Department for Levelling Up, Housing & Communities

Trauma-informed approaches to supporting people experiencing multiple disadvantage

A Rapid Evidence Assessment

April 2023

Contents

About

The Changing Futures programme is a £64 million initiative between Government and The National Lottery Community Fund. It seeks to test innovative approaches to improving outcomes for people experiencing multiple disadvantage – including homelessness, substance misuse, mental ill health domestic abuse and contact with the criminal justice system. The programme is running in fifteen areas across England from 2021 to 2024.

The Department of Levelling Up, Housing and Communities (DLUHC) appointed a consortium of organisations, led by CFE Research, and including Cordis Bright, Revolving Doors, The School of Health and Related Research (ScHARR) at The University of Sheffield, to undertake an independent evaluation of the Changing Futures programme.

This report is part of a series of Rapid Evidence Assessments (REA) produced for the Changing Futures programme by the evaluation team.

The report was written by Revolving Doors with CFE Research in June 2022.

For more information about this report please contact cfp@levellingup.gov.uk

Acknowledgements

List of acronyms and abbreviations

ACE(s): Adverse Childhood Experience(s)

DHSC: Department of Health and Social Care

DLUHC: Department for Levelling Up, Housing and Communities (also **DCLG**: *Department for Communities and Local Government* and **MHCLG**: *Ministry for Housing, Communities and Local Government*)

ECM: Enhanced Case Management (ECM)

ICM: Intensive Case Management

LEAD: Let Everyone Advance with Dignity

LGBTQ+: Lesbian, gay, bisexual, transgender and queer

PIE(s): Psychologically Informed Environments

PTSD: Post-traumatic stress disorder

QED: Quasi-Experimental Design

RCTs: Randomised controlled trials

REA: Rapid Evidence Assessment

SAMHSA: Substance Abuse and Mental Health Services Administration

WSA: Whole System Approach

Executive Summary

Introduction

This rapid evidence assessment (REA) aims to summarise the evidence on the benefits of taking a trauma-informed approach to address the different needs of people experiencing multiple disadvantage. The review also considers what factors can enable or prevent a service or system from working in a trauma-informed way.
The REA has three broad aims:

- To support central government to build understanding and consensus on the importance of trauma-informed approaches

- To support local service managers and commissioners to implement and enable effective trauma-informed practice, and

- To inform future qualitative "deep dive" evaluation activity exploring the changes being made to local systems as part of the Changing Futures programme.

Defining a trauma-informed approach

Before exploring the evidence-base in relation to trauma-informed approaches it is important to consider how this should be defined as there is no consensus on what this term entails[1]. It is important to note that this is not a specific intervention, but instead a way of working or process of change that can be applied across different geographies, services and activities.

We reviewed different definitions that have been utilised in academic studies, practice guidance, and delivery and policy frameworks to explore where there are similarities and differences in how trauma-informed practice is understood and applied. Key principles identified are:

- **Take a trauma lens** – acknowledge the widespread impact of trauma on thoughts feelings and behaviour, recognise the signs of this and respond accordingly.

- **Prevent further re-traumatisation** – recognise that services and systems can create further traumatisation and work to prevent this.

- Ensure people's **safety** – people need to feel safe to prevent further harm and re-traumatisation. Environments and ways of working (e.g. communication and tailored support) can support this.

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[1] The Office for Health Improvement and Disparities published a working definition of trauma informed practice on 2nd November 2022, after this REA was finalised. This attempts to form a consensus within the health and social care sector on how trauma-informed practice is defined, what its key principles are and how it can be built into services and systems. https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

- **Adopt a strengths-based approach** to give people a sense of control and empowerment.

- **Build trust** between staff/volunteers and people accessing services.

We identified two further principles that appear important to creating a trauma-informed approach despite being covered less often in the literature. **Consideration of cultural, historical and gender contexts** is important as people from different communities may react to trauma differently. So too is addressing power imbalances through **collaboration between stakeholders at all levels**.

How taking a trauma-informed approach can benefit people experiencing multiple disadvantage and/or services and systems working with this group

There is a plethora of high-quality evidence showing how trauma can have a negative impact on different aspects of someone's life, including their health and wellbeing, employment and educational outcomes, and likelihood of experiencing multiple disadvantage (Felitti et al., 1998; Copeland et al., 2018; Watson et al., 2019). This has contributed to a broad uptake in trauma-informed approaches in both England and internationally. Those who advocate for trauma informed approaches highlight that trauma is widespread and has far-reaching consequences. Proponents argue that interventions need to address this trauma so that people can access and benefit from services organisations offer and ultimately thrive (SAMHSA, 2014; NPC, 2020).

