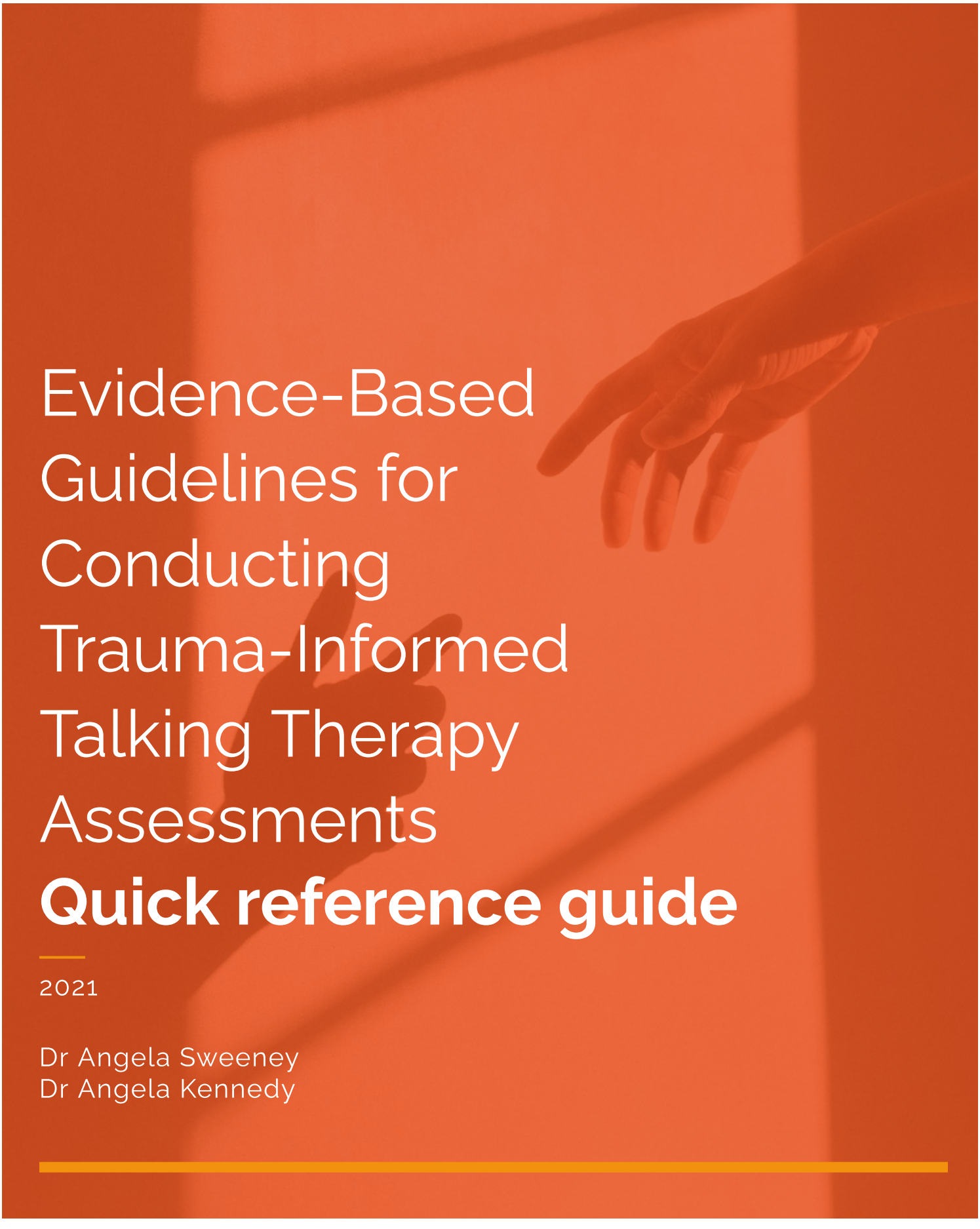

Evidence-Based Guidelines for Conducting Trauma-Informed Talking Therapy Assessments

Quick reference guide

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TICA Trauma Informed Community of Action

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Quick reference guide

This summary guide is an abbreviated version of the good practice guidelines for conducting trauma-informed talking therapy assessments. This guide is for people who conduct assessments or initial meetings in community-based talking therapy services in the NHS and third sector. It is intended to support the safe, trauma-informed assessment of all clients, including trauma survivors. It is not intended for trauma specific services only, but for all therapy modalities and services where there is an initial assessment or meeting.

