ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Professor Neal Cook
Date: 08 April 2024

I, Neal Cook, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of Ulster University, School of Nursing and Paramedic Science in response to a request for evidence by the Inquiry Panel. This statement has been prepared in partnership with Professor Owen Barr as the lead for Learning Disabilities in the School.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be “Exhibit 1”.

Qualifications and positions

1. I am a qualified adult nurse (1999) and higher education academic. I hold a degree in Nursing (BSc Hons Nursing, 1999). I hold a master’s degree in advanced nursing (MSc Advanced Nursing, 2002). I hold a Post Graduate Diploma in Nurse Education (2005), I have a Post Graduate Certificate in Specialist Practice (2001), I have a Diploma in Aromatherapy (2006). I hold a PhD (Doctor of Philosophy, 2017). I am a Principal Fellow of the Higher Education Academy (2019).

2. I have held the following positions. From 1999 to 2001 I was a Staff Nurse in the Royal Group of Hospitals. From 2002 to 2014, I was a Lecturer in Nursing at Ulster University. From 2014 to 2021 I was a Reader at Ulster University. From 2021 to

present, I am a Professor of Nursing. From 2008 to 2013 I was the Academic Lead for Practice Learning at Ulster University. From 2017 to 2022 I was the Associate Head of School for the School of Nursing and Paramedic Science at Ulster University and since 2022 I have been Head of School at Ulster University. I have also worked as a Nursing Consultant for Carmoney Care from 2006 to present.

Module

3. I have been asked to provide a statement for the purpose of M2: Professional Education.

4. My evidence relates to paragraphs 9 and 17 of the Inquiry's Terms of Reference.

5. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn.

Q1. What is the structure for Registered Nurses in Learning Disability to access post-registration education?

6. The commissioning of nursing education programmes from Ulster University by the Health and Social Care Trusts is through the Education Commissioning Group. The model places the Health and Social Care Trusts in collaboration with the Department of Health as commissioners of education and the universities as providers of education.

7. This is a four-phase process (See Figure 1 below) working from a learning needs analysis completed by staff in the Health and Social Care Trusts (Phase 1), through to the enrolment of students on the university programme (Phase 4). In Phase 1, if the learning needs analysis undertaken in the Health and Social Care Trusts identifies the needs for new education provision a proforma is completed and

shared with the universities. Following the sharing of this, universities may develop proposals to meet the identified learning need.

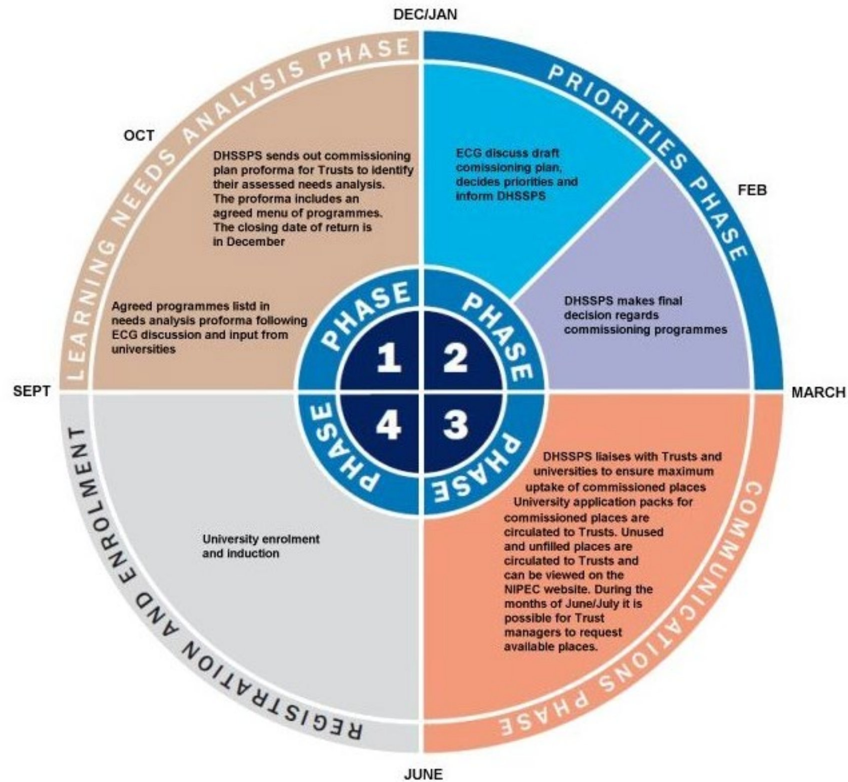


Figure 1: Education Commissioning process

8. Representatives from the university and the Department of Health meet at Agreement Monitoring meetings to review the strategic arrangements in place for the commissioning of and delivery of commissioned programmes.

Q2. Describe the post-registration courses available that are specific to Registered Nurses in Learning Disability.

9. Ulster University School of Nursing and Paramedic Science has a combination of standalone modules and Nursing and Midwifery Council approved specialist nursing practice programmes specific to caring for people with learning disabilities that are available. These modules and programmes can be commissioned by the

Health and Social Care Trusts, via the Department of Health in line with the Education Commissioning Process outlined in Figure 1 above. Current available programmes are:

(i) Principles of assessing people with learning disabilities and mental health problems (standalone module)

10. This module is available at both Level 6 (Final year Undergraduate) and Level 7 (Postgraduate) and is worth 20 academic credits. The aim and learning outcomes of this module are as follows:

Aim:

- The overall aim of this module is to provide the student with the critical knowledge and skills to work under supervision, appraise evaluate the assessment/screening of an individual with a learning disability and a mental health problem.

Learning outcomes:

- Critically evaluate the factors that predispose, precipitate and maintain mental health problems in people with learning disabilities.
- Develop a critical knowledge of the co-morbidity, including the typical and atypical symptoms, often displayed by this population.
- Appraise and justify a detailed knowledge base of the different assessment instruments available to screen this population.
- Critically discuss and reflect upon the benefits of using a bio-psycho-social model to assess mental health problems in people with learning disabilities.

11. Between 2012 and 2023 this module was commissioned on three occasions (2012, 2014 and 2021) for 7, 12 and 8 students respectively. This module was not commissioned between 2015 and 2021).

(ii) Specialist nursing practice qualification
– community nursing learning disabilities
– learning disability (until September 2023)

12. This is a Nursing and Midwifery Council recognised specialist nursing practice programme which had pathways, one focused on supporting people with learning disabilities in the community and one which was available to nurses from inpatient settings. These courses were available for delivery as one-year full time programmes or a two-year part time programme.

13. Students undertaking this programme undertake two of the four modules, with other nurses undertaking the specialist practice programmes in other areas of nursing and undertaking two modules specific to supporting people with learning disabilities in a smaller group of RNLDs. The core modules relate to Evidence based practice and Leadership.

14. The aims and learning outcomes of the two-learning disability nursing specific modules at post graduate level are provided below:

(iii) Demonstrating impact in nursing care for learning disability

15. Aims:
    - To enable students to critically analyse the knowledge and skills necessary to deliver specialist nursing care to people with learning disabilities, their families and other carers as competent nurse specialists in a range of community and hospital-based settings through the exercise of higher levels of decision-making and clinical care.
    - To apply acquired knowledge and skills as competent nurse specialists in a range of community-based settings through the exercise of higher levels of decision-making and clinical care.

16. Learning outcomes:

Successful students will be able to:

- Evaluate the theoretical basis of interventions deployed within specialist learning disability nursing services and differentiate between the appropriate strategies from a range of alternatives to meet specified health related needs.
- Critically review ways in which CNLDs / SNLD may provide specialist advice and practical assistance on the clinical nursing care and interventions for individuals in relation acute and continuing care for specific conditions.
- Critically analyse the application of sociological and psychological principles that underpin specialist nursing learning disability practice in community and hospital settings to assist the development of specific individuals and groups of people.
- Integrate the theoretical underpinnings of specialist nursing for people with learning disability with sensitive, caring and evidence-based nursing practice.
- Critically evaluate the available information on the changing patterns of demography, morbidity, and mortality patterns across physical, psychological and social domains of people with learning disabilities, their families and other carers.
- Assess, plan, implement and evaluate specialist clinical nursing care to meet care needs for this client group, their families, and carers in order to develop the individual’s personal capacities and their overall health.
- Formulate specialist nursing care plans based on accurate nursing assessment, available evidence within agreed local, regional, national nursing and interprofessional protocols.
- Support and empower people with learning disabilities, their families, and other carers to participate in and influence decisions concerning their care by the provision of information in an accessible format on a range of specialist nursing care issues and services.
- Deliver coordinated and person-centred nursing care for people with learning disabilities and act as a source of specialist help on learning disability nursing practice to families, other carers and members of the interdisciplinary and primary health care teams while respecting their contributions to care.

- Demonstrate enhanced communication skills required for partnership with colleagues and clients alike, as well as with independent support organisations.
- Demonstrate group facilitation skills and the ability to work effectively in a team.
- Demonstrate confidence in the use of critically thinking in nursing and decision-making.

(iv) Module 2: Delivering new perspectives in Specialist Learning Disability Practice

17. Aim

- The aim of this module is to prepare students to develop critical thinking skills in order that they can competently practice as a specialist nurses learning disability recognising the range of factors that will impact on and direct the decision-making process in relation to clinical practice and service delivery.
- Students will acquire knowledge and clinical / academic skills necessary to provide leadership to staff within their sphere of authority and to make necessary referral to appropriate managers when necessary to promote safe standards of care.
- Students will critically apply theory to practice and respond competently to changes occurring in their personal practice as well as the wider organisation and delivery of specialist nursing services for children and adults with learning disabilities.

18. Learning outcomes

- Articulate a critical understanding of the principles of leadership and demonstrate skills in their implementation, especially in relation to person-centred care.

- Demonstrate a critical understanding of the health and social care commissioning, policymaking and change management processes and the opportunities to influence these.
- Differentiate between the professional, political, legal and ethical factors affecting care, respond proactively, where appropriate, through initiation and promotion of change, within the professional domain and expressed client need.
- Critically analyse current methods of teamwork and service response (within a mixed economy of care) to meet the changing abilities and needs of people with learning disabilities.
- Through the critical analysis of current and proposed social policy and legislation actively contribute to the development of health and social care policies in relation to people with learning disabilities at local and national levels.
- Undertake a key role in the leadership and management of care, identifying and selecting from a range of interdisciplinary and interagency health and social care agencies, those that will assist and improve the care of individuals and groups.
- Initiate strategies to maximise the potential for independent living and minimise the effects of disabilities amongst people with learning disabilities living in the community.
- Implement standards developed in collaboration with children and adults with learning disabilities, their families and other carers in order to maintain high quality evidence-based service delivery.
- Critically analyse factors affecting safe and effective nursing care and the management of clinical emergencies and critical events for people with learning disabilities and their families / carers that promotes and maintains their health and use this analysis to prioritise workload and appropriate referral.
- Demonstrate a commitment to the evolving role of the community nurse as a specialist nursing practitioner that displays a reflective approach to practice and keeps abreast of current developments in the care of people with learning disabilities.

- Demonstrate enhanced communication and decision-making skills required for partnership, negotiation, conflict resolution and autonomous practice with nursing and interdisciplinary / interagency colleagues and clients alike.
- Demonstrate problem solving techniques and information technology to assist the delivery and development of specialist nursing practice.
- Demonstrate group facilitation skills and the ability to work effectively in a team.

(v) Practice-based learning

19. All students undertook 75 days practice-based learning, students undertaking the community nursing pathway completed their practice-based learning in community nursing – learning disability teams. Students undertaking the Specialist practice – learning disability pathway largely completed their practice-based learning within inpatient facilities for people with learning disabilities in Northern Ireland.

20. During their practice-based learning students were required to apply their theoretical learning to their intended area of practice, for example, community nursing (including working with people with learning disabilities with mental health problems, working with people with learning disabilities with behaviours that challenge) or in-patient settings (including working with people with learning disabilities with mental health problems, working with people with learning disabilities with behaviours that challenge).

21. The evidence of their learning is compiled in a Practice Assessment Document, and this is assessed by a Practice Assessor who is a RNLD and holds a specialist practice nursing qualification or equivalent. Students who successfully complete this programme are awarded a BSc Hons or Postgraduate Diploma from Ulster University and are eligible to record the Specialist Nursing Practice qualification (CNLD or SPLD) with the Nursing and Midwifery Council.