While there is some evidence of positive outcomes for people receiving trauma-informed support, there is a lack of robust evidence which can clearly isolate the contribution of trauma-informed approaches and identify the specific factors that make a difference. However, there is evidence that trauma-informed approaches improve people's experiences of services and enhance engagement – a pre-requisite for achieving other outcomes.

Where people with experience of at least one of the domains of multiple disadvantage have received trauma-informed support it has been possible to identify several individual benefits. This includes housing outcomes, such as improved housing stability (Hopper et al, 2010; Stergiopoulos et al., 2015; Cockersell, 2016). Taking a trauma-informed approach has also been found to have positive impacts on mental health and wellbeing (Han, 2021; Chung et al., 2009; Sweeney et al., 2016). There have been mixed results in relation to substance use. Some studies identified a reduction in substance use (Chung et al., 2009; Stergiopoulos et al., 2015), whilst others found no change (Sweeney et al. 2016).

Trauma-informed approaches in the criminal justice sector have also been found to reduce reoffending (Cordis Bright, 2017; Collins et al., 2017), address criminal risk factors (Miller and Najavits, 2012) and reduce time to discharge from secure care (Greenwald et al., 2012). There is also promising evidence about Psychologically Informed Environments

achieving more positive outcomes than services not run in this way (Cockersell, 2016; London Housing Foundation, 2018).

Improved engagement with services has also been identified as an outcome of working in a trauma-informed way. This is important in the context of supporting people experiencing multiple disadvantage as this group are recognised as being unable or reluctant to access services (Prestidge, 2014; Moreton et al., 2018). Studies have shown how trauma-informed interventions for 'hard to reach' populations increase engagement with treatment (Chung et al., 2009; Gatz et al., 2007) and reduce risky behaviour such as alcohol use and incidents that require the use of seclusion and restraint (Borckardt et al., 2011) or result in eviction (Cockersell, 2016). Reasons given for this improved engagement include greater empathy with people, relationship building and having workers with lived experience involved in the design and delivery of services (DHSC, 2019).

More generally, several benefits for staff have been found from studies looking at the impact of a trauma-informed approach, including improvements in wellbeing, confidence, morale and resilience (Hopper et al, 2010; Prestidge, 2014; Moreton et al. 2018). Reasons for this include that training opportunities enhance skills, making staff feel more able to do their job and overcome challenges, that reflective practice sessions provide a chance for staff to share their concerns and access mutual support and that improving support for beneficiaries through taking a trauma informed approach increased job satisfaction. However, a systematic review (Purtle, 2020) highlighted that it was less clear whether such outcomes were retained over time and translated into client outcomes.

A trauma-informed approach has been judged to be cost-effective because the benefits of introducing such an approach are felt to outweigh the negative economic consequences of the cycle of traumatisation and re-traumatisation (Bowen & Murshid, 2016; Sweeney et al., 2016; Becker-Blease, 2017). However, only one study included in the review compared the cost of a trauma-informed approach to care as usual and overall, there is a lack of data on the potential cost savings provided by adopting a trauma-informed approach.

Factors influencing the implementation of a trauma-informed approach

It is possible to identify factors that support a programme, organisation or wider system to become trauma-informed, building on guidance for implementing a trauma-informed approach that was developed through research, clinical practice and listening to the voices of trauma survivors (SAMHSA, 2014) and the wider literature. Likewise, several studies have outlined challenges to delivering a trauma-informed approach and numerous authors have attempted to summarise this evidence so it is also possible to understand the obstacles that prevent the implementation of a trauma-informed approach. An overview of factors that have been found to either positively or negatively influence trauma-informed ways of working is included in Table 1 below.

Table 1 Enablers and barriers of implementing a trauma-informed approach

Area	Enablers of a trauma-informed approach	Barriers to a trauma-informed approach
Moving towards a trauma-informed approach	Governance and leadership that advocate for and support this way of working	Change fatigue
Moving towards a trauma-informed approach	Effective use of evidence-based trauma-specific screening, assessments and treatment	Limited capacity to implement new/additional tools
Working in a trauma-informed way	Policies and procedures that enable trauma-informed principles to be put into practice	Staff turnover
Working in a trauma-informed way	A physical environment that promotes trauma-informed principles (e.g. by creating a safe and collaborative space)	Resistance to idea that there is prevalence of trauma in society and that individuals and organisations play a role in this
Working in a trauma-informed way	Collaboration between staff at all levels, organisations, sectors and people accessing services and their support networks to design and deliver services	Funding cuts which lead to competition between local organisations. Services being commissioned separately, which creates fragmentation and duplication.
Working in a trauma-informed way	Training and workforce development that gives staff/volunteers the confidence, knowledge and support to be able to work in a trauma-informed way	Not recognising and addressing secondary trauma amongst staff
Monitoring the implementation of a trauma-informed approach	Ongoing assessment, tracking and monitoring of trauma-informed principles	Lack of consensus on what constitutes a trauma-informed approach and how this should be implemented
Providing evidence on the benefits of a trauma-informed approach	An evaluation methodology that reflects trauma-informed principles	Lack of a single trauma-informed approach that other models can be compared against
Resourcing a trauma-informed approach	Financing structures that enable sufficient resources to be dedicated to a trauma-informed approach	Context of austerity and short-term funding contracts

