factors do you think contribute to delivering trauma-informed care?

Thinking about the training you have attended, how might you understand presentations on the ward (particularly with people who you might find challenging to work with):

Is there anything you think might help in delivering trauma-informed care? If so, please elaborate:

Thank you for taking the time to complete this questionnaire

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Appendix G

Email to prospective participants

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS

NHS South West Yorkshire Partnership NHS Foundation Trust

Message subject heading: HAVE YOUR SAY

"Dear colleague,

As you will already be aware, the psychology department are in the process of developing a Trauma Informed Care workshop, and we are keen to listen to all staff who will be participating so that we can ensure that you can get the most from the training.

An important part of this is finding out from you how familiar you are with this way of working and your confidence in using this way of working in your setting.

We are lucky enough to have Stacey Boardman, who is currently completing a doctorate in Clinical Psychology, working with us in evaluating the project, and as such we have been able to put an online questionnaire together to capture your views.

If you follow the link https://leeds.onlinesurveys.ac.uk/trauma-informed-care , you will be taken to a webpage with all the information about how your responses will be used, and if you choose to continue, will complete a short survey (no longer than ten minutes). This questionnaire will remain open until **Friday 29th July**.

If you have any questions about this, you can speak to Stacey Boardman on ps10s2b@leeds.ac.uk or myself on louise.brittleton@swyt.nhs.uk, or just catch me on the ward!

Thank you for your time,

Louise and Stacey"

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Appendix H

Reminder email to prospective participants

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS

NHS South West Yorkshire Partnership NHS Foundation Trust

Message subject heading: "HAVE YOUR SAY – LIMITED TIME LEFT"

"Dear colleague,

Thank you to everyone who has completed the online questionnaire relating to Trauma Informed Care Training! We have received many responses and would like to extend the invitation to participate to those who have not yet had an opportunity to do so.

As you will already be aware, the psychology department are in the process of developing a Trauma Informed Care workshop, and we are keen to listen to all staff who will be participating so that we can ensure that you can get the most from the training.

An important part of this is finding out from you how familiar you are with this way of working and your confidence in using this way of working in your setting.

We are lucky enough to have Stacey Boardman, who is currently completing a doctorate in Clinical Psychology, working with us in evaluating the project, and as such we have been able to put an online questionnaire together to capture your views.

If you follow the link https://leeds.onlinesurveys.ac.uk/trauma-informed-care , you will be taken to a webpage with all the information about how your responses will be used, and if you choose to continue, will complete a short survey (no longer than ten minutes). This questionnaire will remain open until **Friday 29th July**.

If you have any questions about this, you can speak to Stacey Boardman on ps10s2b@leeds.ac.uk or myself on louise.brittleton@swyt.nhs.uk , or just catch me on the ward!

Thank you for your time,

Louise and Stacey"

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Appendix I

Pre-training by email participant information sheet

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS

NHS South West Yorkshire Partnership NHS Foundation Trust

Participant Information Sheet: Evaluating the Staff Understanding of Trauma Informed Care in Forensic Services

You are being invited to take part in a service evaluation project. Please take time to read the following information carefully. If you have any questions or would like more information please contact the research team using the details below.

Purpose of the project
We would like to explore staffs' current understanding of trauma, and confidence in practising trauma-informed care. It is hoped that this service evaluation will help to inform future training.

Who is organising this project?
This service evaluation is organised by researchers at the University of Leeds and healthcare professionals at the South West Yorkshire NHS Foundation Trust (SWYT). The project is being conducted as part of a doctorate in clinical psychology.

The project has been approved by Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC 21-009) on 1st March 2022.

Do I have to take part?
No. Participation in this service evaluation is entirely voluntary. If you do not wish to take part your employment will not be affected in any way.

What will happen to me if I decide to take part?
If you decide to take part, you will be asked to complete a brief online demographic survey and questionnaire; together these will take around 5 minutes. The questionnaire will ask about your understanding of trauma and confidence in implementing trauma informed care.

What will happen if I no longer wish to take part?
Participants can withdraw at any time without giving a reason. However, any data already provided will be retained due to the anonymity of responses.

What are the possible risks and benefits of taking part?
Taking part in the project may provide an opportunity to reflect on your understanding of, and confidence in using, trauma informed care. There are no serious risks to taking part. Your responses will be confidential and will have no impact on your employment or training. If you feel you need support following your involvement in the service evaluation, you can speak with your manager.

What will happen with the results of the project?
Data gathered from this project will be analysed and a report will be written; this report will form part of an assessment for a doctorate in Clinical Psychology. If quotations from questionnaire responses are used, any identifying information will be removed to preserve anonymity. The report will be used within SWYT (e.g. at departmental and

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service level meetings) to inform service development. Parts of the project may be published in peer-reviewed publications or at research conferences. Updates will be available on the SWYT intranet and may be shared in team meetings.

How will the data be stored?
Information gathered from the demographic survey and the questionnaire will be stored securely on SWYT trust networks. Once the service evaluation is complete, anonymised study data will be kept for two years on SWYT networks and may be used to support other service evaluations. Anonymised data will be kept on University of Leeds Networks until project completion, which is anticipated to be in November 2022. The University guidelines on the use of personal data will be adhered to. More information on the University guidelines can be found here:
https://dataprotection.leeds.ac.uk/research-participant-privacy-notice

You can find out more about how we use your information

- by emailing Stacey Boardman, the principal investigator (ps10s2b@leeds.ac.uk)

How do I take part?
By completing the questionnaire on the next page, you are consenting to participate in the service evaluation. This means that you have read and understand the information presented above. By continuing, you agree that you have had the opportunity to ask questions and understand that your participation is voluntary and will have no impact on the training or your employment.

