research
in practice

Leaders'
Briefing

Developing and leading trauma-informed practice

Dartington

www.rip.org.uk

Introduction

Repercussions of trauma experienced in childhood may persist through adolescence and into adulthood. The intention of trauma-informed practice is an increased understanding of the ways in which present behaviours and difficulties can be understood in the context of past trauma.

The approach offers a framework for a common set of values, knowledge and language across services (eg, social care, health, education, housing and criminal justice). Trauma-informed approaches (TIAs) can also be applied to understanding and protecting the workforce from secondary or vicarious trauma as a consequence of the emotional demands of their work.

This briefing summarises evidence to inform the development of trauma-informed organisational and locality approaches and explains why, through using TIAs to re-shape services and practice, we are more likely to be able to engage with people affected by trauma. It includes sections on:

- Adverse childhood experiences.
- Trauma and its impacts on children, young people and adults.
- Secondary trauma amongst the workforce.
- Community-level trauma.
- Principles of trauma-informed practice.

Adverse childhood experiences

Traumatic experiences can take many forms and can occur as a result of a natural event, as well as being human-caused through accidental or intentional acts. Trauma is generally categorised into two sub-groups:

- Type 1 trauma refers to events which are one time or short-lived occurrences.
- Type 2 trauma (also referred to as complex or developmental trauma) comprises chronic traumatic events, which persist over longer periods of time (eg, repeated abuse, neglect, separation and other adverse experiences). This type of trauma generally occurs in the context of relationships (Kinoglu, 2017; Herman, 1992).

A substantial body of epidemiological research which originated in the United States has tracked long-term consequences of a selected group of ten Adverse Childhood Experiences (known as ACEs) in terms of outcomes such as life expectancy and long-term physical and mental health. The ACE research organises these experiences into two categories:

- Child maltreatment (eg, verbal, physical and sexual abuse; emotional and physical neglect).
- Household adversity (eg, mental illness; domestic violence; alcohol abuse; drug abuse; incarceration; parental separation).

The ACE studies have found that, when people are asked to look back on their own experiences, these adverse issues are reported very commonly. ACE studies in the US, recently replicated in Wales, found that more than half of people reported at least one significant form of childhood adversity and a quarter reported two or more (Feletti et al, 1998). In Wales, 14 per cent and, in England, 9 per cent of respondents reported experiencing four or more ACEs in childhood (Bellis et al, 2014 and 2015).

For many people there may be no lasting negative effects of ACEs while others with similar experiences may develop a range of difficulties. This diversity of outcomes is influenced by a range of factors, including the age at which the experience occurs; the intensity, frequency, duration and types of adverse experiences; and the characteristics of individuals. The research indicates the cumulative effect of ACEs; the greater the number of ACEs the greater the risk of negative outcomes (Anda et al, 2006; Bellis et al, 2014).

In 2018 ACE research is gaining a good deal of policy attention in the UK. There are also strong critiques of the ACE analysis; see for instance *The Problem with ACEs* submission to the Select Committee evidence-based early-years intervention inquiry (Edwards et al, 2017). Key questions include:

- The issue of 'net-widening' – what are we aiming to achieve in identifying ACEs in the general population for which there may be no 'service response'?
- What is the 'right' level of local or national state involvement in individual citizens' and families' lives, even if for benevolent principles?
- How can the somewhat fatalistic messages of the ACE research be useful in strengths-based working with individual people or capacity-building work in communities?

One powerful effect of the ACE research is that it is supporting the increasing recognition across human services of the long-term impact of trauma experienced in childhood.

How does trauma affect children and young people?

Children enduring complex trauma make behavioural adaptations focused on keeping the self safe in relationship to others. These adaptations may have been developmentally appropriate and necessary responses to repeated, interpersonal danger; nevertheless, we know from decades of clinical and epidemiological research that these difficulties have a significant impact upon psycho-social development across the lifespan, increasing the risk of attachment insecurity, poor behavioural and/or emotional regulation, lack of self-esteem, feelings of guilt and shame (see Taggart, 2018).

Young people responding to their own unmet needs may engage in behaviours that leave them vulnerable to exploitation and/or criminalisation (Hanson and Holmes, 2014). Young people's relationship-based difficulties can be compounded by un-reflective professional responses (Knight, 2015). On the other hand, positive changes to the caregiving environment – specifically, the quality of relationships and the provision of nurturing, stable and consistent care – can help children and young people recover (Hughes et al, 2016).