Reflections on the evidence-base

Reliable comparisons of the relative effectiveness of taking a trauma-informed approach (compared to not doing this) rest on the development of specificity in definition (e.g., activities, competencies and principles) and measurement (Holly, 2017). The lack of a specific definition of a trauma-informed approach makes it difficult to measure the extent to which programmes, organisations or systems have adopted a high-fidelity trauma-informed model. This is useful context in understanding the current evidence-base. For example, only one of the studies we identified measured practices and behaviours before and after an intervention was delivered. However, there is a relatively large body of literature (including systematic reviews) seeking to outline key features of trauma-informed interventions and definitions. One type of source most referenced has been grey literature such as policy papers or guidance documents with recommendations for delivering a trauma-informed approach.

There could be benefits to implementing randomised controlled trials (RCTs) or quasi-experimental design (QED) methodologies to evaluate effectiveness of a trauma-informed approach, as these are considered the most robust, and so could support buy-in for this approach amongst commissioners and policymakers. However, as outlined in our other REA on frontline support models (DLUHC, 2023), there are ethical and methodological challenges in evaluating the impact of frontline support models and approaches for people experiencing multiple disadvantage using RCT and QED studies. For example, in a complex programme an individual receives multiple interventions and engages with multiple organisations across various sectors so there is often not an 'identifiable treatment' that is the sole cause of an observed change (Byrne, 2013 and HM Treasury, 2020 cited in DLUHC, 2023).

No studies conducted in England that are included in this review implemented either of these more robust methods, and the small number that have were from the United States. Hence, the evidence-base for the effectiveness and impact of taking a trauma-informed approach is relatively weak. Instead, the evidence is largely drawn from qualitative research, mixed methods evaluations or research projects, and literature reviews that sought to identify good practice. As our other review found (DLUHC, 2023), a challenge of evaluations of wider programmes is that it is not possible to isolate the impact of specific approaches, which in this case is understanding how taking a trauma-informed approach affected outcomes achieved.

As well as issues with the quality of the available evidence, there are also limitations in the amount of relevant literature. Many studies included in this review were completed in the United States. There is a higher proportion of evidence from the criminal justice sector (the youth justice system in particular) and mental health sector, where a trauma-informed approach appears more common. While many studies involved people with lived experience of single issues, very few sources explicitly included people with experience of multiple disadvantage. However, we know that where individuals have experience of homelessness, for example, they are likely to have previous or current experience of wider needs such as domestic violence and substance use (Safe Lives, 2018; Crisis, 2017).

Despite the limitations in the evidence base, it is important to acknowledge that there is consensus across grey literature, qualitative research and programme evaluations that

trauma-informed approaches create more positive experiences for individuals accessing services and staff providing support.

The Changing Futures programme has the potential to contribute to the evidence-base, which is particularly scarce in England. It will be important for the evaluation to try and address some of the different questions raised in this review. For example, capturing how a trauma-informed approach is understood and adopted across the different funded areas, the factors that are supporting and preventing this (e.g. workforce skills and approaches to risk management) and any perceived and tangible outcomes from working in this way.

1   Introduction

1.1   Overview

This rapid evidence assessment (REA) summarises the existing evidence-base (such as journal articles, research reports and policy papers) to demonstrate why a trauma-informed approach is important for supporting people experiencing multiple disadvantage. The review highlights where there are gaps in the evidence that require further research and exploration to support decision-making.

The review also outlines factors which have been shown to support or prevent the successful implementation of trauma-informed practice. The purpose of this is to improve understanding of how a trauma-informed approach can be designed and implemented for people experiencing multiple disadvantage, and to help explain why a trauma-informed approach may or may not prove successful.

The REA has been commissioned by the Department for Levelling Up, Housing and Communities (DLUHC) as part of the evaluation of the Changing Futures programme.

Definition of people experiencing multiple disadvantage

For the purposes of this REA, we have worked to the definition of multiple disadvantage included in the Changing Futures programme prospectus, which is:

"[…] adults experiencing three or more of the following five: homelessness, substance misuse, mental health issues, domestic abuse, and contact with the criminal justice system. Many people in this situation may also experience poverty, trauma, physical ill-health and disability, learning disability, and/or a lack of family connections or support networks." (Ministry of Housing, Communities and Local Government, 2020)

Why focus on a trauma-informed approach?

