University of Suffolk

"I think if you cut me open, it runs through my veins"[1]

TRAUMA-INFORMED PRACTICE PROVISION AND TRAINING IN SUFFOLK

Final report

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December 2023

1 Interviewee 10

Contents

Disclaimer

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Abbreviation	Meaning
TIP	Trauma-informed Practice
ACEs	Adverse Childhood Experiences
PTSD	Post-traumatic Stress Disorder
UoS	University of Suffolk
VCSE	Voluntary, Community, or Social Enterprise

Executive Summary

Trauma is a pervasive and complex public health issue that has been exacerbated by societal polycrisis such as COVID-19, the cost of living crisis, and ongoing global conflicts. To date there has been no cross-sector systemic exploration of Trauma-informed Practice (TIP) provision in the UK, making the current research timely and crucial. The objectives of this project were to gauge the extent and quality of TIP training and provision across Suffolk and North East Essex (SNEE), to make recommendations for more consistent provision of TIP and training across the system in SNEE and beyond.

A mixed-methods approach was taken. First, survey data was collected from 72 respondents via Suffolk County Council's (SCC) local networks, asking about training and organisational practice relating to TIP and Adverse Childhood Experiences (ACEs). The data was analysed using frequency analysis. Following this, 10 interviews were conducted with Statutory health service providers, educators, and voluntary sector providers. The interview data was transcribed and a thematic analysis carried out to generate themes across the dataset.

Key findings include:

From the survey, 55.6% of respondents indicated that their organisation practiced trauma-informed care, 54.2% of respondents had received training related to ACEs, while 68.1% had received trauma-informed training. There was notable variability in length of training: for TIP training, four out of six different time periods had over 10% of responses, though the majority fell into shorter time periods. For ACEs training, responses were spread broadly across the two shortest time periods. This indicates inconsistencies in training across the system. Similarly to this, where respondents indicated when their training was, there was again variability in both TIP and ACEs training, but a notable trend towards participants having received training some time ago. This may be related to factors such as staff turnover, budget, and training availability. Given the high percentage of respondents indicating their organisation practiced TIP, it is crucial to standardise TIP training across the system so TIP can be done in a complete and consistent manner.

From the thematic analysis, five main themes were generated, which were linked to each other (see Figure 8: Map of Themes and Subthemes). These were:

1. Conceptualisation of good trauma-informed practice: interviewees conceptualised good TIP in context of their own practice, others' lack of good practice, and barriers/gaps, as well as 'what is needed'. Three subthemes were generated from this main theme:
    a. TiP is always at the forefront of everything.
    b. Internal attitudes necessary for good TIP.
    c. Being flexible and allowing agency is crucial to good TIP (but boundaries are equally important).
2. Systemic resource constraints as barriers: Participants identified the system as being 'broken', referring to individual pockets of good practice within this context, and cited many different types of resource constraints which presented barriers to doing good trauma-informed practice. These included time pressures, capacity issues, and budgetary constraints.
3. Individuals as barriers: People within and across organisations either did not believe in trauma-informed practice as a useful or workable approach, or were not trauma aware at all. On some occasions leadership was not supportive of a trauma-informed approach or training needs, and some leaders were only supportive from a distance, showing tokenistic support.

4. Facilitators for doing good trauma-informed practice: Participants spoke about what helped them do good TIP and embed it into their organisation. Most participants spoke about having a passion for TIP, making it so they had no choice but to be trauma-informed; and having knowledge and confidence in their work, which training often helped to validate. Another facilitator was leading by example, which helps to evidence to organisations and individuals not yet on board that TIP works.
5. Needs of the system for doing good trauma-informed practice: Participants suggested that what was most needed was for the system to be aware of trauma-informed practice as a culture and a journey (not as a 'tick-box exercise') and that a culture change is needed; for the approach to be completely service user and needs centred; and for change to begin with policy and commissioning strategies.

Four key recommendations were made:

1. To use training to address misconceptions about what TIP is and is not, and inspire passion in service providers, before then embedding TIP conceptual frameworks.
2. For commissioners and trustees to shift focus onto metrics and outcome measures that are flexible, person-centred, and trauma-informed.
3. To place emphasis on early intervention and prevention across all public services, as this should ease the system-wide pressures of resource constraints.
4. 4. Structured communities of practice within and between organisations and sectors, as already exist in some forms, were recommended to help service providers learn from and support each other.

This valuable benchmarking exercise has provided insights into not only the gaps and challenges of implementing trauma-informed provision and training, but also into what we can learn from the passion for TIP and good practice which already exists.

1. Introduction

1.1 Background

1.1.1. Trauma and trauma-informed practice

Trauma is a pervasive, underreported, and complex public health issue (Lanius et al., 2010). The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as an "event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning" (SAMHSA, 2014). As this definition highlights, trauma is multicausal, heterogeneous and subjectively mediated, arising when an experience or situation overwhelms an individual's ability to comprehend, cope and adapt (Herman, 1992, van der Kolk, 2014). While trauma can be the result of a singular, acutely stressful event such as a natural disaster (Madianos & Evi, 2010), it can also occur in response to chronic, prolonged and/or repeated events, typically occurring in the interpersonal realm (Van Nieuwenhove & Meganck, 2019). Potential sources of trauma include direct or indirect exposure to abuse, coercion, exploitation, violence and/or neglect, including peer rejection and bullying (Bellis et al., 2014; Brison, 2002; Felitti et al., 1998; Finkelhor et al., 2013; Hughes et al., 2017), illness and medical intervention (Capaldi et al., 2023; Cordova et al., 2017), parental separation or divorce (Dube et al., 2001), bereavement (Djelantik et al., 2020), poverty (Finkelhor et al., 2013), discrimination (Bernard et al., 2021) and displacement (Due et al., 2020; Wood et al., 2020).

At the individual level, experiencing trauma during childhood is associated with reduced emotional and social wellbeing and adverse outcomes throughout the life course, including increased risk of cancer, skeletal fractures, ischemic heart disease, lung and liver disease, health-harming behaviours, substance dependency, mood disorders, chronic pain, self-injury, and premature death (Felitti et al., 1998; Talbot et al., 2009). Collectively, this link to early morbidity and mortality contributes to increased strain on healthcare services and substantial social and economic costs (Adisa et al., 2023).

As this body of evidence demonstrates, when designing, delivering, monitoring, and evaluating human services, trauma should be the "expectation, not the exception" (Barnett Brown, 2018). That is, to ensure that an organisation can understand and meaningfully address the barriers which prevent trauma survivors from shaping and accessing their services, meet people on their own terms, and fulfil staff and service users' needs, they need to see their services through a 'trauma lens' (Barnett Brown, 2018).

Trauma-informed practice (TIP) is a "systemic change approach" rooted in recognising the prevalence and significance of trauma – particularly trauma sustained in response to interpersonal violence and victimisation (Quadara & Hunter, 2016. TIP entails working to create services that are accessible to, and responsive to the needs of, individuals from a range of backgrounds, with varying experiences of trauma, coping and recovery (Harris & Fallot, 2001). TIP is "a universal framework that requires changes to the practices, policies and culture of an entire organization, so all staff have the awareness, knowledge, and skills needed to support trauma survivors" (DeCandia et al., 2014, p.4). Centrally, TIP invites organisations to develop policies, procedures and a physical environment that promotes staff and service users' safety, autonomy and wellbeing and minimise barriers to access and/or the risk of secondary victimisation. Embedding a trauma-informed approach not only benefits service users and staff but builds organisational resilience since "services are delivered by people, and the people who deliver these services may be, at any point in time, experiencing stressful events in their own lives" or be reckoning with past traumas (Bloom, 2010, p.295).

TIP is guided by a set of key principles, which vary from five (Harris & Fallot, 2001) to six (SAMHSA, 2014). The five original principles are safety, trustworthiness, peer support, collaboration, and empowerment, with SAMHSA's additional principle including cultural, historical, and gender issues. When designing the evaluation and interpreting data, these core principles were drawn on, including ongoing attention to issues of marginality and intersectionality.