22. The Nursing and Midwifery Council regulations for Specialist Practice Nursing changed in May 2022 and from September 2024. The Nursing and Midwifery Council will only record Specialist practice nursing qualifications in six areas of community nursing, one of these is Community Nursing Learning Disability. Ulster University has written a new programme, which also incorporates a registered qualification in Independent and Supplementary prescribing. This new programme was approved by the Nursing and Midwifery Council with no conditions on the 19 January 2024. This new programme will commence in September 2024.

23. In addition to the RNLD specific programmes outlined above, most of the post registration nursing programmes, including MSc programmes within the School of Nursing and Paramedics Science are available to RNLDs through the education commissioning process or self-funding routes.

24. Between 2012 and 2023 this programme was commissioned on four occasions (2013, 2016, 2020 and 2022) for 10, 13, 11 and 9 students respectively. This programme was last commissioned as a full-time programme in 2016 and has been commissioned as a part time programme since then.

Q3. Are there specialist programmes for Registered Nurses in Learning Disability relating to the management of distressed and challenging behaviours? If so, please provide details.

25. There are two opportunities for RNLDs to undertake programmes that include content in this area. These are the standalone module on Principles of assessing people with learning disabilities and mental health problems and the Specialist practice Nursing – community nursing learning disability programme. Students undertaking the new Specialist practice nursing: Community Learning Disability programme (with integrated Independent and Supplementary prescribing) from September 2024 will continue to have the opportunity to develop knowledge and skills in working with people with learning disabilities who were distressed and present behaviours that challenge services within their role as a community nurse.

26. The previous Specialist practice nursing – Learning Disability enabled RNLDs to undertake a programme within which it would have been possible to develop knowledge, skills and expertise in working with people with learning disabilities who were distressed and presented behaviours that challenge services. This specialist practice programme was not revalidated in January 2024 as it was not requested by the Health and Social Care Trusts in Northern Ireland.

27. Between 2004 and 2007 Ulster University provided a three-module short course and a two-year (six module and 75 days practice-based learning) part time Nursing and Midwifery Council specialist practice nursing programme, specifically focusing on supporting people with learning disabilities who had mental illness or presented behaviours that challenged services. This was written at the request of the Health and Social Care Trusts through the Education Commissioning programme process in 2003-2004. This was available for commissioning between 2004 and 2009 by Ulster University. The short course and specialist practice programme was available to the Health and Social Care Trusts to commission and over the years it was available it was commissioned on two occasions for a total of nine RNLDs (2004 and 2008). When the programmes were being revalidated these pathways were not included as they were not being commissioned by the Health and Social Care Trusts.

Q4. Does the University of Ulster provide a nursing research programme with studies including regarding inpatient learning disability settings? If so, please provide details.

28. Ulster University has a very active research programme across all the faculties within the university. The Institute of Nursing and Health Research is one of the key research centres and has received international recognition for its work. There are three centres within the Institute for Nursing and Health Research, one of which is the Centre for caring for people with complex needs. There are six key themes

of research within the Centre for caring for people with complex needs, one of which is the theme of Neurodevelopmental and Intellectual Disabilities[1].

29. The research undertaken within the theme is interdisciplinary and focuses on health, social isolation, communication, and behaviours that challenge through five cross cutting areas of research:
    - Understanding the health determinants of children, adults, and older adults with intellectual and developmental disabilities.
    - Promoting health access, and diminishing health and social disparities, experienced by people with intellectual and developmental disabilities.
    - Understanding behaviours that challenge within the context they occur and supporting families and communities to respond effectively.
    - Development and testing of multi-component interventions for children and adults with intellectual and developmental disabilities.
    - Using 'big data' from different sources to identify improvement to the health and social care of this population across its lifespan.

30. Three current projects are focused on services for people with learning disabilities and additional needs due to mental health difficulties or behaviours that challenge. These projects are:

    a. The Intensive Support Teams – Intellectual Disabilities (IST-ID) study, led by Professor Angela Hassiotis, University College London aims to evaluate the clinical and cost-effectiveness of intensive support teams for adults with intellectual disabilities and challenging behaviour. It is funded by the NIHR. Dr Taggart (Ulster University) is a co-Principal Investigator on this project.

    b. The Personalised treatment packages for adults with learning disabilities who display aggression in community settings (PERTA-LD) project, funded by the NIHR and led by Professor Angela Hassiotis, University College London, aims to develop and test in a randomised controlled trial, a personalised treatment

[1] Neurodevelopmental and Intellectual Disabilities (ulster.ac.uk)

package for aggression for adults with learning disability. Dr Taggart (Ulster University) is a co-Principal Investigator on this project.

c. Trauma informed care for adults with intellectual disability. This was a PhD successfully undertaken by Dr Paddy McNally and led to the publication of a document entitled ‘A framework for the implementation of trauma informed care in residential services for adults with a learning disability’. This document can be found at Exhibit 1 (accessed 29 February 2024).

31. None of the current projects being undertaken in the Institute of Nursing and Health Research are focused on inpatient learning disability settings. Previous research has been undertaken relating to inpatient settings for people with learning disabilities and these include projects undertaken by Emeritus Professor of Developmental Disabilities, Roy McConkey (retired), Dr Eamon Slevin, Reader, (retired from Ulster University) and Professor Laurence Taggart. The outputs of these projects have been published in the international literature.

Q5. Was there any system to ensure post-registration students could raise concerns about placements?

32. Yes, there are agreed processes in place and these processes mirror the expectations of the Nursing and Midwifery Council. Flow charts outlining these processes are detailed in Appendices 1, 2, and 3 of the students’ the Practice Learning Handbook for Community Nursing Specialist Practice Students and those Supporting and Assessing them in Practice. These diagrams have been provided in Exhibits 2-4 of this statement.

Q6. Did post-registration students raise concerns about the delivery of care at MAH? If they did, please provide details.

33. No concerns raised.

Q7. If concerns were raised, what action was taken, if any?

34. No concerns raised.

Q8. If the answer to question 6 is in the negative, when and how did the School of Nursing first hear about concerns at MAH?

35. Professor Owen Barr became aware that concerns had been expressed about the quality of care at Muckamore Abbey Hospital in early December 2017. On the 08 December 2017, following an approach from Brenda Creaney, Executive Director of Nursing, Belfast Health and Social Care Trust, it was agreed by Professor Sonja McIlfatrick (Head of School or Nursing) that Professor Barr could become a member of an Independent Assurance Team. The other members of this team were Yvonne McKnight, BHSCT and Frances Cannon, Northern Ireland Practice Education Council.

36. The agreed objectives for this work were:
    - To provide a level of independence and transparency in relation to key decision-making processes.
    - To provide an independent view on specific key decisions that have been made to date in relation to staff moved to other facilities, precautionary suspensions or restricted duties of staff involved in identified incidents.
    - To offer advice and support to lead Director(s) and where appropriate to constructively challenge and/or make recommendations.
    - To support the Co-Director in terms of service improvement and modernisation.

37. A final report was provided to Brenda Creaney, Executive Director of Nursing, on the 25 September 2018.

Q9. What action was taken, if any?

38. It was confirmed that we had no pre-registration or post-registration nursing students from Ulster University undertaking or scheduled to undertake practice-based learning at Muckamore Abbey Hospital.

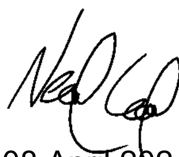
Q10. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of paragraphs 9 and 17 of the Terms of Reference?

39. Staff in the School of Nursing and Paramedic Science remain committed to developing nursing and wider services for people with learning disabilities across all settings in which they are supported through the development of teaching and research. We will continue to be responsive to the needs identified within by the Health and Social Care Trusts and the Department of Health in relation to education, research and policy development.

40. Staff from within the school have been actively engaged in supporting the development of the new Service Model for people with learning disabilities. Professor Owen Barr has also had a key role in the development of a report for the Chief Nursing Officer on the future role of RNLDs. This wide-ranging report is due to be completed in April 2024.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 08 April 2024

List of Exhibits (Neal Cook)

Exhibit 1: A framework for the implementation of trauma informed care in residential services for adults with a learning disability.

Exhibit 2: Raising and Escalating Concerns Protocol

Exhibit 3: Protocol for Bullying and Harassment

Exhibit 4: School Fitness to Practice Identification

Exhibit 1
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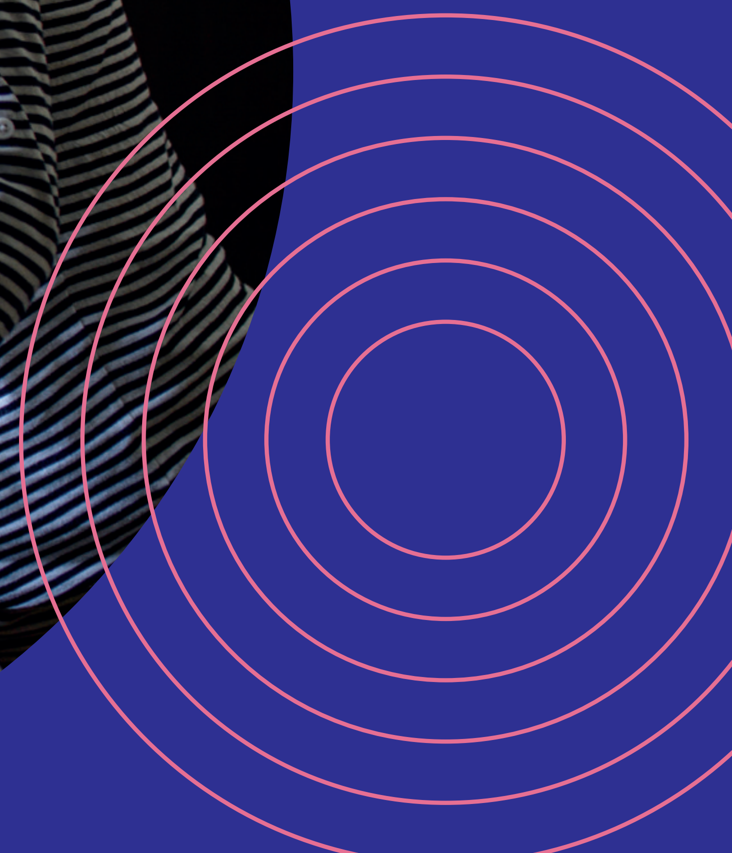


A Framework for the Implementation of

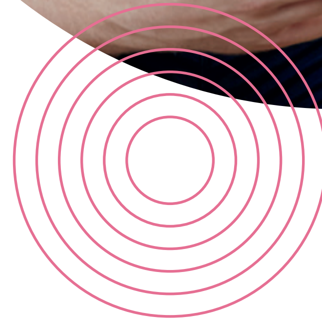
TRAUMA INFORMED CARE

in Residential and Supported Living Services for Adults with a Learning Disability

October 2022

Acknowledgements

This framework has been prepared by Dr Paddy McNally, Consultant Clinical Psychologist and PhD researcher at Ulster University (Supervisors: Professor Laurence Taggart & Professor Mark Shevlin), in co-production with residents, staff, managers and specialist practitioners across the Northern Health and Social Care Trust, South Eastern Health and Social Care Trust, Belfast Health and Social Care Trust, Praxis Care and Positive Futures, and in line with the current evidence - base.



Terminology

Learning disability The term learning disability is used for the local context across the UK, but it is recognised that intellectual disability is more typically used internationally.

Trauma informed Being trauma informed means that you are aware of the widespread impact of trauma, recognise the signs and symptoms and understand the path to recovery.

Trauma responsive Being trauma responsive means that your organisation develops their service based on being trauma informed. It ensures that practice within the organisation seeks to embody the principles of trauma informed care and promote recovery from trauma.

Trauma lens Considering practice through a trauma lens means being sensitive to the impact of trauma on residents, staff and your organisation. For example, think about the impact that the introduction of a new staff member has on both the staff and resident experience, while balancing the organisational ethos with service demands.

Re-traumatising The term re-traumatising refers to an individual's re-experiencing of a traumatic event that has occurred in their life.

Vicarious trauma Vicarious trauma can result from the experience of being exposed to difficult or disturbing stories of some-one else's trauma.

Who is the Target Audience for this Framework?

