Trauma-Informed Practice: A Toolkit for Scotland

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Key Principle 5: Empowerment

Acknowledgements

We would like to thank all the dedicated people from case study areas for taking their time to contribute to this toolkit, explaining how and why their services are trauma responsive and the motivators and barriers to delivering these invaluable services.

We would also like to thank our expert panel for their contributions and Resilience Learning Partnership for their support in ensuring we could include people with lived experience throughout this project.

We have met some inspirational people over the two year journey of this project and we hope their experiences will prove useful to Scottish organisations wanting to start their journey to becoming trauma-informed.

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Foreword

We know that trauma can affect any one of us at any time, but the Covid-19 pandemic has significantly increased and exacerbated both the risk and the impact of trauma, particularly for people already affected by inequalities and Adverse Childhood Experiences (ACES).

Together, we have an opportunity to transform how we understand and respond to trauma in Scotland and we can start by taking a trauma-informed lens to everything we do. We want a Scotland where people are not blamed or punished for adverse experiences which are beyond their control, where a survivor is not made to feel shame or stigma for the trauma they have suffered. We want a culture where people experience empathy and kindness and are empowered to access the services they need to help support their recovery, and to build or strengthen trusting relationships with others.

Preventing and mitigating the impact of trauma and support for recovery is part of our fundamental human rights and I am proud that Scotland is set to become the first nation in the UK to embed the United Nations Convention on the Rights of the Child (UNCRC) into domestic law. This builds on the solid foundations that have already been built up over a number of years through the principles of Getting It Right for Every Child, a rights-based approach and one that firmly recognises the strength of relationships and human connections.

The Scottish Government's ambition, shared by COSLA and partners, is for a trauma informed workforce and services across Scotland. We have already invested over £1.5 million in our National Trauma Training Programme, led by NHS Education for Scotland (NES) and have made a commitment to extend this Programme for a further two years to support our workforce in developing a long-term, trauma informed approach to recovery from the pandemic.

This Trauma Informed Practice Toolkit has been developed to further support that ambition by providing our workforce with clear, tangible examples of where trauma informed practice has been successfully embedded across different sectors of the workforce and how that learning can be applied in a range of contexts. I would encourage you to use this Toolkit to help spark ideas and conversations within your own service or organisation as we continue to work together, to drive forward progress across professional boundaries, to enable the transformational change in our society that we all want to see.

Thank you

Clare Haughey

Minister for Mental Health

Executive Summary

- This Toolkit has been developed by the Rivers Centre (NHS Lothian's specialist service for people affected by psychological trauma) to support organisations, departments and teams across all sectors of the workforce, in planning and developing Trauma Informed Services. It should be used in conjunction with the training and implementation resources provided for both frontline staff, leaders and managers through the [National Trauma Training Programme](#), led by NHS Education for Scotland (NES).

- Together, these resources support the ambition of the Scottish Government, COSLA and many other stakeholders across Scotland for a trauma-informed and trauma-responsive workforce and services. They will help ensure that our services are delivered in ways that reduce barriers and prevent further harm or retraumatisation for those who have experienced psychological trauma or adversity at any stage in their lives.

- In recent years the field of psychological trauma has generated multiple toolkits aimed at helping organisations become more trauma-informed. Relatively few, however, have been based on trauma survivors' and staff views of what trauma-informed practice looks like in a real-world setting. Moreover, none of the toolkits has been based on real-world settings in Scotland.

- Firmly embedded in the existing published literature, the toolkit operationalises the NES TIP principles (Safety, Trust, Choice, Collaboration and Empowerment), (adapted from Fallot and Harris, Trauma-Informed Services: a Self-Assessment and Planning Protocol, 2006) by exploring real life, concrete examples of TIP being delivered in Scotland.

- The voices of trauma survivors, staff and leaders in the field are used throughout the document to define the steps organisations can take and the barriers that might get in their way. Case studies are drawn from settings across Scotland, namely general practice, mental health, residential care, police, criminal justice social work, addiction services and education.

- Findings have been translated into a set of questions (Appendix 1) to guide organisations in their self-assessments. A set of resources is offered to provide practical help with implementation (Appendix 2). Together, these comprise a toolkit for Scotland, aiding organisations on their journey towards becoming trauma-informed.

Introduction

Evidence of the full impact of trauma has been emerging now for several decades, establishing beyond doubt that its effects can be wide-ranging, substantial, long-lasting and costly. Resulting from harmful experiences such as violence, neglect, war and abuse, trauma has no boundaries with regard to age, gender, socio-economic status or ethnicity, and represents an almost universal experience across the countries of the world. The seminal Adverse Childhood Experiences (ACE) study (Felitti, et al., 1998) suggests that childhood trauma is common: 30 per cent of the sample of over 17,000 people reported substance use in their household; 27 per cent reported physical abuse; 25 per cent reported sexual abuse; 13 per cent reported emotional abuse; 17 per cent reported emotional neglect; 9 per cent reported physical neglect; and 14 per cent reported seeing their mother treated violently.

Research exploring the distribution of traumatic events based on gender, age, ethnic background and socio-economic status has shown that traumatic events are more frequently experienced by people in low socio-economic groups and from black and minority ethnic communities (Hatch & Dohrenwend, 2007). In Scotland, one in seven adults reported four or more ACEs, with those in the most deprived areas twice as likely than those in the least to experience this quantity of ACEs. ACEs have also been shown to be highly correlated with socio-economic disadvantage in the first year of life (Marryat & Frank, 2019). Those who reported four or more ACEs were significantly more likely to have lower mental wellbeing scores, be obese, have cardio-vascular disease and/ or limited long term physical or mental health conditions (Scottish Health Survey, 2019). A study involving a systematic review of the international literature estimated that half of the people in contact with mental health services had experienced physical abuse and more than one-third had experienced sexual abuse in childhood or adulthood, indicating rates that were significantly higher than the general population (Mauritz, Goossens, Draijer, & van Achterberg, 2015). Other surveys have found that people using mental health services are substantially more likely to have experienced domestic and sexual violence in the previous year compared to the general population (Khalifeh, et al., 2015).

These prevalence rates have driven a stream of research studies that have explored the ways trauma can lead to mental health problems (Cooke, 2016; Harper, Stalker, & Gadbois, 2008; Karatzias, Ferguson, Gullone, & Cosgrove, 2016; Kucharska, 2018; Mueser & Rosenberg, 2003; Salter & Richters, 2012; Xie, Jiuping, & Zhibin, 2017). The impact of trauma on behaviour has also been demonstrated in terms of contact with Social Work or the Criminal Justice System (CJS), or difficulties in education, employment or the primary care system (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014).These studies have all added to a growing evidence base demonstrating that large numbers of people in contact with public services have experienced traumatic events (Greenwald, et al., 2012); that these experiences are causal in the development of mental distress (Morrison, Frame, & Larkin, 2003; Dillon, Johnstone, & Longden, 2012) and that there is a relationship between the severity, frequency and range of traumatic experiences, and the subsequent impact on mental health.

In the wake of the COVID-19 global pandemic the impact of trauma has seldom been more evident, with many organisations increasingly seeing the need to address trauma as an essential component of service delivery. Addressing trauma, however, requires a multifaceted, multi-agency approach that includes awareness-raising and education, upstream working, and effective trauma focused assessment and treatment. To maximise impact, all of these efforts will need to be made in a context that is trauma-informed, based on a sound understanding of trauma and its far reaching implications.

The journey towards becoming a trauma-informed organisation will require organisations to move beyond their traditional models of service delivery and to re-evaluate their entire organisational practices and policies through a trauma-focused lens. As part of this reconceptualisation of services, organisations will need to reframe complex behaviours as potential responses to trauma related triggers and will be required to prioritise the building of trusting, mutual relationships above all else. A rich body of work on trauma-informed practice points the way in this respect (Harris & Fallot, 2001; Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; Chandler, 2008; Domino, Morrissey, Chung, & Nadlicki, 2006; Gatz, et al., 2007; Greenwald, et al., 2012; Messina, Calhoun, & Braithwaite, 2014; Morrissey, et al., 2005; Weissbecker & Clark, 2007; Bloom S., 2013), identifying the direction of travel for new models of service delivery: "from fear to safety, from control to empowerment, and from abuse of power to accountability and transparency" (Concetta, 2018). Scotland became the first country to recognise and respond to this need by implementing a National Trauma Training Programme (NTTP), led by NHS Education for Scotland. It provides evidence-based training resources which can help raise awareness, knowledge and confidence among the Scottish workforce, so people are equipped to embed trauma-informed practice throughout services.

Fundamental to this direction of travel has been the development of a working concept of trauma and a shared understanding of the steps organisations can take in their journey towards trauma-informed practice. Although decades of work have generated multiple concepts and a range of terminology, however, there has been substantial consensus concerning a definition of trauma (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014) and the following working definition will be used for the purposes of this document:

> **Trauma**
>
> **Individual trauma results from an event, series of events, or set or 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 and mental, physical, social, emotional or spiritual well-being.**

What is Trauma-informed Practice?

The development of Trauma-informed Practice (TIP) can be traced to the USA and to the ground breaking work of Maxine Harris and Roger Fallot (Harris & Fallot, 2001), and Sandra Bloom (Bloom S., 2013). Based on the models they developed, TIP is now widely understood as follows (Paterson, 2014):

> **Trauma-informed Practice**
>
> **A model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development.**

As such, TIP is informed by neuroscience, psychology and social science as well as attachment and trauma theories, and gives a central role to the complex and pervasive impact trauma has on a person's world view and relationships. It is applicable across all sectors of public service, including social care, physical health, housing, education, and the criminal justice system (Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2008; Havig, 2008; Cole, Eisner, Gregory, & Ristuccia, 2013). Trauma-informed organisations assume that people have had traumatic experiences, and as a result may find it difficult to feel safe within services and to develop trusting relationships with service providers. Consequently, services are structured, organised and delivered in ways that promote safety and trust and aim to prevent retraumatisation. Thus, trauma-

informed services can be distinguished from trauma-specific services which are designed to treat the impact of trauma using specific therapies and other approaches.

Adapting an analogy used by Harris & Fallot (Harris & Fallot, 2001), the development of organisations that are trauma-informed is akin to the development of organisations that are disability-informed. The Disability Discrimination Act of 2005 states that organisations must make reasonable adjustments to their services and premises to ensure that disabled people can access them. As a result, buildings must provide access for people in a wheelchair, services need to provide written information in a variety of formats, and convenient parking must be provided for people with a disability. In this context, organisations were not required to deliver specific services to people with disabilities, but instead were required to make their services more accessible.

Why is it important to be trauma-informed?

A review of the literature provides evidence that trauma-informed practice is effective and can benefit both trauma survivors and staff. For trauma survivors, trauma-informed services can bring hope, empowerment and support that is not re-traumatising. Moreover, such services can help close the gap between the people who use services and the people who provide them (Filson & Mead, 2016).

"I think one of the key benefits is about creating more empathy within staff. For some reason it just really hits a note with people and behaviours which they had… You know, they've been given some of this information before but it just draws it together, and it seems like quite a powerful way to help staff make sense of people's presentation." (Mental Health)

For trauma survivors involved with the Criminal Justice System, evidence has suggested that trauma-informed practice can reduce the time to discharge for youth in secure care (Greenwald, et al., 2012). Another study found evidence of increased offender responsivity to evidence-based cognitive behavioural programmes that reduce criminal risk factors (Miller & Najavits, 2012). Trauma-focused alternatives to seclusion in an in-patient ward were also found to reduce restraints and seclusions for youth in secure psychiatric care (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011). Furthermore, trauma-informed interventions for 'hard-to-reach' populations were found to increase engagement with treatment, reduce substance misuse, and reduce trauma-related symptoms (Cocozza, et al., 2005; Chung, Domino, & Morrissey, 2009; Gatz, et al., 2007).

"Understanding distressing behaviour amongst pupils means a calmer school. More compassionate staff. Better-behaved children. More emotionally stable children. You can see their self-esteem begin to build ... Attendance improved and exclusions dropped. Improved behaviour overall. Wellbeing language improved. Children's confidence and self-esteem improves." Education

"If you're going to work in a trauma-informed practice approach, that actually benefits everybody because it actually then means that the people who are keeping all of that buried, who may be…you know, repeatedly presenting as physical complaints, that actually that then enables them. And actually, in the longer term, it actually means you provide better care........ What I try and get across to people though is that if you do…if you apply trauma-informed practice approaches, then actually what that means is that over serial consultations,… you save time, people seem to feel better. And you get to where you need to with healthcare concerns." General Practice (GP)

With regard to the benefits of trauma-informed practice for staff, evidence is emerging that people who work in human services have a high prevalence of ACE scores themselves (Esaki & Larkin, 2013). Healing thus becomes just as relevant to staff as it is to service users, making the provision of staff training, supervision and support of utmost importance (Menschner & Maul, 2016b). Indeed, organisations that do not support their staff to take care of themselves run the risk of exposing them to secondary traumatic stress, vicarious trauma and burnout, all of which will inhibit their ability to provide high quality care (National Child Traumatic Stress Network (NCTSN), 2011).

> *"You're coming from a very kind of trauma-informed place with the knowledge of why somebody might be acting in a certain way. I think you can feel more confident about the action that you're taking and not over-react or be overly kind of punitive.... It reduces staff burnout and it also kind of is good to think about the impact of trauma on staff and that you feel kind of more confident to talk about how you might be feeling when things are difficult." (Police)*

The importance of staff support in the context of a global pandemic has been particularly evident recently, with studies demonstrating that levels of stress and burnout are reduced among frontline workers when they feel well prepared for their role as a result of specialised training, or when they feel confident in their own knowledge and understanding of the situation (Lai, et al., 2020; Brooks, Rubin, & Greenberg, 2019; Wong, Wong, Lee, & Goggins, 2007; Maunder, et al., 2006). The importance of leaders that convey compassion and sensitivity has also been underlined (Trauma-informed Oregon, 2020; Shanafelt, Ripp, & Trockel, 2020), and evidence is growing that the nurturing of self-compassion among healthcare staff can enhance staff wellbeing (Cole, et al., 2020; Flowers, et al., 2018). Recent studies have also suggested that the building of support mechanisms into daily work routines can provide space for staff to look out for each other and reflect on shared experiences, with reports that time spent on such exercises can result in significant improvements in staff wellbeing (Bailey & West, 2020).

Key principles

The key principles underlying TIP are listed below, adapted from Fallot and Harris (Fallot & Harris, 2006).

Key principles of trauma-informed practice

1. Safety

Efforts are made by an organisation to ensure the physical and emotional safety of clients and staff. This includes reasonable freedom from threat or harm, and attempts to prevent further retraumatisation.

2. Trustworthiness

Transparency exists in an organisation's policies and procedures, with the objective of building trust among staff, clients and the wider community.

3. Choice

Clients and staff have meaningful choice and a voice in the decision-making process of the organisation and its services.

4. Collaboration

The organisation recognises the value of staff and clients' experience in overcoming challenges and 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 the organisation to share power and give clients and staff a strong voice in decision-making, at both individual and organisational levels.

Although there may be differences in terms of their application, it is widely acknowledged that these principles are relevant across the public sector and its range of services. It is also recognised that the development of trauma-informed practice requires systematic alignment with these five principles, along with change at every level of an organisation. For this reason, the implementation of TIP is often described as an ongoing process of organisational change, requiring a profound paradigm shift in knowledge, perspective, attitudes and skills that continues to deepen and unfold over time (Alive and Well Communities Educational Leader's Workgroup, 2014). Thus the literature increasingly refers to a 'continuum' of implementation, where TIP is a journey, not a destination.

The 5 key drivers for organisational change recognised by NES include: 1) Leadership and Management; 2) Workforce Wellbeing; 3) Workforce knowledge and skills; 4) Experts by Experience; and 5) Data and information. For the purposes of developing a toolkit, we have used SAMHSA's published guidance (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014) which adopt more detailed implementation domains, drawn both from the organisational change management literature and from models of trauma-informed practice (Farragher & Yanosy, 2005; Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Huang, et al., 2012; Fallot & Harris, 2006). Not all implementation domains will be directly attributable to every organisation, however they have provided the necessary detail needed to ensure the toolkit is detailed enough to be actionable across organisations.

Ten implementation domains

1. Governance and leadership

The leadership and governance of the organisation support and invest in implementing and sustaining trauma-informed practice. There is an identified point of responsibility within the organisation to lead and oversee this work. There is inclusion of the peer voice.

2. Policy

There are written policies and protocols establishing trauma-informed practice as an essential part of the organisational mission. Organisational procedures and cross-agency protocols reflect trauma-informed principles.

3. Physical environment

The organisation ensures that the physical environment promotes a sense of safety and collaboration. Staff and clients must experience the setting as safe, inviting, and not a risk to their physical or psychological safety.

4. Engagement and involvement

Staff, clients and their family members have significant involvement, voice, and meaningful choice at all levels and in all areas of organisational functioning.

5. Cross sector collaboration

Collaboration across sectors is built on a shared understanding of trauma and the principles of trauma-informed practice.

6. Screening, assessment and treatment services (Direct service provision)

Practitioners use and are trained in interventions that are based on the best available empirical evidence and science, are culturally appropriate, and reflect the principles of trauma-informed practice. Trauma screening and assessment are an essential part of the work (where relevant). Where interventions are not being delivered in organisations, direct services are provided which are culturally appropriate and reflect trauma-informed practice principles.

7. Training and workforce development

There is ongoing training in trauma chand peer support. The organisation's human resource system incorporates trauma-informed principles in hiring, supervision and staff evaluation. Procedures are in place to support staff with trauma histories and/or those experiencing secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals affected by trauma.

8 Progress monitoring and quality assurance

There is ongoing assessment, tracking and monitoring of trauma-informed principles and effective use of evidence-based trauma-specific screening, assessments and treatment.

9 Financing

Financing structures are designed to support trauma-informed practice which includes resources for: staff training on trauma; key principles of trauma-informed practice; development of safe and appropriate facilities; establishment of peer support; provision of evidence-based trauma screening, assessment, treatment and recovery supports; and development of trauma-informed cross-agency collaborations.

10 Evaluation

Measures and evaluation designs used to evaluate service or programme implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To guide the implementation further, SAMHSA also provided sample questions for each of the ten domains to help stimulate discussion within organisations (Henry, Black-Pond, Richardson, & Vandervort, 2010; Hummer & Dollard, 2010; Penney & Cave, 2013; Fallot & Harris, 2006).