- The principle of safety means working to ensure that service users and staff feel "physically, psychologically and culturally safe," with prevention of retraumatisation as a priority (Barnett Brown, 2018, p.111).
- Trustworthiness is defined as the organisation building trust among staff and service users through clarity, transparency and consistency in policies, procedures, incentives, and consequences (Barnett Brown, 2018). Trauma-informed organisations explain what they will do and why, and reliably do what they say, in addition to managing expectations.
- In relation to the principle of choice, shared decision making is prioritised for service users. The organisation listens to the needs of service users and staff and acknowledges that people who have or may be experiencing trauma may feel a lack of control or agency.
- Collaboration is defined as recognising the value of staff and service user experience in overcoming challenges and improving the system as a whole. This could be done through informal and formal peer support, the organisation asking service users and staff what they need and collaborating on how to meet needs, and actively involving service users in service delivery.
- The principle of empowerment means making efforts to share power, giving service users and staff a voice in decision making at both an individual and organisational level. This could be through validating the concerns of staff and service users, listening to the individual's wants and needs, supporting people in decision making, and acknowledging that people who have or may be experiencing trauma may feel a lack of control in what happens to them, and may feel isolated by low self-worth.

1.1.2. Adverse Childhood Experiences

The concept of Adverse Childhood Experiences (ACEs) refers to a range of potentially traumatic events or circumstances affecting children before the age of 18, which cause mental or physical harm. These include abuse or neglect of any kind; witnessing domestic abuse or substance abuse; having a close family member experience mental health problems or imprisonment; or divorce (Early Intervention Foundation, 2020). Often these ACEs are not experienced in isolation and children experience multiple simultaneously (Finkelhor, 2018). The original study on ACEs, Felitti et al. (1998), found that the more ACEs an individual experienced proportionately increased the odds of poor outcome in adulthood, such as disability, poor mental and physical health, and health-harming behaviours. ACEs are complex, thus prevalence is difficult to determine, however studies have estimated that around 50% of the population report at least one ACE (Bellis et al., 2014).

1.2 Scope and Research Context

This research was carried out within the context of a public services system under severe pressure from a range of interacting factors, including the detrimental effects of long-term austerity measures, the COVID-19 pandemic, and the cost of living crisis (Cheetham et al., 2022; Hernandez, 2021), which have all combined to create a collectively and individually traumatised population, particularly within minoritised populations (Thiara & Roy, 2022). These pressures, contributing to secondary trauma and burnout in service providers within health, education, voluntary organisations and other public services, underscore the need for a consistent trauma-informed approach across the whole system.

A literature review was conducted to explore similar benchmarking or mapping projects in other UK regions. A limited evidence base was identified with most previous studies focused on a single service, such as social care. However, these projects still revealed important insights. For example, Emsley et al., (2022) found that there was a piecemeal implementation of TIP across the UK, with participants feeling that a nationally co-ordinated response would be most beneficial. Similarly, the Early Intervention Foundation (2022) noted that no standardised training model for TIP was used among children's social care teams across 41 local authorities, although training was the second most prevalent trauma-informed activity, with trauma-informed leadership the second least prevalent above 'additional trauma-informed activities'. The lack of cross-system benchmarking research and evaluation for training and practice emphasises the importance of the current project.

1.3 The Research

The project was commissioned by Survivors in Transition and funded by Suffolk County Council's Public Health and Communities. The aim of the research was to gauge the extent and quality of TIP training and Provision across SNEE in order to make recommendations for change based on the findings, including good practice, gaps, and barriers. Specifically, we developed the following research questions:

- RQ1: What do different organisations across SNEE understand to be Trauma-informed ractice? What is the nature and extent of TiP implementation across Suffolk's organisations?
- RQ2: What is the nature of the training offered to different organisations across Suffolk? Who is the training provider/s?
    - RQ2a: Is anything else implemented alongside the TiP training? I.e., policy change, service user-facing initiatives, etc.

2 Survey Methods

2.1 Participants — Demographics

Overall, 72 responses were collected from across the region, with pertinent demographic details below. Table 1 indicates that the Education sector is the most represented in this survey (22.2%), followed by Health (16.7%). Social Care (5.6%) was the least represented. Table 2 indicates that the most frequently indicated provisions were children and young people (25.0%), and Other, which includes items such as housing and community development, substance misuse support, prison/probation family services, and safeguarding partners. There were also some health and mental health services that were indicated in the Other option, which respondents may have felt did not fit within the Allied Health or Primary Care options provided.

Table 1: What Sector is your Organisation?

	N	%
Health	12	16.7%
Social Care	4	5.6%
VCSE	9	12.5%
Education	16	22.2%
Other	8	11.1%
Police	10	13.9%
Missing	13	18.1

Table 2: What Type of Service does your Organisation Provide?

	N	%*	% Cases**
DV/VAWG	13	12.0%	22.0%
Children and Young People	27	25.0%	45.8%
Mental Health Services	11	10.2%	18.6%
Local Authority Education	12	11.1%	20.3%
Special Education Provision	8	7.4%	13.6%
Allied Health	3	2.8%	5.1%
Primary Care	4	3.7%	6.8%
Law Enforcement	8	7.4%	13.6%
Other	22	20.4%	37.3%
Total	108	100%	183.1%

* Percentage of each response out of total responses in the whole dataset. This number is taken as the frequency.

** Percentage of respondents who selected a particular provision – multiple items can be ticked, so the total will not add up to 100%.

2.1.2. Procedure

The survey was distributed through SCC's networks in early April 2023. The invitation included a link, and the landing page of the survey which provided information about the study and survey. Participants clicked through to a consent form and the survey, and all participants received debriefing information after taking part. Questions were about participants' understanding of TIP and Adverse Childhood Experiences (ACEs), whether their organisation implements TIP, whether their organisation has undertaken any training in TIP or ACEs, and the nature, length and funding source of the training. The invited organisations were cross-sector, including but not limited to:

- Police
- Probation services
- Youth services
- Schools
- Health (NHS, Private healthcare)
- Charities/NGOs

Responses were collected until June 2023, when the survey closed.

2.1.3. Analysis

As the sample size was small, and answering the research questions did not depend on any significance testing, simple frequency analyses were used to analyse the data.

2.2 Thematic analysis

2.2.1. Data Collection Method

Participants for the interviews were recruited through SiT and SCC's networks. Ten semi-structured interviews with five education, four statutory health, and one VCSE staff member were conducted throughout April and May 2023. The interviewees comprised a mixture of front line workers, management and senior leadership. Interviews lasted from 21 to 55 minutes, and topic prompts included questions around potential gaps in good practice, examples of good practice, feelings on voicing feedback to management and whether they feel supported emotionally in their role, and questions around training and implementation of TIP.

2.2.2. Analytical Process

Interviews were transcribed after completion, and a reflexive thematic analysis was conducted, utilising Braun and Clarke's (2006) six steps as guidance. Being aware of my theoretical positioning throughout, I familiarised myself with the transcripts, then coded the data, then clustered the codes into candidate themes, identifying the salient patterns within the data. A thematic map (*see Figure 6: Map of Themes and Subthemes*) helped me further refine these into the final themes used in the analysis. I finally defined and named the themes, identifying relevant extracts from the data, then wrote up the analysis.

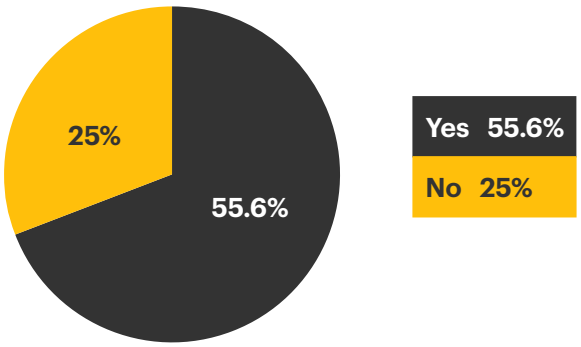
3. Findings

3.1 Survey Findings

3.1.1. Extent of Trauma-informed Practice

Just over half of respondents indicated that their organisation practiced TIP (55.6%). A quarter of respondents indicated that their organisation did not, while 19.4% did not respond to the question, which may indicate a lack of clarity or uncertainty around what TIP is, or whether it is something their organisation practices.

Figure 1: Does your organisation practice Trauma-Informed Care/Practice?



3.1.2. Number of participants who had received TIP or ACEs training

Figures 2 and 3 indicate that over two-thirds (68.1%) of respondents had undertaken some form of training on Trauma-informed Practice, while 54% of respondents had undertaken some form of training related to Adverse Childhood Experiences (ACEs).