An example of how one area of London is approaching the behavioural expression of adverse childhood experiences is provided here:

Camden and Islington 10/10 Project

This project (run by a clinical psychologist and a team of youth workers and assistant psychologists) developed from working with groups of young men (aged 16-25) who had been identified by local services as involved in local communities. The project works on the theoretical assumption that these men are likely to have suffered significant trauma in their lives and that this will have had an impact on the ways in which they communicate their needs.

A crucial element of the work is building up rapport, trust and a long-term relationship with the young men. A key worker helps them with practical things (like home or job searching) and during these times much of the therapeutic work is done. Disclosures are then addressed using appropriate psychological approaches.

Further information on the project can be found here:

www.standard.co.uk/news/uk/nhs-psychologists-meet-london-gang-members-on-streets-in-bid-to-tackle-violence-a3786356.html

www.mac-uk.org/project-1010

Similar principles underpin the Enhanced Case Management (ECM) approach used by the Youth Justice Board Cymru. This is grounded in the Trauma Recovery Model (TRM), which draws on theories about child development and attachment; neurological impairment and the impact of maltreatment; the mental health of young people in the youth justice system; and interventions and effective practice (Skuse and Matthew, 2015).

The TRM involves taking young people through a series of developmental stages over a period of time. Progression to the next level can only occur when needs in the preceding level have been met. Further details of the approach can be found here: **www.cordisbright.co.uk/news/post.php?s=evaluation-of-the-enhanced-case-management-approach**

A useful summary of development trauma and therapeutic care can be found in the Beacon House resource at: **www.beaconhouse.org.uk/wp-content/uploads/Developmental-Trauma-Close-Up.pdf**

This resource discusses developmental trauma in relation to:

- its impact on sensory development; attachment; emotional and behavioural regulation; cognition; self-concept and identity
- what parents and carers can do to aid recovery
- signs of developmental trauma at home and school.

Thrive is an approach to supporting children and young people's social and emotional development that draws on neuroscience, attachment theory and child development. Further information on Thrive can be found here: **www.thriveapproach.com/the-thrive-approach**

Intergenerational trauma on parents and their children

Adverse experiences in childhood can increase the risks in adulthood for a range of negative outcomes, including substance misuse, domestic abuse and mental health problems. The risk of harm to children increases when these factors combine in a family (Brandon et al, 2012).

Coordinated services that address the *causes* rather than just the symptoms of adults' problems are crucial if parents are to address their problems and keep their children safe at home. Broadhurst et al's (2017) study with mothers who were respondents in two or more sets of care proceedings (recurrent care proceedings) found the women had experienced high levels of abuse and neglect in childhood and that 40 per cent of them had been in care. Statistical analysis found there were specific sub-groups of co-occurring issues in women who had more than one child removed from their care.

Subgroup characteristics of women at index and repeat proceedings (Broadhurst et al, 2017)

Subgroups and co-occurring issues	Proportion of women (%)
Subgroup 1 Mental health issues a key feature, co-occurring with substance misuse and domestic abuse.	29
Subgroup 2 Service non-engagement is the only common occurring issue.	27
Subgroup 3 Cognitive functioning is the key concern, but also includes service non-engagement and domestic abuse.	17
Subgroup 4 Co-occurrence of substance misuse, service non-engagement and domestic abuse. High incidence of insecure housing.	14
Subgroup 5 Substance abuse is the dominant characteristic, with some concerns around service non-engagement and domestic abuse. This group shows the greatest reduction in concerns between proceedings.	13

There are many important points of learning raised in this research. One crucial learning point for all local authorities is to use a trauma-informed lens to reflect upon the case work, with the significant proportion of recurrent care-experienced women (27 per cent) for whom 'service non-engagement' was the only common occurring issue.

The removal of a child into care is for most parents an experience of trauma in itself and may well trigger spiralling drug and alcohol misuse or mental ill-health in response to loss, guilt, shame and grief (McCraken et al, 2017). Therapeutic support focused on the parent/s themselves has been sorely missing from child-focused child protection systems for decades but there is increasing activity to develop trauma-informed provision in this field.