The development of a toolkit for Scotland

In recent years the field of trauma has generated multiple toolkits aimed at helping organisations become more trauma-informed. Relatively few, however, have been based on trauma survivors' and staff views of what trauma-informed practice looks like in a real-world setting. Moreover, none of the toolkits has been based on real-world settings in Scotland.

This guidance document aims to fill this gap, using the unifying framework of trauma-informed principles and implementation domains described above. It reports the findings of a two-year piece of translational research, giving a strong voice to both service users and staff, identifying concrete examples of TIP across a wide variety of settings. These findings are translated into a set of questions (Appendix A) and associated tools to help organisations on their trauma-informed journey.

> *"I think there's a lot of misunderstanding about exactly what that phrase is and exactly what true trauma-informed care is. And hopefully by painting a very good picture across sectors in something that's easy for people to read, they'll start realising that actually…a lot of people are not doing trauma…you know, they haven't started their trauma-informed care journey." (GP)*

Methodology

Phase One

A literature review was conducted to establish the theoretical underpinnings of trauma-informed practice and identify the sector areas where an evidence base existed for best practice. The scoping consisted of literature searches, web searches and a Rapid Evidence Assessment (REA), The REA included searches of the following databases:

PsycINFO, Medline, CINAHL+ with full text, ERIC (Education Resources Information Centre), Criminology Collection, Education Collection, Social Sciences Database, Sociology Collection, Cochrane Library, and the Campbell Collaboration. A literature review was conducted to establish the theoretical underpinnings of trauma-informed practice and identify the sector areas where an evidence base existed for best practice. The scoping consisted of literature searches, web searches and a Rapid Evidence Assessment (REA), The REA included searches of the following databases: PsycINFO, Medline, CINAHL+ with full text, ERIC (Education Resources Information Centre), Criminology Collection, Education Collection, Social Sciences Database, Sociology Collection, Cochrane Library, and the Campbell Collaboration. Final results from the literature searching are included in Appendix 11. All findings from the literature review were recorded in excel spreadsheets, including key themes, Trauma-informed model adopted, barriers to implementing TIP and adopted outcome measures. Useful general, and sector specific toolkits and reading from the literature review are included in Appendix 8.

Phase Two

The following sources were used to identify potential areas of best practice in Scotland:

- findings from two focus groups with survivors on their experiences of services (recruited through Resilience Learning Partnership);

- information gathered at attendance of conferences and seminars on Trauma-informed Practice in Scotland; and

- findings from a WebQuest survey of members of the National Steering Group on Trauma Training.

Attempts were made to contact each potential case study identified. Data was gathered by telephone interview, based on a paper identifying key ingredients necessary for successful trauma-informed care implementation (Menschner & Maul, 2016a).

The following sector areas and associated case studies were selected:

Sector	Case Study
General Practice	Homelessness GP services, Glasgow
Mental Health	Learning Disability Services, Fife Rivers Centre, Edinburgh
Residential Care	Kibble, Paisley
Police	Violence Against Women and Community Policing, Clackmannanshire
Criminal Justice Social Work	Criminal Justice Social Work groupwork[1] services, Edinburgh including the Willow service
Addiction Services	We Are With You (formerly Addaction), South Lanarkshire
Education	Three schools in Edinburgh (Balgreen Primary School, Broomhouse Primary School, Rowanfield Special School)

Overall ethical approval was assessed using the Scottish Government Social Research Ethics Checklist. Ethical approval was also gathered from two case study areas through their own internal systems (We Are With You and Kibble). Council access was granted for Criminal Justice Social Work and Education services. The remaining sites were approved through Quality Improvement (QI) Systems.

Phase Three

In total, 50 depth interviews (primarily paired depth and triad interviews) were conducted as part of the qualitative fieldwork. Semi- structured interviews were completed either by telephone or virtually (due to Coronavirus restrictions) with staff (including management) and service users on the implementation of TIP and their experiences of 'touch-points' of direct interaction with services. Information on perceived barriers to implementation were also collected.

Phase Four

The qualitative data gathered from the case study areas during the course of the fieldwork were transcribed and analysed using a coding framework based on the SAMHSA principles and implementation domains (SAMHSA, 2014). The data was then triangulated with findings from the literature review.

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1   Domestic Abuse Services, Crossroads and Community Intervention Service for Sexual Offending

Key Principle 1: Safety

Efforts are made throughout the organisation to ensure that staff and the people they serve feel physically and psychologically safe. Staff and clients should experience the setting and the interpersonal interactions taking place within the setting as safe, inviting, and not a risk to their physical or psychological safety.

Physical Environment

All of the case studies demonstrated an understanding that safety was a priority for their clients. Each case study organisation had taken steps to ensure the physical environment promoted a sense of safety and protection, and created a welcoming and domestic atmosphere. Considerable effort had been made by staff to create waiting rooms and consulting rooms with a 'living room' ambience, where people could feel comfortable and at ease.

Opaque screening and sound proofing were used where possible, to reinforce a sense of privacy and confidentiality. Furnishings were chosen specifically for their non-institutional qualities, and attention was paid to detail such as the selection of neutral pictures for the walls, ambient music instead of a radio playing, and the availability of reading materials that were non-triggering. In police stations, a living room style was created in interview rooms for victims and/or vulnerable people to try to promote a sense of safety.

A waiting room (Mental Health), a treatment room (Addictions) and a nurture room (Education).

Toolkit

? How does the physical environment promote a sense of safety, calming and de-escalation for clients and staff?

? In what ways do staff members recognise and address aspects of the physical environment that may be retraumatising, and work with either a) improving the environment and/or b) with people on developing strategies to deal with this?

🔧 Trauma-informed Lens

? How do the organisation's written policies and procedures include a focus on trauma and issues of safety and confidentiality?

🔧 Policy and Procedures review

? How has the organisation provided space/opportunities that both staff and people receiving services can use to practise self-care?

In some cases, areas were zoned to maximise a feeling of protection. In the waiting room of one service, this was created using seating clusters and high-backed curved-carcass chairs. In one case study area, this was created using panel boards. In the context of residential care, the needs of children and young people were addressed through the creation of calm areas or communal zones. In most cases, lighting was usually intentionally kept subdued and colour schemes neutral to avoid overstimulation.

A classroom using "zoning"

Interviewees described conducting a 'trauma-informed walk through' of their respective premises to inform the establishment of a physically and emotionally safe environment for service users and staff.

> *"…a really simple example is we did a walk round and thought, what is potentially scary here? And an example were there was a smashed window that nobody had noticed for like six months, just a tiny one. There was burglar-proofing, like barbed wire stuff on a drainpipe. Loads of things like that, and it was like, why are these still here? It was just asking that question and we made some good changes to that."* (Residential care).

Several case study areas described the importance of taking into account gender differentials when choosing a site, ensuring there are waiting rooms with enough space to provide distance when needed, especially for people who have experienced gender-based violence.

> *"For these kids, it was about having different areas for different moods or needs, if you like. So, a play area, a calm area, a communal area, lots of outside area."* Residential setting.

> *"It's a female only, and I know that sounds horrible, but we're not men haters or that, but it's just easier, like to sit and like talk and that, if that makes sense…. Just because a lot of women have been hurt or been in like domestic abuse relationships and that, so it's not really good or handy like to have a man around, much better and easier for women to open up to women."* (CJSW)

The premises of some case studies had kitchen areas connected to the reception, adding to an atmosphere of domesticity, where people were encouraged to prepare their own tea or coffee on arrival. Alternatively, welcoming reception staff offered drinks to visitors, or a water cooler was available.

"They also offered to make you a cup of coffee and all that... I thought that was... That's a nice touch, you know what I mean? That is a nice thing… because that makes you feel like a human." (Addictions)

The importance of the environment was highlighted by interviewees with lived experience.

"It just makes you feel like you're not in a threatening place, and for me anyway, somewhere…clinical places can often be a bit, because they remind you of police cells or police stations or hospitals or, for me, care, like secure units." (Police)

Interviewees regularly highlighted that staff working with trauma survivors should be empathetic, compassionate, non-judgemental and have good listening skills. In every case study area, these qualities and skills were clearly prioritised, and were reflected by recruitment processes in the form of person specifications and job descriptions. In one case study area, the reception staff were mentioned in every interview as being central to the creation of an emotionally safe environment for both staff and service users.

"…you come in, and [receptionist], she's amazing, she's like the most friendliest like receptionist I've ever known in my life, and she just makes you so welcome, and like do you want a cup of tea, coffee, so then you'll sign in and you'll say who you're here to see. And then you might sit in the like…the sitting area with [receptionist]." (Criminal Justice Social Work)

It was also acknowledged that a balance had to be struck between attempts to create an atmosphere of domesticity and the need for appropriate security measures, such as door buzzers and secure entry systems, to help service users and staff feel safe.

Toolkit

? How has the organisation specifically recruited for individuals who have the skills and qualities necessary to be trauma-informed, e.g. empathetic, welcoming and caring?

🔧 Hiring a Trauma-Informed Workforce

🔧 Getting Lived Experience on Board

? How will the organisation ensure all workers respond to survivors in a way which is emotionally safe? For example, providing training to staff at all levels.

? How does the organisation ensure that all staff (direct care, supervisors, front desk, etc) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions?

🔧 Training

Screening, assessment and treatment services

Trauma screening has been described in the literature as: "a brief, focused inquiry to determine whether an individual has experienced specific traumatic events" (Harris & Fallot, 2001).

In most case study areas, universal trauma screening was not considered appropriate for the organisation. In these sectors, creating the milieu which made people feel at ease to maximise disclosure, and directly asking the person if they had experienced a traumatic event were deemed more appropriate.

Universal screening for trauma was adopted in three case study areas, using psychometric tools such as the International Trauma Questionnaire (ITQ), ACEs and BCEs. Most services also screened for socio-demographic factors, employment status and life skills.

One case study area described working alongside healthcare services to develop their own tailored screening tool called the Trauma and Mental Health Screener (TAMHS). Staff received specific training in how to use this, as well as additional mental health training which was particularly important to their sector.

> *"one section of the TAMHS is a kind of summary / formulation of the findings, and that summary / formulation often goes into the report ... with quite a strong caveat that this…so it's a screening tool, rather than a thorough mental health assessment or trauma and mental health assessment." (Criminal Justice Social Work)*

In most of the other case study areas, staff would screen for trauma histories at the assessment stage, or when they felt it was appropriate.

> *"the first time you meet somebody, that rapport isn't there, they maybe don't feel safe coming to a service. And then if you're asking these questions on a questionnaire, that really, it could put the fear into them, and you might never see them again. So it was very much, gauging when the right time is to do that." (Addictions)*

Toolkit

? Is timely trauma-informed screening and assessment suitable for your service? If so, is it available and accessible to individuals receiving services?

? How does the organisation address gender-based needs in the context of trauma screening, assessment, and treatment? Do they offer gender specific services? Can they refer to someone who does?

? If suitable, how do staff still ask the difficult questions which need to be asked to identify trauma and how are they supported to do this? How confident are they in doing this? So they need further training?

Asking about trauma

? Is there an organisational policy on how screening should be completed and/or how service users should be asked about trauma? Should there be?

Policy and Procedures review

Training

Staff Wellbeing

Trauma-specific models and therapeutic modalities

There should be an agreed format to follow (an agreed screener/questionnaires for the team to use, as well as a clear format for assessment). Trauma training provided to staff should include an element focusing on these issues as workers responses are important when a disclosure is made, as they can reduce the risk of traumatisation or retraumatisation.

Most of the case study areas used an appropriate model to underpin their service delivery, as this was deemed important for the congruence of practice. The most commonly used trauma-informed models were based on the work of Harris & Fallot or SAMHSA. Two case study areas had adapted existing models to meet their own requirements.

Trauma-specific models included Judith Herman's phased-based trauma model and the Seeking Safety model developed by Lisa Najavits (2002).

Case study organisations that were involved in the delivery of treatment services confirmed that their clinicians and practitioners were trained in the use of evidence-based interventions and adhered to the recommendations of treatment guidelines and guidance documents, such as the NICE guidelines for PTSD or the Matrix.

Staff commonly described the importance of having tools they could use to help stabilise their clients. Interviewees emphasised the need for staff to be trained in the delivery of safety and stabilisation interventions in particular, given the role of these self-management skills in increasing a sense of emotional safety for clients. Highlighted interventions included grounding techniques, breathing exercises and mindfulness.

> *"The big difference for me out of the whole thing was given the practical tools because that's stuff that you could take with you for the rest of your life, you know. I've never had that kind of help before." (Addictions)*
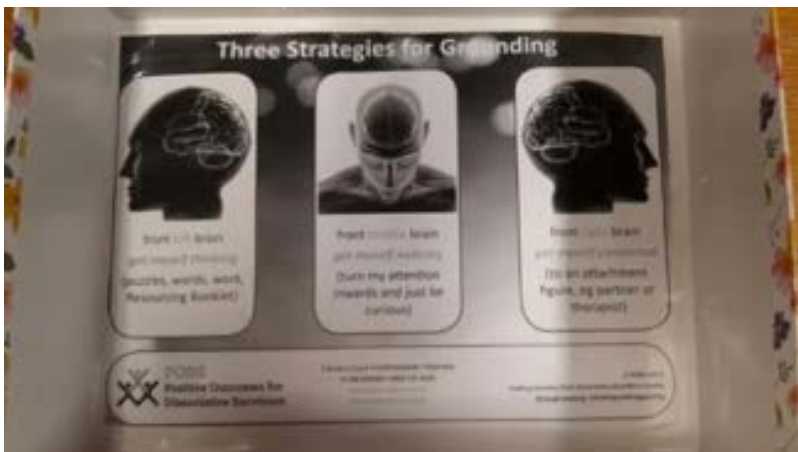
Toolkit

? What is the specific model underpinning the organisation's trauma-informed work? Their trauma-specific work?

? Does the organisation have the capacity to provide trauma treatment or refer to appropriate trauma treatment services? Is there a wait for these? If so, is there an alternative way of providing this service?

Trauma-specific models and therapeutic modalities

? Do staff members talk with people about the range of trauma reactions and work to minimise feelings of fear or shame and to increase self-understanding? Can/should they be completing safety and stabilisation work with the client?

Background materials for explaining effects of trauma

Trauma training

Advice on how to use trauma-sensitive language

? How are these trauma-specific practices incorporated into the organisation's ongoing operations?

Policy and Procedures Review

In one case study area, a specific safety and stabilisation training programme was routinely provided to a sub-group of clinical staff.

The training introduced staff to the concept of the 'window of tolerance' and referred to various methods of emotion regulation. The programme was being evaluated with a view to rolling it out to other staff groups. Another case study area provided 'calming boxes' to trauma survivors. Others offered 'fidget' objects that supported the safety and stabilisation work delivered in the course of psychological treatment.

To support staff in the delivery of such interventions, interviewees highlighted the importance of self-care, supervision and opportunities for reflection.

> *"About self-care, so when you first come to [name of service], everybody has a self-care plan which…it's mandatory to kind of create in a collaborative way."* *(CJSW)*

> *"we have group supervision weekly, a reflection space where we can bring difficult exchanges…it's about kind of the emotional impact of the work." (CJSW)*

Toolkit

? How does ongoing workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors?

🔧 Trauma training

? What types of training and resources are provided to staff and supervisors on incorporating supervision in their work?

🔧 Staff Wellbeing

? Would creating a specific policy in accessing supervision in your service create more service congruency?

🔧 Policy and Procedures review

? Are staff given the opportunities to come together and reflect?

🔧 Staff Wellbeing

In a police setting, the inherent stigma which can be attached to selfcare was raised as a barrier, although it was recognised this has changed in recent years and the mental health and safety of officers and staff is now better recognised. There is now a range of tools and networks to support wellbeing and resilience (including Lifelines Scotland).

Training and workforce development

Some staff talked about an inherent tension between the trauma-informed principle of safety and practices that related to the core function of their organisations. Some practices, staff suggested, would inevitably compromise a trauma survivor's sense of safety and would potentially cause retraumatisation. For example, being held in police custody, receiving a custodial sentence, being detained under the Mental Health Act, or having children removed by Children and Families Social Work, were all seen as potentially re-traumatising processes.

In these circumstances, it was suggested that an awareness of a client's trauma history and the diverse ways that traumatic experience can manifest itself can help staff to reframe complex behaviours as a response to relational triggers. Hostility, manipulative behaviour, lack of motivation, or resistance to services can be reframed as survival mechanisms that are triggered in the face of perceived threat. Through the consistent communication of empathy, warmth, respect and hope, staff maintained that they could provide powerful corrective relational experiences, challenging a client's working models of self and others, and enabling them to update these models in the context of new relational experiences.

> *"The more cynical officers are the ones that have been exposed to more things, you know, or potentially been really assaulted or had really traumatic experiences at the hands of certain people and we're trying to change their viewpoint a bit in how we can help these people not behave the way they've behaved to them before."* *(Police)*

> *"Understanding distressing behaviour amongst pupils means a calmer school. More compassionate staff. Better behaved children. More emotionally stable children."* *(Education)*

> *"…we would be really breaking down barriers of perceptions that police officers already had, you know, just a kind of good/bad thing – people are bad, they're on drugs, if they do this then that's it, they're going to be that way – then fine, we'll just lock them up."* *(Police)*

Pressures on staff time were also highlighted as a potential barrier which could get in the way of a welcoming or engaging approach. However, staff acknowledged that training and the experience of delivering trauma-informed practice would highlight the importance of these methods of informal engagement.

> *"So if a person's waiting outside and I'm coming in, I'll always say, hello, how are you, …so I understand the reasons why sometimes professionals will ignore patients, it is because they don't want to be asked something. They don't want to be interrupted as they're on the move from…and…yeah. And…very occasionally that then does happen. But I think that's okay 'cause that balances out all other many, many times when people are just pleased that person's saying hello to them."* *(GP).*

Toolkit

? How do the organisations written policies and procedures recognise the pervasiveness of trauma in the lives of people (using the services and working in them), and express a commitment to reducing retraumatisation and promoting well-being and recovery?

? How does workforce development/ staff training address the ways identity, culture, community, and oppressions can affect a person's experience of trauma, access to supports and resources and opportunities for safety?

Background materials for explaining effects of trauma

Training

? How do the organisation's written policies and procedures recognise the pervasiveness of trauma in the lives of people (using the services and working in them), and express a commitment to reducing retraumatisation and promoting well-being and recovery?