Figure 2: Trauma-informed Training

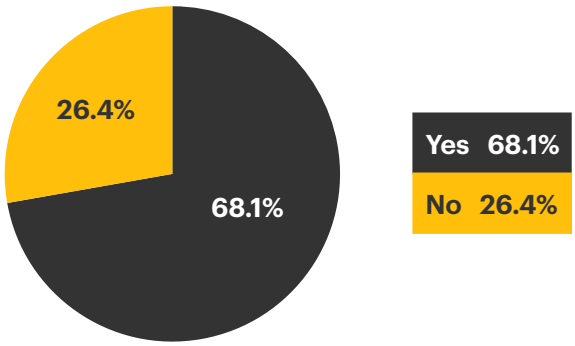
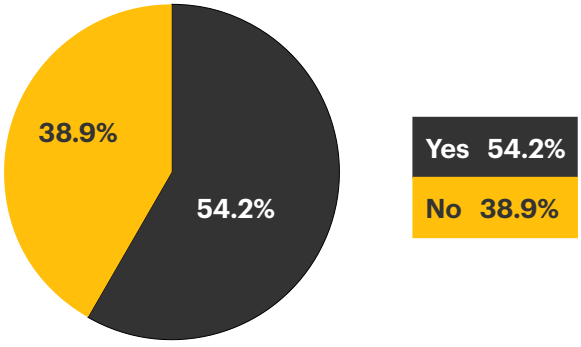


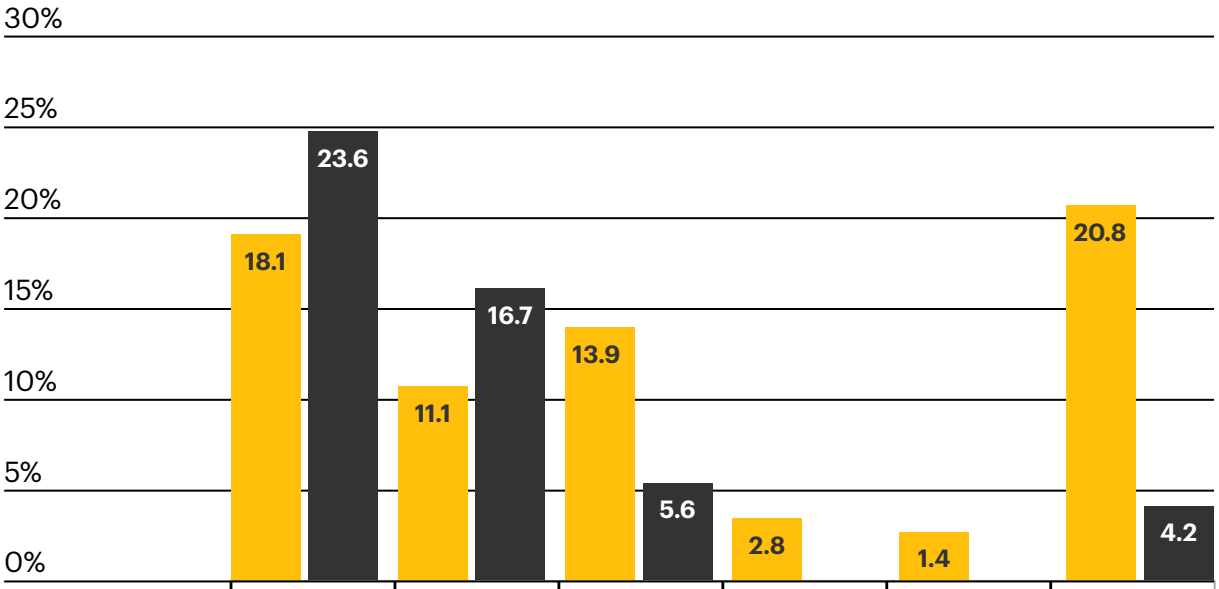
Figure 3: Training on ACEs



3.1.3. Length of Training

Figure 4 indicates that there is a notable amount of variability in the length of training. 18.1% of participants had received TIP training that lasted just 1-2 hours, 13.9% had received training that lasted several days, while 20% received training that lasted from a month to several months. Similarly, 23.6% of participants had received training on ACEs that lasted one to two hours, while 16.7% received training that lasted half a day. This deviation in training lengths, in addition to the overall majority being less than a day's training (29.2% and 40.3% respectively), is suggestive of inconsistency in training approaches to TIP and ACEs across organisations, and a shorter training period would not allow the necessary time to embed TIP into organisational culture. This is particularly concerning given that over half of respondents indicated their organisation practiced TIP.

Figure 4: Length of Training

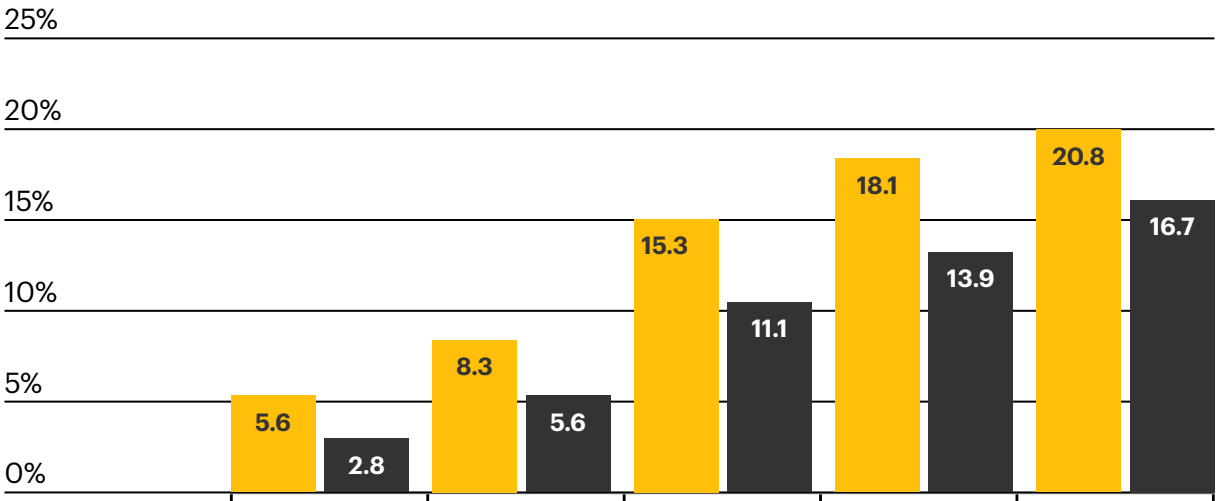


	1–2 hours	Half a day	Several days	Across a week	Across 2 weeks	Longer
How long was the Trauma informed Training	18.1%	11.1%	13.9%	2.8%	1.4%	20.8%
How long was the ACEs training	23.6%	16.7%	5.6%	0%	0%	4.2%

3.1.4. When training was received

Similarly to the length of training, there is some variability in responses, though a trend can be seen — for both types of training, the more frequent responses indicated training occurred longer ago. Figure 5 suggests that 20.8% of trauma-informed training was received longer than a year ago, although 18.1% and 15.3% of respondents respectively received training more recently; in the last year to six months, while much of the ACEs training was received between the last six months (11.1%) and longer than a year ago (16.7%), with 13.9% of respondents indicating they had received training in the last year. Factors that may affect this finding could include staff turnover, availability of training, and other organisational policy-related issues. It could be useful for organisations to consider the question of at what point and how often their staff should receive training.

Figure 5 : When was the training?