The framework has been produced to guide organisations providing residential or supported living accommodation to adults with a learning disability who may have been impacted by a trauma history. Whilst it can be difficult to assess the impact of trauma for many people with a learning disability, particularly those with a more severe/profound learning disability (Kildahl et al., 2020), it is important to recognise the possibility of the impact of psychological trauma. Providing care practices that are trauma informed, person-centred and growth promoting are less likely to be re-traumatizing for those already exposed to trauma (Muskett, 2014).

How to Use This Framework

The framework will help you understand psychological trauma and the potential impact of trauma for adults with a learning disability, staff who support them, and the impact of trauma on your organisation. It will also provide you with an understanding of the approach of trauma informed care and a structure for how to implement it within residential services and supported living services within your organisation. Becoming trauma informed and trauma responsive in your services will help improve the overall quality of life for adults with a learning disability who are likely to have been impacted by trauma. Implementation of trauma informed care is a live and ongoing process that can also create an organisational culture that will enhance the overall wellbeing of staff and help reduce some of the organisational costs associated with staff turnover and absence.

It is important to note that the framework can be applied complimentary to established models of care employed by your organisation, such as the use of Positive Behaviour Support and/or Person-Centred Care.

The framework has been developed in Northern Ireland where there is an ongoing process for resettlement of long-stay patients from learning disability hospitals to community residential and supported living services, and recognition of the challenges to resettlement of individuals with complex and challenging needs (Northern Ireland Audit Office, 2009), many of whom are more likely to have experienced high incidences of trauma. Additionally, Northern Ireland has a long history of conflict-related violence which is shown to have a significant adverse impact on the general population's mental health (O'Neill et al., 2014) and for adults with a learning disability (Berger et al., 2015). To date services have not fully recognised the prevalence of trauma and it's potential impact on people with a learning disability, and many of the symptoms such as depression, anxiety and challenging behaviour are mainly treated with medication and behavioural approaches, which are not the recommended approaches in National Institute for Health and Care Excellence (NICE) guidelines for trauma treatment (2018b). These challenges to service provision are also likely to be reflective of what is happening both nationally and internationally. With this in mind the framework can easily be adapted internationally to take into consideration your own cultural context.

The framework has been co-produced by key stakeholders as guidance for the implementation of trauma informed care in residential and supported living services for adults with a learning disability. Managers of services, direct care staff, service users and practitioners working into services have all been involved in the co-production, through the process of interviews, focus groups and workshops across Northern Ireland (McNally et al., 2022 under review).

The development of the framework has also been guided by the 'Developing trauma informed practice in Northern Ireland' document (Bunting et al., 2018) and takes the form of 4 distinct overarching chapters as described by Hanson and Lang (2016):

1. Setting the Context

This chapter gives the reader an overview of the definitions of trauma and trauma informed care and sets the context from the current literature for adults with a learning disability.

2. Organisational Change

This chapter highlights the core elements of what needs to be done from an organisational perspective to implement trauma informed care in residential and supported living services for adults with a learning disability.

3. Workforce Development

This chapter outlines models of training and support for staff working within residential and supported living services for adults with a learning disability who may have been impacted by trauma. The chapter covers what staff need to know to be able to support residents most effectively and also what staff need to have in place for their own care.

4. Trauma Focussed Services

This chapter considers how to assess for trauma and what trauma focussed interventions can be applied from an organisational perspective. The chapter also outlines the current evidence base for specialist interventions on an individual basis.

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1. Setting the Context

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1. Introduction

This chapter will set the context of the need for trauma informed care for residential and supported living services for adults with a learning disability.

Evidence is growing for the long-term impact of psychological trauma and adverse childhood experiences (referred to as ACEs) on physical and mental health in the general population (Mongan et al., 2017; Kessler et al., 2010; Shevlin et al., 2015; Larkin et al., 2014). The National Society for the Prevention of Cruelty to Children (2016) stated that over one in six 11-17-year-olds in the general population has experienced some type of severe maltreatment, such as neglect, physical abuse, sexual abuse, etc. This is in keeping with the American seminal study by Felitti et al. (1998) of 26,000 patients in the Kaiser Health Plan, noted that one in six adults coming for treatment reported 4 or more adverse childhood experiences and this finding has been replicated in further studies (Felitti & Anda, 2009; Bellis et al., 2015).

In response to this growing recognition of the impact of childhood trauma there is an increase in how services are placing trauma at the centre of their approach, either by increasing access to evidence-based trauma services for individuals (National Institute for Health and Care Excellence, (NICE, 2018b) or by organisations adopting a trauma informed and responsive approach (Bunting et al., 2019: Muskett, 2014). Sadly, the same service provision has not developed for people with a learning disability, even though the literature would suggest that people with a learning disability are more susceptible to significant interruptions in attachment relationships and exposure to adverse life events (British Psychological Society, 2017).

1.1 Definition of Psychological Trauma

Psychological trauma is referred to as *'an event, a series of **events** or a set of circumstances that is **experienced** by the individual as physically or emotionally harmful or life threatening, and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being'* (Substance Abuse and Mental Health Services Administration - SAMHSA, 2014), leading to both an objective and subjective experience for the individual. It follows that the greater the perception of threat in response to an event the greater the experience of trauma. Pearlman and Saakvitne (1995) describe that psychological trauma is the unique experience of an event or enduring conditions in which the individual's ability to integrate their emotional experience is overwhelmed or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity. Additionally, there is evidence to support that the blueprint for responding to traumatic events can begin in-utero as the foetus has raised cortisol levels in response to maternal stress (Baibazarova, et al., 2013).

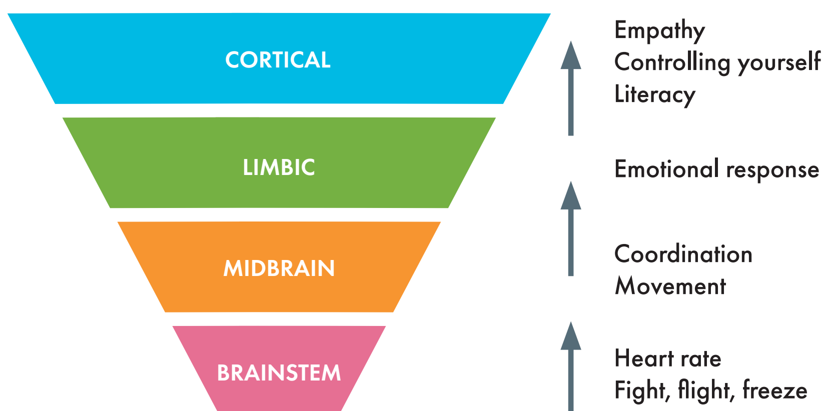
Psychological trauma is also increasingly more commonly defined in two distinct categories (which are not mutually exclusive):

Type 1 – Single incident, such as: natural disasters (earthquakes, hurricanes, floods); technological disasters (plane crashes, chemical spills, nuclear disasters); criminal violence (robbery, rape, physical attack).

Type 2 – Complex/Developmental trauma which relates to abusive or threatening conditions sustained over a period of time, usually pertaining to childhood, and often occurs in (but is not exclusive to) the context of close relationships, such as sexual abuse, physical abuse, emotional abuse, or neglect. This type of trauma is not just related to the occurrence of events or experiences, but can also reflect the absence of love, safety, trust, belonging and connection.

Complex/Developmental trauma can have a significant impact on the developing brain. Brain development is experience dependent and hierarchical (Perry, 2002: See Figure 1) in that positive or negative life experiences influence the development of the brain at each stage in the hierarchy which are dependent on the successful development of the previous stage. The primal developmental function begins at the brainstem, which provides our basic sensory motor and survival functions. Motor development follows in the midbrain and provides the building blocks for the development of the emotional brain in the limbic system. The final stage of brain development is the cortical or thinking brain which promotes thinking, learning and language development. Overdevelopment of the brainstem through trauma can have an impact on the availability of the functions of the other parts of the brain.

Figure 1: Bruce Perry's Neurosequential Model



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Complex/Developmental trauma is increasingly recognised as a set of life experiences/ circumstances that leads to a number of health and psychiatric conditions. In 2018, Complex Post-Traumatic Stress Disorder (CPTSD) appeared in the ICD-11 diagnostic manual for the first time as a distinct diagnostic entity. The symptoms outlined for a diagnosis of CPTSD tend to relate to more enduring personality types in addition to the symptoms experienced in PTSD, such as: Interpersonal disturbances; Negative self-concept; and Affect regulation (Cloitre et al, 2013).

1.2 Resilience

Often the medical model of learning disability can lead us to be deficit-focussed when considering the needs of adults with a learning disability. It is important to acknowledge that someone with a learning disability can also be resilient, which is determined by their ability to recover and learn from negative life experiences. While we think about trauma and its impact it is equally important to consider protective factors that mitigate how an event is experienced or appraised as threatening, or what effects the experience can have on the individual's mental health, physical health, or day-to-day functioning. As part of a trauma informed approach there needs to be a strengths-based focus, improvements to social support systems and introduction of factors that promote resilience. Resilience factors include good emotional coping and problem-solving skills, positive experience of care-giving relationships, education and supportive social networks and communities.

1.3 Increased Risks of Trauma Experience for People with a Learning Disability

The literature clearly illustrates that adults with a learning disability are more vulnerable to traumatic experiences and abuse (Beadle-Brown et al., 2010; Nixon et al., 2017) and environmental stressors such as poverty, social devaluation and rejection (Dion et al., 2018; Wigham and Emerson, 2015) than others in the general population. Additionally, the literature proposes there can be specific trauma related to the experience of disability itself, such as feeling different and a reduced sense of agency (McNally et al., 2021, Hughes et al., 2019 & Schepens et al., 2019).

The Division of Clinical Psychology (DCP) guidance 'Incorporating Attachment Theory into Practice' (British Psychological Society, 2017) highlights that adults with a learning disability, due to the nature of their disability, are more likely to have experiences of multiple placements, sudden changes to their living arrangements, be excluded at times of bereavement, have bullying experiences, lose the right to parent/relationships and generally have a heightened risk of abuse.

A seminal study by Spencer et al. (2005) examined the experiences of 119,000 children born between 1983 and 2001 in the UK and, although this study is somewhat dated within the context of how service delivery has changed in the past two decades, it is worth noting that many of the participants now make up the adult population who currently receive services. They found that children with a learning disability were:

- 5.3 times more likely to be neglected
- 2.9 times more likely to emotionally abused
- 3.4 times more likely to be physically abused
- 6.4 times more likely to be sexually abused.

A study in Nebraska, USA by Sullivan & Knutson (2000) found similarly raised rates of abuse for people with a learning disability compared with the general population. The same study, and a study by Taggart et al. (2010) within Northern Ireland, notes that women with a learning disability are more at risk of sexual assault and domestic violence is a raised risk for women in partnerships.

There have been a number of reports of abuse of adults with a learning disability within institutional settings (Winterbourne View Report – Department of Health, 2012; Muckamore Abbey Hospital Review – Department of Health, 2020; Worthing – BBC news, 2021), and it is important to acknowledge some of the risk factors and protective factors relating to abuse within organisations. In a systematic review of the literature Collins and Murphy (2021) highlighted several risk and protective factors for adults with a learning disability living in residential care.

Risk factors include:

- *Individuals with a learning disability:* Severity of learning disability and ability to communicate what had happened to them
- *Staff:* Low motivation to work in care; limited capacity to manage their own distress; viewing residents as different to them.
- *Organisation:* Poor leadership; high turnover of staff; staff shortages; lack of reflective space.

Protective factors include:

- *Individuals with a learning disability:* More control given to residents and training in what constitutes abuse.
- *Staff:* Better training and staff support; regular clinical supervision and reflective space.
- *Organisation:* Improving staff support and working conditions; improving organisational culture; improving collaboration across the service.

1.4 Vulnerability Factors for People with a Learning Disability

McGilvery (2018) highlighted a number of potential factors that could increase the general vulnerability to trauma for people who have a learning disability, such as:

- The level of the person's expressive language skills, as they may not be able to speak about or notify someone of their abuse.
- Dependence on caregivers to meet their needs.
- Stress of caregivers trying to cope with the demands of their role.
- Lack of credibility, i.e. a person may not be perceived as a credible reporter due to their limited cognitive ability for recall, etc.

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- Physical limitation and their ability to leave situations where they are at risk or are being abused.
- Low self-esteem and consequently may not have the confidence to speak up or believe that they deserve better.
- Cognitive limitations can impact on a person's ability to appraise risk, consequences and to problem solve to avoid risk.
- Drive to fit in with others/ develop a sense of belonging.
- Limited opportunities to develop friendships/ relationships and therefore may accept or tolerate mistreatment to gain approval or acceptance from others.
- Compliance with authority figures.
- Lack of training or education regarding what constitutes abuse and how to advocate for oneself.