? How do the organisation's staffing policies demonstrate a commitment to staff training on providing services and support that are culturally relevant and trauma-informed?

Policy and Procedures review

Trauma training was considered to be a key method of facilitating a raised awareness in this respect and interviewees consistently commented that one outcome of such training was an increased empathy towards clients. It was also reported that training helped staff understand the importance of providing a safe and nurturing environment for the growth and healing of trauma survivors.

"I think one of the key benefits is about creating more empathy within staff. For some reason it just really hits a note with people…it seems like quite a powerful way to help staff make sense of people's presentation." (Mental Health)

"I mean, I think all healthcare professionals should have it, from… if anything just from a professional wellbeing point of view, it means if you understand why some of those difficult consultations that don't seem to make sense happen…if you're able to understand what that is, then that reduces burnout, increases professional wellbeing, all of those things." (GP)

The importance of staff wellbeing was emphasised by interviewees from each case study area, along with the need to incorporate trauma-informed staff wellbeing policies throughout the organisation's human resource systems. Staff identified the need for training in secondary traumatic stress and vicarious traumatisation, and called for procedures to be put in place to support staff who had their own trauma histories or who may have been affected by working with trauma survivors.

Toolkit

? How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors?

Hiring a Trauma-Informed Workforce

Training

? How does the organisation help staff deal with the emotional stress that can arise when working with individuals who have had traumatic experiences?

? How is the emotional safety of staff considered by the organisation? Promoting self care, ensuring staff are adequately supported, staff are involved in feeding into the organisation how this should happen?

Staff Wellbeing

Policy and Procedures Review

Progress monitoring and quality assurance

Mechanisms to monitor trauma-informed principles

All case study areas were collecting some form of data from service users and staff on the implementation of trauma-informed practice (Appendix 7) shows which elements of trauma-informed practice were being evaluated, how the data were collected, which measurements were used and how findings were reported. Other case study areas assessed, tracked, or monitored trauma-informed principles by gathering data specifically relating to trauma training, most often using pre- and post-measures.

Key barriers to the effective assessment and monitoring of trauma-informed principles included the complexity of evaluation systems, a lack of analysis frameworks, and restrictions on time and resources (Purtle, 2018).

Financing

Interviewees emphasised that many changes can be done with minimal cost, and even small changes can make a big difference to trauma survivors. In many of the case study areas, changes to the physical environment had been made as a result of donations from staff, service users or the wider community.

Staff highlighted the need to conduct robust evaluations of any changes, using direct feedback from service users to build a case for additional funding. In this respect applications to local sources of funding, such as health foundations or small grant awarding bodies can be particularly fruitful. Several of the case study services had also secured funding for their work from Scottish Government innovation grants or funds aimed at reducing the poverty gap.

There was widespread acknowledgement that large-scale measures that might greatly improve the physical and emotional safety of staff and clients, such as the relocation of service premises or the upgrading of furnishings and facilities, are usually not possible without additional sources of funding. However, Domino et al. (2005) highlighted they found trauma-informed, integrated services to be cost-effective, improving outcomes but not costing more than 'standard programming".

Toolkit

? How does the budget support provision of a safe physical environment?

? How does the organisation's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development?

? What funding exists for cross sector training on trauma and trauma-informed approaches?

? What funding exists for peer specialists?

? What mechanisms are in place for information collected to be incorporated into service delivery?

Evaluation

Trauma-informed leadership

Evaluation

Problems with the evaluation of trauma-informed practice have been identified in the literature: "…an amorphous concept that has been defined in a number of ways, making it difficult to evaluate initiatives" (Hanson & Lang, 2014). There was evidence that several of the case study organisations were using appropriate trauma-oriented research instruments to evaluate the effectiveness of their services.

Only three case study areas were conducting evaluations involving a control group or theory of change model. The evaluative approaches used in each case study area are shown in Appendix 7.

Toolkit

? Does the organisation gather feedback from both staff and individuals receiving services?

Getting Lived Experience on Board

? What strategies and processes does the organisation use to evaluate whether staff members feel safe and valued at the organisation?

? How does the organisation include cultural factors in monitoring and quality assurance?

? What mechanisms are in place for information collected to be incorporated into the organisation's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?

Progress Monitoring and Quality Assurance

Evaluation

Key Principle 2: Trustworthiness

This principle refers to the degree to which organisational operations and decisions are conducted with transparency, with the goal of building and maintaining trust among clients and their family members, and among staff and others involved in the organisation.

Screening, assessment and treatment services

Service users reported high levels of trust in the staff providing these services. They explained that feeling safe, being treated with respect and being listened to, led to the development of a trusting relationship. Interviewees stressed the importance of professionals realising that trust from service users needs to be "earnt", especially if they have had negative experiences with services before.

> *"...being able to...you know, being able to open up about things that, you know, I haven't told anyone else in the world. Anyone else in the world. Feeling safe enough to be able to do that...that's really special. What I mean to say is, that's the level of safety and trust that was there, you know." (Addictions)*

> *"I know...they've got my best interests at heart and that, unless I need to speak to them, they'll guide me, they'll give me guidance, and I know that a lot of the women trust them and that. I know at first quite a lot of the women don't trust them, they say the same here, because social work, social work, social work, and quite a lot of us have had bad experience with social work, and it's not fair that they tar them all with the same brush." (CJSW)*

Interviewees spoke about the need for clarity and transparency in service delivery. From their initial contact onwards, service users emphasised the need to know what a service could and could not do for them. Interviewees gave a clear message that if a member of staff says they're going to do something, they should follow it through, and if they cannot follow it through they should take the time to explain why.

> *"...make sure that you're making eye contact with them, and you're letting them like talk. You're not just interrupting them every two minutes to say to them, this is how we'll fix it, this is how we'll deal with it. Let that person you're talking to gain your trust that way."*

They also highlighted the need for clarity with regard to the boundaries of confidentiality and the circumstances under which these boundaries would be breached.

> *"We're pretty tight on boundaries as well. So, in terms of like, people should know what they can and can't do in the Centre….expectations of them and their expectations of us." (CJSW)*

Staff acknowledged that the issue of data-sharing was of particular concern to service users and several case study services described the routine use of formal data-sharing agreements. One case study service described efforts to create a transparent system of data recording, where staff checked the accuracy of information directly with their clients prior to its documentation in formal records. Consent was routinely sought from clients before the information was shared with

other professionals, and clients were asked to identify any information that they wished to keep confidential. This was then omitted from the formal record.

> *"…the biggest part […] is trying to give women as much transparent trust and control…by being really clear with her about what our roles and responsibilities are, and how we're going to do that…" (CJSW)*

Interviewees talked about circumstances where they believed trauma survivors were likely to experience a breach of trust in their relationship with individual staff members or with services generally, for example detention under the Mental Health Act, the execution of an arrest warrant by police officers, citation of an individual as a witness in a court case, or the removal of children from their family due to welfare concerns. Staff felt that breaches of trust could be mitigated to some extent by transparent dialogue in advance of any intervention, and a client's sense of attachment to the service as a whole.

> *"…there are some tensions here with trust…there are certain things, you know, certain restrictions on services safety. So sometimes, for example, you have to detain somebody under the Mental Health Act. Sometimes you might have to breach confidentiality… and I think there are some genuine tensions there… so it's not as simple as being nicer to people, although it's not to be undervalued that…I think it's about boundaries and being clear and being really straightforward. I think sometimes we try too hard to be nice or popular." (Mental Health).*

> *"Quite specific but clarifying boundaries with trust – I'm not…you can come here, you know, and I will not be telling them…I'll be crystal clear…I give you my guarantee I will not let the UK border agency know that you are here. I would not do that." (GP)*

Training and workforce development

Staff felt it was essential to have an understanding of the ways that traumatic experiences, particularly pervasive interpersonal trauma, can erode an individual's capacity for trust in others.

They suggested that workforce training should routinely incorporate the impact of trauma on relationships, in order to highlight the importance of treating service users with respect, honesty, transparency and consistency.

A common theme among interviewees was the importance of trust: the impact a trusting relationship can have on an individual, and also the impact when trust in not there or a service user feels it has been breached.

> *"we need to try to change the path…we're only going to change it by building the relationship and trust and then providing the support of guiding them towards the support that's going to change that path." (Police)*

> *"Trust, if you don't have trust, you've got nothing…there's no point you trying to work with people if you can't trust them. There's no point trying to get help for yourself if you don't trust that person because you're they're not going to open up to you, so you are just wasting your time, basically. You'll just keep going round in circles at the same thing, 'til somebody has trust and opens up about it."*

Toolkit

? How is information recorded and how is it passed on, respecting the collaborative and trusting relationship which has been built between staff and survivors?

Policy and Procedures Review

? How does the organisation ensure all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, strategies for trauma-informed approaches across the agency and across personnel functions?

? How does on-going workforce development/ staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors?

Trauma Training

Key Principle 3: Choice

Throughout the organisation, clients and staff are supported to make decisions and choices, and to set their own goals. The organisation recognises that giving people choice can help address power imbalances. Clients and staff therefore have meaningful choice and a voice in the decision-making process of the organisation and its services.

Physical environment

Several organisations involved staff and service users in the design and development of the physical environment. One case study area described the establishment of a focus group of service users with the specific remit of advising on the development of a trauma-informed environment. Clients were at the core of the decision-making process, determining the colour scheme, choice of music in public areas and style of furnishings in the reception and interview rooms. Clients were also involved in the practical implementation of the groups recommendations

Clients involved in choosing the layout of the reception

Artwork in reception area

Engagement and Involvement

All case study areas recognised the importance of choice for service users and attempted to offer it wherever possible. Interviewees noted that offers of choice helped to reduce power differentials between staff and clients, promoting a sense among service users that they were being treated with respect. Staff noted in particular, that by offering choice in the context of a professional relationship, they were modelling the dynamic of a healthy interpersonal relationship and in so doing were helping to prepare clients for the decisions they would be required to make in real-life settings.

The principle of choice was most commonly referred to in the context of appointment scheduling, issues relating to non-attendance, or the application of discharge policies. Most services highlighted the need for maximum flexibility, with some services responding to high rates of non-attendance by modifying their practices and procedures multiple times. One service described a practice of operating "under the radar", keeping clients on the books when formal policy dictated that they should be discharged due to non-attendance.

> *"…it wasn't like they would give you a time or a day, they would say, I'm free this day and this day, and what time would suit you?"*

"…I didn't feel that pressured, if I was having a bad day or that, I knew that it was alright...to have a day off."

"I've had other interactions with other organisations where I've contacted them by email and... I find it difficult to use the phone, and they've insisted that I phone. And I've said, well, I'm really not comfortable doing that and it's basically like too bad, you know, get lost."

"…we've gone through lots of iterations of how we offer care, so we run drop-in surgeries, we've run booked appointments on the day, we've run longer booked appointments….so we would tend to frame that within trauma-informed care, 'cause it's about trying to be collaborative and meet people where they're at." (GP)

Working in the wake of a global pandemic presented particular challenges with regard to the capacity of some organisations to offer choice.

"…at the moment with COVID on the go, we're trying to offer booked appointments only, but we do still have people turning up….pre people being a bit more signed up to all of this, the idea of trauma-informed care, they would have just seen that as problematic….the person would often get, you know, 'why are you here' response. What we try and do now is try and say, you know, it's great you've turned up…and some days a doctor…is available to see a person, but other days they're not. So we'll try our best to either get them to see a nurse or get them to see a pharmacist."

In some case study areas, interviewees explained that their ability to offer choice was compromised by the organisation's primary purpose, its culture or its policies. In these circumstances attempts were made to embed an element of choice, however small, in the daily routines of the organisation whenever possible. For example, in the trauma-informed residential house, children were given the choice of how to paint and decorate their bedroom, or in education, a choice of activities.

"We have a lot of children who struggle in the afternoons as they go to bed late, so we allow them to choose activities when they can't concentrate...so they don't kick off…There's always a 'choice' time but we are always quite structured because that's what these children need. They may have little structure at home…they can choose a book they want me to read." (Education)

"…so part of how you could have more choice is you have more options. You say right, okay, we recognise that you may be at a different stage, so maybe psychology isn't for you, but there is this, so if you want to…if this isn't right for you, there is an option." (Mental Health)

"…being able to negotiate a little bit with people, about what's going to work for them, and what's going to make it most element of choice, however small, in the daily routines of the organisation wherever possible so that they're able to come and be able to engage". (CJSW)

Cross sector collaboration

One case study service re-launched as a Public Service Partnership between statutory and third sector services. The multi-agency partnership maximised choice for service users,

expanding the options available to service users and facilitating the ability of the service to respond to a wide range of need.

Screening, assessment and treatment services

Another case study area described the development of a care pathway that actively encouraged clients to choose from a range of options, selecting the intervention that they believed would best meet their needs. Options included psycho-education courses, and groups focusing on emotion regulation, self concept, or relationships. Interviewees from another case study area described the importance of choice in the context of court orders.

Other services promoted choice by providing "Mind of My Own" facilities on tablet devices, enabling children and young people to express their preferences with regard to food, provide feedback on their feelings prior to LAC reviews, and identify preferred educational and recreational activities. Children and young people then had the option of communicating this information to their key worker, teacher, manager or child protection officer.

Toolkit

? How do the organisation's written policies and procedures include a focus on trauma and issues of safety and confidentiality?

? How do the organisation's written policies and procedures recognise the pervasiveness of trauma in the lives of people (using the services and working in them), and express a commitment to reducing retraumatisation and promoting well-being and recovery?

? What policies and procedures are in place for including trauma survivors/ people receiving services and peer supports in meaningful and significant roles in organisation planning, governance, policy making, services and evaluation?

Policy and Procedures Review

? How can staff and clients be involved with developing a plan for improving engagement and involvement of survivors in service planning and delivery? Has budget been considered to support this?

Getting Lived Experience on Board

? Is an individual's own definition of emotional safety included in treatment plans?

Key principle 4: Collaboration

The organisation recognises the value of staff and clients' experience in overcoming challenges and improving the system as a whole. Attempts are made to level the power differentials between different staff groups, and between staff and clients. This principle is often implemented through the formal or informal use of peer support and mutual self-help. There is recognition that healing takes place in the context of relationships and in the meaningful sharing of power and decision-making .

Governance and leadership

Interviewees emphasised the importance of laying groundwork with leaders and managers, and of providing them with information on trauma-informed practice and ways in which it would benefit their organisation. Multiple forums for collaboration were identified, including one-to-one meetings, team away-days and 'debrief days', where staff could speak openly and honestly with managers about their hopes and concerns.

> *"this is what I come with/want to do. Are you worried about that? Do you have questions about that? Are there things about that you are not sure about?" (CJSW)*

The need to target middle managers was highlighted in particular, as collaboration with this level of management was seen to be an essential part of a long-term strategy for embedding trauma-informed practice in the organisation. By training managers to be trauma-informed leaders, it was believed that these managers would become more confident in providing trauma-focused training and supervision to staff, and would model trauma-informed behaviours, such as the appropriate use of self-care.

Where the impetus for trauma-informed practice was primarily coming from management, it was recognised that groundwork also had to be laid among staff groups across all levels of the organisation, in a way that reduced any power differentials.

> *"I didn't want to patronise people… what I did (which didn't work) was make some assumptions about what their understandings [about trauma] were.*
> *…and afterwards some of the feedback was they didn't know some of that stuff and actually they would have benefited from it…." (CJSW)*

This was usually done in the context of team meetings or supervision groups, however one case study area described their use of NES trauma training materials in the form of the NES Level 1 trauma animation. This resource was used effectively to facilitate discussion and gain the views of staff on the best way to move the agenda forward. Interviewees commented on how important it was in this context to "nurture relationships as much as possible and work really hard to get people on board".

> ### Toolkit
>
> **?** How does organisation leadership show and communicate its support for implementing a trauma-informed approach?
>
> **?** What is the plan for training provision to be provided to management? This should include examples on how to be a trauma-informed leader – including role modelling?
>
> 🔧 Trauma-informed leadership
>
> 🔧 Trauma training

Policy

Two case study areas described organisational recruitment policies that required trauma-informed practice to be an essential element of job descriptions. Questions relating to trauma-informed practice were also standard in recruitment interviews. Staff in these areas acknowledged that these were policies and procedures that they had not encountered before in their sector.

Physical environment

The premises of some case study services had kitchen areas connected to the reception, where clients were offered or encouraged to prepare their own tea or coffee on arrival. Clients regularly commented that this experience made them feel that they were being treated with respect.

Attempts were made across case study areas to address the power differentials that can inadvertently be created in physical environments that are not trauma-informed. For example, clients and staff had access to the same kitchen and toilet facilities in most services, and service users and staff both used seating that was of equal height and quality.

Engagement and involvement

Several case study areas made use of formal or informal peer support mechanisms to enhance collaboration. One service described their use of video-conferencing facilities to keep their peer support group running throughout the COVID-19 pandemic. Another case study area developed a peer support group that enabled clients to share their experiences with each other and with staff.

Interviewees described how this group helped to change the perceptions of professionals working in the wider system, represented an empowering experience for the clients involved.

Most case study areas did not make lived experience an essential requirement of the job, however it was recognised that some of the members of the staff team would have their own trauma histories. One case study service described its attempts to reduce the sense of 'them and us' by recruiting a member of staff who had lived experience of a specific type of trauma, as the post in question was designed to work in that particular field of trauma.

Among staff across the case study areas, the routine use of both formal and informal peer support was very evident. A variety of peer support mechanisms were used to build collaborative working, including buddy or mentor systems that paired experienced staff with inexperienced staff where appropriate, and peer support forums which were available face-to-face or online. In some cases, training was provided on how peers could provide support for each other using a psychological first aid framework. Some interviewees also described dedicated time for staff to talk to each other at the end of shifts, or the organising of informal events that enabled staff to support each other through activities unrelated to their work. In this respect it was noted that a key role of leaders was to ensure that staff had access to protected space where they could be together on a regular basis, even for short periods of time.

Some interviewees identified situations, particularly with reference to General Practice, where they felt it was appropriate for staff to be the experts and they described their sense of reliance on this expertise.