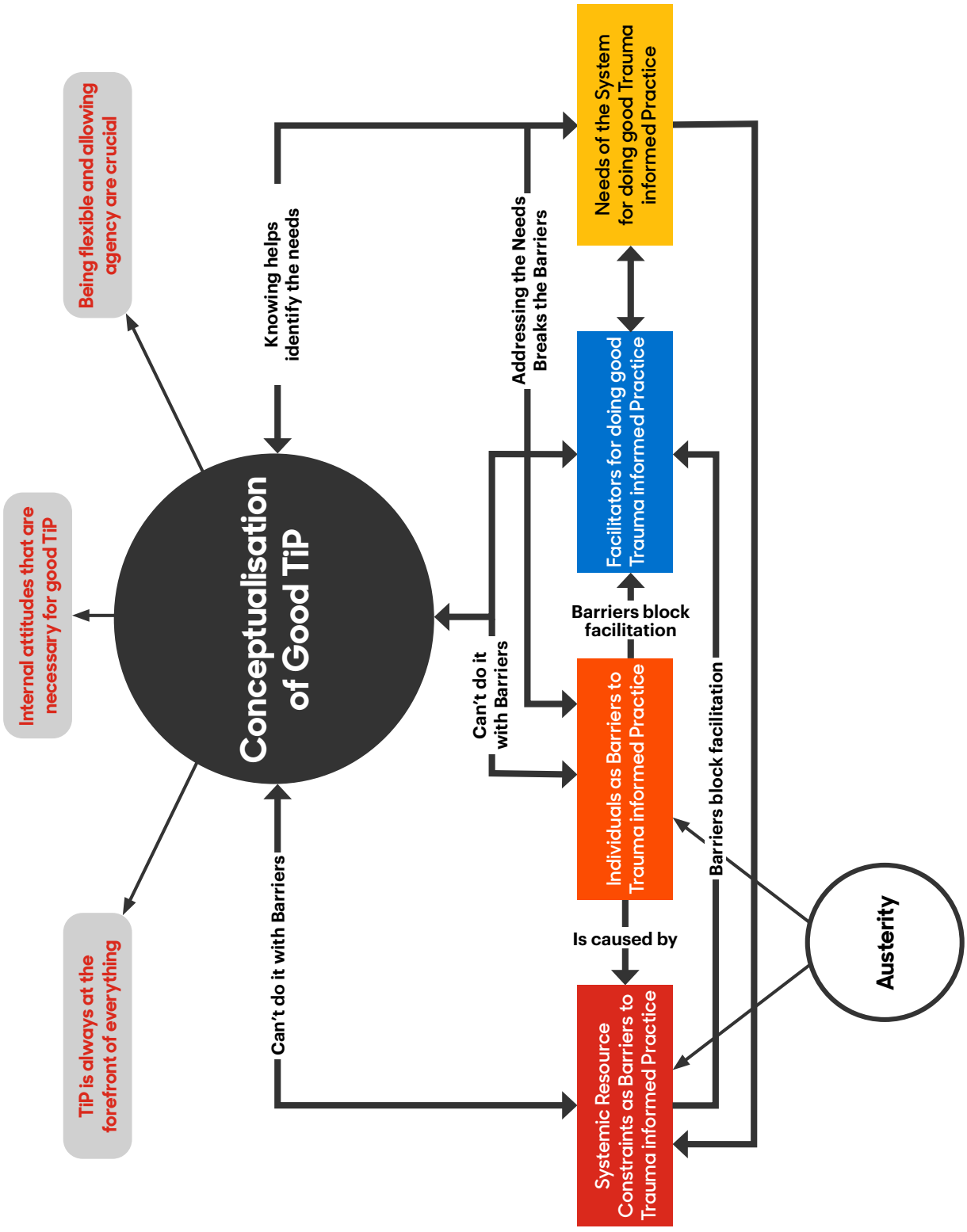


	Last 4 weeks	Last 3 months	Last 6 months	Last year	Longer ago than a year
When was the Trauma informed Training	5.6%	8.3%	15.3%	18.1%	20.8%
When was the ACEs training	2.8%	5.6%	11.1%	13.9%	16.7%

3.2 Thematic Analysis

The reflexive thematic analysis produced five themes and three sub-themes, which can be seen in the theme map below, and the Table 3: Theme Definitions table in the Appendix.

Figure 6: Map of Themes and Subthemes



3.2.1. Theme One: Conceptualisations of good practice

This theme was the 'keystone' theme, it influences and is influenced by the other themes. Participants contextualised good TIP in the contexts of their own practices, others' lack of good practice, and barriers or gaps, as well as in terms of what is needed for good TIP to be achieved. Three subthemes were identified which are connected to what good practice involves.

3.2.2. Subtheme One: TIP is always at the forefront of everything

Some interviewees spoke about trauma-informed practice always being in their minds when interacting with anybody from service users to colleagues:

> *"I certainly feel that it's at the forefront of my mind pretty much every minute of every day in the way that I deliver services, in the way that I talk to my colleagues, in the way that I deal with conflict at work, having to challenge different views or perceptions about things."*
>
> *– Interviewee 2*

Building on this, other interviewees expressed that once TIP has been learnt and internalised, it is not something that can be turned off at will:

> *"It's one of those things that once you've switched the tap on for it, you can't any longer switch it off. So you can't - once you know how people tick and why things happen, you don't really want to ride roughshod over it. You want to be open and you want to help."*
>
> *– Interviewee 3*

This is reflected in Champine et al. (2022), who found that becoming trauma-informed meant looking at the world in completely different ways, which make it difficult to revert to previous ways of thinking. This may be because being trauma-informed involves understanding the potential reasons people behave in certain ways, necessitating empathy and compassion. These are trauma-informed communication skills that, once learned and internalised, may be difficult to choose not to apply due to a new ability to look below the surface.

3.2.3. Subtheme Two: The internal attitudes necessary for good TIP

In addition to the implicit consideration of empathy and compassion, interviewees often referred to important internal attitudes that are crucial to good trauma-informed practice. The attitudes that appeared most important to the interviewees were curiosity, mindfulness, and a person-centred mindset. One interviewee spoke about mindfulness in looking beyond unwanted behaviours to the root cause:

> *"...not only do you have your trauma-informed head on, you have to be mindful. You have to actually sit and be mindfully watching what's going on rather than your kneejerk reaction, - is there a naughty behaviour or whatever behaviour; you actually have to see if you can figure out a little bit what's going on..."*
>
> *– Interviewee 3*

Being mindful in trauma-informed practice helps to prevent initial negative reactions to 'naughty behaviour[s]', which can be an issue for some individuals who do not necessarily believe in trauma-informed approaches, as discussed further in Theme Three. This indicates that as part of good TIP, a mindful 'watch and wait' approach to some situations may help foster curiosity, another internal attitude participants spoke about as being important to good TIP:

"...I'm always genuinely curious about, oh, you've had these experiences and what's that been like for you and obviously holding in my mind lots of things about trauma and things that I might be thinking, but really wanting to understand from that person's point of view what that's been like for them rather than me enforcing a view on them of what trauma means."

– Interviewee 8

Curiosity is mentioned by several of the interviewees as being part of good TIP, which is in line with SAMHSA's (2014)'s first key assumption of a trauma-informed approach. 'Realisation' involves having a basic understanding of trauma, as well as understanding people's experience and behaviours in the context of coping strategies that have helped them to survive adversity. This realisation requires a professional curiosity about who a person is. The quote also speaks to the person-centred mindset necessary for good TIP, in which service users in any sector are all different with differing needs, experiences and presentations. A mindset which considers needs on an individual basis requires flexibility, which the final subtheme addresses.

3.2.4. Subtheme Three: Being flexible and allowing agency is crucial (but boundaries are equally important)

Interviewees spoke about needing to flex somewhat rigid organisational criteria and giving a certain amount of control and agency to service users to prevent or mitigate trauma.:

"If you say to people, 'this door is always open', assuming that they've engaged appropriately right the way through our program...if someone is engaged with our service, we need to basically say to them, you can leave, but if you need to come back, you come straight back. [...] we actually find that people become more independent more quickly if you say to them, this is an open-end service, when you're ready to leave, leave, but you can always come back in."

– Interviewee 5

This quote illustrates that organisations can do good TIP through flexibility and giving service users space to make their own choices; helping to cultivate independence in a safe way. This is further emphasised in the following quote:

"...but if the organisation is a bit more concrete in saying that 'no you've been evicted, that's it, you're never coming back.' Which means people end up long term homeless and going through more and more trauma."

– Interviewee 6

Where organisations are rigid and do not provide choice or agency for service users, this results in further traumatisation and alienation from the system, highlighting the need for flexibility and agency as part of everyday good practice.

Although a flexible system is needed for good trauma-informed practice, a tension needs to be held with ensuring that good boundaries are set. For example:

"...and it's not just 'you can just leave the classroom whenever you fancy, you can do whatever you like.' There is structure, there is boundaries to it. And actually for a lot of these children with high ACEs are craving boundaries and, you know, a consistent approach, they're finding that, they're having positive effects on them."