Contact details:

Stacey Boardman, Psychologist in Clinical Training, The University of Leeds.

ps10s2b@leeds.ac.uk

This project is held together with Louise Brittleton, Assistant Psychologist.

louise.brittleton@swyt.nhs.uk

Complaints and independent advice

If you would like to make a complaint about how your data is managed you should contact the lead researcher, Stacey Boardman.

If you feel this has not resolved the issue you can contact the Data Protection Officer on dpo@leeds.ac.uk

If you are not happy with the response from the Data Protection Officer, or believe that your data is being processed in an unlawful or incorrect way, you can complain to the Information Commissioner's Office (ICO) at:
www.ico.org.uk or call them on 0303 123 1113

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Appendix J

Training participant information sheet

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS

NHS South West Yorkshire Partnership NHS Foundation Trust

Participant Information Sheet: Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

You are being invited to take part in a service evaluation project as you are about to complete training in trauma informed care. Please take time to read the following information carefully. If you have any questions or would like more information, the training facilitators are available to talk to.

Purpose of the project
We would like to explore what impact this training has for staff in relation to their understanding of trauma, and confidence in practising trauma-informed care.

Who is organising this project?
This service evaluation is organised by researchers at the University of Leeds and healthcare professionals at the South West Yorkshire NHS Foundation Trust (SWYT). The project is being conducted as part of a doctorate in clinical psychology.

The project has been approved by Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC 21-009) on 1st March 2022.

Do I have to take part?
No. Participation in this service evaluation is entirely voluntary. If you do not wish to take part, your training and employment will not be affected in any way.

What will happen to me if I decide to take part?
If you decide to take part, you will be asked to complete a brief demographic survey and questionnaire before the training starts; together these will take around 5 minutes. The questionnaire will ask about your understanding of trauma and confidence in implementing trauma informed care. You will be asked to complete this questionnaire again when the training is complete.

What will happen if I no longer wish to take part?
Participants can withdraw at any time without giving a reason. However, any data already provided will be retained due to the anonymity of responses.

What are the possible risks and benefits of taking part?
Taking part in the project may provide an opportunity to reflect on your experience of the training. It is hoped that this service evaluation will help to inform future training. There are no serious risks to taking part. Your responses will be confidential and will have no impact on your employment or training. If you feel you need support following your involvement in the service evaluation, you can speak with a training facilitator or your manager.

What will happen with the results of the project?
Data gathered from this project will be analysed and a report will be written; this report will form part of an assessment for a doctorate in Clinical Psychology. If quotations

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from questionnaire responses are used, any identifying information will be removed to preserve anonymity. The report will be used within SWYT (e.g. at departmental and service level meetings) to inform service development. Parts of the project may be published in peer-reviewed publications or at research conferences. Updates will be available on the SWYT intranet and may be shared in team meetings.

How will the data be stored?
Information gathered from the demographic survey and the questionnaire will be stored securely on SWYT premises, in a locked cabinet and on SWYT trust networks. Once the service evaluation is complete, anonymised study data will be kept for two years on SWYT networks and may be used to support other service evaluations. Anonymised data will be kept on University of Leeds Networks until project completion, which is anticipated to be in November 2022. The University guidelines on the use of personal data will be adhered to. More information on the University guidelines can be found here:
https://dataprotection.leeds.ac.uk/research-participant-privacy-notice

You can find out more about how we use your information
- by asking one of the training facilitators
- by emailing Stacey Boardman, the principal investigator (ps10s2b@leeds.ac.uk)

How do I take part?
To participate in this project, you should complete the consent form provided by the training facilitators. You can keep a copy of the information sheet for future reference.

Contact details:

Stacey Boardman, Psychologist in Clinical Training, The University of Leeds.

ps10s2b@leeds.ac.uk

This project is supervised by Dr Emilie Smithson, Clinical Psychologist.

emilie.smithson@swyt.nhs.uk

Complaints and independent advice

If you would like to make a complaint about how your data is managed you should contact the lead researcher, Stacey Boardman.

If you feel this has not resolved the issue you can contact the Data Protection Officer on dpo@leeds.ac.uk

If you are not happy with the response from the Data Protection Officer, or believe that your data is being processed in an unlawful or incorrect way, you can complain to the Information Commissioner's Office (ICO) at:
www.ico.org.uk or call them on 0303 123 1113

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Appendix K

Training consent form

Programme of Clinical Psychology, School of Medicine

UNIVERSITY OF LEEDS

NHS South West Yorkshire Partnership NHS Foundation Trust

Consent to take part in: Evaluating the Effectiveness of Staff Training in Trauma Informed Care in Forensic Services

		Please add your initials next to the statement if you agree
1.1	I confirm that I have read and understand the information sheet dated 25.02.2022 explaining the above service evaluation project and I have had the opportunity to ask questions.	
1.2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and that my employment and training will not be affected.	
1.3	I understand that if I withdraw from the study, any data collected up to the point of withdrawal will be used.	
1.4	I understand that members of the research team may have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the service evaluation.	
1.5	I understand that my responses will be kept strictly confidential. I understand that my confidentiality will only be breached if the researcher during the study has reason to believe that I am at risk of harming myself or others, and this may involve a member of the research team contacting me.	
1.6	I agree that the information collected about me may be used to support other research in the future but that I will not be directly identified. Anonymous data may be shared with other researchers.	
1.7	I agree to take part in the service evaluation.	

Name of participant	
Participant's signature	
Date	
Name of person taking consent	
Signature	
Date*	

*To be signed and dated in the presence of the participant.