Research suggests that 85% of people facing multiple disadvantage as adults experienced trauma as children (Bramley and Fitzpatrick, 2015). It is therefore vital that provision delivered as part of the Changing Futures programme accounts for this and responds accordingly so that the target cohort engage with services and have positive experiences.

To support this, one of the core principles of the Changing Futures programme is that each of the funded areas take a trauma-informed approach across their local system, services and in the governance of the programme. There is also overlap with other programme principles. For example, partnership working and involving people with lived experience have both been identified as principles and enablers of a trauma-informed approach.

Building on the work of Champine et al. (2019), the remainder of this review will use the term 'trauma-informed approach' to account for interventions at multiple levels - individual, relational (such as those focusing on improving family, peer and interpersonal relationships), organisational and across communities/systems.

1.2 Research questions

This REA aimed to identify and report findings against the following research questions:

1. How can the term 'trauma-informed approach' be defined?

    - What are the similarities and differences in the ways that trauma-informed approaches are described and understood?

    - What are the common features and principles of services and systems that consider themselves to work in a trauma-informed way?

2. Why is taking a trauma-informed approach important when supporting people experiencing multiple disadvantage?

    - What evidence is there of the individual benefits of taking a trauma-informed approach when supporting people experiencing multiple disadvantage?

    - Does taking a trauma-informed approach result in any different or additional changes in people's lives, compared to other ways of working/not applying this?

    - What evidence is there of the benefits for services and local/national systems of taking a trauma-informed approach when supporting people experiencing multiple disadvantage?

3. What factors enable services and systems to work in a trauma-informed way?

4. What factors make it more difficult for services and systems to work in a trauma-informed way?

5. What learning exists about how barriers preventing trauma-informed ways of working can be overcome?

1.3 Methodology

We developed a protocol for searching and prioritising evidence for review, which was agreed with DLUHC.

Search terms

A selection of primary, secondary and tertiary search terms were developed in relation to multiple disadvantage, trauma-informed approaches and evidence/impact to identify sources that could address the research questions. We used search strings formed of one term from each of the columns below (e.g., "Multiple disadvantage" + Trauma-informed + Evidence). The initial search terms used are described in Table 2. This is not an exhaustive list, rather an example of terms that were used in the first instance to identify relevant sources.

We took a flexible approach, refining terms as the search proceeded and we gathered more information on the key terms used in the literature. If searches included too many irrelevant results, we modified our searches by including specific exclusions. We also snowballed sources by reviewing the bibliographies of selected studies. This proved particularly useful in systematic reviews on the evidence around trauma-informed approaches.

Table 2 Initial search terms

Primary search terms: groups/needs	Secondary search terms: support	Tertiary search terms: information type
"Multiple disadvantage" "Complex needs" "Dual diagnosis" "Rough sleep*" "Substance *use" "ACEs"	"Trauma-informed" "Trauma-informed care" "Trauma-informed approach" "Trauma-informed practice" "Trauma-informed response" "Psychologically Informed Environments"	Effective Evaluat* Evidence Enabler Barrier Impact Costs

Identifying, selecting and prioritising articles

Sources

To identify sources a database search was conducted on Google Scholar, Birkbeck University digital library (for academic literature) and Google (for non-academic literature). Each search was limited to the first 20 results.

The relevance of each article was checked before deciding whether to include it as part of the bibliography. We included 88 of the most relevant articles in the review. Please see the bibliography for the full list of articles included.

Inclusion criteria

To be considered for the bibliography, an article had to be relevant to the research questions and meet the inclusion criteria identified in the protocol.

The intention was to prioritise English-language sources from the last ten years to limit the scope to a manageable quantity of the most relevant evidence. However, the initial search and review demonstrated that many well-regarded sources on trauma-informed approaches are more than ten years old. We adjusted our inclusion criteria accordingly and most sources in this review have been authored within the last twenty years. The inclusion criteria also included articles written in English and published in the UK or countries that were relevant to the UK, such as North America or western Europe. In some instances, sources were excluded because they focused on children and so were less

applicable to the Changing Futures programme, which works with adults aged 18 and over.

All sources included were available publicly or via Birkbeck University Digital Library.

Approach to prioritisation

We scanned the titles and abstracts of all articles identified through the searches and excluded those that immediately appeared less relevant to the research questions or that did not meet the revised inclusion criteria above. We also sought to determine an article's relevance to multiple disadvantage.

Once relevance to multiple disadvantage and the research questions was determined, literature was prioritised in the following order:

- Meta-analyses and systematic reviews
- RCT/QED studies
- Other peer-reviewed academic research
- Other independent research and evaluation reports
- Policy reports and grey literature

When reviewing methodologies, we prioritised primary research studies with larger sample sizes, quantitative studies that used validated scales and had statistically significant findings, and studies that took a recognised approach to qualitative analysis (e.g., content analysis or thematic analysis). Other considerations included the strength of evidence and amount of literature available.