1.5 Presentation of Trauma and Interventions for Adults with a Learning Disability

The literature highlights that some of the signs and symptoms typically seen in the general population in response to trauma, such as avoidance, re-experiencing and flashbacks are more difficult to observe for adults with a learning disability and for the individual to describe (Kildahl et al., 2020b, Lemmon et al., 2002). It is more likely that the signs and symptoms of trauma for someone with a learning disability are mediated through challenging behaviours, such as outward expressions of aggression (Clark et al., 2016, Rittmannsberger, et al. 2020) or self-harm (Mason-Roberts et al., 2018). For adults who have a more severe/profound learning disability responses to trauma would more typically be seen in deterioration of their everyday skills (Roswell et al., 2013). The experience of trauma for adults with a learning disability has also been linked to stress related difficulties such as anxiety, post-traumatic stress, and depression (Clarke et al., 2016, Peckham et al., 2007, Stavrakaki et al., 2004) and higher risks of physical health difficulties (Santoro et al., 2018), which is in keeping with the evidence for the general population.

Kildahl et al. (2020a) stated that environments for adults with a learning disability are not always appropriately developed to meet their needs and can result in re-traumatising or increasing their risk to further traumatisation by responses to challenging behaviour that are reactive and restrictive, rather than approaches that are proactive and supportive. Traumatic experiences for adults with a learning disability can be worsened by limited opportunities for self-determination (Schepens et al., 2019) and can be underpinned by the power and trust dynamics in their relationships with others where caregivers are in control (O'Malley et al., 2019).

It is important to consider intervention for the impact of trauma from both an individual and systemic position. Adapted therapeutic approaches for treatment of trauma recommended by the National Institute of Health and Care Excellence (NICE, 2018b) such as Eye Movement Desensitisation and Reprocessing (EMDR) and Trauma Focussed Cognitive Behaviour Therapy (TF-CBT) can be applied with the individual. Holding the environmental context in mind, there is increasing recognition of the need for a more systemic approach of trauma informed care within organisations for adults with a learning disability (Schepens et al., 2019, Truesdale et al., 2019, Keesler, 2014, 2016, 2020 & Rich et al., 2020).

1.6 Trauma Informed Care

Given the increased awareness of the impact of trauma experiences on mental health and physical health there follows a need to consider service delivery that is trauma informed. Keesler (2014) reported that trauma informed care, a systems-focussed model for service delivery, was a fast-developing model of care within the broader field of trauma in the general population (e.g. Inpatient mental health settings (Muskett, 2014) and Looked After Children's settings (Barton et al, 2012)).

Some of the issues in the literature have been in defining what trauma informed care services should look like. The Power Threat Meaning Framework (British Psychological Society, 2018) formalises that the question of **'what happened to you?'** as opposed to 'what's wrong with you?' should underpin any enquiry and intervention, echoing much earlier sentiments of pioneers such as Sandra Bloom in developing trauma informed environments in the 1990s. This position has been infused in the development of key models describing the principles of trauma informed care (Fallot & Harris, 2001), the assumptions of trauma informed care (SAMHSA, 2014), the outlining of training requirements (NHS Scotland, 2017) and the proposed development of trauma informed care in learning disability services (Learning Disability Senate, 2021).

The National Trauma Training Network in Scotland (NHS Scotland, 2017) states that 'trauma is everyone's business' (meaning that everyone in your organisation should know about trauma and the impact of trauma) and sets out very clear guidance on what trauma informed care should look like at different stages of complexity for those coming in contact with services. The 4 levels of knowledge base and intervention are as follows:

1. **Trauma informed practice in all interactions** a baseline understanding of the potential impact of trauma for all.
2. **Dealing with trauma** when staff can expect to directly interact with people who are likely to have experienced trauma.
3. **Enhanced support** for those who provide direct support, advocacy and protocol-based interventions for people who are likely to have experienced trauma.
4. **Specialist trauma** treatment providers using evidenced based interventions both at an individual and organisational level.

Keesler (2014) posited that some individuals with a learning disability comprise a vulnerable subgroup of the population that in large part relies upon the support of organizational services to foster quality of life. Therefore, it is key to develop a trauma informed care framework for residential and supported living services for adults who have a learning disability which encompasses the requirements for all levels in the National Trauma Training Network's guidance.

1.7 Trauma Informed Care Principles and Assumptions: Key Principles

Organisations across the UK that provide residential and supported living accommodation for adults with a learning disability currently implement the principles of person-centred care as recommended by the National Institute for Health and Care Excellence (2018a) guidelines for developing services for people with a learning disability who have behaviours that challenge services, Valuing People (Department of Health, 2001) and Valuing People Now (Department of Health, 2009) government white papers in England, and the Equal Lives Review (Department of Health, Social Services & Public Safety, 2005) in Northern Ireland. The key principles underlying trauma informed care listed below, adapted from Fallot and Harris (2001), have a similar basis, but utilise a trauma lens when considering each principle.

1. Safety: Efforts are made by your organisation to ensure the physical and emotional safety of individuals with a learning disability and staff. This includes reasonable freedom from threat or harm and attempts to prevent further re-traumatisation. Models for trauma informed care, such as Bruce Perry's 3 Pillars (2006) and Golding's (2008) Hierarchy of Need, hold experience of 'safety' as a fundamental for therapeutic change. This safety not only includes a safe physical environment but also the quality of relationships and perceived safety held with others.

2. Trustworthiness: Transparency exists in your organisation's policies and procedures, with the objective of building trust among management, staff, residents, and the wider community. This is important as many who have experienced trauma in the context of relationships will have difficulty in trusting others. The process of transparency and collaboration can also reduce anxieties related to uncertainty and ambiguity.

3. Choice and voice: Residents and staff have meaningful opportunities to make informed choices and have a voice in the decision-making process of the organisation and its services, promoting a sense of agency, while reducing feelings of coercion and powerlessness.

4. Collaboration and mutuality: Your organisation recognises the value of staff and residents' lived experience and their skills and knowledge in overcoming challenges for improving the system as a whole. This is often operationalised through the formal or informal use of peer support and mutual self-help.

5. Empowerment: Efforts are made by your organisation to share power and give residents and staff a strong voice in decision-making, at both individual and organisational levels. There is a strengths-based focus with recognition of opportunities for personal and professional growth.

For trauma informed care to be implemented everyone with a role in your organisation providing residential and/or supporting living services for adults with a learning disability will need to know as much as is appropriate about a person's life experience, how trauma might affect them and how you might best respond either individually or as an organisation.

SAMHSA (2014) describes the 4 assumptions of trauma informed care (adapted to the learning disability context):

Realisation – It is important for everyone to have an understanding of trauma and how it impacts people with a learning disability and people without disabilities, as well as realising it's common occurrence across the human experience.

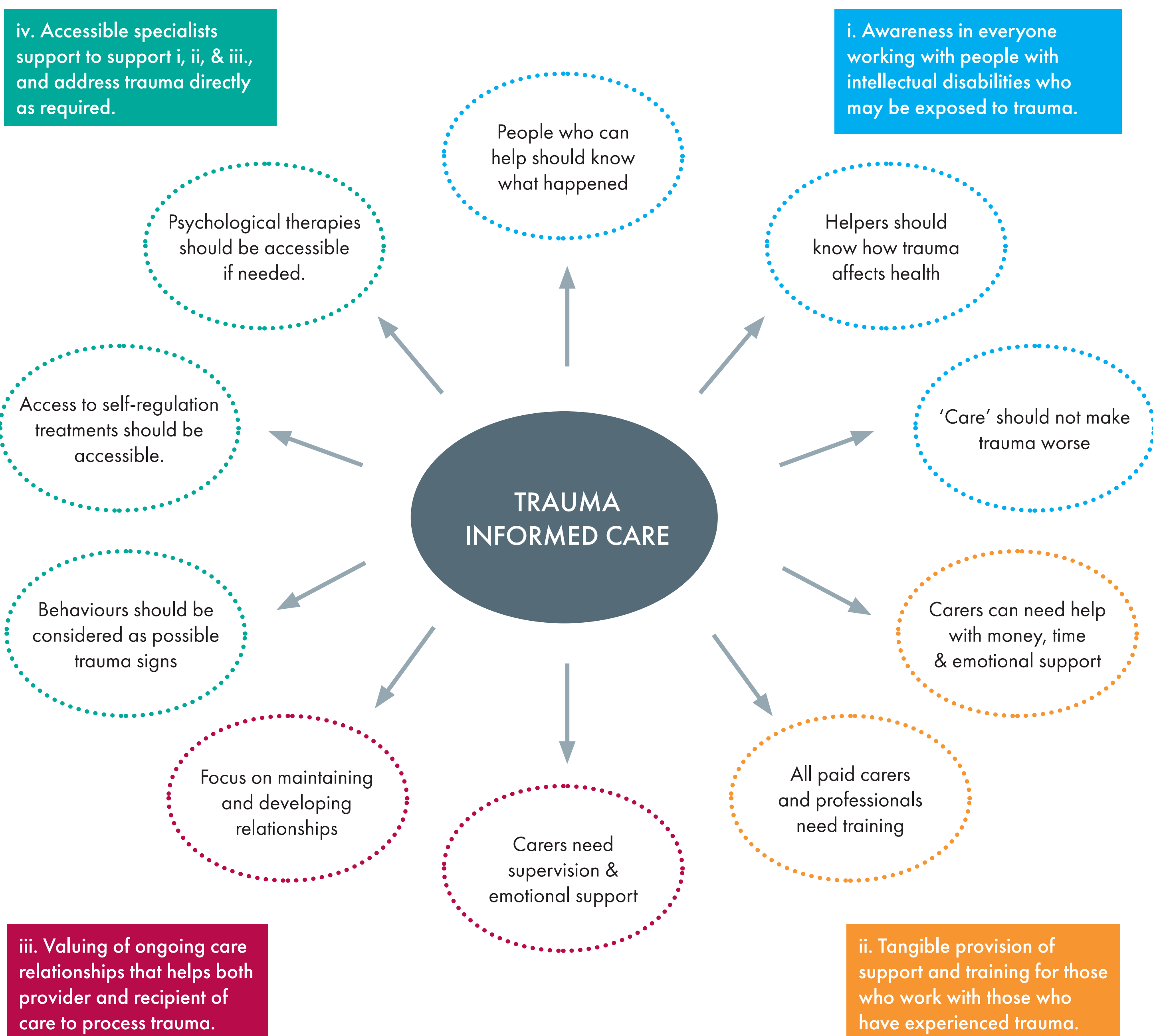
Recognition – It is also important for everyone to have an understanding of the signs and symptoms of trauma for adults with a learning disability, but also that staff have an awareness of the signs and symptoms of trauma that they might experience.

Response – Your organisation, and those who work in it, should respond to others in ways that are in keeping with a knowledge of trauma.

Resist re-traumatisation – In resisting re-traumatisation your organisation should support adults with a learning disability in a way that ensures that they are not re-traumatised by their experience of residential or supported living. Also, staff who support residents should themselves be supported in ways that are not re-traumatising.

The Learning Disability Professional Senate (2021) has outlined key areas for the implementation of trauma informed care for this population, which incorporates SAMHSA's 4 assumptions (See Figure 2).

Figure 2: 10 top tips for Trauma Informed Care



Key Messages:

- Trauma can be caused by a single event, or many difficult experiences growing up.
- Trauma hinders the development of the 'thinking' part of the brain making it harder to manage emotions, plan and organise, problem solve, pay attention and remember.
- People with a learning disability are more likely to have suffered trauma than the rest of the general population, so there is a good chance you are working with someone who has experienced trauma.
- It's important to remember to ask, 'what happened to you?' rather 'what's wrong with you?' when you're thinking about someone's distress.

2. Organisational Change

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2. Introduction

Trauma informed care seeks to develop an organisational culture that is committed to preventing traumatisation, re-traumatisation and promoting healing (Keesler, 2016). It integrates knowledge of the nature, prevalence, and effects of trauma across all layers of an organisational system (Fallot & Harris, 2001) and seeks to promote both staff and resident wellbeing. Your organisation is likely to already share values, and have principles in place, that are in keeping with the principles of trauma informed care, however providing trauma informed care is a fluid and ongoing process which requires your organisation to review its current practice using a trauma lens. This chapter will outline what needs to be done to promote trauma informed care within your organisation, using some examples.