Examples include:

- **Pause:** www.pause.org.uk
- **Strengthening Families:** www.salford.gov.uk/children-and-families/safeguarding-children/early-intervention-and-prevention-service/strengthening-families
- **Positive Choices:** www.suffolk.gov.uk/children-families-and-learning/keeping-children-safe/positive-choices-service

(see also Research in Practice/ Universities of Lancaster and Essex *Recurrent Care Proceedings Change Project* outputs, forthcoming 2018)

The impact of secondary (vicarious) trauma on the workforce

Working with children, young people and families in the context of abuse, neglect and other adversities places high emotional demands on practitioners, and may well expose them to frightening situations where their safety may be compromised. Responding with empathy to traumatised individuals and disturbing situations can have an impact on workers' personal and professional life (Hendricks, 2012; Figley, 2012; Biggart, 2016).

Secondary trauma, also referred to as vicarious trauma, has been defined as 'the stress resulting from helping or wanting to help a traumatised or suffering person' (Figley, 1995).

Experience of secondary traumatisation in a non-supportive environment can affect workers individually and also undermine team working environments, leading to:

- feelings of helplessness
- isolation from colleagues
- reduced critical thinking skills
- impaired judgement
- low motivation and poor quality work
- difficulty recognising and monitoring emotions
- increased absences
- high levels of staff turnover.

(Quinn et al, 2018; Tullberg et al, 2012)

As leaders, developing organisational policies and working conditions that promote wellbeing and self-care, and create a safe and supportive environment, is key to preventing secondary trauma - as exemplified below:

- Ensure that regular, reflective supervision supports direct practice activities (see Earle et al, 2017 - **www.rip.org.uk/reflective-supervision**). Supervisors who show empathy, and are open and understanding, are crucial for reducing the likelihood of practitioners experiencing secondary trauma. Supervisors should be supported to develop skills in containing practitioners' anxiety, enabling a clearer view of what the child and family require and what actions are most likely to produce the best result.
- Good supervision is associated with lower levels of worker stress, burn-out and role conflict, and greater staff wellbeing (again, see Earle et al, 2017, for a summary of research evidence on reflective supervision).
- It is important to create a culture where workers can ask for support. Supervisors can help to develop this culture by proactively acknowledging when staff have difficult cases and encouraging them to take steps to protect themselves from secondary trauma.

- First line managers are also susceptible to secondary trauma through their supervision of frontline practitioners, and will themselves need support to process their feelings.
- Leaders need to be alert to managing caseload levels in the social care workforce. Large caseloads limit practitioners' ability to develop and use their skills with families and can also increase the risk of secondary trauma. An optimum number of cases per worker is difficult to determine, given the varying complexity of cases and differing levels of worker experience. Thus, it is not simply a matter of reducing caseloads, but also of balancing the range of work so that practitioners have caseloads that are manageable.
- In the context of organisational support, practitioners need to find individual ways to deal with the feelings and emotions that accompany their work (Wilkins et al, 2018; Quinn et al, 2018; Collins-Camargo, 2012).

The SPARK tool is an open-access self-reflective evaluation tool for practitioners working in child protection, supporting them to develop a tailored self-care plan: **https://ideachildrights.ucc.ie/resources/tools/SPARK-Tool-Final-UCC.pdf**

The impact of community trauma

There is increasing recognition of 'collective trauma' experienced in the wake of a community disaster. Community trauma may well have impacts on individuals, leading to post-traumatic stress disorder (PTSD) or a variety of affective disorders such as chronic anxiety and depression (Lopéz-Zerón et al, 2015). Community-level traumas both require and elicit collective responses. Aspects of organisational practices that are seen to contribute to the healing of families and communities exposed to traumatic events include:

- Strengths-based perspectives.
- Local systems actively addressing individual, family and community needs.
- Providing education on the impacts of trauma to normalise survivors' experiences.
- Public communication to reduce fear.
- Connecting survivors to social support and systems of care.

(Lopéz-Zerón et al, 2015).

For most people distress will gradually subside over time, particularly with support from family, friends and social networks. In other situations community responses may be intensified, for example where the conditions for the traumatic occurrence are not addressed by local and national state responses.