– Interviewee 3

This participant points out that although children often need to leave the classroom for therapeutic interventions and additional learning, which denotes good flexibility, they also need structure and boundaries. It is likely that children with higher ACEs and more complex traumas do not have these boundaries outside of school (Bradley, 2022). This may also be the case for service users in other sectors, thus consistency in terms of placing and maintaining boundaries is crucial for making sure service provision is trauma-informed, not only for child services but for adults, as reflected in the first quote by Interviewee 5, who places boundaries with service users by ensuring that although the door is always open for them to return if they leave, they must be engaging appropriately with the service.

It was important to begin the analysis with participants' conceptualisations of good TIP to understand not only where the good practice is, but also where the gaps and barriers exist, and the potential learning from the examples of good practice given. There were two separate themes relating to the barriers to doing good trauma-informed practice: systemic resource constraints and individual people. These themes are linked in the sense that often individuals become barriers when systemic resource constraints exist.

3.2.5. Theme Two: Systemic resource constraints as barriers

Interviewees referred to a 'broken system', and many participants identified individual pockets of good practice within this context:

> *"...individual people, practice is good, but they're working within a system that is so broken. So we'll have outside agencies who will 100% recognise that a family needs support. That support won't be there, it won't be available."*
>
> *– Interviewee 3*

This participant speaks to a systemic issue whereby external agencies, or individuals within those agencies, want to provide assistance and support, but due to wider resource scarcity are unable to. This was an issue spoken about by other participants, who referred to time pressures and capacity:

> *"What impact does it have on that colleague in [mental health service] who says, 'I totally get why you're worried about your [individual from specific group], but I've got 60 other people on my caseload and I'm feeling really burnt out and traumatised.' So you're wanting to support your colleague who you can clearly see is overwhelmed and probably on the verge of burnout, and at the same time advocate for your service user."*
>
> *- Interviewee 2*

The quote above illustrates the constraints on service providers in terms of time and capacity, which reflects Interviewee 3's statement. However, it also speaks to the impact being unable to help as a service provider could have, in addition to the impacts of having no time or capacity to pause and reflect. This is summed up poignantly in the following quote:

> *"And I know I'm not alone in the experience of at the end of the week, where by the time the weekend comes, you feel fit for nothing. You feel like you just want to collapse and kind of hide away and recover until you're ready to go again the next week."*
>
> *– Interviewee 8*

This participant, talking mainly about time pressures, speaks to the stress of rushing from one emotionally difficult event to the next, without any time for processing or talking about the

impacts on themself. This causes burnout and vicarious trauma, in addition to making it more challenging to work with service users in a trauma-informed way when there is no time or capacity to tend to staff's own emotional needs on top of service users'.

Interviewees also spoke about budget constraints, particularly regarding education and VCSE, which impacted on being able to recruit the right staff, or the right number of staff, to effectively do trauma-informed practice:

> *"So we're now in that kind of perfect storm where behaviour and society has reached the point where there is a high level of need, partly because of the pandemic and the way that that has changed society. But now in schools, there is no money [...] All of the [interviewee's schools] are in deficit currently [...] and not just a little bit. We're talking about 30-40-50-60-£90,000. We're talking people's salaries here, and the capacity to kind of appoint and employ staff, and that's quite serious."*
>
> *– Interviewee 9*

The interviewee points out that despite the increasing levels of need from the collective trauma of COVID-19 and other societal issues such as increasing poverty, there is very little money available to meet these needs, especially in terms of recruiting staff, and replacing staff who leave. The interviewee also highlighted the further financial barrier of funding being placed elsewhere in the system:

> *"...more often than not when you hear the big announcements from the government, it's 'oh, we're planning X amount, £1,000,000 into secondary education' [...] Actually, we could prevent a lot of that if you just targeted the money at the younger children - particularly further up the kind of political tree that you go, the perception seems to be that mental health isn't a problem in primary, it's secondary. Well, it is a problem in primary. We're coping, but it's manifesting itself in secondary."*
>
> *– Interviewee 9*

This quote illustrates both the issues with financial constraints, but also problems with funders seeking short-term solutions to the needs of children who are already presenting with trauma- or ACE-based needs and other additional needs, rather than taking a long-term view and budgeting for prevention at a young age such that the issues are less likely to arise in secondary school. This is echoed by an interviewee from a VCSE:

> *"Five grand spent with a family here can save millions there. [...] People don't have the five grand here because they're spending the millions there. And you have to say to them; actually, at some point you're going to have to say stop and you're going to have to put the money here, because otherwise this pile is just going to get bigger and bigger and bigger."*
>
> *– Interviewee 5*

Interviewee 5 spoke to the concept of spending smaller amounts of money on early intervention to prevent issues such as drug and alcohol abuse, poor mental health, or homelessness, which are more expensive and complex to solve. However, funders and commissioners, reflective of Interviewee 9 above, appear to hold preference for immediate or short-term rather than preventative solutions (The Health Foundation, 2019). This places pressure on the system as a whole, as service providers find it difficult to do good TIP under budgetary constraints that cannot prevent serious needs arising.

While not a theme in itself, austerity was either alluded to or explicitly mentioned as the cause for these barriers, which is also an influence in the later theme on the system's needs. It is likely that financial constraints as a direct result of policies of austerity impact on capacity and time to be able to do trauma-informed practice. Consequently, individual ability to be trauma-informed is likely affected, which the following theme addresses.

3.2.6. Theme Three: People as barriers

Interviewees referred to colleagues or staff in other organisations who either did not believe in trauma-informed practice, or had no awareness of trauma at all:

> *"...not all of the schools in the Trust see trauma-informed practice in the same way. [...] that can be quite frustrating when you're thinking, 'no that person hasn't got it right.' So to give you an example, I've got a headteacher of a pupil referral unit, who goes, 'no, no, no, we can't use trauma-informed practice because children have to be punished.' I'm like, all right, okay, we've got a long way to go."*
>
> *– Interviewee 4*

The interviewee in the above quote emphasises that colleagues in other schools, particularly those that provide for students traditionally considered 'disruptive', prefer not to take a trauma-informed approach, considering what may have happened to pupils, but instead take a punitive, behaviour-based approach. This is reflected in other interviewees' accounts of colleagues whose misconceptions of TIP lead them to believe a trauma-informed approach is 'namby-pamby' (interviewee 3). In other cases, interviewees indicated that rather than opposition to TIP, colleagues or other services were unaware completely:

> *"...I think there'd be a lot of our practitioners, our clinical staff, who've never even heard of trauma-informed practice. I don't think it's included in the basic training for doctors and nurses. It certainly wasn't in my training, but that was a long time ago. So I think there's this kind of significant sort of baseline gap there."*
>
> *– Interviewee 7*

While the participant here isn't entirely certain, she does point to a perceived gap in baseline knowledge of trauma and trauma-informed practice in the organisation. This is echoed by a VSCE interviewee:

> *"...those little tiny pockets of support are so appallingly outnumbered by people, frankly, who have not got a bloody clue how what they are doing is retraumatizing people."*
>
> *– Interviewee 5*

This quote speaks to the wider systemic issues caused by a general lack of awareness of trauma and trauma-informed practice, which contributes to retraumatisation and subsequently further pressure on health organisations when the effects of retraumatisation manifest. This also links to the previous theme - a 'vicious cycle' may exist in which systemic resource scarcity places pressure on service providers, both at an organisational and individual level; individual staff thus have less emotional and time-based capacity to learn about or do trauma-informed practice, staying at risk of burnout and secondary trauma. This lack of TIP knowledge on an individual level may then begin the cycle again.