2.1 Leadership Buy-in & Strategic Planning

2.1.1 Training for Directors and Senior Management

Initial training will be required for directors and senior managers of your organisation to fully understand the prevalence, nature, and consequences of trauma for adults with a learning disability and the impact of trauma/vicarious trauma on staff members and the organisation, following SAMHSA's 4Rs as outlined in Chapter 1. The training should also include the principles of trauma informed care, sharing an understanding of how individuals, staff and systems respond to trauma and compassionate leadership. The task for leaders in your organisation is then to consider how closely your current culture and organisation's models of care are aligned to the principles of trauma informed care and to ensure resources are available to facilitate new working initiatives. Leaders need to embody the principles of trauma informed care by working collaboratively with staff and residents, and by ensuring that people throughout the organisation feel safe and cared for, for it to be truly embedded in the culture of your organisation moving forwards.

2.1.2 Review of Policies and Procedures

It is important that your organisation prioritises the use of a trauma lens in the reviewing of existing policies and procedures. Trauma informed care champions or leads should be identified in your organisation as those who will take oversight of implementing and reviewing policies, procedures, induction etc, to ensure that the culture of trauma informed care is a live and ongoing process. Examples of key policies that should be held under ongoing review:

- **Moving to a new home:** Prior to someone moving to their new home within your organisation a full assessment of their history should be made which includes enquiry about potential traumatic experiences for them, as recommended in guidance for people with a learning disability who have mental health difficulties or behaviours that challenge services (NICE: 2015, 2016, 2018a). If trauma has been identified in someone's history, then further enquiry would be necessary to understand the impact of their experience on them. Staff should be required to know as much of each resident's history as possible before working with them. Those staff spending most time building safe relationships with residents should be most informed about their history and be aware of potentially re-traumatising experiences. There should still be a respect for the resident's right to confidentiality and specific details of traumatic experiences do not need to be shared universally, however a general awareness of the fact that the individual has experienced trauma and the potential for re-traumatising should be known. For some people, the move itself may hold potential for re-traumatising the individual and the process, and speed of the move, should also be considered in the context of their life experience. Additionally, consideration should be given to how residents maintain important relationships when they move, such as those with previous staff members or friends they lived with.

- **Recruitment and selection:** Job descriptions for staff should reflect the culture of trauma informed care and emphasise the role of healing relationships as key to the job role, which can have a significant emotional impact. In addition to their practical skills and experience, staff should be recruited on their value base and ability to work alongside someone with a learning disability, whilst being sensitive to the possibility of a history of traumatic experiences in relationships. Residents/peers should be involved in the recruitment process and in developing job descriptions for new staff. Training on trauma experiences of adults with a learning disability should be mandatory as part of induction for all new staff.

> *"Hire your people with care and care for the people you hire"*
>
> – anonymous

- **Debriefing policies:** Debriefing policies should reflect both incident and emotional debrief, ensuring that reviews with those staff and residents involved in an incident not only considers what has happened, and what could have been done differently, but also explores the triggers and emotional impact for both staff and resident through a trauma lens. In line with the principles of trauma informed care, debrief should feel like a safe exploration of a potentially distressing event where participants can discuss and reflect on its impact, feeling heard without judgement or repercussion.

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- **Restrictive practice policies:** Ensuring that all other attempts are made to make sure that those who are distressed are made to feel safe and that the process of implementing any restrictive practice is considered for potential for re-traumatising all those involved.

2.1.3 Reviewing the culture

Managers within your organisation should be mindful of promoting a culture that is trauma informed within the residential and supported living environments, advocating for a culture that reflects the principles of trauma informed care. This can be encouraged through regular meetings with staff where consideration of the principles of trauma informed care are standing items. Examples of key cultural considerations are:

- Promoting a culture of mutuality of decision making in the adult's own home.
- Respecting the power of language: considering the person's home as 'their home', and not a 'scheme' or 'facility'; reflecting on terminology such as 'refusal' and 'non-compliance' in the context of control and decision making; taking a different position to understand 'attention seeking', 'tantrum behaviour', 'attacking' or 'challenging behaviour' as 'distress behaviours', 'survival strategies' and 'attempts at self-regulation'. Failure to consider the words and language used could result in communication that makes a resident feel disrespected, uncared for and devalued (Robinson et al., 2022).

''I think the phrasing and how we speak about behaviours and categorise the actions of service users should be prioritised.''

– direct care staff

- Employing compassionate leadership and demonstrating an awareness of the organisations response to staff who may experience vicarious trauma from hearing other's stories, witnessing harm, or from being involved in distressing incidents.
- Pro-actively promoting care for staff throughout your organisation.
- Leaders should be able to balance collaborative working across the organisation whilst holding in mind the need for clearly defined job roles and manageable workloads for staff.
- The principles of trauma informed care should be embedded in day-to-day activity in addition to individual support plans.
- Acknowledging and celebrating achievements at all levels across your organisation.

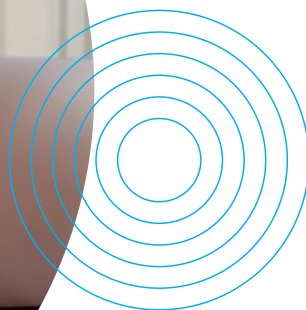
2.2 Collaboration

Collaboration calls for a sharing of power and influence with all levels of management, staff and residents within your organisation. While there will still be a requirement for clear leadership, this in part will involve listening, communicating and shared decision-making throughout. As trauma is inherently disempowering, trauma informed care involves opportunities to establish, and subsequently exert, control over one's life (Rich et al., 2020). Some examples of where collaboration can be enhanced are:

- Having a shared understanding of trauma informed care, which is brought into everyday conversation and is jargon free to make it accessible for everyone. It is important to make sure education material on trauma is available to all residents. These resources can be developed in co-production with residents and your specialist teams.
- Promoting person-centred communication and care, which aims to reduce anxiety and increase resident choice and control, whilst being mindful that a shift towards self-determination can induce its own anxieties, given residents often reduced experience of making autonomous decisions. (Schepens et al., 2019).
- Staff and residents working together to decide on day-to-day household rules, activities, new experiences, but also being involved in wider organisational decision making.

''If I want something I can speak to staff I trust in my core team.''

– resident



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- It is important that there should be opportunities for praise when things are done well, as when staff feel valued they in turn can offer a valued experience to the residents.
- Collaboration should also reflect wider community links for residents.
- Managers working alongside staff, which can be at an organisational level in co-development of parts of the service or in practical, hands-on support during shifts.
- Collaboration is extended between your organisation and external specialist services. There should be clear inter-agency pathways highlighting who holds responsibility for what aspect of the resident's care. Residents who are struggling with the impact of trauma should also have access to specific evidence-based therapies (See Chapter 4 for more details).

2.3 Resident and Staff Involvement

Staff and resident involvement reflects the control, empowerment, choice and voice aspects of trauma informed care. Having staff and residents involved in organisational decision-making helps promote a sense of belonging and a sense of community.
Some good examples of how to promote resident and staff involvement are:

- Establish a commitment to increasing the voice of all staff and residents within your organisation's decision-making processes and policy development, for example through working groups and consultation.
- Routinely seek staff and resident feedback, for example through short surveys, meetings, suggestion boxes.
- Promote positive risk taking, creating options for choice and exploring novel experiences for residents.
- Making use of a strengths-based approach grounded in staff interests and skills to promote staff responsibilities in their role.

2.4 Physical and Relational Environment

The creation of physical and relational safety for staff and residents from a trauma informed perspective is very much aligned with the principles of person-centred, user-led care described in Transforming Your Care (Department of Health, 2012), Valuing People (Department of Health, 2001 & 2009) and the Equal Lives Review (Department of Health, Social Services & Public Safety, 2005). There is a recognition that safe and trusting relationships are part of connecting and humanised services and that physical environments need to be welcoming and safe for both residents and staff. Promotion of safe physical and relational environments can come from:

- Emphasis of the physical/ relational environment as a therapeutic tool in its own right.

''Relationships matter: the currency for systematic change was trust, and trust comes though forming healthy working relationships. People not programs, change people.''

\- Bruce D. Perry

- Having dependable, compassionate relationships are vital for residents with a learning disability who have experienced trauma, particularly in the context of past relationships, as current relationships become the primary agent of growth and renewal (Brown et al., 2012) ,especially through their predictability and continuity.
- Exploring how consistency of relationships can be maintained where agency staff are required, for example, have agency staff on long-term booking contracts, providing them with appropriate levels of training, and requiring accountability.

''It's good to know that staff are there if I need them.''

\- resident

- There should be recognition that a sense of safety can also come through routine, predictability, and feeling like "someone" is in control. Too much choice and autonomy for some residents can also increase anxiety. Similarly, in times of crisis, staff may look to management to take leadership and be in control of the situation.
- Proactively support residents to understand and express their emotions. Building on their strengths, improving coping skills, developing social networks and a sense of belonging, facilitating positive experiences and connections promotes resilience (Masten and Barnes, 2018: See Figure 3).

Figure 3: Building resilience

- Help promote residents' awareness of their rights, develop an understanding of what constitutes infringements of their rights and provide them with a platform or venue to let concerns or disagreements be heard.
- It is important for staff and residents to have comfortable places to retreat to in order to be able to feel safe or to emotionally regulate and this can include outdoor space.
- Considerable thought should be put into the 'matching' of people who live and work together. Too often equally traumatised people live together, so making sure that the home set up and potential peer relationships are a good fit for the person moving is vital.
- There should be respect for the person's home, which facilitates residents to make their own choices on how they use their own home, their space and the people who work in their home.
- Ensure the home environment is stimulating and offers access to new and enriching experiences.
- Relationships within your staff team and between your organisation and external services should be considered from a trauma lens, i.e. where feelings of threat are held in the system.

It is important to have robust response systems, such as crisis response teams. Whilst it is unlikely that anyone will be in high level crisis all of the time it is highly supportive for staff and residents to know that there is an effective response system in place for when it is required.

2.5 Monitoring and Review

There should be an ongoing process of review to maximise trauma responsiveness from your organisation. Set clear goals and targets with regular communication with staff and residents to check that targets are being achieved (See checklist tool in conclusion). Outcomes can be measured in multiple ways from the perspectives of residents, staff and the organisation e.g. reduction in distress, changes in attitudes and cultures, staff sickness and turn over etc. More formalised measures, such as the 'trauma informed organisational culture measure for staff' (Kusmaul et al., 2015), 'The ProQOL' (Stamm, 2010) or the 'Group Home Culture Scale' (Humphreys et al., 2020) can also be routinely applied.

Key Messages:

- Leaders of organisations need to promote a culture and environment that recognises the effects of trauma and how to work with it.
- Staff need training in trauma, perhaps developing 'trauma champions' in each service.
- Relationships are the most important factor in healing from trauma.
- Good collaborative relationships with residents and staff, residents and families and staff and managers are key.

3. Workforce Development

3. Introduction

For residential and supported living services that support adults with a learning disability who are likely to have been impacted by psychological trauma, it is important that trauma informed approaches are at the core of staff development, training and practice. The additional organisational support structures required for staff should be explicit and training should be available to all new staff before they meet with any residents.

3.1 Training

The National Trauma Training Network in Scotland (NHS Scotland, 2017) has suggested that 'trauma' is everyone's business and sets out very clear guidance on what trauma informed care should look like at different stages of complexity for those coming in contact with services. The 4 levels of knowledge base and intervention are as follows:

- **Level 1 –** Trauma informed practice in all interactions, which should include administration, secretarial or human resources staff.
  - Training at this level should include a general awareness of what is trauma, what is the prevalence and impact of trauma for both the general population and for adults with a learning disability. This training should also raise awareness of how interactions within your organisation might be experienced by others who are potentially impacted by trauma histories. The Safeguarding Board NI have developed basic training on Adverse Childhood Experiences (ACEs) that is available to all staff across child welfare, health, education and justice systems in Northern Ireland.
- **Level 2 –** Dealing with trauma when staff can expect to directly interact with those impacted by psychological trauma, which can include all residential and supported living staff, including managers.
  - Training at this level should be more detailed with regards to the types of trauma experienced by people with a learning disability, how trauma presents for people with a learning disability, and how to respond therapeutically in every day interactions, such as being able to maintain consistent healthy boundaries and provide emotional containment for when someone gets upset. Training at this level should also include awareness of routine enquiry or 'what has happened to you?', with consideration of trauma triggers and how to respond to distress. Staff should also know how to respond to disclosures made by residents. Staff should be introduced to the principles of trauma informed care and overlaps with their current model of care.
- **Level 3 –** Enhanced support for those who provide direct support, advocacy and protocol-based interventions, such as residential and supported living staff who support residents who are significantly impacted by their trauma history, and this is reflected in interventions outlined in their support plan. Managers should also be included in this training.
  - At this level of training staff and residents should be involved in implementing individualised trauma related formulation and support plans that have been devised by specialist practitioners. Training for staff should reflect a more complex relational understanding of trauma and provide the building blocks to help those who are very distressed to regulate. There is also a requirement for staff to have more awareness of their own emotional responses to trauma and the potential interactions that are re-traumatising.