The guide is based on robust, survivor-led research that learns from, and builds on, existing good practice in the sector. Rather than focusing on the technical aspects of how to conduct assessments, the guide aims to integrate trauma-informed practice into assessment processes, grounded in a thorough understanding of trauma and how it impacts on people. There are eight core good practice principles.

Box 01.

What is it like to undergo assessment for a talking therapy?

Our research programme included a qualitative study of people's experiences of being assessed for talking therapies. Key findings included:

- Trauma frequently diminishes people's sense of self-worth and self-belief, and breaks their faith in others and in authority.

- Assessments are the present-day focal point for the desperation and accumulated trauma of a lifetime. Yet assessments can compound trauma where people feel that another person has the power to decide whether or not help is received: "*this assessment…feels like it's either hope or it's the end…It's gonna make or break you*".

- Common feelings associated with undergoing assessment include worry, desperation, shame and fear of judgment alongside a fragile sense of hope.

- Trauma survivors may question their right to support, feeling that others have greater needs. Many feel that they need to prove they are worthy of support yet feel profoundly unworthy.

- There is potential for significant harm where a trauma survivor reaches out for help but is turned away, reinforcing shame, worthlessness and hopelessness. Survivors are aware of the potential for rejection which causes fear and anxiety, particularly where they have no alternatives.

- Because of the nature of interpersonal trauma, survivors can find it hard to trust people, particularly those in authority, with implications for relationship building and disclosures: "*it's a trust issue isn't it; you have to build up the trust that they're not gonna judge you*".

- There is a dilemma at the heart of assessments between revealing experiences that are deeply personal and may feel shameful, and that carry the risk of judgement and retraumatisation, or maintaining safety by not disclosing experiences and risking not being seen as needing help: "*I think if you just completely give everything, for me if I make myself too vulnerable then I can put myself in quite a bad place*".

- Authentic, human connection is vital in creating safe, healing assessments: "*it wasn't so much what she did…it's who she was*".

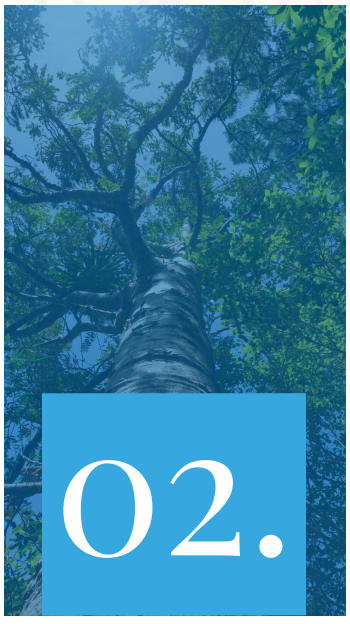
- Validation coupled with compassion can help people to understand themselves in the contexts of their past trauma, and feel believed and worthy of help: "*She would say to me 'no you are not crazy it is part of the impact of what you are going through'. And that started making me a feel a little bit more normal*".

- Collaborative assessment processes, where there are attempts to reduce power imbalances between assessor and service user, can support safety and healing. "*It was just like you were sat there and someone is in tune with you in your journey and feeling that pain*". In reality, assessors always hold power where they decide whether or not a person goes on to receive therapy.

- Whilst some people feel '*wretched*' and '*deconstructed*' after the assessment, there are often also fragile feelings of hope.

PRINCIPLES FOR TRAUMA-INFORMED TALKING THERAPY ASSESSMENTS

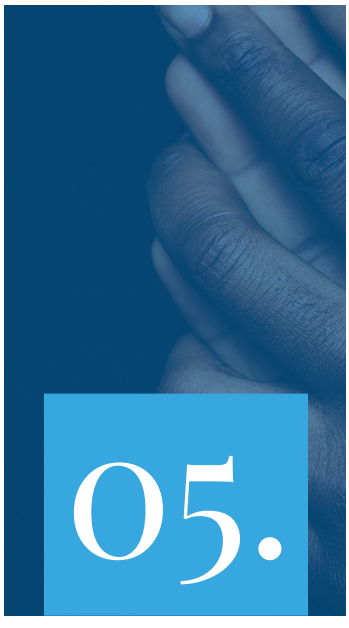
Reflections on power



Focus on relationships

From systems to people

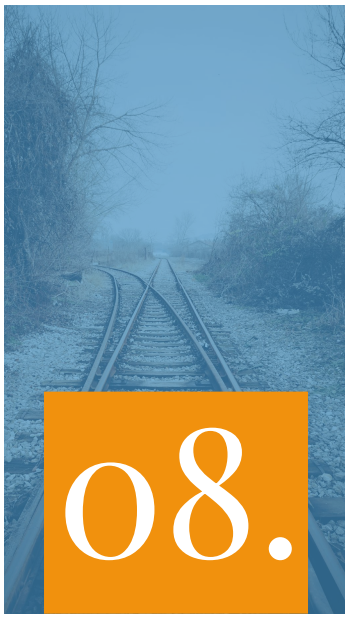
Supported trauma-competent therapists



Understanding trauma, intersectionalities, & anti-oppression

Healing environments

Post-assessment support



Clarity & options when therapy is not offered

01.