Linking to this cycle was the issue that while some leaders were highly supportive of implementing trauma-informed practice across the whole organisation, especially in education,

some leadership was unsupportive of TIP or TIP training needs, or were supportive but from a distance and in a very 'tokenistic' way. This is reflected in the report by the Early Intervention Foundation (2022), who found that trauma-informed leadership was notably uncommon:

> *"I do not believe that those above me are trauma-informed. And I think quite often the way that I'm spoken to and the way I'm interacted with is quite triggering for me. You know, I absolutely love my job. But I have been on the brink of resigning numerous times because of the way that I've been treated."*
>
> *– Interviewee 2*

This participant acknowledged that while her team remains a significant protective factor and source of psychological safety in her day-to-day job, her leadership is not trauma-informed. There is a sense of feeling unsupported by those above her, which is a necessary element of a trauma-informed workplace, and can help protect service providers from vicarious trauma and burnout. Lack of psychological safety from management may contribute more to these issues. Similarly, while other interviewees mentioned that their leadership was supportive of TIP, they implied that the support was very 'distant':

> *"...trustees and governors, they want to, but often they kind of go, 'okay, I've listened. I've listened. So, yes, we know that, you know, this is very difficult and dealing with that child who's very traumatised. But, well, that's what you're there for, isn't it?' "*
>
> *– Interviewee 4*

This quote suggests that while senior leadership within organisations are happy to listen to the concerns of service providers and staff members, there may be a gap between listening and taking actionable steps to provide support such as appropriate supervision, particularly where leaders believe that dealing with something potentially traumatic is simply part of 'their job'. This is reflected in other interviews:

> *"Our trauma-informed ideals are naturally at odds with the stresses of running a school sometimes. So, you know, albeit I would love it that everything was always listened to, empathised with and reacted upon, the reality is that, you know, they've got bigger fish to fry sometimes."*
>
> *- Interviewee 3*

It is possible that while leaders want to help, this support ends up being more 'tokenistic', and the lack of any real steps taken is perhaps indicative of a 'tick-box exercise' attitude which runs counter to TIP as an approach (Bailey et al., 2020), but which is likely caused by the systemic barriers discussed above.

As discussed previously, the time and capacity pressures placed upon people in all sectors lead to burnout, fatigue and vicarious trauma, which means that service providers may not have the time or emotional space to consider trauma-informed practice in their everyday work, especially if it would involve making changes to practice. Budget constraints can put pressure on leadership to prioritise initiatives or make decisions that may not be trauma-informed, for example inadequate supervision for staff members. Despite these barriers, the interviewees spoke about some factors that helped to facilitate good trauma-informed practice for them, which is important to consider in terms of protective factors and wider recommendations going forward.

3.2.7. Theme Four: Facilitators of good Trauma-informed Practice

Participants spoke about what helped them do good trauma-informed practice and embed it into their organisation. Most participants expressed a deep passion for TIP which meant that now they knew about it, they could not help but be trauma-informed:

> *"I would say my team and I are a group of people who are very passionate and interested enough to go out and go on lots of conferences. So not necessarily courses but conferences, events, read lots of books and share lots of knowledge amongst ourselves."*
>
> *– Interviewee 2*

The quote above illustrates that although the participant had received no formal training on trauma-informed practice, her and her team's passion for the approach meant that they were motivated to learn as much as they could to elevate their practice. Conversely, another interviewee had done formal training, which instilled a lifelong passion for TIP:

> *"That was probably the best course I've ever done in all my career. In all honesty. Helped me understand myself better. Helped me understand the people around me [...] It's made me a better wife, better friend, better parent, better colleague, better practitioner, everything. Totally changed the way I think about people and situations, really."*
>
> *- Inverviewee 10*

This validates the concept of trauma-informed practice as a way of being, rather than a thing to do (Penna, 2021), and it is possible that TIP training should begin with inspiring passion, with the concepts and knowledge coming after. Supporting this, interviewees often mentioned that having the knowledge and confidence in their work was important to being trauma-informed:

> *"...I think that's half the problem. Knowing and being confident in the training and the ground that we're on."*
>
> *– Interviewee 1*

This participant acknowledged the importance of being able to know the ground they stand on to work with service users in an appropriately trauma-informed way. This reflects the importance of having good boundaries and structure, as discussed in the first theme, as service providers who know exactly what they can and cannot do as part of their role know their boundaries and thus may be more confident in their trauma-informed practice. Similarly, any training interviewees had received helped to validate their work:

> *"And then when I did the Thrive Approach senior leader training, all of sudden, 'oh yeah, that's why so-and-so behaves in that way,' and, 'oh I totally get that.' So that raised my level of understanding and my confidence in what we were doing being the right thing to do was kind of increased massively."*
>
> *– Interviewee 9*

This quote highlights that in addition to validating and helping to increase understanding, training often confirmed knowledge and good practice that already existed; bolstering confidence. This is noted in research by the Early Intervention Foundation (2022). Conversely, sometimes participants had never received any formal TIP training, and did not know any particular trauma-informed models, yet still worked in a completely trauma-informed way, which reflects Penna's (2021) observations:

"Because we're a lived experience organisation. We come from a position of experience which we then translate into real life situations, that we discover labels exist for what we're actually doing, rather than follow a practice based on a label."

– Interviewee 5

This participant spoke to creating the service that they and their colleagues wished they had received themselves – a lived experience-led organisation based again on a passion for trauma-informed practice and consideration for individual needs. This interviewee acknowledged not knowing the concepts or the principles of trauma-informed practice, yet when I listed the principles, they were confident that the organisation lived by those principles, and gave examples. This indicates that while good practice may not always be called 'trauma-informed', and people across the system may not have formal knowledge, this good practice exists regardless, which may again lend itself to the idea of first creating passion or interest in TIP as a holistic approach, with knowledge and concepts coming later.

Leading by example and evidencing that trauma-informed practice works - through either holding agencies accountable or using data - was also something interviewees found helpful:

"...how do I convince this group over here that trauma perceptive practice is really, really important and that we need to implement that? And the way that I'm thinking that I'm going to have to do it is through numbers because they see numbers and they see outcomes. Well, actually, [...] if you had focused some of your time and energy on 5% of these children with SEMH, you would have had X percentage of impact upon your outcomes. So all of a sudden they can see, blimey, instead of getting kind of 55%, I could have ended up with 60-65% if I'd taken this approach."

– Interviewee 9

The quote above is indicative of the way some interviewees influenced other organisations or other parts of their services – as some service providers are numbers and target-oriented, it is strategically advantageous to evidence the positive impact of trauma-informed practice in empirical terms. Another interviewee influenced other organisations through accountability and education:

"You can get some stunning outcomes just actually saying to someone, 'do you understand how this has happened?' and changing the attitude of the professionals around them to actually go, 'Jesus Christ, we need to show some respect here.' "

– Interviewee 5

This interviewee holds other agencies and professionals accountable and educates them on being more trauma-informed during their working relationship. This is in itself trauma-informed, but also helps her do good trauma-informed practice, as in the future the other services educated by the interviewee across the course of a case will themselves become more trauma-informed, theoretically bringing down barriers.

Despite the necessity of educating on TIP and leading by example, one participant mentioned how it was difficult emotional labour to get other organisations and services on board:

"So I think when we're talking to organisations, we're also in some ways educating other organisations about how to be trauma-informed at the same time as we're interacting with them [...] I think it is a lot of emotional labour - I think, you know, you've got a traumatised

workforce trying to look after traumatised service users and their traumatised families in a community that's quite traumatised..."

– Interviewee 2

It is vital to acknowledge the emotional labour of the service providers - who in this study were often the 'individual pockets of good practice' discussed - who go above and beyond with limited resources, not only doing good trauma-informed practice with their service users and colleagues, but also educating others in the system on how to be trauma-informed.

Understanding the facilitators of good trauma-informed practice, in addition to the barriers and general good practice, helps to articulate what is most needed across the system, which the final theme discusses.

3.2.8. Theme Five: What does the System Need?

"It's been a journey, quite a big journey, but over a period of years, so lots of training and support and opportunities to really embed that in what I do and what others do."

– Interviewee 10

Through speaking about good practice, gaps and barriers, and what helped facilitate good practice, interviewees articulated what was most needed across the system. Organisations and individuals need to be aware that trauma-informed practice is a culture and an ongoing journey, rather than a 'tick-box exercise'. Interviewees expressed that a culture change is needed:

"It's as simple as, you know, when somebody arrives in the in the physical building, they say they have an appointment. How does the receptionist behind the desk interact with them, are they asking them personal questions in front of, you know, in earshot of other people? [...] have they thought about anything that's actually on the walls that might be triggering for somebody coming into that building, to - I mean, I even think before they get there, it's like the parking can be a real trigger for a lot of people. Have we got enough disabled parking spaces?"