    Goad (2020) has outlined staff training for residential and supported living services for adults with a learning disability that transcends levels 2 and 3 and includes: 1) understanding trauma and its presentation for people with a learning disability; 2) implementation of the elements of trauma informed care; 3) re-traumatisation within the care setting; 4) relational and attachment aspects of trauma; and 5) understanding the three emotional regulation systems to support staff to regulate themselves to co-regulate with others.

    In a systematic review of trauma informed care in residential and inpatient services for young people in the general population Bryson et al. (2017) highlighted better outcomes for staff and residents with ongoing coaching of staff in addition to didactic teaching. An important aspect of coaching is to provide live scenarios or to model ways of working alongside staff members. Training should also aim to develop staff therapeutic skills for engaging with residents who are experiencing basic emotions such as, worried, upset, sad. Staff should also be aware of specialist trauma treatments that are available and know how to access them.

> *"The people that need the most care and are the most vulnerable, why aren't they getting the most trained and experienced staff?"*
>
> – direct care staff

- **Level 4 –** Specialist trauma treatment providers using evidenced based interventions recommended by NICE (2018b) guidelines, such as psychological interventions of EMDR and trauma focused CBT delivered by an appropriate qualified mental health professional, and pharmacological interventions administered by the appropriate medical professional, if required.

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Following the National Trauma Training Network guidance, the workforce development for all staff in your organisation should include training at levels 1-3. For maximum impact, all training should consider not only what needs to be known by staff, but also processes to support how learning can be implemented (Taggart et al., 2021). Additionally, there should be measures in place to monitor training requirements and evaluation of training impact on staff knowledge, attitudes, wellbeing and practice and the overall impact for residents, such as improved quality of life, reduction in trauma symptoms, reduction in restrictive practices, in line with initiatives such as Restraint Reduction Network (British Institute of Learning Disabilities, BILD) and Stopping Over Medication of People with a learning disability (STOMP).

Training in specialist trauma treatments described in level 4 will be discussed more fully in Chapter 4.

3.2 Ongoing Staff Support

The process of ongoing staff support is imperative to maximise the impact of staff training, provide staff space to breathe and consider self-care, and embed trauma informed care and trauma responsive practice.

3.2.1 Working Conditions

- It is important that your organisation does not compound the stress for staff by not being trauma-sensitive or providing enough resources. Staff workload should be realistic with each member having clearly defined roles. There should be appropriately assessed staff ratios for supporting resident needs and a focus on relational aspects of the roles should be balanced with other service pressures, which will maximise responsiveness and minimise the distress impact on both staff and residents. Additionally, there should be opportunities for staff relief at times of high distress, perhaps creating a system of on-call or rotation, balanced alongside resident's needs.
- There should be clear competencies outlined for the role of supporting someone with very complex emotional needs and the salary point/ job grading should reflect the high level of skills, training and experience required for the job. Skill sets should include an understanding of mental health.

> *"It's good when staff don't have to look up your support needs."*
>
> – resident

- Staff should have appropriate employment contracts and working conditions that allow for regular breaks, sick leave and appropriate levels of annual leave for them to feel cared for within your organisation. Your organisation should show a commitment to paid leave for staff injury as a result of workplace incidents if required, with the same conditions for regularly booked agency staff. There should also be facility for direct therapeutic support to staff if they have been injured during work.
- There should be realistic expectations and induction periods for new staff, offering opportunities to shadow experienced staff and getting to know each resident, developing relationships, before being the lead person working with them.
- Staff should have opportunities for development and career progression, such as access to relevant training, skills development, development of their role. In line with the principles of trauma informed care they should feel nurtured, rewarded, and have their achievements recognised.
- Staff should have a platform within the organisation to contribute to how the service is delivered, such as through meetings, taking part in working groups etc.

3.2.2 Support Structures

Research indicates that workers in human services have a greater frequency of Adverse Childhood Experiences (ACEs) than other professionals (Esaki & Larkin-Holloway, 2013; Keesler, 2018). Your organisation needs to take into account staffs' own trauma history, that staff can experience trauma in their work, and that staff can also become re-traumatised. Staff support structures are important to promote a model of 'caring for the carer' and seeks to avoid compassion fatigue and burnout for staff. Compassion fatigue in staff means that they will not be as emotionally available or responsive to residents' needs, which is important for positive and trauma healing relational experiences.

- **Handovers** – Handovers should happen regularly and allow enough time for discussion that promotes good communication, consistency of approach, and sharing of information that is relevant to a residents' trauma experiences.
- **Team meetings** – There should be good communication systems within your organisation to allow for transparency, collaboration and promotion of a joint vision. This can be achieved with regular team meetings that holds trauma informed care as a standing item on the agenda.

- **Supervision** – Staff at all levels should have regular, predictable and prioritised managerial and clinical supervision. In addition to formal supervision, managers can show interest in staff, provide ad hoc support and foster moments of light relief.
- **Consultation** – Staff should have access to specialist staff such as psychologists, psychiatrists, or mental health practitioners for consultation to further aid consolidation of training.
- **Reflective practice** – Staff at all levels in your organisation should have access to reflective practice space to explore and understand the interpersonal dynamics involved in supporting someone who has complex emotional needs as a result of trauma. These sessions should also promote staff well-being and allow a safe space for them to explore their own emotional responses to residents' distress. This space should ideally be facilitated by an external specialist mental health practitioner that also has a good understanding of organisational/group dynamics.
- **Debrief** – Staff should have the opportunity for debrief following any incidents in work that are highly distressing and/or involved restrictive practices. This debrief should not only explore what happened in the incident but should also consider the emotional impact and staff resources to manage the emotional impact. Signposting to formal counselling post-incident should be available if required.
- **Access to others** – Staff should feel safe in that they have access to additional staff responders should an incident occur. Staff should also be linked to external organisations for support, such as Intensive Support Services or Crisis Response Teams.
- **Acknowledgement of achievements** – In addition to formal recognition of achievements, staff can recognise each other with small gestures and acknowledgements of having done a good job, such as discussing achievements in staff meetings, staff newsletters, or simply making a point of verbalising with each other what you've noticed as having gone well each day.
- **Available resources** – staff should have access to written resources on topics relating to providing therapeutic support to residents, such as, how to support someone who has experienced loss, how to respond to disclosures, how to support someone following a therapy appointment etc. Many of these resources can be co-produced with residents and members of the specialist and direct care staff team.

"I think having the right resources in their houses would go a long way. For example, I had a book which had resources for talking about bereavement." – direct care staff

3.3 Staff Care and Self-Care

Staff wellbeing is key to continued compassion satisfaction and the emotional availability of staff to engage in trauma reducing relationships with residents. Staff should have an awareness of their own trauma history/ triggers and have the opportunity to develop basic skills in what grounds and soothes them when distressed so that they are able to co-regulate with a resident who is distressed by a triggering event/ interaction. It is important to note that staff care also exists in the context of relationships and the key things for staff to consider are:

- Promote staff wellbeing and resilience by recognising and building on their strengths and support systems. Build 'feel good' moments into the working week, such as 'doughnut Fridays' or soft music played in the staff lounge area and encourage a sense of supporting each other.
- Take time with staff to develop self-care skills and care plans for themselves. Staff should have access to training in self-care and the opportunity to avail of psychological first aid. In a self-care plan staff should know their own tolerance levels for distress and ways to manage their distress at work e.g. finding joy in their day, exercise breaks, looking after physical health, engaging with meditation/ spirituality, considering elements of work where they have control etc.
- There is a role for supporting staff care through supervision, where supervisors can explore staff risk appraisals of working with residents, particularly following incidents where there has been the potential for/ or actual harm caused. Staff anxieties should be acknowledged and balanced with perception of risk or how they now view the resident.

Key Messages:

- Staff require training in trauma, backed up with supervision and time to reflect and think about how they can apply their training to meet residents' needs. Staff also need opportunities to reflect on the effect that working with people in distress has on them.
- Emotion regulation skills are required for both residents and staff.
- Staff care is vital when working with people who have experienced trauma.

4. Trauma Focussed Services

4. Introduction

It is important to acknowledge from the outset that not all people living in residential or supported living accommodation will have been impacted by a trauma history and that not all behaviours are trauma related. That being said, the application of a trauma informed care approach will create an enriching environment regardless of someone's life experiences.

4.1 Intervention at a Systemic Level

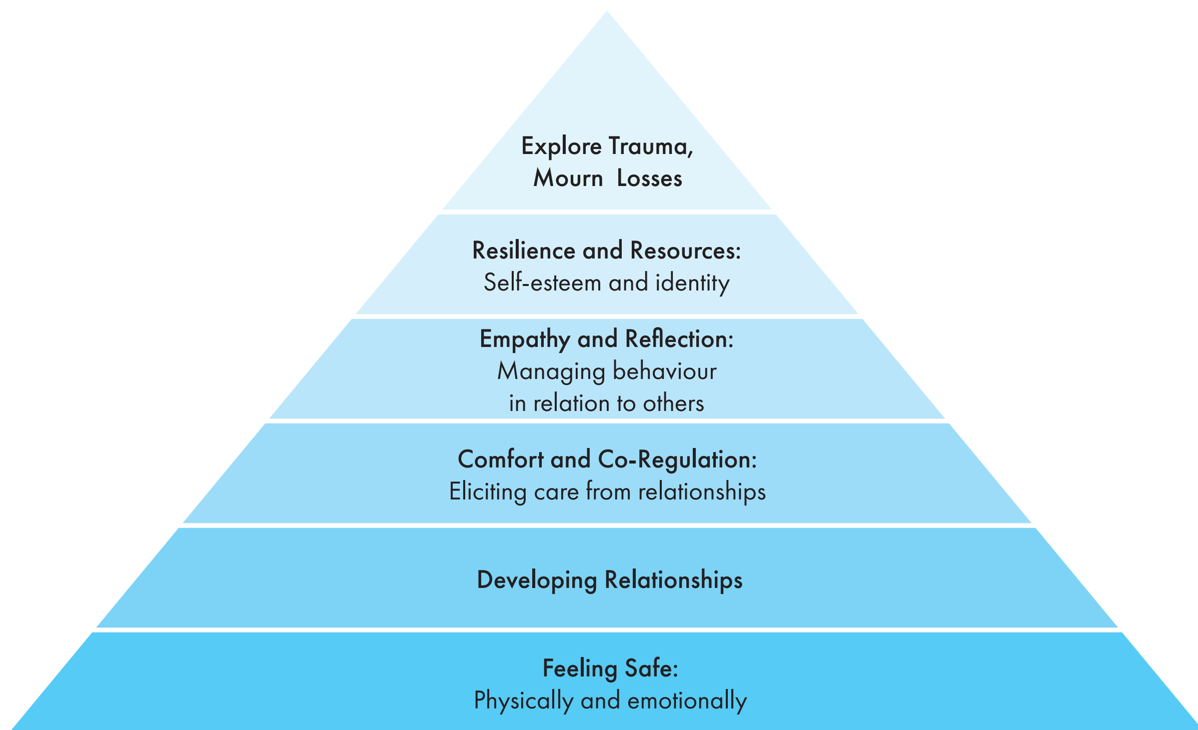
The recommendations outlined in the first 3 chapters describe what is required from residential and supported living services to support adults with a learning disability to successfully access specific therapeutic interventions for their trauma. From Golding's pyramid of need (See Figure 4) it is clear that the building blocks of safety, positive relationships, and opportunities for co-regulation are necessary before experiences of trauma can be explored. Your organisation may benefit from access to specialist trauma practitioners in supporting staff to implement what is required in the foundational building blocks of this model. Without intervention at the base levels of the pyramid of need i.e., developing safe environments and safe relationships, trauma focussed therapy will be limited. The timing of referrals for specialist trauma intervention at an individual level should only occur when base levels of the pyramid have been established. For some adults with a learning disability the foundational building blocks in the pyramid of need will be as much as they require to manage the psychological impact of trauma, for example if they feel safe in their relationships and their environment then they may not experience high levels of trauma symptoms. For some adults with a learning disability, providing an environment that follows the principles of trauma informed care will be the main focus of intervention and staff will engage in the healing relationships that promote overall wellbeing for residents.