1.4 Limitations

The lack of consensus on what constitutes a trauma-informed approach makes it difficult to evaluate effectiveness of interventions and organisations that appear to be working in this way. This is addressed in more detail in Chapter 2 and Chapter 5.

Furthermore, there is a limited body of recent literature on trauma-informed approaches in England. When looking at sources that also cover multiple disadvantage this narrows the evidence-base further. The research drawn upon in this review is more often taken from specific sectors such as mental health.

1.5 Structure of this rapid evidence assessment

The review begins by attempting to define what is meant by trauma-informed approaches through identifying common principles across different descriptions and practice. We then focus on exploring why this is important by bringing together the evidence on the difference that trauma-informed approaches make to people accessing services and staff experiences, and how a trauma-informed approach impacts individual, service and system outcomes. We then consider how to put a trauma-informed approach into practice by outlining barriers and enablers to implementation, before summarising our findings.

2   What do we mean by 'trauma-informed approach'?

2.1 Key findings

There is not an agreed definition of a trauma-informed approach.[2] Terms such as trauma-informed practice, trauma-informed care, trauma-informed approach, and trauma-informed systems are used widely and often interchangeably to refer to the broad notion of a programme, organisation or system that is designed to support people experiencing trauma. However, these terms are often not clearly or consistently operationalised (Hanson et al., 2018).

This chapter therefore attempts to demonstrate where there are similarities in how this is understood and implemented and where there are differences. It considers the theory behind a trauma-informed approach as well as how this has been adopted by services across various sectors, including mental health services and women's services.

Although there are a range of studies that seek to define a trauma-informed approach, including systematic reviews, some of the key literature is more than ten years old and many of the sources referenced are from the United States, where trauma-informed practice is more established.

Similarities in how trauma-informed approaches are understood

Commonalities in how trauma-informed approaches are defined and implemented include a recognition that services and systems can cause harm and re-traumatise people (Infield and Boswell, 2020; Wilton & Williams, 2019) and therefore need to respond accordingly (Hopper et al., 2010; SAMHSA, 2014; McCarthy et al., 2020). It is also emphasised that trauma-informed services are separate from medical models that aim to treat the impacts of trauma using specific therapies and other approaches (Sweeney et. al., 2016; Addis et al., 2020).

There is agreement in the literature on the importance of positive relationships (Bath, 2008; Sweeney et al., 2017) and creating a safe environment (Bath, 2008; Sweetney et al., 2016). The literature also regularly highlights the importance of staff wellbeing and support (Hanson and Lang, 2016; HMIP, 2020; Academic Science Health Network, 2021), recognising an individual's strengths and skills (Willis and Ward, 2013; Hopper et al., 2010) and addressing the disempowerment created by traumatic situations through giving people choice (Harris and Fallot, 2001; SAMHSA, 2014; Sweeney et al; 2019).

Table 3 at the end of the section summarises the key principles of a trauma-informed approach that are most common in the literature. These principles are:

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[2] The Office for Health Improvement and Disparities published a working definition of trauma informed practice on 2nd November 2022, after this REA was finalised. This attempts to form a consensus within the health and social care sector on how trauma-informed practice is defined, what its key principles are and how it can be built into services and systems. https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

- take a trauma lens (recognising that people may have experienced trauma which can impact how they feel, think and behave, and responding accordingly)
- prevent further re-traumatisation
- ensure safety
- take a strengths-based approach
- build trust

Differences in how trauma-informed approaches are understood

Consideration of cultural, historical and gender contexts appear key in the success of a trauma-informed approach because trauma disproportionately affects marginalised populations (Bowen and Murshid, 2016; Becker-Blease 2017). However, many studies on trauma-informed approaches have largely included primarily White or European American populations (Champine et al., 2019), and it is unclear whether trauma-informed approaches applied in services for people experiencing multiple disadvantage account for the variations and complexities of experience between different groups (McCarthy et al., 2020).

Collaboration in the context of trauma-informed approaches means involving those accessing services in treatment plans and ensuring that stakeholders at all levels are included in wider service and system level planning and practice. As Elliot et al. (2005) explain, the principle of collaboration is the least well represented in the literature; however, it is through the integration of people accessing services into organisational decisions and activity, such as through peer support, that many of the other principles of a trauma-informed approach are realised.

This section also covers the concept of Psychologically Informed Environments (PIEs). Trauma-informed practice and PIEs are related and complementary approaches to service delivery for people with complex needs (Homeless Link, 2017). PIE services can adopt a range of psychological frameworks, rather than having to be shaped by trauma theory and research and taking a trauma lens to service design and delivery. In addition, measuring and reflecting on outcomes is seen as integral to PIE, but evaluation is not an underlying principle of trauma-informed approaches in the literature. PIEs are more common in services for people at risk of or experiencing homelessness than in other sectors or for the multiple disadvantage cohort.