"They've got the knowledge and they know what the treatment option would be…what the consequences of that would be." (Speaking about GPs)

Toolkit
? What strategies are used to reduce the sense of power differentials among staff and clients?
⚕ [Advice on how to use trauma-sensitive language](#)
? How does the physical environment promote a sense of safety, calming and de-escalation for clients and staff?
? What policies and procedures are in place for including trauma survivors/people using services and peer supports in meaningful and significant roles in agency planning, governance, policy making, services and evaluation?
? How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
? How does on-going workforce development/ staff training provide staff supports in developing the knowledge and skills to work collaboratively and effectively with trauma survivors?
⚕ [Getting Lived Experience on Board](#)
⚕ [Hiring a Trauma-Informed Workforce](#)
⚕ [Policy and Procedure review](#)
⚕ [Training](#)

Staff did not think that taking on the role of expert necessarily compromised their ability to work collaboratively. Some staff, for example, spoke about instilling a sense of power-sharing by ensuring that consultations were always focused on the needs and wants of the client. They made a clear differentiation between being a source of knowledge and being a source of authority.

Cross Sector Collaboration

Interviewees commonly emphasised the need for cross sector collaborative working, particularly in cases where the client had complex needs and multiple agencies were involved in the care and support of the individual. In some cases, strong links between agencies were required to facilitate referrals. In others, multi-agency teams were involved in care planning or in the creation of formal links between services operating within the same system.

Senior staff from some of the case study services spoke about the importance of laying the groundwork for cross-sector collaboration. Examples were given of hosting round-table events for key stakeholders in order to underline the purpose and importance of trauma-informed practice. One case study area described initial groundwork that had involved bringing together representatives from community planning in order to secure the buy-in necessary for the subsequent roll out of trauma-informed training across multiple partner agencies.

Screening, assessment and treatment

Interviewees across the case study areas described attempts to develop ways of delivering interventions that reflected the trauma-informed principle of collaboration. Most services had adopted person-centred processes that maximised choice and emphasised the position of the service user as an expert by experience.

Staff pointed out that there are some settings that necessitate a hierarchy between service users and providers, citing examples from the fields of education, policing and residential care. In the context of services for children and young people, however, there was evidence of good practice where efforts had been made to share decision-making. Several interviewees spoke about the importance of dialogue between school staff, pupils, and parents, for example, and the need to create a sense that all work would together, driven by a common interest in the welfare of the pupils.

> *"It's difficult in a school setting but we do try to instil in the pupils a feeling that we are all in this together by talking to them and agreeing steps forward out of a bad situation together."*

Staff from another case study area described their efforts to set up mechanisms that would give young people a voice in how they were cared for. Staff frequently described taking a 'doing with, not doing to' approach to working with service users.

> *"It's about being alongside people…we're not here to tell you what to do, we're here to be alongside them."*

Other attempts to recognise the value of service users' experience included the recruitment of staff members with lived experience, and the use of service 'graduates' to deliver support groups. Staff felt that these types of approaches helped to develop a collegiate atmosphere where the line between expert and service user was blurred.

Toolkit

? Have suitable collaborations been identified? How? Is this process sufficient? Does it cover all bases?

? Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions?

? Are collaborative partners trauma-informed?

? How does the organisation identify community providers and referral agencies that have experience delivering evidence-based trauma services?

? What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?

Trauma-informed leadership

Getting Lived Experience on Board

Setting up a Trauma-Informed event

Training

Financing

Across all case study areas, interviewees emphasised the importance of gaining buy-in from their leadership. A common theme was the importance of getting senior management to commit long term to this approach. Reflecting the international literature, some organisations committed to a statement of intent to become trauma-informed.

> *"It's a five year vision…you're not going to get the results in the first year or two. It's a long term piece of transformational change or culture."(CJSW)*

Key Principle 5: Empowerment

Efforts are made by the organisation to share power and to give clients and staff a strong voice in decision-making, at both individual and organisational levels. Each level of the organisation, including management, operations, service delivery and staff training, is designed to be empowering for both staff and service users. Staff are empowered by mechanisms of organisational support, and clients are empowered by services that are person-centred, and based on belief in the resilience of individuals and their ability to heal and recover from trauma.

Governance and Leadership

Two key themes emerged from the interviews: the importance of senior management support; and having trauma-informed leaders who could model trauma-informed behaviour and language, and ensure successful implementation.

Case study services referred to the importance of establishing an implementation group and/or identifying a trauma champion within the organisation. Where there was regular movement within an organisation of staff members from one post to another, interviewees said that they had found it helpful to identify several trauma champions to ensure sustainability of the role.

A common barrier in terms of implementing plans for trauma-informed practice was the trauma champion's lack of seniority within the organisation. One case study service found that it had been useful for their trauma champion to be given a seat at senior management meetings, as they had been able to provide regular updates in the form of a standing item on the agenda. Another case study service confirmed the importance of feeding into a high level strategic management group.

> **Toolkit**
>
> **?** How does organisation leadership communicate its support for implementing a trauma-informed approach?
>
> **?** What is the plan for training provision in TIP to be provided to senior management? This should include examples on how to be a trauma-informed leader – including role modelling.
>
> 🔧 [Trauma-informed leadership](#)
>
> 🔧 [Using Trauma sensitive language](#)
>
> 🔧 [Trauma training](#)
>
> **?** How do the organisation's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?
>
> 🔧 [Policy and Procedures Review](#)

"I needed them to want to become trauma-informed leaders in order to take it forward, which translated into practices which would turn into improved outcomes for service users." (CJSW)

"I think it's really important that we look at the way that services are designed to enable staff to be trauma-informed. You need time and space around you, your caseload can't be too big. Again, some of the things that we see are caseloads creeping up in all sorts of different services. I suppose it's then buying into all of the principles to embed into their own organisation." (Police)

"..And we created this role, but we still don't have the best name for it, but it's been called Model Holder…[someone] who understands and has got all the knowledge and skills anyway, that they can help and act as an implementation driver, if you like, and ensures that every bit that we try to operationalise is actually happening." (Residential)

Implementation groups and trauma champions often took the lead in conducting a preliminary assessment of their organisation's current trauma-informed practice. One case study service found it useful to conduct this assessment as a team exercise, adapting the forms in the toolkit to the needs of their own organisation.

Case study services also described the importance of supporting and taking part in a "Trauma-informed Lens" workshop or a trauma-informed service "walkthrough". Interviewees described the need for staff and clients to come together to look at how the service is designed, and to place the service in the context of the wider system. They also highlighted the need to make a clear plan to take trauma-informed practice forward, identifying "SMARTER" objectives and clear lines of accountability based on the results of the preliminary assessment and service walkthrough. It was emphasised that implementation groups should meet regularly to review this process and should feed any updates into senior leadership groups.

A manager from one of the case study services recognised that management support needed to be highly visible in order to drive the agenda forward. In most cases, staff described making presentations to senior managers and leaders, in which they would define the concept of trauma-informed practice and link it to tangible outcomes.

> **Toolkit**
>
> **?** What preliminary assessment of the organisation's current TIP is taking place? Are toolkits being used? Who is accountable for this?
>
> Other toolkits for Organisational change
>
> **?** How will a Service Walkthrough be completed, and how will the findings from this be built into the plan to help the service become trauma responsive?
>
> Trauma-informed lens
>
> **?** How does organisation leadership communicate its support for implementing a trauma-informed approach?
>
> Trauma-informed leadership
>
> Other toolkits for organisational change

"I started to ask them to do an assessment of their team and their service…I asked them to fill out forms – a group exercise…..I adapted the forms for X in Scotland from the Homelessness Toolkit. Very, very detailed stuff about what do you do when a client walks through the door? What is your signage like?" (CJSW)

"When the new building opened the Justice Secretary came to come and cut our ribbon for us, the Chief Social Work Officer from Edinburgh City Council and the NHS….so senior figures in council and NHS – part of that was saying… look what we can bring you with trauma-informed care …the service users were there. I wanted them to hear from service users. I have been through a million services and this is the only one which has really helped me." (CJSW)

Clients were often involved in these events and the voice of service users was seen to have a particularly powerful impact. In several of the case studies, the people leading the drive towards trauma-informed practice were staff working directly with service users, some of whom had lengthy experience of working in their field, coupled with a good understanding of the ways in which trauma-informed practice could improve their services.

Staff talked about the importance of finding 'like-minded' individuals within their organisation and the need to gain 'buy-in' from these individuals. This was commonly done on an informal basis. Several case study services held "kick off" events, which they found were a useful way of meeting like-minded individuals and facilitating wider system change.

Leadership also played an important role in empowering staff to look after themselves, especially in the modelling of self-care, for example by attendance at reflective practice sessions or group supervision. Staff clearly valued attempts by their organisation to actively monitor their wellbeing or to prioritise supervision or reflective practice, and they described a sense of empowerment created by leaders who collaborated closely with staff to produce collective problem-solving.

"…[it's] borne out of 30 years of frustration of seeing things not change." (Addictions)

"… it was all very much bringing together people who had shared interest in this and trying to coordinate efforts….." (CJSW)

"…with each individual house, there were lots of staff development days, there were lots of buy-in days, there was, let's all get behind this. We brought in ex-care experienced young people and other people to all try and get this momentum. We did plenty of presentations, lots of training. Yeah, loads of stuff actually." (Residential)

"Well, we had an event… a town hall event two years ago…or almost two years ago now, which we pulled together about 120 people into the town hall. That followed up a previous trauma-informed event the year before…we had one which was much more around, let's share the trauma-informed message right across a community, let's try and get buy-in for the trauma-informed thinking, as it were, right across community planning...Then we agreed that at that point there needs to be a leadership commitment. So from the first conference we had a paper going to the [x], which was the top level of decision making was well-recognised by interviewees, progress in this area had been problematic across most of the case study services." (Local Authority/ Police)

Toolkit

⚑ Setting up a Trauma-Informed event

⚑ Trauma-informed leadership

⚑ Staff wellbeing

? Does your organisation have a survivor involvement policy, outlining your mission and what you want to achieve by involving survivors? Have staff been involved in discussions on how this will work/barriers to implementation?

⚑ Getting Lived Experience on Board

One organisation described the establishment of a service user reference group as a key part of its governance structure, however the reference group had been discontinued due to the organisation's inability to secure sustainable funding. Three other case study organisations described different ways that they had established service user involvement. These had initially been set up through informal discussions with service users who had completed their own journey through the service and had expressed an interest in continued involvement. Their motivation was usually described as a wish to help others and a desire to feel part of the service community.

Staff reported a number of barriers relating to the inclusion of the service user voice. These included perceived and actual difficulties in finding "suitable" trauma survivors; the lack of financial remuneration; access issues relating to disability; and mental health related problems such as anxiety, social isolation, lack of confidence and low self-esteem. "Red tape" was identified as another factor that impeded attempts to integrate service user groups into governance structures. Some interviewees also suggested that professionals generally occupy the expert role and that they might feel uncomfortable sharing this role with service users in the context of service governance.

One case study service partnered with a group of people with lived experience and felt that this had been pivotal in gaining the level of lived experience necessary for taking forward this agenda. Paid lived experience representatives had been involved in service planning, training and service delivery. This was the only case study service that had people with lived experience who were paid and were embedded in the team, delivering support to people affected by gender-based violence.

"I think the biggest barrier is that that part of the work is never resourced properly. People think, oh we can get that for free, and in reality, what then happens is, because they're not paying for it, they don't value it." (Police)

Lived experience representatives from Resilience Learning Partnership

"This was one of the first principles we were defining with [X], is that people with lived experience deserve to get paid for their contributions as experts of lived experience, because they have something more valuable to offer than anybody else does in a lot of respects." (Police)

"…start by looking at where there's good engagement. In [X] we have a mental health user group. We've got an active recovery community for substance misuse. We've got [Lived Experience expert group]. … I think the more of these groups that you have, the better, by and large…I think it's that whole process of ensuring that individuals are empowered at every stage of the process. The danger is sometimes I think that professionals start to pay lip service to it or they sometimes look at it as a tick-box thing rather than something that they really need to embed in absolutely everything that they do." (Police)

Toolkit

? How can staff and clients be involved with developing a plan for improving engagement and involvement of survivors in service planning and delivery? Has budget been considered to support this?

? What can be done to improve trust and transparency in staff, for survivors who do become involved in service planning and delivery? How has their role been collaboratively identified and clearly outlined to avoid any confusion?

🔧 [Getting Lived Experience on Board](#)

🔧 [Trauma-informed leadership](#)

Policy

As a matter of policy, one case study service routinely involved service users in the recruitment of staff. Staff described the process by which service users would meet candidates prior to the interview and would then represent service users' voices by being a member of the interview panel.

Staff from another organisation described how they changed their main method of written communication with the aim of empowering their clients. In place of traditional letters to the professional who had made the referral, staff addressed their letters directly to the client and wrote in a jargon-free, accessible format. In a collaborative process, prior consent was sought from the client to copy the correspondence to any professionals involved in their care. Clients were also asked to identify material that they wished to keep confidential and this was omitted from the correspondence. Clients were then encouraged to check the content of correspondence to ensure that the information and decisions reached were accurately represented. Based on client feedback, any misunderstandings were corrected in the formal medical record.

Toolkit

❢ Trauma-informed lens tool

❢ Hiring a Trauma-Informed Workforce

? What strategies are used to reduce the power differentials among staff and clients?

❢ Getting Live Experience on board

Dear [first name of client]

Thank you for coming to [name of service] on 26th August 2019.

As promised, I'm writing with a brief summary of our discussion.

You said that a few things have happened recently that have brought back memories from your childhood and you're finding it hard to deal with this. You told me that ... All of these things have made life very difficult for you at the moment.

In terms of a plan, we agreed the following next steps:

- *I am registering you with...*

- *I will ask [name of link worker] to help you engage with...*

- *I plan to stay in the picture and will arrange to meet up with you again in two months time to see where things are up to for you. We can discuss further options at that point if appropriate.*

In the meantime I hope that our meeting was helpful and I'll keep in touch with [name of link worker] to hear how you're getting on.

With best wishes [Name of staff member]

Engagement and involvement

One organisation described their use of focus groups, satisfaction questionnaires, feedback boxes and a "happy-or-not" system to create a direct and ongoing dialogue between the organisation and its service users.

Other case study areas described efforts to engage clients by building a sense of community. They invited service users to contribute to the physical environment, decorating community areas using photos, artwork made by service users, or potted plants.

Specific challenges were described with regard to the empowerment of children and young people, particularly in the context of educational or residential settings. In some cases, however, staff described a shift in focus towards ensuring that children have hope in their future.

"We are continually evolving how the Nurture Room works by engaging the children. Maybe they want some different role play costumes or want to make a specific good. So they are involved to some extent." (Teacher)

"How did our staff do today?"

"we get women's stories, we get their versions of what their experience of our service has been, and then we try to use that to kind of create a kind of service improvement plan." (CJSW)

Patchwork of empowerment by service users (CJSW)

Service user artwork (Addictions)

"I think it makes it easier for them to like kind of build a relationship with me, if that makes sense, because like, well, she's been in and done it, and she's managed to change, so there's hope for me." (CJSW)

A key part of engagement was the development of peer support groups and/or peer buddying. These were particularly important groups in terms of helping people to normalise their reactions, and empowering people to build corrective relationships.

> *"I suppose it was a really good way of having a transition out of one-to-one and still have an environment to talk about…how you're doing and different people have lots of different ideas and we'd chat." (Addictions)*

> *"…every Wednesday 12 o'clock, this is my time. And I look forward to it because I can go for days…days and don't speak to anyone." (Addictions)*

One peer support forum had developed into a group that campaigned to change the criminal justice system by sharing lived experience with professionals and strategists. This group had been successful in applying for additional funding for group advocacy activities.

> *"...the thing is, it's like people want to hear our stories, they don't want to like push us away and that any longer, and I think it's important that people hear like with help and that and support, you can change your life" (CJSW)*

Cross sector collaboration

To find 'like-minded' people who would collaborate on leading the development of trauma-informed practice, some case study services looked outside of their own organisation and approached professional colleagues in other sectors. Interviewees described various methods of facilitating this process, including the setting up of workshops, conferences and events where people across sectors could meet up. Delegates typically included representatives from healthcare, social work, police, education and third sector organisations.

> *"…we had a couple of those meetings, and it took a little while for everybody to kind of work out what we were doing, but then we started getting into, what are we doing, what do we all do, what's different, where are the gaps." (Mental Health)*
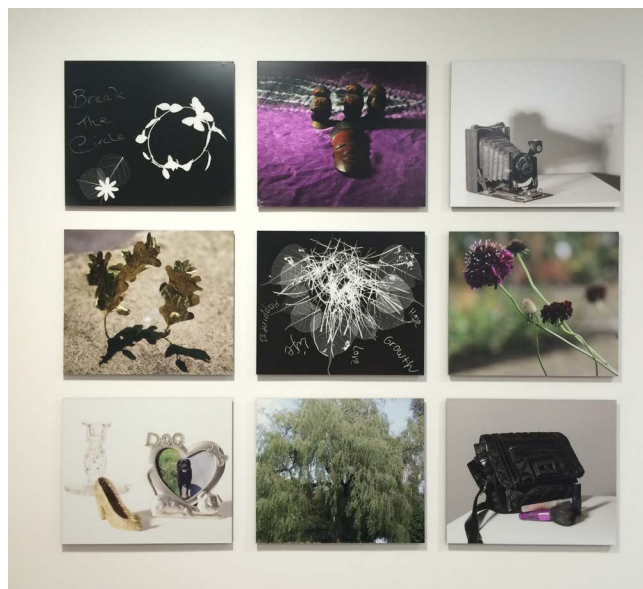
Photographic work by service users (CJSW)

One case study service worked in collaboration with a range of cross sector organisations to enable service users to create images that explored their identity. Photos were taken of objects with a personal value to the client and these became emblems of self and belonging.

Another case study service employed link workers as core members of the staff team. The link workers focused on social connection, enabling clients to engage with community resources that would further their recovery, including access to education facilities and employment schemes, leisure and recreational activities.

Screening, assessment and treatment services

Staff in the case study areas described themselves as being "facilitators" rather than "controllers" of recovery. They viewed their clients as experts by experience and emphasised the importance of supporting trauma survivors to cultivate self-advocacy skills. This positioning of service users in the expert role was acknowledged by survivors.