Narrative Exposure Therapy (NET) is a treatment approach for individuals suffering from complex and multiple trauma. It is most often used in community settings and with individuals who experienced trauma as a result of political, cultural or social forces (such as refugees). Small groups of people receive four to ten sessions of NET together. The approach is based on the understanding that the story a person tells themself about their life influences how they perceive their own experiences and wellbeing. Framing one's life story solely around the traumatic experiences leads to a feeling of persistent trauma and distress. NET is conditionally recommended for the treatment of PTSD by the American Psychological Association: **www.apa.org/ptsd-guideline/treatments/narrative-exposure-therapy.aspx**

An example of community-level responses following the Manchester Arena bombing is provided below.

Lessons from the Manchester Arena terrorist attack

Following the Manchester Arena terrorist attack in May 2017, a multi-agency care pathway for children, young people and their families was developed by the Greater Manchester Combined Authority (GMCA). This set out the values and principles for the coordinated response. It included using a multi-agency stepped model that provides a continuum of holistic care:

- **Universal**
  Provision of psycho-social support, including listening and providing a safe space to talk; working with schools to ensure a consistent approach.
- **Targeted**
  Provision of psycho-social support and mental healthcare, including support for parents/carers; calming strategies to support emotional regulation.
- **Specialist**
  Provision of mental healthcare through Child and Adolescent Mental Health Services (CAMHS) psychological therapies.

For further information see the GMCA response here:
www.partnersinsalford.org/documents/Post-incident_support_pathways_for_children_and_young_people.pdf

The people of Manchester's community-generated response to the attack mobilised the symbol of a worker bee. First used during the Industrial Revolution as a tribute to Mancunians' work ethic and community spirit, the bee appears on bins, lampposts and paving stones in the city. Within a few weeks of the attack an estimated 10,000 people worldwide had a bee tattoo 'to show their support for the victims and as a symbol of strength', raising more than half a million pounds for victim support.

What is trauma-informed care?

Trauma-informed care developed in the United States in light of a growing awareness that service and practice responses need to be designed to recognise and respond to the experience of complex trauma in the lives of the people with whom they interact (Hickle, 2018). Although there is no consensus on a definition that explains the precise nature of trauma-informed care, the underpinning assumption is that it involves relational and strengths-based ways of working to address the impact of trauma.

Trauma-informed approaches (TIAs) differ from trauma specialist services:

- Trauma *specialist* services provide therapeutic interventions for those known to have experienced trauma.
- Trauma-*informed* approaches demonstrate an organisation or service commitment to responding to the needs of trauma survivors regardless of the services' primary purpose (eg, mental health, substance abuse services).

TIAs recognise that developmental trauma as a result of childhood experiences may well lead to the loss of a sense of safety and control and difficulties in developing trusting relationships. Mistrust may be displayed as hostility, lack of motivation or resistance to help being offered.

Trauma-informed practitioners recognise individuals' emotional vulnerability and how their present difficulties can be understood in the context of past trauma. TIAs incorporate a set of core principles for practice in order to avoid inadvertently re-traumatising individuals (Taggart, 2018; Sweeney et al, 2016; Levenson, 2017; Knight, 2015).

The trauma-informed practitioner's role as facilitator contrasts with that of the social worker in a risk-focused 'child protection paradigm' as an 'uninvited intruder' whose primary responsibility is the assessment of risk (Atwool, 2018) and whose presence will likely be fraught with stress and worry for families, even if no further action is taken (Wilkins and Whittaker, 2017).

The national Substance Abuse and Mental Health Services Administration (SAMSHA) has developed a framework for a trauma-informed approach (SAMSHA, 2014). Six key principles guide practice:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration
- Empowerment and choice
- Recognition of cultural, historical and gender issues.

Further information and resources can be found on the SAMSHA website - **www.integration.samhsa.gov/clinical-practice/trauma-informed** - and the National Traumatic Stress Network website - **www.nctsn.org**.

The key principles that underpin trauma-informed approaches have been summarised by Sweeney et al (2016) (see next page).

Although trauma-informed care is a relatively new concept in the child welfare system in the UK, similar principles underpin strengths and relationship-based practice models that have been implemented around the country. Examples include:

- **Restorative practices**, which focus on building respectful, collaborative relationships of challenge and support with a view to resolving difficulties and repairing harm.
- **Signs of Safety**, which is a strengths-based, solution-focused framework for collaborative engagement with families.
- **Family Group Conferences**, which is a family-led restorative practice that draws on the family network to safeguard children and support parents.
- **Motivational Interviewing**, which helps parents to find the internal motivation they need to change their behaviour.