2.2 Describing 'trauma-informed approaches'

For the purpose of this review, when we talk about trauma, we are referring to stressful, frightening or distressing events in which a person is threatened or feels threatened and/or the impact of this (Mind, 2020; SAMHSA, 2014). These situations can be one-off or multiple experiences that happen over an extended period, and they can have a lasting impact on many aspects of someone's life including their mental and physical health, relationships, thoughts and feelings and behaviours.

The American Psychiatric Association (2013) define trauma as exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing the event; (b) witnessing, in person, the event occurring to others; (c)

learning that such an event happened to a close family member or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders. However, this is fairly narrow definition of trauma. The broader definition above encompasses a wider range of distressing events and could include trauma as a result of poverty or contact with the criminal justice system.

Trauma can be triggered by physical, environmental and/or emotional factors such as sound, smell, visuals, taste, physical sensations, significant dates, stressful events, behaviours, thoughts and unexpected situations. Re-traumatisation involves the reactivation of emotions and/or memories associated with past negative life events. When this happens, it can activate strong emotional reactions and destructive coping attempts (Dallam, 2010).

Beginning with the adverse childhood experience (ACE) study (Felitti et al.,1998), there has been a rise in research that has demonstrated the harmful effects of childhood exposure to traumatic events on health, behavioural health, education, employment, and criminal justice system involvement across the life course (Copeland et al., 2018).

The concept of a 'trauma-informed approach' was developed by Harris and Fallot (2001) to improve clinical practice and service delivery through returning a 'sense of control and autonomy to the [trauma] survivor.' This idea developed momentum throughout North America, and in 2005 the Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Centre for Trauma-Informed Care.

Since then, numerous models of a trauma-informed approach have been developed in England and internationally, alongside accompanying implementation guidance, delivery frameworks and, as this review demonstrates, research and commentary focusing on this. DeCandia and Guarino (2015) explain that mounting neurodevelopmental research on the prevalence and impact of trauma, and the recognition of the social determinants of health (e.g. family and community factors), have created a context that has enabled this field to evolve.

However, as McCarthy et al. (2020) explain, despite the increasing amount of literature on trauma-informed care, this provides little clarity or consensus on a definition that clearly explains exactly what the concept entails.

Terms such as trauma-informed practice, trauma-informed care, trauma-informed approach, and trauma-informed systems are used widely and often interchangeably to refer to the broad notion of a programme, organisation or system that is designed to support people experiencing trauma. However, these terms are often not clearly or consistently operationalised (Hanson et al., 2018).

In this chapter, we identify similarities and differences in how trauma-informed approaches have been implemented and understood in order to outline common principles of trauma-informed initiatives, organisations and systems.

2.3 Similarities in how trauma-informed approaches are understood

There appears to be consensus that **trauma-informed services are distinct from trauma-specific services,** which are medical models that aim to treat the impacts of trauma (such as post-traumatic stress disorder) using specific therapies and other approaches (Sweeney et. al., 2016; Addis et al., 2020). A trauma-informed approach is instead focused on people and processes. Many definitions of trauma-informed care have outlined that organisations taking this **approach realise the widespread impact of trauma, recognise signs of this and respond accordingly** (Hopper et al., 2010; SAMHSA, 2014; McCarthy et al., 2020).

There is also a **recognition that services and systems can re-traumatise people.** Services can cause harm due to ways of working (e.g. efforts to manage risk), and the systems of which services are a part can also perpetuate trauma due to power-dynamics that reinforce exclusion. As stated by Infield and Boswell (2020), power-based relationships between the professional and service user can trigger distress responses in survivors of trauma, which undermines their recovery from abuse. Furthermore, wider research shows trauma disproportionately affects marginalised populations and is linked to structures of power and oppression (Wilton & Williams, 2019).

In response**, empowerment and choice** are two other terms regularly used in definitions of a trauma-informed approach. Control is often removed in traumatic situations, which leads to feelings of disempowerment. Trauma-informed services therefore aim to give people control over their lives and the support that they receive, whilst addressing power imbalances in relationships which could trigger 'distress responses' (Harris and Fallot, 2001; SAMHSA, 2014; Sweeney et al; 2019). Trauma-informed services can help close the gap between the people who use services and the people who provide them (Filson & Mead, 2016).

Linked to the risk of harm another theme of the literature is that of **creating a safe environment** because trauma can provoke feelings of danger. Safety is one of the three critical pillars for trauma-informed intervention as prescribed by Bath (2008). Several authors have acknowledged that the notion of safety is multi-faceted and has many elements that need to be considered, including emotional and physical safety as well as 'social, moral and cultural' safety (Sweeney et al., 2016).