Working collaboratively in a person-centred way was common to all of the case studies. A strengths-based approach was used by most services, with staff and clients highlighting the importance of safety and stabilisation skills due to the ability of these practical tools to empower clients.
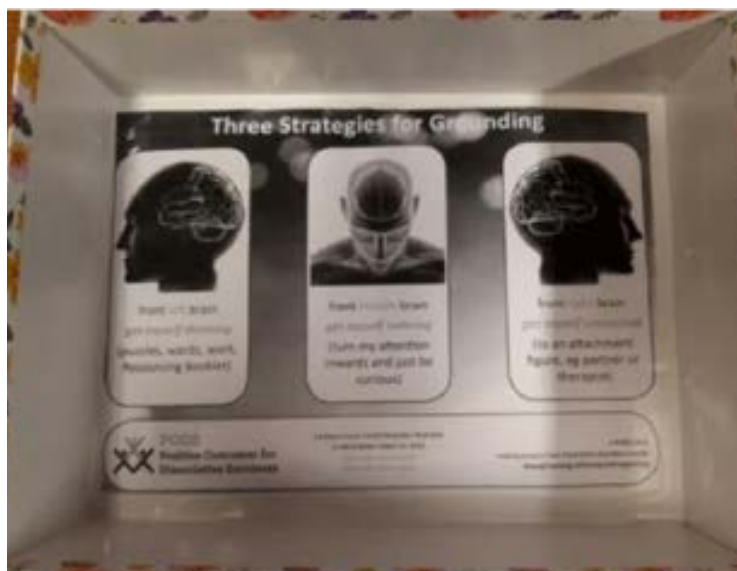
Self-soothing box used for safety and stabilisation

"It's so important, because we didn't want a fixer. How are we going to learn from our mistakes and how are we going to get on with life? We need to figure things out for ourselves. It's alright to ask for help and that, but people can't make the decisions for you, you're the only one that can make the decisions." (CJSW)

"The big difference for me out of the whole thing was [being] given the practical tools because that's stuff that you could take with you for the rest of your life, you know. I've never had that kind of help before." (Addictions)

Training and workforce development

The degree to which staff feel that they have a sense of agency, control and preparedness in performing their roles is key to their perception of empowerment. Interviewees emphasised the need for training to be readily available to staff, enabling them to update their knowledge and skills, particularly with regard to trauma and its impact. The need for training in a range of psycho-education and self help resources was identified, including information on normal reactions to trauma, resilience, and the importance of self-care. Strategies emphasising the role of social connection, routine, exercise, relaxation and good sleep were commonly mentioned. One case study area involved lived experience in their training and workforce development sessions.

Most case study organisations described clear channels for regular communication, such as daily huddles, weekly team meetings or operational debriefs, providing opportunities for staff to voice their opinions and have open and honest discussions.

Staff also described input and feedback mechanisms such as listening groups, email suggestion boxes or visits to services by leaders. Some organisations had processes that clearly demonstrated the ways that working practices had been changed in direct response to staff input and feedback.

Toolkit

❯ [Getting lived experience on board](#)

? How do staff members help people to identify strategies to feeling comforted and empowered?

❯ [Training](#)

❯ [Progress Monitoring](#)

❯ [Evaluaiton](#)

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Appendices

Appendix 1

How to use the toolkit for Scotland

To assist in guiding implementation, a full list of the sample questions included in this toolkit is provided below. The questions are adapted from SAMHSA's "Concept of Trauma and Guidance for a Trauma-Informed Approach" document (2014), with supplementary items added as a result of the findings from our qualitative fieldwork conducted in Scotland.

Organisations across systems and sectors are encouraged to adapt the sample questions to fit the specific needs of their organisation, staff and service users. Once an organisation has decided on relevant questions and areas of focus, relevant outcome measures should be identified (Appendix 7) and an appropriate evaluation framework should be adopted.

Safety	Trust	Choice	Collaboration	Empowerment
10 Implementation Domains				
Governance, management and leadership	• How does organisation leadership show and communicate its support for implementing a trauma-informed approach? • How do the organisation's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for including survivors with experience of using their service in this process (from start to finish)? • How will a Service Walkthrough be completed, and how will the findings from this be built into the plan to help the service become trauma responsive? • What is the plan for training provision in TIP to be provided to senior management? This should include examples on how to be a trauma-informed leader – including role modelling. • What plan does organisation leadership have to amend the language used in relation to survivors and trauma among staff in their organisation? For example, to reduce power differentials. • What systems are in place to encourage innovation in the workplace in relation to Trauma-Informed practice?			

Safety	Trust	Choice	Collaboration	Empowerment
Policy	• How do the organisation's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the organisation's written policies and procedures recognise the pervasiveness of trauma in the lives of people (using the services and working with them), and express a commitment to the reducing retraumatisation, and promoting well-being and recovery? • Has the organisation a specific health and wellbeing plan in place for staff, which recognises the pervasiveness of trauma and helps supervisors and workers support staff who have experienced trauma? If not, why not? • How do the organisation's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed? • How beneficial would it be to have an organisational policy on how screening should be completed and/or how service users should be asked about trauma? • Would creating a specific policy in accessing supervision in your service create more service congruency? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in organisation planning, governance, policy-making, services and evaluation? • Does the language used in these policies position trauma as a natural reaction to traumatic events? Does it normalise trauma? And behaviours and coping strategies related to trauma?			

Safety	Trust	Choice	Collaboration	Empowerment
Engagement and involvement of survivors	• Does your organisation have a survivor involvement policy, outlining your mission and what you want to achieve by involving survivors? Have staff been involved in discussions on how this will work/ barriers to implementation? • How can staff and clients be involved with developing a plan for improving engagement and involvement of survivors in service planning and delivery? Has budget been considered to support this? • How does your organisation specifically take into account the experiences, and needs of Black and Minority Ethnic people? • What can be done to improve trust and transparency in staff, for survivors who do become involved in service planning and delivery? How has their role been collaboratively identified and clearly outlined to avoid any confusion? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?			
Workforce development and support	• How does the agency help staff deal with the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organisation ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, race, ethnicity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors? • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognising the value of peer support as integral to the organisation's workforce?			

Safety	Trust	Choice	Collaboration	Empowerment
Physical & Emotional Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • How is a gender differential taken into account in site selection (if possible) and recruitment? • How is a race and ethnicity differential taken into account in recruitment? • In what ways do staff members recognise and address aspects of the physical environment that may be retraumatising, and work with either a) improving the environment and/ or b) with people on developing strategies to deal with this? • How has the organisation provided space that both staff and people receiving services can use to practice selfcare? • How has the organisation developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities)? • How has the organisation specifically recruited for individuals who have the skills and qualities necessary to be trauma-informed, e.g. empathetic, welcoming, caring? • How will the organisation ensure all workers respond to survivors in a way which is emotionally safe? For example, providing training to staff at all levels. • How is the emotional safety of staff considered by the organisation? Promoting self care, ensuring staff are adequately supported, staff are involved in feeding into the organisation how this should happen.			
Cross Sector Collaboration	• Have suitable collaborations been identified? How? Is this process sufficient/does it cover all bases? • Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organisation identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote crosssector training on trauma and trauma-informed approaches?			

Safety	Trust	Choice	Collaboration	Empowerment
Screening, Assessment and Treatment	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment suitable for your service? If so, is it available and accessible to individuals receiving services? • If it is not suitable, how do staff still ask the difficult questions which need to be asked to identify trauma and how are they supported to do this? How confident are they in doing this? Do they need further training? • How is this recorded and how is information passed on, respecting the collaborative and trusting relationship which has been built between staff/survivor? • Does the organisation have the capacity to provide trauma treatment or refer to appropriate trauma treatment services? Is there a wait for these? If so, is there an alternative service where the wait is less? • How are peer supports integrated into the service delivery approach? • How does the organisation address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, do they offer any gender specific services? If not are there any they can be referred to which are? • Do staff members talk with people about the range of trauma reactions and work to minimise feelings of fear or shame and to increase self-understanding? Can/should they be completing safety and stabilisation work with the client? • How are these trauma-specific practices incorporated into the organisation's ongoing operations?			
Finance	• How does the organisation's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?			

Safety	Trust	Choice	Collaboration	Empowerment
Progress Monitoring and Quality Assurance	• Does the organisation gather feedback from both staff and individuals receiving services? • What strategies and processes does the organisation use to evaluate whether staff members feel safe and valued at the organisation? • How does the organisation include cultural factors in monitoring and quality assurance? • What mechanisms are in place for information collected to be incorporated into the organisation's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?			
Evaluation	• How does the agency conduct a trauma-informed organisational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to gather feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organisation's progress in becoming trauma-informed?			

Appendix 2: The tools

Toolbox 1: Background materials for explaining effects of trauma	
Understanding the impact of stress on the brain, Blue Knot Foundation	[Link to Appendix 3](#)
Understanding the stress response, Blue Knot Foundation	[Link to Appendix 3](#)
The window of tolerance Blue Knot Foundation and locally developed tool	[Link to Appendix 3](#)
A useful film on neuropsychology and trauma (NHS Lanarkshire)	https://vimeo.com/325875547
National wellbeing hub - is it normal to feel like this?	https://www.promis.scot/resource/common-reactions/

Toolbox 2: Staff wellbeing	
Staff wellbeing - NES	https://sway.office.com/p3QWjY4altHviB6o?ref=Link
Mind - wellness action plans	https://www.mind.org.uk/media-a/5760/mind-guide-for-employees-wellness-action-plans_final.pdf
National Trauma Training Programme Online Resources	[Link to Appendix 4](#)
National wellbeing hub - coping and self-care	https://www.promis.scot/resource/coping-and-self-care
Emergency service staff wellbeing	https://www.lifelines.scot/

Toolbox 3: Trauma-informed leadership	
National Trauma Training Programme Online Resources	[Link to Appendix 4](#)
National wellbeing hub resources for leaders	https://www.promis.scot/resource/leadership/
Trauma-informed leadership for Organisational Change: A framework (MHCC)	https://www.mhcc.org.au/resource/trauma-informed-leadership-for-organisational-change-a-framework/

Toolbox 4: Getting Lived Experience on Board	
Good starting points for lived experience involvement (adapted from Harris & Fallot)	[Link to Appendix 5](#)
Inclusive Justice: Co-producing Change	https://www.cycj.org.uk/resource/inclusive-justice-co-producing-change/
Scottish independent advocacy alliance -	https://www.siaa.org.uk/
Health Improvement Scotland - Participation toolkit	https://www.hisengage.scot/equipping-professionals/participation-toolkit/

Toolbox 5: Trauma Training	
National Trauma Training Programme Online Resources	[Link to Appendix 4](#)

Toolbox 6: Evaluation

Outcome measures table - from scoping phase	Link to Appendix 6
Outcome measures used in case studies	Link to Appendix 7
Evaluation Scotland resources - logic models	https://evaluationsupportscotland.org.uk
Better evaluation	https://www.betterevaluation.org/en/what-evaluation

Toolbox 7: Progress monitoring and Quality Assurance

Data collection	Link to Appendix 7
The Participation Toolkit (Scottish Healthcare Improvement Scotland)	https://www.hisengage.scot/equipping-professionals/participation-toolkit/
Inclusive Justice: Co-Producing Change	https://www.cycj.org.uk/resource/inclusive-justice-co-producing-change/

Toolbox 8: Other Toolkits for Organisational Change

Trauma-informed Oregan Roadmap	https://traumainformedoregon.org/roadmap-trauma-informed-care/screening-tool/
Trauma-informed Practice Guide (British Columbia)	https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
CCTIC (Fallot & Harris, 2009)	https://www.theannainstitute.org/CCTICSELFASSPP.pdf
Becoming Trauma-informed Tool Kit for Women's Community Service Providers (Stephanie Covington, 2016)	https://www.mappingthemaze.org.uk/wp/wp-content/uploads/2017/08/Covington-Trauma-toolkit.pdf
TICPOT	https://mhcc.org.au/resource/ticpot-stage-1-2-3/
Useful reading and toolkits by sector	Link to Appendix 8

Toolbox 9: Hiring a Trauma-Informed Workforce

Toolbox 9: Hiring a Trauma-Informed Workforce	https://www.chcs.org/resource/laying-groundwork-trauma-informed-care/

Toolbox 10: Trauma-specific models and therapeutic modalities

Post traumatic Stress Disorder NICE guideline	https://www.nice.org.uk/guidance/ng116
What is complex PTSD", the Psychologist	https://thepsychologist.bps.org.uk/what-complex-ptsd
Example of treatment approaches (Prolonged Exposure, EMDR, Seeking Safety, etc)	https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
Trauma-informed Care in Behavioural Services	https://www.ncbi.nlm.nih.gov/books/NBK207201/
EMDR	https://emdr-europe.org/

Toolbox 11: Trauma-informed lens tools

NES Trauma-informed Lens workshop	[Link to Appendix 4](#)
Sowing Seeds animation	[Link to Appendix 4](#)
Opening Doors Animation	[Link to Appendix 4](#)

Toolbox 12: Advice on how to use trauma-sensitive language

Recovery Orientated Language Guide (MHCC, 2019)	https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf
Example of a Shared Language document (Lancashire Police, 2019)	https://www.lancashiresafeguarding.org.uk/media/1406/A-Shared-Language-for-ACEs-and-TIP.pdf

Toolbox 13: Asking about trauma

How to ask about trauma	[Link to Appendix 9](#)

Toolbox 14: Setting up/running a Trauma-Informed event — https://mhcc.org.au/wp-content/uploads/2018/05/ticp_checklist_v4_20180222.pdf

Toolbox 15: Policy and Procedures review — [Link to Appendix 10](#)

Appendix 3 – Background materials for explaining trauma

(adapted from Blue Knot guidance for Primary Care staff).

(1)   UNDERSTAND THE IMPACTS OF STRESS ON THE BRAIN
Under stress, we can all lose the ability to be calm, reflect and respond flexibly

(See `Effects of stress on the brain')

(2)   SIGNS OF TRAUMA CAN TAKE DIFFERENT FORMS
Trauma responses include both:

Hy**per**arousal (obvious agitation; e.g. shaking, sweating, raised voice)

AND

Hy**po**arousal (e.g. glazed eyes; `zoning out'; `shut down'; can be harder to detect)

(3)   SIMPLE WAYS TO LOWER AROUSAL CAN RESTORE SAFETY
We can all learn to do this for ourselves and others.

Lowering arousal allows the person to return to a place where they can tolerate their feelings (`the window of tolerance'; example used in case study area) and avoid being overwhelmed from hyper- and hypoarousal.

### (4)   CHALLENGING RESPONSES AND BEHAVIOURS CAN BE DEFENCES AGAINST STRESS
Traumatised people develop coping strategies to protect them from being overwhelmed.

Understanding this allows us to consider what may have `happened to' a person rather than what is `wrong' with a person.

(5)   THE `WAY IN WHICH' WE INTERACT WITH A TRAUMATISED PERSON (NOT JUST `WHAT' WE SAY AND DO) IS IMPORTANT
It can also either increase or decrease a person's stress levels. This underlines the importance of knowing how to interact in a trauma-informed way, not make things worse, and `do no harm'.

EFFECTS OF STRESS ON THE BRAIN
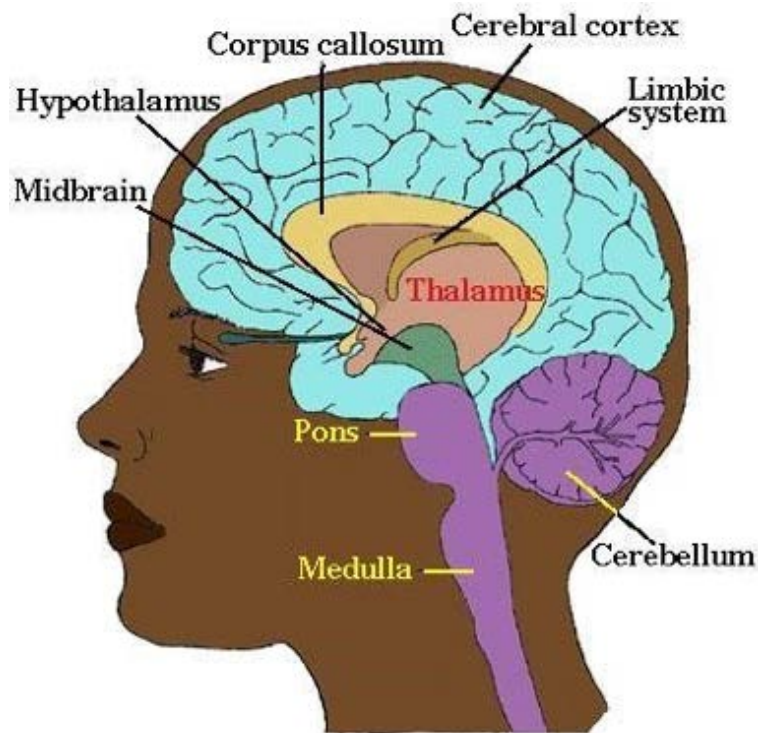
Brain Stem: Basic survival response, states or arousal; Automatic

Limbic: Emotion (fear), evaluation; Unconscious

Cerebral Cortex: Thinking, concepts, reflection; Conscious

Under conditions of stress, our 'lower' brain stem responses become dominant (`bottom up') and we are less able to be calm, reflect and respond flexibly. Trauma activates the `lower' brain stem region (the area below the cortex)

Conditions of stress affect our `higher' brain functioning (cortical; our ability to think). This is especially during times of overwhelming stress such as trauma.