It is worth noting that direct care staff and managers report their experience that times of transition and disruption in routines are often trigger points for residents with trauma histories (McNally et al., 2022). These can include holiday times, staff change overs, staff hand overs and mealtimes. Your organisation should consider what scaffolds of support can be put in place for residents at these times.

4.2 Intervention at an Individual Level

Providing intervention at an individual level may require specialist mental health practitioners such as psychologists and psychiatrists to work closely with the adult with a learning disability and the staff that supports them. Intervention with the specialist practitioner may involve a combination of a systemic and individual approach. Some ways of engaging both at an individual and systemic level include:

Figure 4: Golding's Pyramid of Need



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- **Knowledge of history –** Staff should have knowledge of a person's history and a general understanding of what experiences they may have had. Simply by having knowledge that trauma exists in someone's background and that it may be impacting on them currently is enough for staff to be thoughtful about the nature of their relationship with the resident and the impact of their interactions. The aim is to ensure staff are aware of what a safe, connected relationship looks like for that particular resident and this should be reflected in their care plan.
- **Formulation –** With the resident's consent and where appropriate, staff should be involved in formal mapping of the origin and impact of their trauma history. This will allow staff to understand what events might trigger trauma memories, how others response to their distress may be re-traumatising, what trauma related behaviours or interactions they might expect to see, what best supports residents at times they are distressed, and to optimise what is protective factors in their emotional development. Formulation should consider staffs' own responses to resident's distress and in the context of the resident's past trauma experiences.
- **Support plans –** A resident's Positive Behaviour Support plan or Wellness Recovery Action Plan should include trauma informed assessment and interventions. Each of these plans should reflect collaboration with residents in their development, where they give voice to how the resident would like to be supported when they are distressed. Support plans should include both environmental factors and relational factors for establishing a sense of physical and emotional safety.
- **One-page profiles –** There should be a balance of what is needed to be known about a resident and the level of contact members of staff have with them. Those who are core members of their support team and are likely to have the potential for the most healing relationships should hold the most knowledge. For those with less frequent contact, for example a visiting member of staff or an agency worker, an accessible one-page profile outlining what might be a potential trigger for causing distress for the resident should reduce the likelihood that the resident will experience contact with them negatively.
- **Therapeutic skills –** Staff should be aware of what positive interactions they can provide to support residents who have been impacted by their trauma experiences, but also be able to differentiate what will require specialist intervention. Staff can develop their skills in basic therapeutic engagement with residents that offers them a supportive relationship. For adults with a more severe learning disability, skills in intensive interaction (Hewitt & Nind, 2012) and sensory regulatory activities will be important for the development of safe relationships between staff members and residents.
- **Mental health specialism –** There is a need for a mental health specialism within your organisational structure and, in addition, it is important for your organisation to enhance the skill set of behaviour practitioners with an understanding of trauma, skills teaching such as Dialectical Behaviour Therapy (DBT), and an ability to layer behavioural approaches with relational aspects of support in multi-dimensional Positive Behaviour Support plans.
- **Skills development for residents –** All residents should have the opportunity to learn about their rights and responsibilities in their own home. They should be informed about how they should expect to be treated and should have information about what is considered to be restrictive for them. This can be included as an extension of their tenancy agreement. All residents should also have the opportunity to develop their skills in being assertive and keeping themselves safe. They should be informed of policies and procedures for them to report infringements of their rights and staff should augment their capacity to make reports.
- **Acknowledgement of rights to be upset –** There should be an acknowledgement that people with a learning disability have full range of emotions and the culture of your organisation should be to support them to express their emotions, whilst holding an awareness that others emotional upset can be difficult for staff and other residents to bear witness to and tolerate.

4.3 Screening and Assessment

Before residents move into their home in your organisation there should be an understanding of **'what has happened to them?'** This information can come from many sources and staff should have an awareness of the potential signs and symptoms of the impact of trauma for someone with a learning disability, in particular noting times of emotional dysregulation, low self-esteem, and difficulties in their relationships with others.

For some people their trauma memories may be emotionally connected and have multisensory aspects to triggers, which can make assessment difficult. As previously stated, there will be some people with a learning disability where you will never know the details of what has happened to them, but their current behavioural and relational presentation will be indicative of the traumatic experiences they are likely to have had in their past.

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General enquiry and assessment of the existence of adverse events is typically completed by the resident's key worker, as someone who has experience in bringing together the salient pieces of information about their life. Assessment regarding the psychological impact of trauma should be completed by a specialist mental health practitioner.

- Informal assessment with the adult with a learning disability:
  - Review of files.
  - Gathering information from previous staff or family members.
  - Talking to the adult with a learning disability themselves.
  - Behavioural observation.
  - Observing interactions, processes and interpersonal dynamics.
- Formal assessment with the adult with a learning disability:
  - Impact of Events Scale – Intellectual Disabilities (IES-ID; Hall et al., 2014) which measures the traumatic experience of life events for adults with a learning disability.
  - Lancaster and Northgate Trauma Scale (LANTS; Wigham et al., 2011) – both self-report and informant scales measuring the impact of traumatic events for adults with a learning disability.
  - Bangor Life Events Scale for Intellectual Disability (BLESID; Wigham et al., 2014). This tool assesses either a positive, negative or neutral experience to twenty-four defined life events, which includes few typical life events for people with a learning disability, such as changes in living circumstances.

The general approach to assessment should be multi-dimensional and individualised, given that trauma experiences can be very different for people with a learning disability and the impact of traumatic experiences is hugely variable. Assessment is an ongoing process and will require good communication and awareness of what is happening for the adult across all environments e.g. Home, day care, work.

NB Consideration needs to be given to your organisation's response when you screen for trauma. If you screen for trauma you will need to be prepared to support the enquirer, respond to any disclosures and provide timely access to specific trauma focussed services/ evidence-based interventions if required.

4.4 Evidence-Based Treatment/Trauma Focussed Services

Your organisation should have timely access to psychiatry, psychology and mental health professionals who can provide specialist interventions for adults with a learning disability. There is also a wider requirement to develop this workforce to provide specialist skills for staff supports and evidence-based interventions for trauma for the individual, with a clear pathway to accessing interventions in a timely manner. There is a growing evidence base for NICE recommended interventions for adults with a learning disability:

- **Eye Movement Desensitisation and Reprocessing (EMDR) –** There is an increasing evidence base for positive outcomes from this approach for adults with a learning disability, across the ability range (Barol et al., 2010, Mevissen et al., 2011, Barrowcliff et al., 2015, Karatzias et al., 2019, Porter, 2021).
- **Trauma Focussed – Cognitive Behaviour Therapy (TF-CBT) –** There is also an increasing evidence base for positive outcomes from this approach for adults with a learning disability (Jones et al., 2007, Kroese et al., 2016, Carrigan et al., 2017).
- **Psychotherapy –** There is some evidence to support that a more generic psychotherapy approach to trauma has positive outcomes (Nunez-Polo et al., 2016, O'Malley et al., 2019)
- **Dialectal Behaviour Therapy (DBT) –** This is a commonly used approach to help adults who have a learning disability develop skills in distress tolerance, emotional regulation and interpersonal effectiveness. More recent evidence has demonstrated its effectiveness for adults who have experienced complex trauma (Kleindienst et al., 2021).

Outcome measures should be selected that evidence reduction in trauma symptoms, whatever they may be for that individual e.g. more engagement with others, reduction in distress, ability to manage emotional upset, reduced emotional response to known triggers, behavioural change etc.

Families and networks beyond residential and supported living staff need to be informed about trauma too, where appropriate. Since family members often have a shared experience of trauma it will be important that they can be sign-posted to services that can provide interventions for them too.

Key Messages:

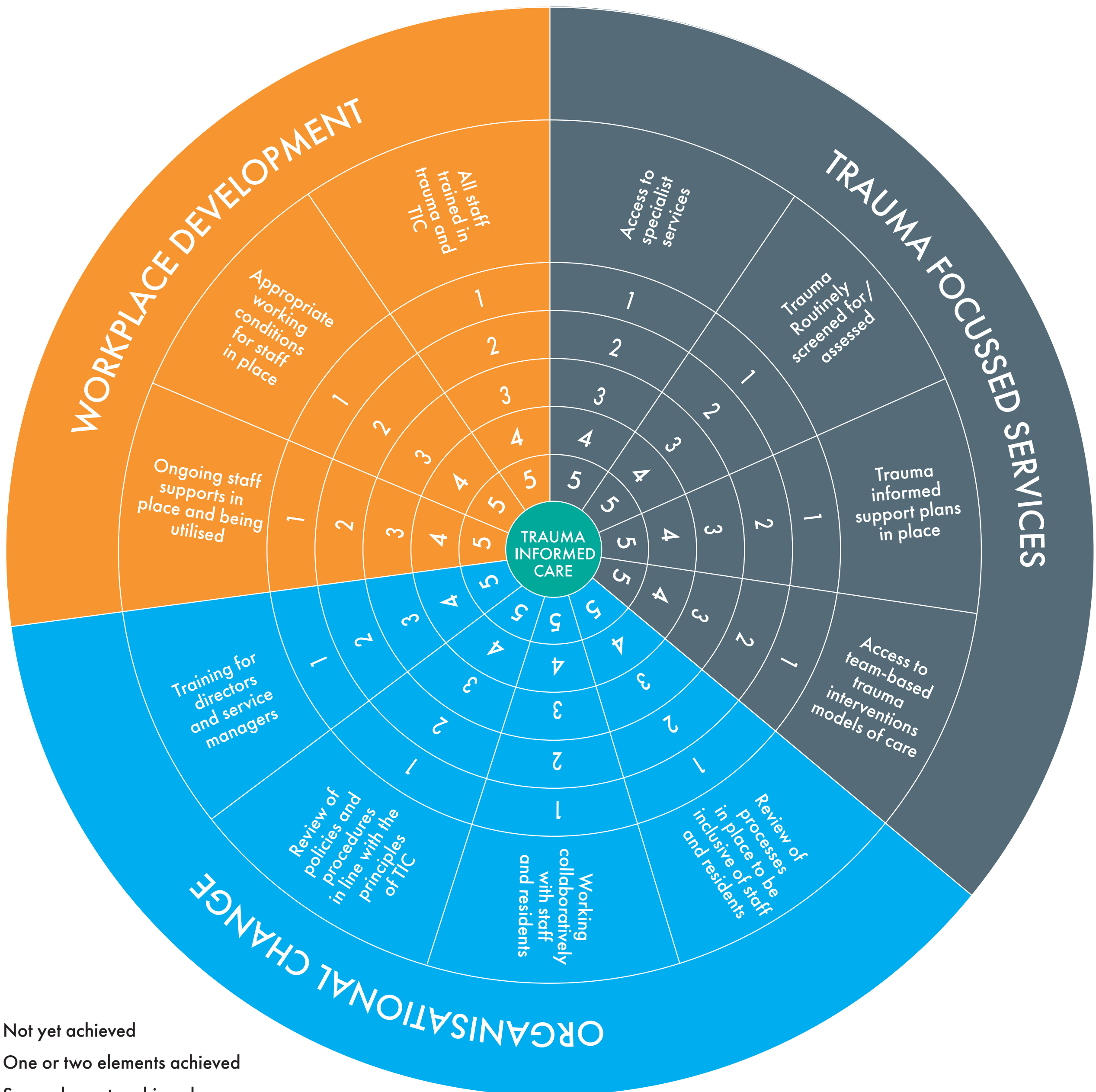
- Recovering from trauma can involve individual work for the resident with a learning disability but equally important is the therapeutic impact of the environment and the people around them.
- It's about understanding people's experiences, pulling it together and making sense of why people are struggling.
- There are specific treatments that can help.