Reflections on power

The foundational pillars of trauma-informed approaches include that people seeking support have voice and choice, are not labelled and feel accepted authentically. In most current approaches, therapists typically hold decision-making power in a top-down process, only one therapy approach is available, and assessments are conducted some time before active therapy begins.

A trauma-informed approach to engagement allows time to build relationships, a shared narrative and a way forward. Assessment processes are developed by trauma survivors and the service through co-production.

- There is an initial meeting, rather than an assessment.
- A person's eligibility is established before they are offered an initial meeting.
- Service inclusion criteria are flexible and staff have the skill and authority to adapt to the needs and choices of people as individuals.
- The main purpose of the assessment is relationship building.
- Therapists reflect on the implications of the forms of power that they hold and use their power positively to enable others and advocate for inclusion.
- Therapists ensure that they need the information they are asking of people in order to minimise burden and intrusiveness.
- People take decisions about the support that is meaningful to them.

02.

Focus on relationships

Therapists communicate their humanity to clients and this is experienced as authentic. This includes through: prioritising building trust; avoiding pathologising language; demonstrating empathy, a lack of judgement, honesty and transparency; collaborating and negotiating; and clearly and actively listening. Therapists are not administrative gatekeepers or treat the people coming to them for help as another "*case*" but are warm, compassionate, empathic and sincere.

- Therapists explore people's understanding and expectations of the assessment.
- Therapists understand and acknowledge the potential for people to have previous negative experiences of services and for this to impact the current assessment/meeting.
- Therapists hold in mind how difficult the process can be, listen and recognise the strengths and expertise that people bring.
- Therapists clearly convey that the purpose of assessments is not to judge people but to understand them.
- The range of possible outcomes is explained and the person is engaged towards informed choices.
- Therapists endeavour to be compassionate, trustworthy and sincere.

03.

From systems to people

The needs of service systems should not be prioritised over people's needs and systems should be able to accommodate complex needs: less "*box-ticking*" and "*red tape*".

In trauma-informed assessments, processes are co-created (with trauma survivors) that foreground safety and flexibility and provide therapists with the skills and structures they need to engage compassionately with the person before them. Whilst therapists are trained in particular therapy modalities and assessment processes, they tailor these to individuals, supporting people's emotional, psychological and physical safety.

- Referral pathways are simple, inclusive and well publicised.
- Therapists listen closely to what safety - physical, emotional, psychological and relational - means for that particular person.
- Therapists and services accommodate people who struggle with traditional modes of engagement and respond flexibly to people's needs, circumstances and preferences.
- Rapid assessment and support are available for people in intense distress.
- Assessment takes as long as is needed; there is sufficient time to listen to people.
- People are offered a brief call/email contact with the assessor before the assessment so they aren't meeting someone for the first time in the assessment.
- Assessment tools (e.g. questionnaires, outcome measures etc) are used flexibly according to need and choice and are secondary to the relationship.
- Therapist workloads are manageable.

04.

Supported trauma-competent therapists

Assessments can represent a focal point for the emotional pain that people have been carrying, with some trauma survivors feeling unworthy, desperate, ashamed and afraid of judgment and rejection (see Box on page 3). As most assessments bring people into contact with their traumatic experiences, whether or not those experiences are verbalised, there is a significant risk of harm.

Staff may bring with them their own histories and struggle to maintain solidarity and empathy for people's trauma narratives and the resulting impacts on their minds and lives. Services need to pay sufficient attention to the emotional health of their workforce. Therapists receive the support, supervision and professional development they need to prevent vicarious trauma and burnout, particularly where they have lived experience of trauma.

- Therapists receive ongoing professional development on trauma and trauma-informed practices, including for specific groups such as women, Deaf and disabled people and people of colour.
- Therapists understand historical, structural and social traumas and intersectionality, and operate according to anti-oppressive practice.
- Therapists are able to share trauma knowledge in ways that help people understand their feelings and behaviours.
- Therapists recognise the signs of burnout and/or vicarious trauma and take action.
- Therapists are supported to manage the demands of frequently assessing trauma, particularly if they have trauma histories themselves.
- Therapists with their own trauma histories know how and when to use this.
- Managers relate to staff with respect and are coached to create a context for staff to thrive.