`When we are calm it is easy to live in our cortex, using the highest capacities of our brains [to reflect] But if something...intrudes on our thoughts...we become more vigilant and concrete, shifting the balance of our brain activity to subcortical areas...., '(Perry, 2006:49)

`As we move up the arousal continuum towards fear... we necessarily rely on lower and faster brain regions. In complete panic...our responses are reflexive and under virtually no conscious control'

(ibid)

UNDERSTANDING THE STRESS RESPONSE

HYP*ER*AROUSAL	HYP*O*AROUSAL
• Increased heart rate	• Having feeling of being 'shut down' or 'cut off'
• Increased rate of breathing	• Avoidant – avoiding places, events, feelings
• Blood flows from the arms and legs to organs and major muscle groups	• Withdrawn
• Tension in the person's muscles	• Loss of humour, motivation, pleasure and connection with others
• Hypervigilance i.e. being on guard (for threat)	• Disturbance of sleep and energy levels
• Problems with the digestive system	
• Disturbance of sleep and energy levels	

TIPS TO REDUCE STRESS

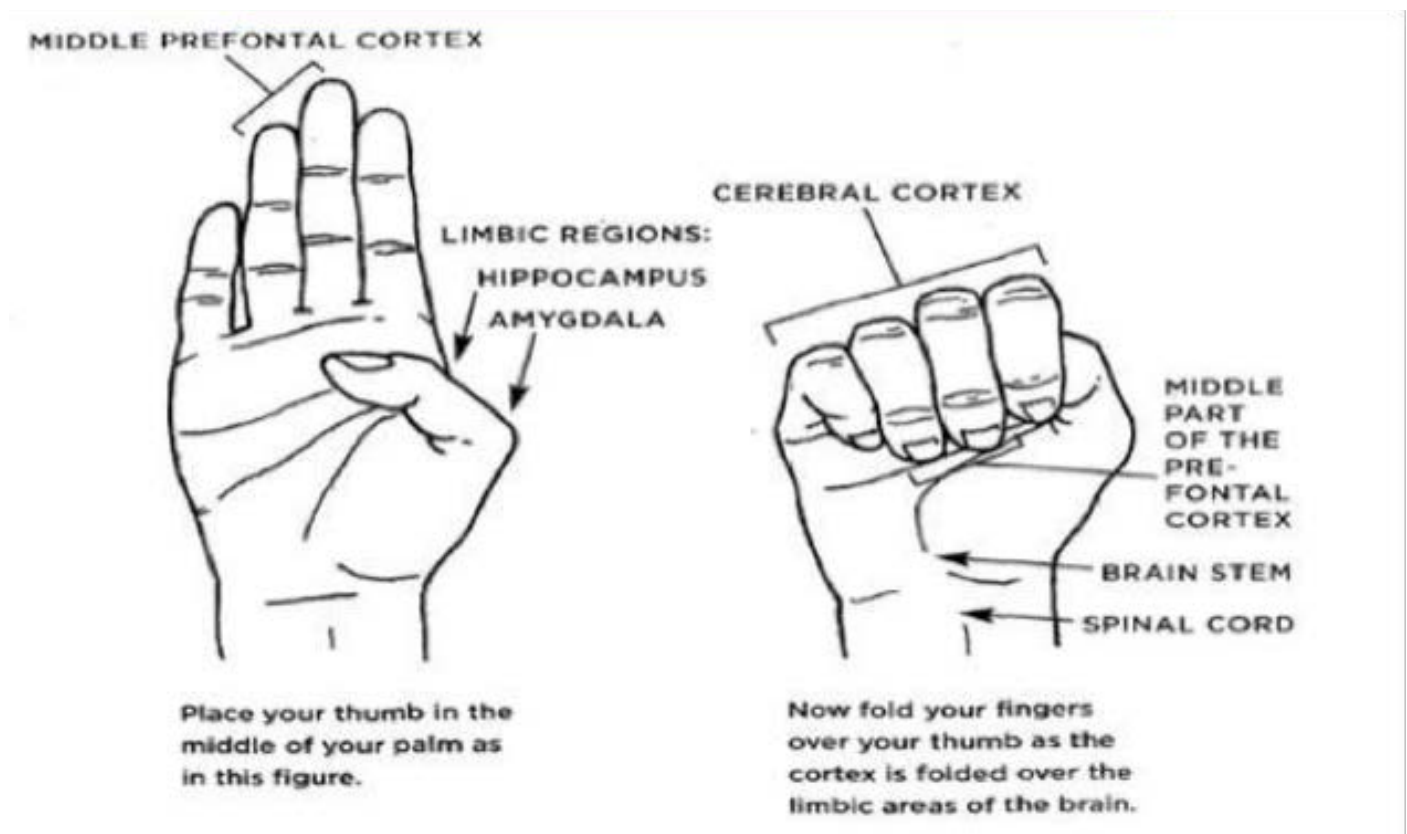| HYP*ER*AROUSAL	HYP*O*AROUSAL
• Recognise being hyper-aroused is a distress/fear response	• Recognise being hypo-aroused is a distress/fear response
• Validate their response ('I can see you are...')	• Support the person to feel safe
• Support the person to feel safe	• Provide an opportunity for the person to express their current needs without pressuring them to do so
• Turn the person's focus to their current need/task	• Pay attention to the physical space (more or less proximity to others?)
• Support gentle ways for the person to release some energy	• Help the person to become aware of their current surroundings and to tune into their senses
• Help the person to feel grounded, and feel settled in their body (e.g. feet firmly on the floor; some stretches)	• Encourage the person to move a little, change their posture/position or practice a familiar ritual or rhythm. Emphasis should be on movement rather than sensations for hypo-aroused states.
	• Direct attention outward (e.g. noticing objects in the room) rather than inward

HAND MODEL OF THE BRAIN

(Daniel J. Siegel, 2009) Demonstration at
https://www.youtube.com/watch?v=gm9CIJ74Oxw

The `hand model' of the brain is a simple and effective way of introducing the three basic areas of the brain (i.e. *brain stem, limbic system and prefrontal cortex*). It is also helpful to understanding of what happens in and to the brain under stress. As such, it provides a valuable illustration of information of which all primary care practice staff should be aware.

In the `hand model', the different parts of the human hand represent each of the above three brain regions. The brain develops with the bottom region forming first and the top region last. Hold hand upright with palm facing outward. The *wrist* represents the brain stem (the part which controls level of arousal and which developed first).The *palm with thumb folded over it* represents the limbic system (the `emotional' part of the brain which developed next). The *fingers* (folded down to cover the thumb and palm) represent the cortex or cognitive (`thinking/reflective') part of the brain which evolved last.

The simple shift of moving your fingers upright and away from your palm (so that thumb and palm are exposed) represents how severe stress can cause us to `flip our lid'. Stress activates our arousal (`survival') responses – represented by the upright wrist - and 'knocks out' our capacity to think and reflect:

MIDDLE PREFONTAL CORTEX

LIMBIC REGIONS:
HIPPOCAMPUS
AMYGDALA

Place your thumb in the middle of your palm as in this figure.

CEREBRAL CORTEX

MIDDLE PART OF THE PRE-FONTAL CORTEX

BRAIN STEM

SPINAL CORD

Now fold your fingers over your thumb as the cortex is folded over the limbic areas of the brain.

THE WINDOW OF TOLERANCE

(Siegel, 1999; Ogden et al, 2006)

The `window of tolerance' is the state in which we can tolerate our feelings without becoming stressed, distressed, and overwhelmed. We all need to be in this state (also called the `optimal arousal zone') *to maintain our well-being*. If we stray outside of this zone and become hyper- or hypoaroused, we have exceeded our level tolerance and need to return to the `window of tolerance' state.

1. We can monitor our own stress levels if we consider `what part of the brain' we are in at any particular time.

If distressed and/or fearful, we will be in the `lower' (subcortical, represented by the wrist) part of the brain. We need to return to the `higher' functioning part (cortical, represented by the folded fingers) to be calm and to be able to respond flexibly.* *

See tips to reduce stress

2. People who experience the impacts of interpersonal trauma can be easily `triggered' by stress and can find themselves outside the window of tolerance.
   Interacting in a trauma-informed way can assist them – and ourselves - to stay within `the window of tolerance'.

3. We also need to know how to assist people to RETURN to the window of tolerance if they stray outside it (i.e. if they become either hyper- or hypoaroused).

Hyperarousal zone – reacting too much   I may feel:

Defensive   Angry   My mind is racing   Overwhelmed Too many thoughts and feelings

Upset   Scared

Optimal arousal zone – Window of tolerance   I am interested in other people

I feel OK. I can cope   I can concentrate and think clearly   I can help others

Hypoarousal zone – reacting too little   I may feel:

No feelings - "flat"   I cannot defend myself

No energy   Ashamed or embarrassed   Sad. Want to be alone

Ditte Holm Sorensen, Psychology Assistant & Dr Eleanor Porter, Clinical Psychologist

Appendix 4

Click here to continue

CONTENTS

Introduction to the National Trauma Training Programme
(8mins)

with Dr Sandra Ferguson

About the Programme

This document summarises the key trauma training resources from the National Trauma Training Programme that are openly available to support all members of the Scottish workforce to meet the vision of:

"A trauma informed and responsive nation and workforce, that is capable of recognising where people are affected by trauma and adversity, that is able to respond in ways that prevent further harm and support recovery, and can address inequalities and improve life chances."

Trauma is **'everyone's business'** and every member of the Scottish Workforce has a role to play in understanding and responding to people affected by trauma. This doesn't mean that everyone needs to be a trauma expert —we know that different expertise and skills are required to support people's recovery — but it does mean that all workers, in the context of their own role and work remit, have a unique and essential trauma informed role to play in responding to people who are affected by trauma.

To find out more about the National Trauma Training Programme go to our website **here**.

"Trust is the biggest issue. I decided at onset I would be honest and have stuck with that. If I am giving honesty, I want that back. I am lucky, I get that. I ask questions and I get honest answers. For someone who has my background, trust will be broken easily. You have never had it your entire life."

"Don't try to make it right, but hold people in their pain and remind them they won't be crushed by the pain."

"We don't heal because we see a psychologist, I heal because I have been given the skills to release the pain."

"[She] is a tremendous listener, she really hears me. She remembers, she knows, she offers guidance. [She says] 'I am willing if you are' rather than talking about her expertise."

"[She was] genuine, calm, fair, truthful. Never reactive when I have been defiant and unreasonable. I can trust her judgement. She can tell the truth and even if I don't like it I will take it."
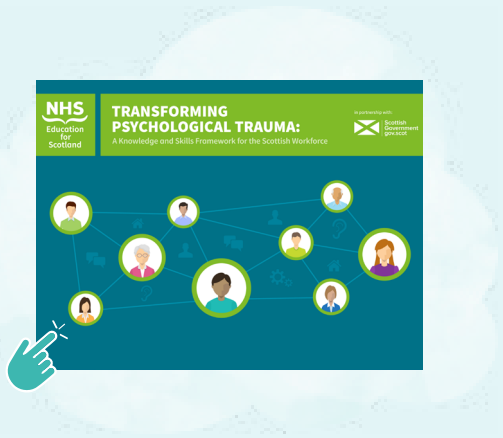
Transforming Psychological Trauma:
Knowledge and Skills Framework for the Workforce

This framework lays out the essential and core knowledge and skills needed by all tiers of the Scottish workforce to ensure that the needs of children and adults who are affected by trauma are recognised, understood and responded to in a way which recognises individual strengths, acknowledges rights and ensures timely access to effective care, support and interventions for those who need it. The framework also has an essential focus on staff well being, and is designed to support managers and supervisors to recognise the learning and development needs of staff in the workplace and trainers to develop training to meet these learning needs.

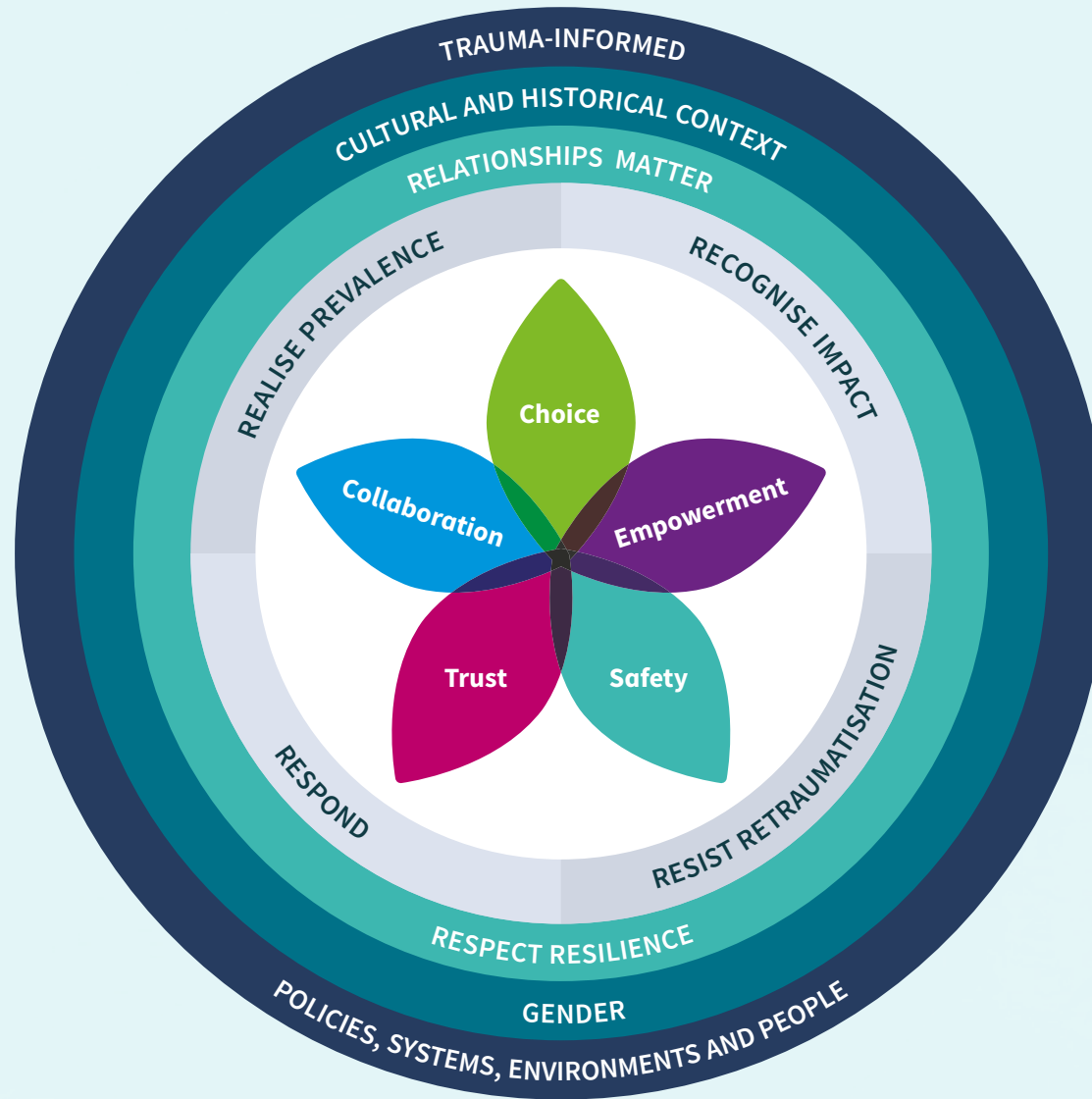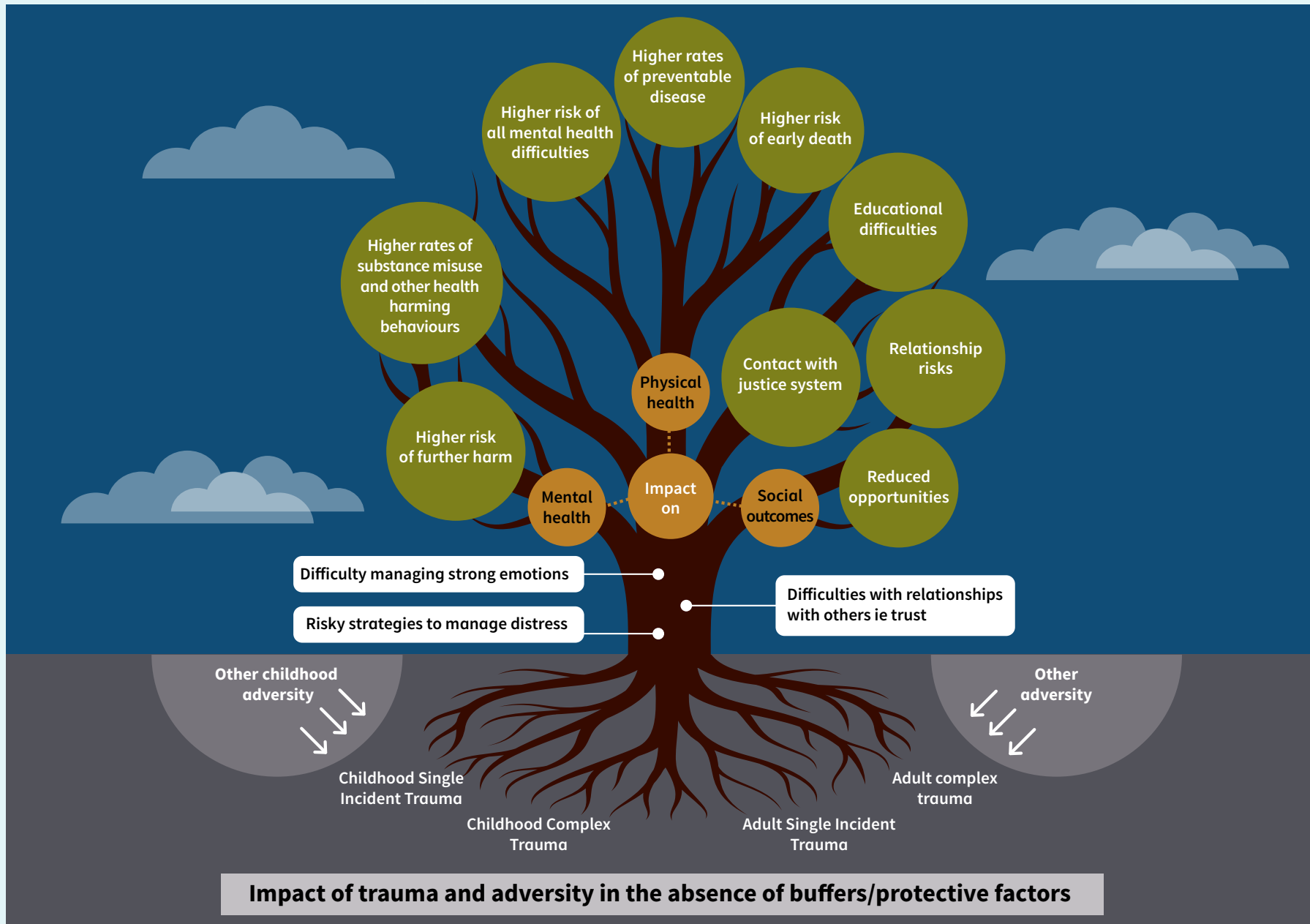📄 **Executive summary (coming soon)**