Conclusion

This framework provides the structure for your organisation to review its approach to providing residential and supported living services to adults with a learning disability who have been impacted by trauma. It is understood that there may be initial challenges to the implementation of trauma informed care in your organisation, such as workload pressures, access to appropriate training, high staff turnover, availability of trauma expertise in the community and underfunding. However, for your organisation to effectively be trauma responsive and provide trauma informed care in residential and supported living services, you should strive to maximise change in all 3 areas outlined in the framework: organisation change; developing your workforce; and ensuring availability of trauma focussed services (See Figure 5: Trauma Informed Care checklist).

Check in where you are at in your service in the development of Trauma Informed Care.

Figure 5: Trauma Informed Care checklist



1	Not yet achieved
2	One or two elements achieved
3	Some elements achieved
4	Most elements achieved
5	Fully achieved

Planning for development of Trauma Informed Care

What is currently in place:

Organisational Change | Review date

Workforce Development | Review date

Trauma-Focussed Services | Review date

Planning for development of Trauma Informed Care

Areas of planned development:

Organisational Change Review date

Workforce Development Review date

Trauma-Focussed Services Review date

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It is my pleasure, as the Mental Health Champion in Northern Ireland, to write a letter in support of the framework for the implementation of trauma informed care in residential/supported living services for adults with a learning disability which has been prepared by Dr Paddy McNally, Consultant Clinical Psychologist and PhD researcher at Ulster University.

Through my ongoing work as the Mental Health Champion and as a Professor of Mental Health Sciences, I have been advocating the use of a trauma informed approach in service delivery given the specific needs of the Northern Ireland population. There is evidence to suggest that adults with a learning disability are much more vulnerable to traumatic experiences than others in the general population and the same treatment options are not currently available to them. I am also pleased that the framework was prepared in coproduction with service users, Health and Social Care staff and Community & Voluntary organisations.

The development of this framework is timely in considering how services are developed to meet the mental health needs for adults with a learning disability. The 10 year Mental Health Strategy seeks to put in place a regional mental health service to ensure consistency in service provisions throughout Northern Ireland. As we now work to develop the single regional mental health service this provides an excellent framework for the implementation of trauma informed practice for this group and I recommend that it is implemented and used in the training of staff across the service.

I fully support this framework and commend Dr McNally along with Supervisors: Professor Laurence Taggart and Professor Mark Shevlin for its co-production.

Siobhan O'Neill
Mental Health Champion

16 June 2022

I am grateful to have had the opportunity to read the draft framework for the implementation of trauma informed care in residential/supported living services for adults with a learning disability which has been prepared by Dr Paddy McNally and colleagues. The framework presented has much in common with work on the Northern Ireland Framework for Integrated Therapeutic Care for Care Experienced Children and Young People (NIFITC) which I have been leading on for the Department of Health in collaboration with colleagues in Health and Social Care (HSC) Trusts and partner agencies,

and alongside our children and young people.

The aim of the NIFITC is to provide Trusts with a framework, implementation structures and supports to assist them to best organise services to match the complexity of needs among our care-experienced young people. As well as acknowledging the central importance of a rights-based approach to service delivery, this requires understanding, throughout caregiving systems and the organisations that support them, of the impacts of trauma and adversity and how these impacts interact with a range of other factors to create complex needs. Influencing policy review and the development of processes and practice within health and social care provision, this trauma-informed, rights based approach can shape the creation of circumstances and delivery of supports required for recovery and growth, while also minimising or avoiding experiences that perpetuate the impacts of trauma.

The framework developed by Dr McNally and colleagues and the very clear and coherent document that has been written to describe it, provide similar guidelines. I hope this work will be extremely helpful to colleagues providing residential and supported living services for adults with learning difficulties in adopting a trauma-informed perspective to service provision. Furthermore, it is encouraging to see parallel developments in diverse areas of service delivery supporting the emergence of a consistently trauma-informed approach to care and therapeutic delivery.

Tom Teggart

Dr Tom Teggart
Regional Implementation Lead
Framework for Integrated Therapeutic Care for Looked After & Adopted Children NI (NIFITC)

18 May 2022

Dear Colleague,

Thank you for sharing your trauma informed care framework for residential and supported living accommodation for adults with a learning disability, developed by Dr Paddy McNally, Consultant Clinical Psychologist, as part of his PhD research at Ulster University. We are pleased to see that the framework has also been developed in collaboration with adults with a learning disability, staff from the voluntary organisations and the Health and Social Care Trusts.

The framework will greatly benefit organisations in service design that aims to support the mental health needs of adults with a learning disability and the British Psychological Society, Division of Clinical Psychology NI fully support this document.

Nichola Rooney

Professor Nichola Rooney BSSc Msc PhD FBPsS
Chair, British Psychological Society, Division of Clinical Psychology NI

the british psychological society
promoting excellence in psychology

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To whom it may concern

The Faculty for People with Intellectual Disabilities recognises the importance of trauma informed care, and therefore I am delighted to write a letter of support for "A framework for the implementation of Trauma Informed Care in residential/ supported living services for adults with a learning disability" written by a Faculty member, Dr Patrick McNally from the University of Ulster.

This document helpfully summarises the relevant literature in this area, with a focus on research and useful models of care. Practical suggestions for organisational change are highlighted, alongside workforce development considerations and recommendations for trauma specific interventions.

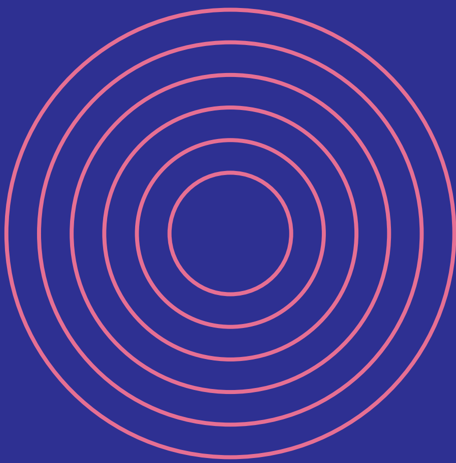
Although developed within a Northern Ireland perspective, these guidelines have clear application across the UK and should be promoted as best practice within services that are supporting individuals with intellectual disability.

Clinical psychologists are well placed to support the implementation of trauma informed care for people with intellectual disability and therefore these guidelines will be shared across our membership to support clinical psychologists working with individuals with intellectual disability and their supporters, to ensure local services are working in a trauma informed way.

SEDoswell

Dr Sophie Doswell
Chair, Faculty for People with Intellectual Disability

July 2022



For further information contact:
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Exhibit 2 – Raising and Escalating Concerns Protocol

Appendix 1 – Escalating Concerns Regarding a Student in Practice Learning Environments

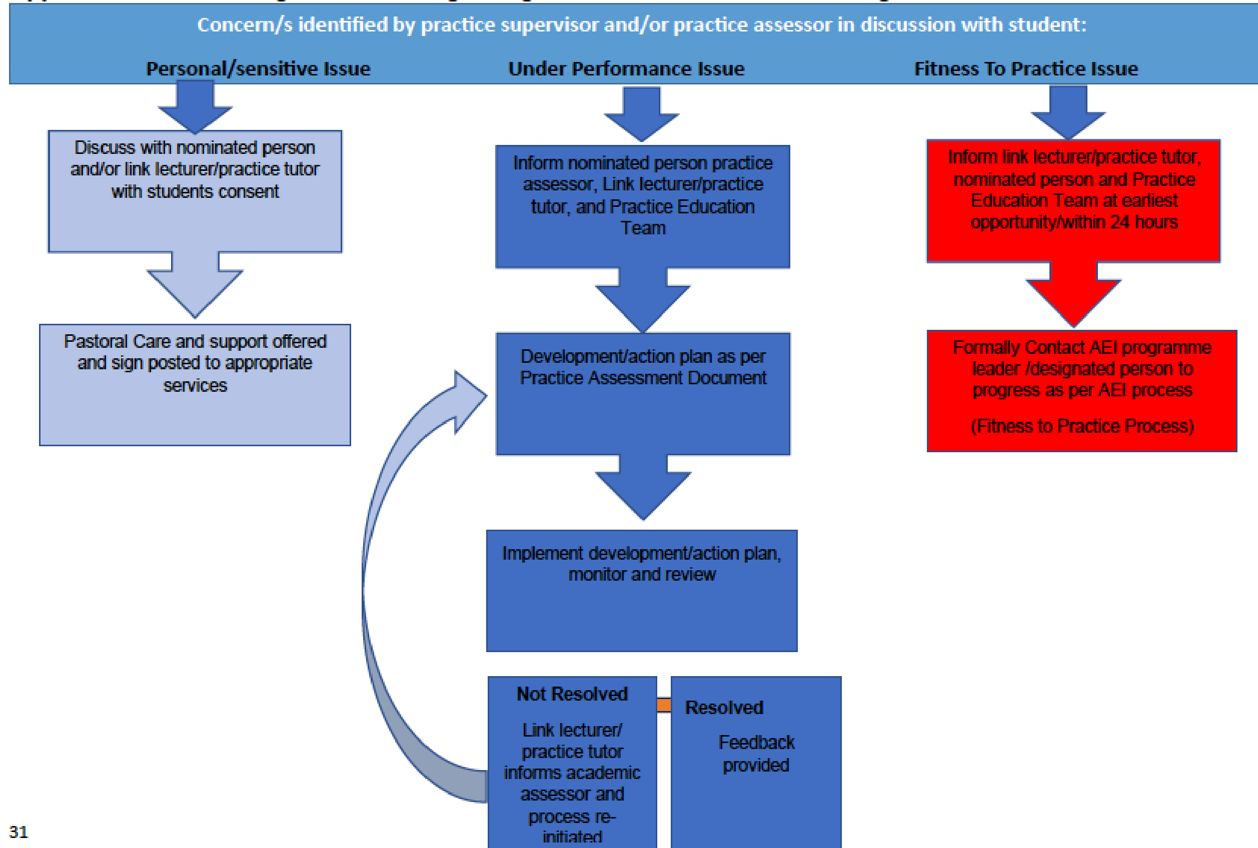

Exhibit 3: Protocol for Bullying and Harassment

Appendix 2 – Protocol for Bullying and Harassment

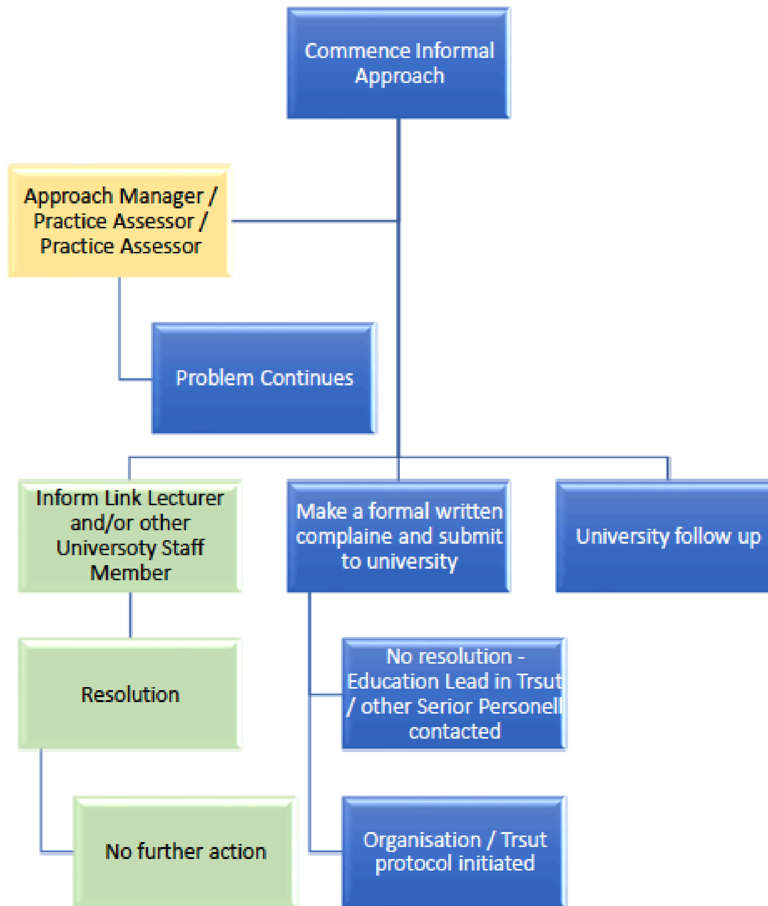

Exhibit 4: Fitness to Practice Identification