The need for **positive relationships** between staff/volunteers and people accessing services is also regularly highlighted as enabling engagement and positive experiences of services. The second pillar of trauma-informed care ascribed by Bath (2008) is connections. It is assumed that people who have experienced trauma may find it difficult to develop trusting relationships with providers as a result (Sweeney et al., 2017). Different elements are identified across the literature as constituting a good quality relationship. These include a focus on compassion and respect, empowering relationships and creating hope (Sweeney et al. 2018; DHSC, 2018; Bath, 2008).

In addition, **recognising an individual's strengths and skills** is frequently considered fundamental to taking a trauma-informed approach. Willis and Ward (2013) argue that trauma-informed approaches are rooted in strengths-based research and practice, and a

literature review found that helping people to identify their strengths and develop coping skills to further develop resilience was a key element of trauma-informed care (Hopper et al., 2010).

Lastly, there is consensus that attention must also be paid to **supporting staff, both in terms of their wellbeing and skills development through training.** A review of seven trauma-informed frameworks in the United States identified 'training of all staff in awareness and knowledge on the impact of abuse or trauma' as one of the most common components (Hanson and Lang, 2016). In England, a research paper that summarised the evidence around trauma-informed practice for probation and youth offending services (HMIP, 2020) outlined that being trauma-informed means training staff in how best to communicate and interact with service users. It also explains that trauma-informed workforce means a reflective workforce that is supported, supervised, and enabled in a pro-active way. As Academic Science Health Network (2021) guidance explains, a trauma-informed service could contribute to the wellbeing of the workforce through the same principles of noticing the person in their context and taking steps to prevent and support constructively.

2.4 Differences in how trauma-informed approaches are understood

Around 1 in 3 adults in England report having experienced at least one traumatic event, and many people will feel emotionally and physically better over time and recover gradually (Mental Health Foundation, 2016). Traumatic experiences typically do not result in long-term impairment for most individuals: people will respond differently to trauma depending on a range of contextual, individual and sociocultural features that serve as risk or protective factors (SAMHSA, 2014).

Recognition of how trauma affects different groups

Trauma is not evenly distributed in society (McLaughlin et al., 2013; Magruder, et al., 2017). It disproportionately affects marginalised populations and is inseparably bound up with systems of power and oppression (Bowen and Murshid, 2016; Becker-Blease 2017). Hence, when principles of a trauma-informed approach were developed by SAMHSA in 2014, recognising cultural, historical and gender issues was included, and several attempts at defining a trauma-informed approach have referenced this (Sweeney et al., 2018).

However, not all definitions of a trauma-informed approach in the sources reviewed for this report referenced gender and/culturally informed approaches, and research has found that many studies on trauma-informed approaches have largely included primarily White or European American populations (Champine et al., 2019).

Additionally, as McCarthy et al. (2020) explain, the evidence is limited in that it does not show whether trauma-informed responses used with people experiencing multiple disadvantage account for the variations and complexities of experience between different groups with different support journeys and needs. Discrimination can cause symptoms of trauma (Kirkinis et al., 2018; Williams et al., 2018). Minoritised groups face systemic and structural injustices and oppression, whilst discrimination and marginalisation can make

such communities more vulnerable to other forms of trauma and maltreatment (McCormick et al., 2018).

Although the literature on gender-specific responses is now more established, a particular gap remains around ethnicity and how services might become culturally informed (McCarthy et al., 2020). Likewise, there is a risk that the experiences of LGBTQ+ people can be overlooked and/or understated. The trauma experienced by people who identify as LGBTQ+ is rarely discussed, despite evidence that this group experience high-rates of trauma and mental-ill health. This community's voices can be lost in large-scale group decision making processes (McCormick et al., 2018).

The role of coproduction

Collaboration is one of the five core values of trauma-informed care outlined by Harris and Fallot (2001) when they coined the term. More recently, guidance on providing effective trauma-informed care for women (Wilton and Williams, 2019) included empowerment through co-designing and co-producing services with a diverse group of women as a key principle. Similarly, Hopper et al. (2010) explained that involving 'consumers' in the design and evaluation of services can help people who have experienced trauma to re-build control.

However, lived experience involvement in decisions about the design and delivery of services is not always identified as a key part of taking a trauma-informed approach. Elliot et al. (2005) also came to this conclusion, explaining that this principle is the least well covered in the literature, but that it is through this true integration of consumers that many of the other principles are realised.

Psychologically Informed Environments

The concept of Psychologically Informed Environments (PIEs) was originally developed by Johnson and Haigh (2012). PIEs are services that are designed and delivered in a way that takes into account the emotional and psychological needs of the individuals using them. (Homeless Link, 2017) Hence, PIEs are about setting the conditions or environments that support delivery.