– Interviewee 2

This participant understands TIP to be embedded across the whole service, from before service users arrive at the service, to upper management. This would seem to require significant changes to a service. However, creating a trauma-informed environment requires only small, incremental changes and adjustments to make a significant difference (Homes & Grandison, 2021), such as allocating more disabled parking and ensuring clear signposting to the service, making sure that any wall displays are appropriate, and that receptionists and medical secretaries have the necessary training to interact appropriately and sensitively with service users. These smaller changes, in combination with TIP training and potentially frameworks built around Psychologically Informed Environments (PIE; Johnson & Haigh, 2010), can help prevent TIP being a 'tick-box exercise', which is referred to below:

"...Particular trauma-informed pilots that have been done in various other parts of the system I know have experienced that shortfall of being expected to work in a way that would fall under a trauma-informed umbrella but without the appropriate structures and supports in place to really be trauma-informed. [...] The risk, I think, is that it becomes watered down into something that is another thing to do rather than a way of being and relating to each other."

– Interviewee 8

This participant highlights the necessity of having wider support structures for staff to work in a trauma-informed way. If these structures do not exist, then it would be difficult for an organisation to be trauma-informed as a whole culture, which was reflected in the themes about ongoing individual and systemic barriers. Appropriate supervision is one such example, which is the kind of support the interviewee is speaking of above, but the smaller changes referred to previously could also help provide these structures and supports.

Interviewees also spoke about the approach as needing to be completely service user- and needs-centred in order to be fully trauma-informed (McAnallen & McGinnis, 2021), which links to good trauma-informed practice being flexible and allowing agency and control:

> *"Social care is a lot more person-centred and, you know, individually driven care. And so I think there's a lot that we can learn there, I think in children's services as well, so we do have some children's services and, including community children's services, and again I think there's been more sort of thought given to approaching children and thinking about trauma and thinking about things that might have happened to them rather than adults."*
>
> *– Interviewee 7*

The participant notes other services in the sector that are further along in the trauma-informed practice journey than their own service, highlighting the necessity of being person-centred. It is likely that, reflecting the earlier discussed theme that participants often spend time educating other organisations on TIP, some organisations can learn from others, or some services can learn from others within the same organisation, potentially through the use of communities of practice or networks.

For these systemic needs to be met, policy and commissioning strategies must be developed with trauma-informed practice at the forefront, which several interviewees spoke about. This will help to shape organisations and services in a trauma-informed way:

> *"The [commissioning body] should be saying, 'how many of your staff have received trauma-informed training? How many of your staff have access to clinical supervision, reflective practice sessions? How do you look after your own staff's wellbeing?' You know, 'how trauma-informed is your physical environment that you work in? Do you have, you know, single sex toilets, you know, a gender-neutral toilet? Do you consider everybody in your building?' [...] these things just aren't put into the KPI [Key Performance Indicator], so basically we have KPIs that aren't trauma-informed, so services just get shaped and developed around meeting a tick-box as opposed to meeting the real needs of the individual."*
>
> *– Interviewee 2*

The interviewee highlights a core issue with commissioning trauma-informed services: ensuring that targets and KPIs are themselves trauma-informed. These are part of the appropriate supports and structures necessary for an organisation to be trauma-informed. Instead of KPIs such as this for services to aim for and meet, services and organisations instead have other performance indicators such as appointment uptake and non-attendance metrics (in the case of health organisations), or grade outcomes and discipline referrals (in the case of education providers). This creates less space for service providers to work in a trauma-informed way due to the need to meet non-trauma-informed KPIs.

4. Conclusions and Recommendations

To summarise, this project found that there was marked variability in both length of training and when the training had been received; suggestive of inconsistencies in training staff across the system, and with fully embedding TIP into organisational culture. This is reflective of the interview participants, who fell into two different groups. One had received longer term formal training with managerial support, and often referred to 'individual pockets of good practice' in other services and organisations. The other group either had no training at all or very little, token, or no support from leadership, and were self-taught on trauma-informed practice. They tended to be the pockets of good practice that the first group referred to. Within this interesting dynamic, the PI identified the five main themes, including the conceptualisation of good TIP, systemic and individual barriers, facilitators, and the needs of the system. Based on these findings, a set of recommendations has been developed to improve the implementation of trauma-informed training and practice in the region.

1. Training should begin by addressing misconceptions about the nature of TIP. This includes emphasising making smaller changes, and highlighting TIP as a culture, or way to be, as opposed to as a 'thing to do'. This should be followed by instilling genuine passion for TiP in service providers – the thematic analysis indicated that from passion comes excellent practice and culture. This is reflected in a quote by Moreland-Capuia (2019): 'systems change when people change, and people change when they feel something'. This highlights how systems are more able to transform when individuals experience a deeper emotional connection. Once this has happened, then the conceptual framework around TIP can be introduced into training and embedded. In addition, there is merit in potentially tailoring training to an organisation's specific needs, as, while there may be some overlap in barriers and facilitators within various sectors such as education, health, and VCSEs, it is important to recognize that each sector may need to adopt distinct, yet standardised approaches to trauma-informed care in order to cater to the specific needs of their respective service users.
2. Commissioners and trustees should adopt metrics which are flexible enough to allow a service-user-centred approach and allow service providers the necessary 'wiggle room' to be trauma-informed.
3. A strong focus should be placed on recognising the significance of early intervention and prevention across all public services. This would help to ease pressure on the system as a whole, as mentioned by several interviewees and aligns with Adisa et al.'s (2023) report regarding delayed disclosure of child sexual abuse (CSA) in the NHS, which underscored the critical importance of prevention and early intervention.
4. Organisations and public services should promote structured communities of practice, where organisations can learn from each other within their own sector and across sectors. Many interview participants benefited from self-teaching (in the absence of any formal training or support) and mutual learning among staff members. For example, one interviewee engaging with other leaders in her sector and sharing their knowledge to improve practice. Another interviewee facilitates a network for TIP learning that includes a wide range of service providers. However, as one interviewee pointed out, there is a lot their service can learn from services in both her own and other sectors.

This report concludes by reaffirming that despite the gaps, barriers, and pressures on public services, there is some excellent passion-driven knowledge and practice across the region, and this potentially reflects the broader landscape throughout the UK, although there is a larger piece of work to be done to explore this. The individuals interviewed and their team members are exemplars of effectively incorporating trauma-informed approaches into both their professional and personal lives; offering valuable lessons and insight as much as the systemic issues that were highlighted.

References

Adisa, O., Hermolle, M., & Ellis, F. (2023). Denial, disbelief & delays: examining the costs on the NHS of delayed Child Sexual Abuse disclosures in England and Wales.

Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020). *Adverse childhood experiences: What we know, what we don't know, and what should happen next*. Early Intervention Foundation.

Asmussen, K., Masterman, T., McBride, T., & Molloy, D. (2022). *Trauma-Informed Care: Understanding the Use of Trauma-Informed Approaches Within Children's Social Care*. Early Intervention Foundation.

Bailey, K., Trevillion, K., & Gilchrist, G. (2020). "We have to put the fire out first before we start rebuilding the house": practitioners' experiences of supporting women with histories of substance use, interpersonal abuse and symptoms of post-traumatic stress disorder. *Addiction Research & Theory*, 28(4), 289-297.

Barnett Brown, V. (2018) *Through a Trauma Lens: Transforming Health and Behavioral Health Systems*. Routledge.

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC medicine*, 12(1), 1-10.

Bernard, D.L., Smith, Q. & Lanier, P. (2022). Racial discrimination and other adverse childhood experiences as risk factors for internalizing mental health concerns among Black youth. *Journal of traumatic stress*, 35(2), 473-483.

Bloom, S.L. (2010). Organizational stress and trauma-informed services. *A public health perspective of women's mental health*, 295-311.

Bradley, S. W. (2022). Exploring the K-12 School Experiences that Contribute to Resilience in Adulthood as Described by Resilient Adults with Adverse Childhood Experiences: A Phenomenology. *Doctoral Thesis*.

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A practical guide*. Sage.

Brison, S. (2002). *Aftermath: Violence and the Remaking of a Self*. Princeton University Press.

Cameron, G., Alderwick, H., Bowers, A., & Dixon, J. (2019). Shaping Health Futures: Preparing for tomorrow's possibilities today. *Health Foundation*.

Capaldi, J.M., Shabanian, J., Finster, L.B., Asher, A., Wertheimer, J.C., Zebrack, B.J. & Shirazipour, C.H. (2023). Post-traumatic stress symptoms, post-traumatic stress disorder, and post-traumatic growth among cancer survivors: a systematic scoping review of interventions. *Health Psychology Review*, 1-34.

Champine, R. B., Hoffman, E. E., Matlin, S. L., Strambler, M. J., & Tebes, J. K. (2022). "What does it mean to be trauma-informed?": A mixed-methods study of a trauma-informed community initiative. *Journal of Child and Family Studies*, 1-14.