Scottish Transforming Psychological Trauma Training Plan

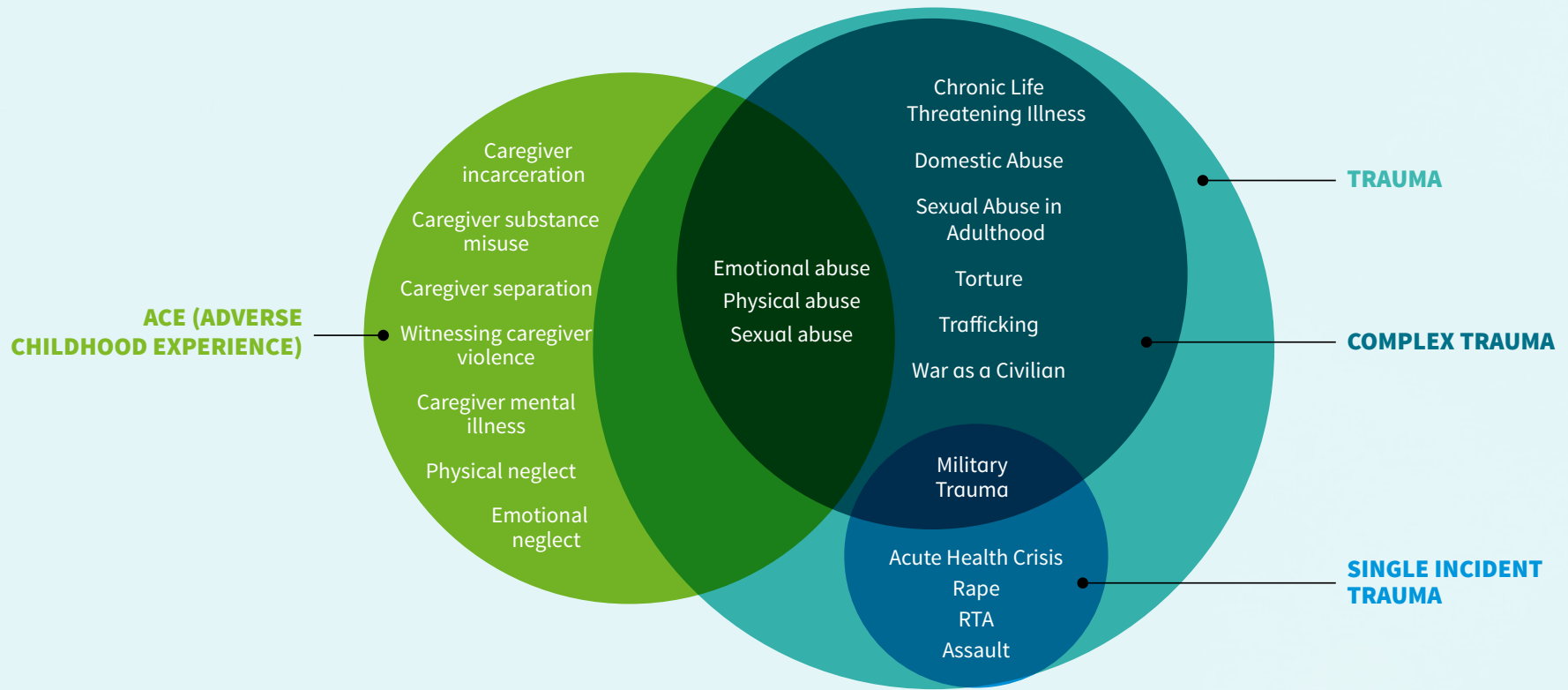**The Trauma Training Plan provides essential guidance and planning tools to support:**

+ Workers, managers and organisations to identify their own trauma training needs with reference to the Trauma Framework
+ Service managers and commissioners to develop or commission training to address the needs of their organisations and workers
+ Training providers to develop and deliver high quality trauma training
+ An understanding of key principles to bear in mind in developing and commissioning trauma training
+ An understanding of organisational factors that will support and maintain the translation of training into practice

Trauma Informed Systems

TRAUMA-INFORMED

CULTURAL AND HISTORICAL CONTEXT

RELATIONSHIPS MATTER

REALISE PREVALENCE

RECOGNISE IMPACT

RESIST RETRAUMATISATION

RESPOND

RESPECT RESILIENCE

GENDER

POLICIES, SYSTEMS, ENVIRONMENTS AND PEOPLE

Choice

Collaboration

Empowerment

Trust

Safety

Higher rates of preventable disease

Higher risk of all mental health difficulties

Higher risk of early death

Educational difficulties

Higher rates of substance misuse and other health harming behaviours

Relationship risks

Physical health

Contact with justice system

Higher risk of further harm

Mental health

Impact on

Social outcomes

Reduced opportunities

Difficulty managing strong emotions

Difficulties with relationships with others ie trust

Risky strategies to manage distress

Other childhood adversity

Other adversity

Childhood Single Incident Trauma

Adult complex trauma

Childhood Complex Trauma

Adult Single Incident Trauma

Impact of trauma and adversity in the absence of buffers/protective factors

The language of Trauma and Adversity

ACE (ADVERSE CHILDHOOD EXPERIENCE)

Caregiver incarceration

Caregiver substance misuse

Caregiver separation

Witnessing caregiver violence

Caregiver mental illness

Physical neglect

Emotional neglect

Emotional abuse
Physical abuse
Sexual abuse

Chronic Life Threatening Illness

Domestic Abuse

Sexual Abuse in Adulthood

Torture

Trafficking

War as a Civilian

TRAUMA

COMPLEX TRAUMA

Military Trauma

Acute Health Crisis

Rape

RTA

Assault

SINGLE INCIDENT TRAUMA

Looking after yourself: Wellbeing planning tool and animation (brief e-module coming soon)

To be able to look after others safely and effectively, we first have to take care of ourselves. You can use this animation along with the wellbeing planning tool to help you create your own unique plan for looking after yourself and protecting your wellbeing.

▶ **Wellbeing Animation**

## Protecting the Psychological Wellbeing of staff for Managers and Team Leaders*

The purpose of this unit is to help managers, planners and leaders of teams understand the evidence based factors that support the wellbeing of teams through crisis events such as COVID-19. It contains information about proactive strategies to protect the wellbeing of teams, and how and when to respond effectively to concerns about an individual's mental health during and after the crisis.

*Access to all of the NTTP e-learning modules is via Turas Learn. Registration with Turas Learn is necessary, but **anyone with an email address can register no matter their location or role.** You can register for an account **here**. If you are registering from outside of Scotand, please choose "international" as your sector.

Trauma Informed

All members of the workforce, whether paid or unpaid.
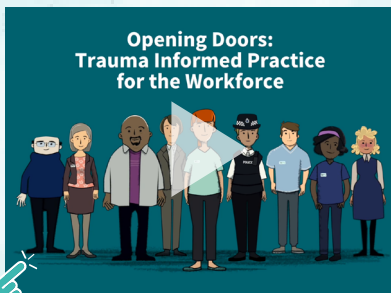
Trauma Informed Practice for the Workforce: Opening Doors Animation

This animation explains why and how trauma is everyone's business. It is designed to support anyone to become trauma informed - no matter what their job or role in society. It covers traumatic events like childhood sexual abuse and domestic abuse, so it is important to look after yourself as you watch it.

Trauma Informed practice for anyone working with children and young people: Sowing Seeds

This animation was developed by NHS Education for Scotland, in partnership with the Scottish Government. It is designed for everyone who works with children and young people. It aims to support people to understand the impact of trauma and to know how to adapt the way they work to make a positive difference to the lives of children and young people affected by trauma.

Taking a Trauma Informed Lens to Your Practice Workshops

The aim of these two workshops is to help individuals and teams examine how they work through a trauma informed lens. There are five key pause points for reflection, discussion, planning and commitment. Whether you watch this as an individual or a team, it will help you to reflect on

1. the extent to which the people you work with may have experienced trauma, and the impact that might have on your work

2. recognising and celebrating your existing trauma informed practices and how to sustain these

3. Identifying, and making an active commitment to the small changes you can make to help you recognise where someone may be affected by trauma, and respond in a way that limits re-traumatisation and supports their recovery using the principles of trauma informed practice.

Taking a Trauma Informed Lens to your service and practice: Opening Doors for working with adults

Workshop With Dr Caroline Bruce, NHS Education for Scotland

📄 **Workshop guide (coming soon)**   📄 **Planning tool (coming soon)**

Taking a Trauma Informed Lens to your service and practice: Sowing seeds for working with children and young people

Workshop with Dr Nina Koruth, NHS Education for Scotland

📄 **A facilitators guidance (coming soon)**   📄 **Planning tool (coming soon)**

Trauma Skilled

Workers who are likely to be coming into contact with people who may have been affected by trauma.

### Developing your trauma skilled practice module*

This module is consists of five units, and takes around 1.5-3 hours to complete. It is designed to increase your understanding of what psychological trauma is and how it can affect us, how to support recovery and develop trauma informed relationships that incorporate trust, safety, choice and collaboration, and control and empowerment, and how to recognise when a person may benefit from a trauma specialist intervention.

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*Access to all of the NTTP e-learning modules is via Turas Learn. Registration with Turas Learn is necessary, but **anyone with an email address can register no matter their location or role.** You can register for an account **here.** If you are registering from outside of Scotand, please choose "international" as your sector.

Understanding how the experience of trauma can affect our Window of Tolerance
(20 mins)

Jennie Young, NHS Education for Scotland
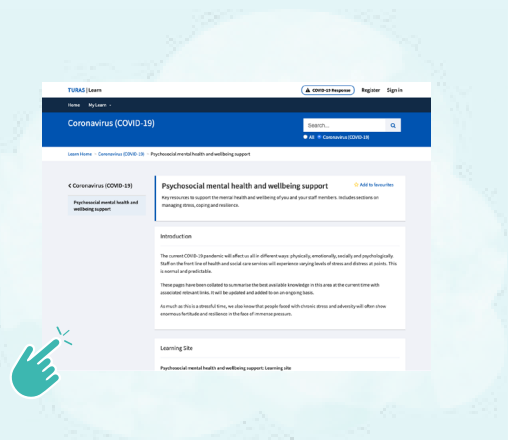
COVID 19 resources

In the context of COVID 19, NES developed a number of specific resources to support staff to look after others, themselves, and their staff teams, which will remain relevant on the post Covid world.

Psychological First Aid e-module

Psychological First Aid is an effective (according to various studies and the consensus of many crisis helpers) set of principles that anyone can use to support people during or after any kind of crisis. It involves offering humane, supportive and practical help, and paying attention to the factors that seem to be most helpful to people's long-term recovery. This brief module cover the seven key elements of PFA, with the second half dedicated to planning for your own wellbeing. It takes around 1 hour to complete.

Trauma Enhanced

Workers who have a specific remit to respond to people know to be affected by trauma

AND are required to provide advocacy support or interventions

OR are required to adapt the way they work to take into account trauma reactions to do their job well and reduce risk of retraumatisation.
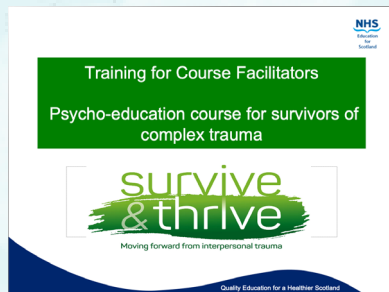
Trauma Specialist

Workers who have a specific remit to provide specialist interventions or therapies for people known to be affected by trauma with complex needs.
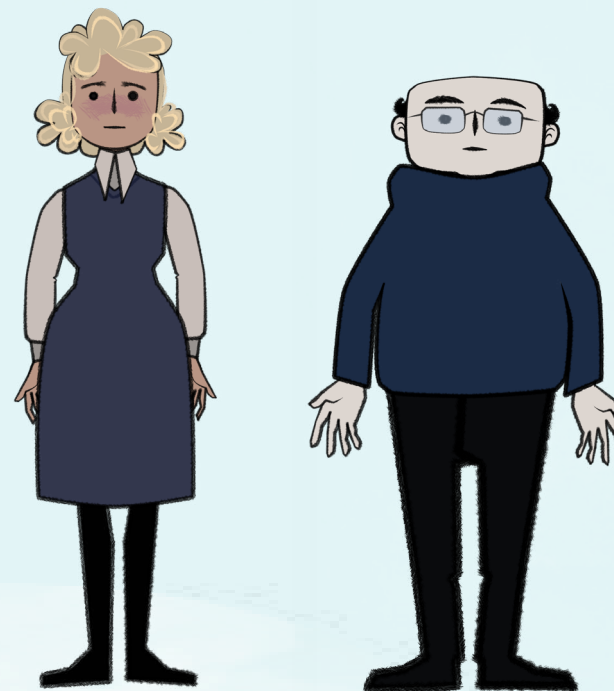
Most elements of the NES/SG National Trauma Training Programme at Enhanced and Specialist level are delivered face to face, and are **not** available online.

Trauma Enhanced Training Programme

Safety and Stabilisation is a 2 +1 day training to develop the skills and competencies to deliver safety and stabilisation interventions as part of the phased based treatment of people affected by experiences of prolonged and repeated trauma.

Survive and Thrive is a 2 + ½ day course where attendees develop the competencies and skills to deliver Survive and Thrive, a group based psycho-educational course as part of the phased based treatment for people affected by prolonged and repeated trauma.

Supporting children and young people to recover from the effects of psychological trauma (10 mins)

Filmed interview with Dr Nina Koruth, NHS Education for Scotland

Trauma Specialist Training Programme

+ Specialist CBT for PTSD workshop
+ Specialist Masterclasses

Ways to avoid re-traumatising witnesses part 1: Trauma and Credibility (9mins)

Dr Caroline Bruce,
NHS Education for Scotland

Ways to avoid re-traumatising witnesses part 2: Trauma Informed Approaches (6mins)
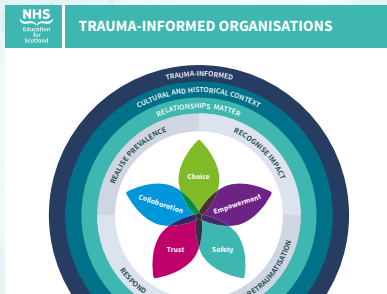
Dr Caroline Bruce,
NHS Education for Scotland

Ways to avoid re-traumatising witnesses part 3: Window of tolerance (7mins)

Dr Caroline Bruce,
NHS Education for Scotland

Trauma Informed Sexual Offences Examinations, for Forensic Medical Examiners (50mins)

Dr Julie Cumming, Forensic Medical Examiner and Dr Caroline Bruce, NHS Education for Scotland

Trauma informed organisations

The NES Scottish Trauma Informed Leaders Training (STILT) training programme was created in recognition that trauma informed and responsive practice can only happen in the context of trauma informed and responsive environments, policies, systems and organisations. STILT was initially designed as a 1 + ½ day programme to support leaders of organisations to develop trauma informed systems, processes, environments and teams from top down as well as bottom up. We are currently in the process of reviewing STILT training resources in response to social distancing, and plans for the new STILT programme will be announced in Autumn 2020. Some key STILT resources below.

The impact of psychological trauma on the window of tolerance in organisations, services and systems (15mins)

Jennie Young, NHS Education for Scotland
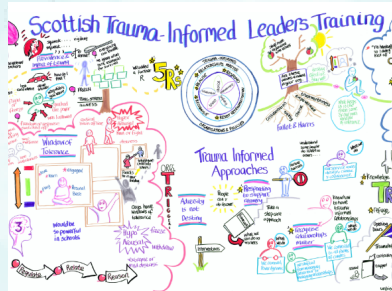
Scottish Trauma Informed Leaders Training (STILT) workshops

The following workshops are currently delivered as part of the NES face to face STILT programme and are **not** available online.

Taking a Trauma Informed Lens to your Organisation Workshop

The Scottish Informed Leaders Training (STILT) workshop, the PDF "trauma informed lens tool" and the Opening doors and Sowing seeds animations are used to support managers and leaders to actively take a trauma informed lens to their own organisations and plan for change.

📄 **Trauma Informed Lens Tool (coming soon)**   ▶ **Opening Doors**   ▶ **Sowing Seeds**

Identifying and Addressing Organisational Trauma Related Training Needs Using the Transforming Psychological Trauma Framework and Training Plan

This is another STILT workshop to support managers and leaders to take a strategic approach to understanding and addressing the trauma related training needs of their staff groups. There is also a brief version of this workshop that is used with mixed staff groups (frontline or leaders) to think about the different roles and practice levels within their organisation. Both are good ways for managers to become familiar with and start using the framework and training plan.

📄 **Identifying trauma training needs tool (coming soon)**

Working with experts by experience in developing and delivering trauma informed service (3.5 mins)

Shumela Ahmed,
Resilience Learning Partnership

The importance of co-designing trauma informed environments and systems in secure care with children and young people (4.5mins)

Dan Johnson, Clinical Director, Kibble Education and Care Centre.

The importance of Trauma Informed Practice for refugees and asylum seekers (3.5mins)

Dr Rachel Morley, NHS Greater Glasgow and Clyde

Trauma informed Policing (5mins)

Paul Main, former Chief Superintendant for Police Scotland

Creating trauma informed working environments (3mins)

Sandie Barton, Rape Crisis Scotland

Trauma informed education in schools (3.5mins)

Gail Nowek, Education Scotland

NHS Education for Scotland
Westport 102
West Port
Edinburgh EH3 9DN
tel: 0131 656 3200
www.nes.scot.nhs.uk

Appendix 5 - Good starting points for lived experience involvement

Generally the following are good starting points for service user involvement (adapted from Harris & Fallot, 2001):

Clearly identify the strengths expected from achieving this organisational shift and promote this change among staff using this information. Potentially create a survivor involvement policy, outlining the mission and what you want to achieve

- Be proactive in getting buy in/laying the groundwork – get stakeholders on board early, encouraging an open dialogue about their concerns already creates buy in and identifies barriers. Groups could be organised by the allocated trauma representative, with attendance from management as well to highlight the importance being placed on this culture change.

- Create a plan – this needs to include concrete terms that are measurable

  a. Define terms – what is meant by involvement; survivor; representation; advocate

  b. Identify the goal – for example, to gain funding for a lived experience worker; to set up a panel of survivor service users; to gather information to quality assure services and feed it back into development.

  c. Measure and monitor progress – how are you going to monitor the progress of each?

  d. Outline how this is going to be maintained/become sustainable? Survivor leads? How will they be reimbursed to facilitate input?

Review policies – this links to the prior section, but some of the barriers listed above will need to be addressed in policies, particularly those that focus on benefits, contracts, budget and hiring. Adapting leave policies to reflect the sensitivity to the fluctuating needs of survivors in extreme conditions, unanticipated leave may be needed for substance abuse relapse, mental health and wellbeing days, as well as flexible working policies. Although, in a TI organisation, this would be the same for all staff.

Allocating money for survivor involvement – expenses including recruitment, training, travel, interpreters where necessary.