Further information on these approaches can be found in the evaluations of the Children's Social Care Innovation Projects that implemented these models:

www.gov.uk/government/publications/childrens-social-care-innovation-programme-final-evaluation-report

http://reescentre.education.ox.ac.uk/wordpress/wp-content/uploads/2017/07/Thematic-Report-2017-Social-Work.pdf

Features of trauma-informed approaches and their application to working with children, young people and parents (based on Sweeney et al, 2016)		
	What this means for services	**What this feels like for children, young people and parents**
Recognition of trauma	Practitioners recognise the prevalence, signs and impacts of trauma and find a way to check if anything has happened to the person. Some people may not volunteer information about their past trauma due to feelings of guilt and shame; questions need to be sensitive to this to avoid retraumatisation.	*"I am being seen and believed."* Creates feeling of validation, safety and hope.
Avoidance of retraumatisation	There is an understanding that practices can lead to retraumatisation and that staff may suffer secondary trauma. Try to minimise taking control away from the person and be transparent.	*"They are not like the people that hurt me."*
Cultural, historical and gender contexts	Being sensitive in selection of key workers and treatment to the individual's specific identity.	*"They thought about me as a unique person. Me as a whole person."*
Trustworthiness and transparency	Being explicit at all times regarding what services are doing and why.	*"When they say they will do something they do it."*

Collaboration and mutuality	Understanding power imbalances and working to 'flatten the hierarchy'. There is a focus on building relationships based on respect, trust, connection and hope.	*"We are working through this difficult stuff together."*
Empowerment, choice and control	Enable the development of agency through access to resources. Practitioners adopt strengths-based approaches.	*"I am taking control of my life now."*
Safety	Developing safe systems, from admin processes through the entire organisation, to be trauma-informed.	*"I feel like I can finally begin to trust people again."* *"It might be worth seeing if they're trustworthy."* *"I feel emotionally and physically safe."*
Survivor partnerships	Peer mentor, peer support and co-production of services.	*"Meeting other people like me makes me feel less alone."*
Pathways to specialist trauma treatment	Development of links and clear pathways to specialist, evidence-based psychological therapies - CBT, EMDR, 3-Stage model of trauma work.	*"I go somewhere safe to talk through what happened to me."*

Becoming a trauma-informed organisation

Isolated pockets of training for frontline staff are not sufficient for effecting these quite fundamental changes in systems and practice. Organisational support and engagement of locality leadership across human services are important aspects of successful implementation (Atwool, 2018), as are the involvement of the workforce and service users. Some examples of what is needed to become a trauma-informed organisation are provided below, alongside some practice examples.

Commitment to becoming a trauma-informed organisation

> Strategic plans, policies and procedures should reflect the values of trauma-informed care (see table on pages 14 and 15), within the organisation and across locality partnerships. This might include:

- Training and resources for staff and supervisors to incorporate trauma-informed practice and supervision in their work.
- Recruitment practices that reflect a commitment to trauma-informed care. This might include hiring staff who have lived experience of trauma and recovery; have a good understanding of trauma-informed approaches; are representative of the community they serve.
- Policies and procedures to help staff deal with the emotional demands of their work and secondary stress (eg, providing a designated space for staff to go to when self-care would be helpful).

- Leaders should ensure training and development plans provide opportunities for staff to learn about the impacts of trauma for children and families, and how to prevent retraumatisation, for themselves and for the children and families they work with.

- An example of one organisation's (North Ayrshire Police) commitment to becoming trauma-informed is available here:

www.northayrshire.community/2018/02/police-scotland-ayrshire-division-become-trauma-informed

Partnership working

This requires a shared understanding of trauma-informed practice, as well as a shared set of outcomes so that all agencies are clear about what they are trying to achieve in partnership with children, young people and families.

Existing multi-agency partnerships such as health and wellbeing boards could form a basis for trauma-informed partnership working. Awareness-raising and training across children's and adults' services, schools, health and the police is key to developing joined-up, trauma-informed approaches.