Cheetham, M., Gorman, S., Pollard, F., Ward, S., & Wiseman, A. (2022). "I think people have been in survival mode": a qualitative study of community connectivity in a neighbourhood of North East England before and during COVID-19. *BMJ open*, 12(7).

Cordova, M.J., Riba, M.B. & Spiegel, D. (2017). Post-traumatic stress disorder and cancer. *The Lancet Psychiatry*, 4(4), 330-338.

DeCandia, C., Guarino, K., & Clervil, R. (2014). *Trauma-Informed Care and Trauma-Specific Services: A Comprehensive Approach to Trauma Intervention*, Washington: American Institutes for Research (AIR).

Djelantik, A.M.J., Smid, G.E., Mroz, A., Kleber, R.J. & Boelen, P.A. (2020). The prevalence of prolonged grief disorder in bereaved individuals following unnatural losses: Systematic review and meta regression analysis. *Journal of Affective Disorders*, 265, 146-156.

Dube, S.R., Anda, R.F., Felitti, V.J., Chapman, D.P., Williamson, D.F., & Giles, W.H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *JAMA*, 286(24), 3089-3096.

Due, C., Green, E. & Ziersch, A. (2020). Psychological trauma and access to primary healthcare for people from refugee and asylum-seeker backgrounds: a mixed methods systematic review. *International journal of mental health systems*, 14(1), 1-18.

Emsley, E., Smith, J., Martin, D., & Lewis, N. V. (2022). Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives. *BMC Health Services Research*, 22(1), 1-12.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14(4), 245-258.

Finkelhor, D. (2018). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child abuse & neglect*, 85, 174-179.

Finkelhor, D., Shattuck, A., Turner, H. & Hamby, S. (2013). Improving the adverse childhood experiences study scale. *JAMA pediatrics*, 167(1), 70-75.

Harris, M. & Fallot, R.D. (2001). Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift. *New Directions For Mental Health Services*, 89, 3-22.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, 5(3), 377-391.

Hernandez, T. A. (2021). The consequences of the austerity policies for public services in the UK. *Studies in Social Justice*, 15(3), 518-537.

Homes, A., & Grandison, G. (2021). *Trauma-informed Practice: A Toolkit for Scotland*. Scottish Government & NHS Scotland.

Huang, L. N., Flatow, R., Biggs, T., Afayee, S., Smith, K., Clark, T., & Blake, M. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., ... & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet public health*, 2(8), 356-366.

Johnson, R., & Haigh, R. (2010). Social psychiatry and social policy for the 21st century – psychologically informed environments. *Journal of Mental Health and Social Inclusion*, 14(4).

Lanius, RA, Vermetten, E, & Pain, C. (2010). *The Impact of Early Life Trauma on Health and Disease : The Hidden Epidemic*, Cambridge University Press.

Madianos, M.G. & Evi, K. (2010). Trauma and natural disaster: The case of earthquakes in Greece. *Journal of Loss and Trauma*, 15(2), 138-150.

McAnallen, A., & McGinnis, E. (2021). Trauma-informed practice and the criminal justice system: A systematic narrative review. *Irish Probation Journal*, 18, 109-129.

Moreland-Capuia, A. (2019). The Challenge and Hope of System Change. *Training for Change: Transforming Systems to be Trauma-Informed, Culturally Responsive, and Neuroscientifically Focused*, 337-373.

Penna, S. (2021). Trauma-Informed Practice. *Children and Young People Now Select*, 2021(3), 29-33.

Quadara, A., & Hunter, C. (2016). *Principles of Trauma-Informed Approaches to Child Sexual Abuse: A Discussion Paper*. Sydney, Australia: Royal Commission into Institutional Responses to Child Sexual Abuse.

Talbot, N.L., Chapman, B., Conwell, Y., McCollumn, K., Franus, N., Cotescu, S. & Duberstein, P.R. (2009). Childhood sexual abuse is associated with physical illness burden and functioning in psychiatric patients 50 years of age and older. *Psychosomatic Medicine*, 71(4), 417.

Thiara, R. K., & Roy, S. (2022). 'The disparity is evident': COVID-19, violence against women and support for Black and minoritised survivors. *Journal of gender-based violence*, 6(2), 315-330.

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York.

Van Nieuwenhove, K. & Meganck, R., (2019). Interpersonal features in complex trauma etiology, consequences, and treatment: A literature review. *Journal of Aggression, Maltreatment & Trauma*, 28(8), 903-928.

Wood, S., Ford, K., Hardcastle, K., Hopkins, J., Hughes, K. & Bellis, M., 2020. *Adverse Childhood Experiences in child refugee and asylum seeking populations*.
Available at: https://research.bangor.ac.uk/portal/files/29132989/ACEs_in_child_refugee_and_asylum_seeking_populations.pdf [Accessed: November 2023].

Appendix

Table 3: Theme Definitions

Theme	Definition	Subthemes
Conceptualisation of Good Trauma-informed Practice (Keystone Theme)	Participants conceptualised good TIP in context of their own practice, others' lack of good practice, and barriers/gaps, as well as 'what is needed'. Spoke about good TIP in terms of "always being at the forefront of mind", and in relation to various different behaviours and attitudes needed for TIP. Strong sense of TIP being crucial for staff as well as service users.	TiP is always at the forefront of everything.
		Internal attitudes necessary for good TIP: Curiosity, Mindfulness, person-centred mindset.
		Being flexible and allowing agency is crucial to good TIP: But boundaries are equally important.
Systemic Resource Constraints as Barriers	Participants identified the system as being 'broken', referring to individual pockets of good practice within this context, and cited many different types of resource constraints which presented barriers to doing good trauma-informed practice, including time pressures, capacity issues, and budgetary constraints.	
Individuals as Barriers	People within and across organisations either didn't believe in trauma-informed practice (i.e. thought it was silly or 'namby-pamby'), or weren't trauma aware at all. Leadership sometimes wasn't supportive of TIP/TIP training needs or were only supportive from a distance, showing token support.	
Facilitators for doing good Trauma-informed Practice	Participants spoke about what helped them do good TIP and embed it into their organisation. Most participants spoke about having a passion for TIP which made it so they couldn't help but be trauma-informed, and having knowledge and confidence in their work, which training often helped to validate. Leading by example, which helps to evidence that TIP works to organisations and individuals not yet on board.	
Needs of the System for doing good Trauma-informed Practice	In speaking of the good practice, gaps, and barriers about TIP, participants articulated what was most needed: for the system to be aware of trauma-informed practice as a culture and a journey (not as a 'tick-box exercise') and that a culture change is needed; for the approach to be completely service user and needs-centred; and for it to begin with policy and commissioning strategies.	

Table 4: Has your organisation undertaken any Trauma-informed training?

	N	%
Yes	39	54.2%
No	28	38.9%
Missing	5	6.9%

Table 5: Has your organisation undertaken any training related to ACEs?

	N	%
Yes	39	54.2%
No	28	38.9%
Missing	5	6.9%

Table 6: How long was the Trauma-informed training?

	N	%
1–2 Hours	17	23.6%
Half a Day	12	16.7%
Several Days	4	5.6%
Across a Week	0	0.0%
Across Two Weeks	0	0.0%
Longer, i.e. from a month to several months	3	4.2%
Missing	36	50.0%

Table 7: How long was the training on ACEs?

	N	%
1–2 Hours	13	18.1%
Half a Day	8	11.1%
Several Days	10	13.9%
Across a Week	2	2.8%
Across Two Weeks	1	1.4%
Longer, i.e. from a month to several months	15	20.8%
Missing	23	31.9%

Table 8: When was the Trauma-informed training?

	N	%
In the last four weeks	4	5.6%
In the last three months	6	8.3%
In the last six months	11	15.3%
In the last year	13	18.1%
Longer than a year ago	15	20.8%
Missing	23	31.9%

Table 9: When was the ACEs training?

	N	%
In the last four weeks	2	2.8%
In the last three months	4	5.6%
In the last six months	8	11.1%
In the last year	10	13.9%
Longer than a year ago	12	16.7%
Missing	36	50.0%

Table 10: Does your organisation practice Trauma-informed Care/Practice?

	N	%
Yes	40	55.6%
No	18	25.0%
Missing System	14	19.4%

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