05.

Understanding trauma, intersectionalities, and anti-oppression

Dominant models of therapy provision in the UK are typically rooted in white Western approaches that can fail to understand the oppression and discrimination that can cause and compound mental distress. Implementing anti-oppressive practice – which is consistent with trauma-informed approaches – can help to address this. Trauma-informed services, therefore, have strong anti-oppressive policies, strategies, training and supervision in place. Therapists use reflective supervision to consider and address personal and theoretical biases.

- Therapists and services understand institutional discrimination and develop anti-oppressive practice.
- Therapists are aware of any ways that their discipline and/or its theoretical frameworks have – historically and now - pathologised minority groups and trauma survivors.
- Therapists are aware of the potential for people's experiences of discrimination and oppression to be pathologised.
- Therapists are aware of common assumptions and stereotypes about minority groups, gender, and violence and abuse.
- Therapists understand and reflect on their knowledge, awareness and experiences in relation to diversity and oppression.
- Therapists do not assume that minority identity (e.g. being black, gay, transgender and/or disabled) is the reason people are seeking therapy.
- Therapists discuss with individuals what they need to be able to participate in assessments through sensitive and supportive discussion.
- People are offered a therapist of their preferred age, gender, language and/or cultural heritage, but therapists do not assume similarity with a client based on shared demographics.
- People have access to independent interpreters, materials in their first language and easy read materials.

06.

Healing environments

The physical environment, including waiting areas and assessment rooms, can signal to therapists and clients their worth and create a sense of community or belonging which, at its most successful, counteracts the isolating impacts of trauma. The environment can also facilitate emotional regulation and a sense of safety.

- Physical layouts are reviewed to maximise accessibility, welcome, confidentiality and appropriateness for the activities to be delivered.
- All staff, including non-clinical, understand the ways that trauma may be impacting on people.
- Sterile and/or clinical environments are avoided or softened.
- Artwork is diverse.
- Waiting rooms are staffed.
- Assessment rooms create a sense of safety and are private (not overheard).
- People have choices over their environment (e.g. lights on or off).
- People have access to smells, images, sounds, tastes and objects that enable them to stay grounded in the present.

07.

Post-assessment support

In the aftermath of assessments, trauma survivors can feel "*deconstructed*"; as though a wound has been surgically opened and left unstitched. Support after an initial meeting may well be needed. This might include developing (optional) self-care plans with people, communicating outcomes as soon as possible, facilitating support whilst people are waiting for therapy and making appropriate onward referrals.

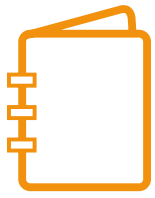
- The assessment period is transitioned sensitively towards what is agreed next.
- Immediate emotional and physical safety is considered and therapists offer to develop a plan with people for the hours and days after the assessment.
- People can use quiet, private or communal spaces immediately after the assessment.
- People can contact the service if they need support in the days/weeks following the assessment.
- People understand what will happen next and when.
- Reports and letters are negotiated with people to ensure accuracy and transparency.
- People are involved in the outcome of the assessment process, and know the reasons for potential therapy plans, as soon as possible.
- Consent is obtained before information is shared with any third party, including referring or onward agencies.
- People are involved in deciding which therapist to see.
- The conventions (unwritten rules) of therapy are clearly explained.
- There are ways of engaging and supporting people waiting for therapy, though waiting lists are avoided by adequate capacity wherever possible.
- Referrals to specialist trauma services are facilitated, where people want this.
- There are clear formal and informal complaints and feedback procedures, and independent complaints are possible.

08. Clarity and options when therapy is not offered

Clarity and options when therapy is not offered

Experiencing rejection from a service can be particularly painful for trauma survivors who may have waited years without support before reaching out for help. There should be a clear path ahead, including whether, how and when people might return to that service. Any options should be clearly explained and communicated in a way that meets the person's communication needs.

- Clear reasons for not being offered therapy are given, although this is rare due to solid front-end processes.
- Outcomes are given face-to-face/by telephone and in writing.
- Alternative options are discussed and appropriate referrals made, where wanted. This means having good knowledge of and relationships with relevant local services.
- Onward referral and assessment processes are explained.



Full guidelines

This quick reference guide is based on full guidelines which contain much more information on trauma-informed approaches, trauma-informed assessments and the eight principles. To read the full guidelines, including references and acknowledgements, click here.

Thank you

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