Examples of partnership working in children's and adults' services

Adopting a whole school trauma-informed approach in the London Borough of Islington - TIPPS (Trauma-informed Practice in Primary Schools)

Islington is piloting trauma-informed practice in the pupil referral unit and five primary schools. It is a collaboration between the Clinical Commissioning Group, local CAMHS and the school improvement service. All staff in the schools, alongside community partners, receive two days' training on developmental trauma, its impact on children and ways schools can create a supportive environment for pupils who may have experienced complex trauma.

This is supported by a CAMHS professional visiting the school once a fortnight to support staff to be curious about children's behaviour and respond empathetically. The CAMHS professional also works with senior leaders to review policies and strategies to ensure they are trauma-informed. The programme uses the ARC (attachment, regulation and competency) framework with the aim of providing early help through universal services to support children in school. There is an ongoing evaluation of the pilot; however, early positive indications mean Islington will be looking to roll out the approach to more schools in the future. **http://democracy.islington.gov.uk/documents/s13649/Evidence%20from%20Helen%20Cameron.pdf**

Further information on becoming a trauma-informed school can on found at the Teacher Toolkit website: **www.teachertoolkit.co.uk/2017/12/05/trauma-informed**

Fulfilling Lives

Fulfilling Lives is a Big Lottery funded programme for partnership working across a number of local authority areas. The aim is to improve services for people with multiple and complex needs. It includes collaborations between, for example, local councils, mental health trusts, the police and voluntary sector organisations (eg, homelessness, substance abuse and domestic abuse services).

Many of the principles that underpin the programme fit with a trauma-informed approach. One such approach used by a number of the projects is to create a *Psychologically Informed Environment*. This approach focuses on relationship-building to promote recovery.

Further information on the Fulfilling Lives programme can be found here: **www.biglotteryfund.org.uk/global-content/programmes/england/multiple-and-complex-needs**

Further information on creating psychologically-informed environments can be found here: **www.homeless.org.uk/trauma-informed-care-and-psychologically-informed-environments**

Frontline practice

- Practitioners' learning and development should emphasise the importance of:
  - Seeing people's behaviour as a symptom of the problem, not the problem itself.
  - Approaching families with empathy.
  - Building trusting relationships with, and empowering, children and families.
  - Power differentials between practitioners and families, and how to reduce them.
  - Being gender and culturally sensitive.
  - Where children are removed from their family to safeguard and protect them, doing so in the most humane way possible to reduce the risk of retraumatisation for both the child and the family.
  - Supporting placement stability and avoiding frequent placement moves.
  - Promoting the continuation of existing positive relationships between children, their family and their wider social network.
- Models such as Signs of Safety and Motivational Interviewing are designed to support strengths-based partnership working with families and can be useful tools for direct practice.
- Developing consistent, reliable and trusting relationships with children and families is crucial. This requires time and manageable caseload levels to enable staff to build these relationships. It also requires a stable workforce to ensure that, wherever possible, the key worker remains working with the child, young person and family. Staff retention can be supported by factors such as:
  - high quality, reflective supervision
  - training, development and career progression
  - peer support
  - organisational support for emotional wellbeing
  - celebrations of success so practitioners feel valued.

Reflective questions for leaders to consider

1. Does local strategy, policy and procedure reflect a commitment to providing trauma-informed services and supports?
2. Are partner agencies trauma-informed?
3. Are there effective links with providers that have experience of delivering evidence-based trauma services?
4. What training is in place to help the workforce increase their knowledge of trauma-informed care?
5. Is specialist training available for foster carers, special guardians and adopters to help them understand the impacts of trauma on children and young people and how best to support them?
6. How does your organisation's quality assurance activity support trauma-informed reflection on the issue of 'failure to engage' with practitioners and services?
7. Where possible, are joint assessments conducted by multi-disciplinary teams in order to minimise the number of times children, young people and families have to re-tell their story?
8. When a child is removed from parents at birth, how might this be done in the most humane and ethical way possible? How might you bring midwives, nurses and social workers together to improve practice in local hospitals?
9. What forms of post-removal support are provided for birth parents?
10. What steps has the organisation taken to support workforce retention so that children and families have the opportunity to develop trusting relationships with a consistent key worker?
11. What proactive approaches are in place to avert placement moves for children in care to prevent retraumatisation through further experiences of separation and loss?

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