Appendix 6 – Table showing outcome measures adopted by studies across sectors (from literature review)

TI Practice Sectors	Outcomes and measures adopted	Study
Mental Health (including inpatient adult and youth)	Seclusion and restraint events measured by admin data	Azeem, Auja, Rammerth,
		Binsfield and Jones (2011), Azeem et al. (2015), Blair et al. (2017); Borckardt et al. (2011)
	Time to discharge, Improvement in presenting symptoms (using e.g. Trauma-informed System Change Instrument)	Bartlett et al (2016);
		Greenwald (2012); Messina (2014);
	Trauma sensitivity ratings among patients and staff, measure via quality of care measure; Favourable beliefs about TIC (Trauma-informed Beliefs Measurement)	
		Bockardt et al. (2011); Brown et al., 2012;
	Pre and post staff feedback (specifically designed questionnaire for service)	
		Hall et al. (2016); Candler et al. (2008);
	Treatment retention	
		Hortensia et al. (2007)
	Staff injuries and staff perception of safety (developed internally)	Goetz & Taylor-Trujillo (2012)
	Reactivity, measured via single item Subjective Units of Distress (SUDS) and "compassion towards clients" (internally developed measure)	Greenwald et al. (2012)
Crime and Justice	MH symptoms	King (2015)
	Injuries to staff, assaults on staff, staff fear for safety, staff grievances (admin data)	Elwyn, Esaki and Smith (2015)

TI Practice Sectors	Outcomes and measures adopted	Study
Medical (Primary Care, Dental)	Knowledge of health related manifestations of trauma	Raja et al. (2014); Raja et al. (2015); Hall et al. (2016); Strait and Bolman (2017)
	Confidence in treating survivors of trauma	Raja et al. (2014); Raja et al. (2015); Hall et al. (2016); Strait and Bolman (2017)
	Knowledge, skills and attitudes related to TIP (questionnaire developed by developers)	
	Patient/provider rapport (measured via patient report); perception of clarity of information from providers (patient report); perceptions of shared decision making between patient and providers)	Choi & Seng (2015)
		Green et al. (2016)
	Patient-centeredness score (Roter Interactional Analysis System rating of taped visits between primary care providers and users)	Green et al. (2015)
	Integration of trauma-informed practice and confidence in delivering TIC (via Trauma-Informed Medical Care Questionnaire)	Weiss et al. (2017)
Residential Care	Satisfaction with training and knowledge.	Crable et al. (2013);
Substance misuse	Alcohol use Drug use MH symptoms Admin data (length of time using drugs, court ordered treatment, exposure to interpersonal abuse; other stressful events. Knowledge of traumatic stress Frequency of asking patients about trauma exposure, attitudes towards trauma inquiry and response, confidence in trauma inquiry (all internally designed)	Morrissey et al. (2014); Cocozza et al. (2005); Gatz et al. (2007); Lotzin et al. (2007)

TI Practice Sectors	Outcomes and measures adopted	Study
Social Work (C&F)	TIC knowledge and Self reported use of TI Practices (developed internally Perceptions of individual and agency capacity to provide TIC, measured via Trauma System Readiness Tool	Connors- Burrow et al (2016); Kenny et al. (2017)
Education	Disciplinary office referrals and suspensions, via admin data	Dorado et al. (2016)

Appendix 7 – Table showing data collected in case study areas for audit and evaluation purposes

Case study area	Data collected

CJSW	• Psychometric Data
	
	  • ACE (Adverse Childhood Experiences)
	  • BCE (Benevolent Childhood Experiences)
	  • CORE 10 (General mental well being)
	  • ITQ: International Trauma Questionnaire (measure of trauma related symptoms including PTSD and Complex PTSD)
	  • PHQ9 - measure of level of low mood/depression
	  • GAD7 – measure of level of anxiety
	
	• Staff Questionnaires
	
	• Focus groups (externally facilitated separately for workers and leaders)
	
	• Training Evaluation Forms (pre and post measures completed by participants)

Mental Health 1	• Psychometric Data
	
	  • ACE (Adverse Childhood Experiences)
	  • BCE (Benevolent Childhood Experiences)
	  • ITQ: International Trauma Questionnaire (measure of trauma related symptoms including PTSD and Complex PTSD)
	  • Life events checklist – measure of exposure to potentially traumatic events
	  • Childhood Trauma Questionnaire
	  • Cognitive Emotion Regulation Questionnaire – measuring cognitive coping strategies
	  • WSAS – measures work and social functioning
	  • IROC – measures recovery
	  • HADS - measure of anxiety and depression
	  • ADMN20 – assessment of Adjustment Disorder
	  • a bespoke measure on behaviour following life events

Mental Health 2	Bespoke pre and post training measures
Residential	ARTIC measure – Attitudes Related to Trauma-informed Care
GP	CARE questionnaire scores (from 20+ patient consults every 5 years for GP appraisal)
Police	Bespoke pre and post training measures
Addictions	• Psychometric Data • CORE-10 • Service user questionnaires

Glossary of measures:

International Trauma Questionnaire (ITQ) (Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., ... & Hyland, P. (2018). The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD. Acta Psychiatrica Scandinavica, 138(6), 536-546.)

Hospital Anxiety and Depression Scale (HADS) (Spinhoven, P. H., Ormel, J., Sloekers, P. P. A., Kempen, G. I. J. M., Speckens, A. E. M., & Van Hemert, A. M. (1997). A validation study of the Hospital Anxiety and Depression Scale (HADS) in different groups of Dutch subjects. Psychological medicine, 27(2), 363-370.)

I-ROC (Monger, B., Hardie, S. M., Ion, R., Cumming, J., & Henderson, N. (2013). The individual recovery outcomes counter: preliminary validation of a personal recovery measure. The Psychiatrist, 37(7), 221-227.)

Work and Social Adjustment Scale (WSAS) (Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. M. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. The British Journal of Psychiatry, 180(5), 461-464.)

ADMN-20 (Kazlauskas, E., Gegieckaite, G., Eimontas, J., Zelviene, P., & Maercker, A. (2018). A brief measure of the international classification of diseases-11 adjustment disorder: investigation of psychometric properties in an adult help-seeking sample. Psychopathology, 51(1), 10-15.)

Childhood Trauma Questionnaire (Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., ... & Ruggiero, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. The American journal of psychiatry.)

ACEs (Felitti, V. J. (1998). The relationship of adult health status to childhood abuse and household dysfunction. American Journal of Preventive Medicine, 14, 245-258.)

Life Events Checklist (Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. Assessment, 11(4), 330-341.)

Relationship Questionnaire (Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: a test of a four-category model. Journal of personality and social psychology, 61(2), 226.)

Cognitive Emotion Regulation Questionnaire (Garnefski, N., & Kraaij, V. (2006). Cognitive emotion regulation questionnaire–development of a short 18-item version (CERQ-short). Personality and individual differences, 41(6), 1045-1053.

Benevolent Childhood Experiences scale (Narayan, A. J., Rivera, L. M., Bernstein, R. E., Harris, W. W., & Lieberman, A. F. (2018). Positive childhood experiences predict less psychopathology and stress in pregnant women with childhood adversity: A pilot study of the benevolent childhood experiences (BCEs) scale. Child abuse & neglect, 78, 19-30.)

Attitudes Related to Trauma-informed Care. (ARTIC). Baker, C. Traumatic Stress Institute. USA.

Barkham, M., Bewick, B., Mullin, T., Gilbody, S., Connell, J., Cahill, J., Mellor-Clark, J., Richards, D., Unsworth, G. & Evans, C. (2012). The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. Counselling and Psychotherapy Research, 1–11. http://doi.org/10.1080/14733145.2012.729069.

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613. doi:10.1046/j.1525-1497.2001.016009606.x

Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. doi: 10.1001/archinte.166.10.1092. PMID: 16717171.

Appendix 8: Useful reading and toolkits (sector specific) from the literature review

Mental Health

- Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? (2016). Mental Health Review Journal. ISSN: 1361-9322

- Sweeney, A. & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health, Journal of Mental Health, 27:5, 383- 387, DOI: 10.1080/09638237.2018.1520973

- Wilton, J. & Williams, A. (2019) Engaging with Complexity. Providing effective trauma-informed care for women. https://www.mentalhealth.org.uk/sites/default/files/Engaging-WithComplexityTraum-Informed_0.pdf

- Practice Guidelines for Treatment of Complex Trauma and Trauma-informed Care and Service Delivery. (2012). Blue Knot foundation. https://doi.org/10.1111/inm.12012

- Muskett, C. (2014) Trauma-informed care in inpatient mental health settings: A review of the literature. https://doi.org/10.1111/inm.12012

- Wilson, A., Hutchinson, M. & Hurley, J. (2017) Literature Review of Trauma-informed Care: Implications for mental health nurses working in acute inpatient settings in Australia. https://doi.org/10.1111/inm.12344

CJSW

- Covington, S. (2016). Becoming Trauma-informed: toolkit for women's community service providers. Part of the One Small Thing Initiative www.onesmallthing.org.uk

- Levenson, J. Trauma-Informed Social Work Practice, Social Work, Volume 62, Issue 2, April 2017, Pages 105–113, https://doi.org/10.1093/sw/swx001

- Levenson, Jill. (2017). Trauma-Informed Social Work Practice. Social Work. 62. 10.1093/sw/swx001.

- Knight, Carolyn. (2015). Trauma-Informed Social Work Practice: Practice Considerations and Challenges. Clinical Social Work Journal. 43. 10.1007/s10615-014-0481-6.

Prisons

- Allcock, A. (2016). Developing a TI approach to rehabilitative groupwork in prisons. Winston Churchill Trust.

- Miller, N.A, Najavits, L.M. Creating trauma-informed correctional care: a balance of goals and environment. Eur J Psychotraumatol. 2012;3:10.3402/ejpt.v3i0.17246. doi:10.3402/ejpt.v3i0.17246

- Vaswani, N & Paul. S (2019). It's knowing the right things to say and do - challenges and opportunities for trauma-informed practice in the prison context.The Howard Journal of Criminal Justice. https://doi.org/10.1111/hojo.12344

Education

- Missouri model for Trauma-informed Schools

- Child Trauma Toolkit for Educators, NCTSN (2008)

- The Compassionate and Connected Classroom curricular resource

Homelessness

- DeCandida, Beach & Clervil. (2013). Closing the gap: Integrating services for survivors of domestic violence experiencing homelessness. A toolkit for transitional housing programs.

- Trauma-informed care for women veterans experiencing homelessness: a guide for service providers (Women's Bureau US Department of Labour)

- Trauma-informed Organisational Toolkit for Homeless services – the National Center on Family Homelessness.

Social Work

- NCTSN Child welfare Trauma Training Toolkit

- What is a trauma-informed child and family service system, NCTSN Factsheet (2016)

- A Social Worker's tool kit for working with immigrant families. Healing the damage (Sept, 2010). https://bettercarenetwork.org/sites/default/files/A%20Social%20Worker%27s %20Toolkit%20 for%20Working%20with%20Immigrant%20Families.pdf

Judiciary

- Primer for juvenile court judges: A trauma-informed approach to judicial decision making for newcomer immigrant youth in juvenile justice proceedings (NCTSN)

- Juvenile court assessment (NCTSN)

- NCTSN Benchcard for the trauma-informed judge

Residential Care

- Johnson, D. (2017). Scottish Journal of Residential Child Care 2017 – Vol.16, No.1

- Hanson, R. F. and Lang, J. (2016) 'A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families', Child Maltreatment, 21(2), pp. 95–100. doi: 10.1177/1077559516635274.

- Bath, H. (2008). The Three Pillars of Trauma-Informed Care. Reclaiming Children and Youth, v17 n3 p17-21 Fall 2008

GPs

- Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S., Rajagopalan, C. Trauma-informed Care in Medicine, Family & Community Health. July/September 2015. Volume 38. Issue 3. P216-226

- Blue Knot guidelines for those working in primary care

- Brennan, R., Bush, M. & Trickey, D. (2019). Adversity and Trauma-informed Practice: A short guide for professionals working on the frontline. Young Minds.

- RACGP. Abuse and violence. Working with our patients in General Practice. 4th edition.

- Trauma-informed Practice Guide. (2013). BC Provincial Mental Health and Substance Use Planning Council

Older adults

- Ganzel, B. (2018) Trauma-informed Hospice and Palliative Care. *The Gerontologist*, Volume 58, Issue 3, June 2018, Pages 409– 419, https://doi.org/10.1093/geront/gnw146

- Hey (2018). Foundations of Trauma-informed Care: An introductory primer. Resilience For All Ages.

- Implementing TIC: A guidebook.
  https://www.leadingage.org/sites/default/files/RFA%20Guidebook.pdf

Appendix 9: Asking about Trauma

Before asking, it is important the questions have a preface, which normalises the question and explains that they do not have to answer it if they do not want to. For example,

> *"We know that difficult experiences people have been through, maybe linked to the mental health difficulties they are experiencing. I am going to ask you some questions we always ask people, we know they can be difficult questions for some, and you do not have to answer them if you don't want to."*

The actual question needs to be specific and clear. When Sweeney et al. (2016) implemented TIC in Newcastle and Tyne NHS, a specific policy was created on how people should ask about trauma and how to respond/next steps to take. If an individual does not want to answer the question, that needs to be understood by staff as disclosure needs to go at the pace of the individual. The box below provides recommendations on how a practitioner should respond to trauma and abuse disclosures.

Where a person discloses trauma and abuse, Read and colleagues (2007) recommend the practitioner responds in the following way:

- reassure the person that disclosure is a good thing

- do not try to ascertain the details of the trauma or abuse

- ask if anyone has been told previously and how that went

- offer trauma-specific support and know how to refer people to it

- ask whether the trauma is related to their current difficulties

- check their current safety (freedom from abuse)

- check the person's emotional state after the conversation

- get in touch to follow up with them.

Adapted from Sweeney et al. (2018)

A common misconception when a disclosure is made, is that the person receiving the disclosure needs to gather detailed information about the trauma. This is not the case, as long as enough information is gathered to ascertain if the person is still at risk, or others are could still be at risk. When safety and stabilisation work is not available within the organisation, there should be a clear referral system in place so workers know the correct next steps in helping someone in their recovery.

Appendix 10: Policies and procedures checklist

An important part of building a trauma-informed culture is including trauma-informed care in the organisations policies and procedures. This includes both how policies and procedures are developed, and how they are operationalised. In the journey of becoming trauma-informed, tending how trauma-informed principles and practices are threaded through policies and procedures will advance success. Leaders need to ensure that all relevant policies and procedures reflect the organisation's trauma-informed principles and practices. Pay particular attention to the following:

Human Resources

Background screening

New staff induction

Training – staff and supervisors

Support for supervisors to coach employee performance using a trauma-informed lens

Performance review documentation and process

Employee development plans including progressive discipline grievance and other conflict resolutions models and practices

Employee Assistance Program

Temporary or agency staff

Contracted health professionals

Environmental Services

Safety, Privacy, Security

Abuse and Reporting

Quality Assurance and Performance Improvement

Financial and Budget Policies

Communications

With employees

With service users

With others – volunteers, stakeholders, vendors, and contractors

Adapted from Resilience for all ages, Leading Age Maryland, p27

Appendix 11: Database Searching

Databases were searched across the EBSCO and ProQuest hosted databases, as well as the Campbell Collaboration database. Databases were searched for literature review articles discussing trauma-informed care, published from 2001 onwards. 2001 was selected as the cut-off date due to the publication of Harris & Fallot's (2001) Using trauma theory to design service systems. We reviewed only literature review articles due to time resources available. An overview of the searches conducted and results retuned are presented in table 1. The final articles used to inform the current project are presented in table 2.

Databases	Search terms	Where in Article	Limiters	Number of results	Full Text Reviewed
EBSCO: PsycINFO, Medline, CINAHL, ERIC	" Trauma informed OR trauma-informed OR trauma focused OR trauma-focused OR trauma responsive OR trauma-responsive" AND " Care OR approach OR system OR practice"	Abstract	2001-2019 Methodology= ' literature review' , ' systematic review'	114	39
ProQuest: Criminology collection, education collection, social sciences database, sociology collection	" Trauma informed OR trauma-informed OR trauma focused OR trauma-focused OR trauma responsive OR trauma-responsive" AND " Care OR approach OR system OR practice"	Abstract	01/01/2001-present Full text available Peer reviewed ' literature review' , ' review'	39	5
Campbell Collaboration	" Trauma"	Anywhere	None	13	0

Author	Title	Area
Kulkarni (2018)	[Intersectional Trauma-Informed Intimate Partner Violence (IPV Services: Narrowing the gap between service delivery and survivor needs](#)	Domestic Violence
Ko et al. (2008)	Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice	Child Welfare; Education; Emergency Services; Criminal Justice
Reeves (2015)	[A Synthesis of the literature on trauma-informed care](#)	Healthcare
McDonnell & Garbers (2018)	Adverse Childhood Experiences and Obesity: Systematic review of behavioural interventions for women	Healthcare
Muraya & Fry (2015)	[Aftercare services for child victims of sex trafficking: a review of policy and practice](#)	Child Welfare
Lucio & Nelson (2016)	[Effective practices in the treatment of trauma in children and adolescents: from guidelines to organisational practices](#)	Mental Health
Hegarty et al. (2016)	[Interventions to support recovery after domestic and sexual violence in primary care](#)	Primary Care
Bryson et al. (2017)	[What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review](#)	Residential Treatment
Krause et al. (2017)	[Solution-Focused Trauma-informed Care (SF-TIC): An Integration of Models](#)	Child Welfare

Author	Title	Area
Branson et al. (2017)	Trauma-Informed juvenile systems: a systematic review of definitions and core components	Criminal Justice
Miller & Najavits (2012)	Creating trauma-informed correctional care: a balance of goals and environment	Criminal Justice
Rapp (2016)	Delinquent-victim youth – adapting a trauma-informed approach for the juvenile justice system	Criminal Justice
Le Brocque et al. (2017)	Schools and natural disaster recovery: the unique and vital role that teachers and education professionals play in ensuring the mental health of students following natural disasters	Education
Record-Lemon & Buchanan (2017)	Trauma-Informed practices in schools: a narrative literature review	Education
Raja et al. (2015)	Trauma-informed Care in Medicine – Current knowledge and future directions	Healthcare
Muskett (2014)	Trauma-informed care in inpatient mental health settings: a review of the literature	Mental Health
Wilson et al. (2017)	Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia	Mental Health
Ganzel (2018)	Trauma-Informed Hospice and Palliative Care	Healthcare

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