Trauma-informed practice and PIEs are related and complementary approaches to service delivery for people with complex needs (Homeless Link, 2017). Both approaches aim to improve the psychological and emotional wellbeing of people accessing, or working in, services and acknowledge that individual's experiences will impact how they present and engage with support (Ibid). Hence, both focus on principles including safe environments, prioritising relationships between frontline staff and clients, and providing training and support to staff.

However, guidance from the Department for Communities and Local Government and National Mental Health Development Unit (2012) that outlined five key areas to foster more PIEs also demonstrates differences between the approaches. Firstly, PIE services can adopt a range of psychological frameworks, including the psychodynamic paradigm, cognitive and behavioural approaches and humanistic psychology, rather than having to be shaped by trauma theory and research and taking a trauma lens to design and delivery decisions. In addition, measurement of and reflection on outcomes (at different levels) is

understood as integral to PIE. In contrast, having an element of evaluation is not an underlying principle of trauma-informed approaches in the literature, although monitoring implementation is recognised as enabling a trauma-informed approach, as discussed in Chapter 4.

It should also be noted that the concept and implementation of PIEs is more common in services for people at risk of or experiencing homelessness than across the other Changing Futures domains, or multiple disadvantage more broadly.

Different levels of trauma-informed working

Some studies and organisations use the term 'trauma aware' rather than trauma-informed or perceive there to be differences in the extent to which organisations are trauma-informed. For example, Gerber (2019) explains that being 'trauma aware' is the critical first step of an organisation on the continuum of trauma-informed care. The charity One Small Thing define three different levels of an organisation being trauma informed (described below). A quick review of the literature indicates that this tiered approach to trauma-informed care is more common in education settings (see Berger, 2019).

One Small Thing - Working with Trauma Quality Mark[3]

The Working with Trauma Quality Mark is a national benchmark developed by the charity One Small Thing in partnership with Dr Alexandria Bradley from Leeds Beckett University. following extensive analysis of global standards, principles and values associated with trauma informed working practices. It was then peer reviewed by The Nelson Trust and Together Women.

It is a set of best practice standards in trauma-informed working. It is intended to be a practical and accessible tool to help organisations review, develop and evidence trauma-informed practice throughout their organisation.

There are three levels of accreditation that organisations can receive. Organisations can apply for an award at bronze, silver or gold level, but silver must be achieved before applying for gold level.

- **1. Bronze: Trauma Aware.** An understanding and awareness of trauma and its impact and organisational plans in place ready to implement trauma informed practice.
- **2. Silver: Trauma Informed.** Trauma informed working is implemented across the culture, practice and environment of the organisation and individual needs and well-being are prioritised.
- **3. Gold: Trauma Responsive**. Extensive and embedded trauma informed working practices. The organisation prioritises user voice in strategic decision-making and is a centre of excellence.

The tool is considered beneficial in helping organisations to build trauma informed practice and to support funding applications.

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[3] https://onesmallthing.org.uk/quality-mark

2.5 Common features of principles of trauma-informed services and systems

Table 3 below outlines the common principles of a trauma-informed approach identified through reviewing the available literature, and what these mean for an organisation or wider system that intends to work in a trauma-informed way.

Table 3 Key principles of a trauma-informed approach

Principle	Implication
Trauma lens	Services and systems need to recognise that people have trauma, understand how this could impact the way that they think, feel and behave, and be able to respond accordingly. Staff training and support to do this is key. This may also include use of evidence-based tools such as screening tools to identify clients who have experienced adversity and self-assessment tools to measure the extent to which trauma-informed principles are being adhered to.
Prevent further re-traumatisation	A service or system that takes a trauma-informed approach will acknowledge that practices and behaviours can re-traumatise and take steps to prevent this from happening.
Safety	To prevent harm and re-traumatisation, people need to feel safe. Consistency, reliability, predictability, availability, honesty, and transparency are all carer attributes that are related to the creation of safe environments. (Bath, 2008). Feelings of safety can also be created through choice and control as well as cultural and gender awareness.
Strengths-based approach	Trauma-informed approaches enable individuals to take control of their lives and feel empowered to build on their strengths, advocate for themselves and make decisions about their care/support.
Build trust	Trust is needed to support engagement and positive relationships between staff/volunteers and people accessing services. Being transparent about decisions taken can support this.
Cultural, historical and gender contexts*	Acknowledge community-specific trauma and its impacts (in recent UK context this could include the murder of Sarah Everard, the Grenfell Tower disaster and the Manchester Arena attack). Ensure services are culturally and gender appropriate to account for the fact that men and women experience and respond to trauma differently, and experience will differ further across cultures, ethnicities and age groups.
Collaboration*	Address power imbalances traditionally experienced in services through mutual relationships and collaboration (e.g. peer support and coproduction).

*Important principles but less commonly covered across the sources reviewed compared to other features listed.

Overview of available evidence

Quantity of evidence on the definition of trauma-informed approaches is not an issue. Most studies explicitly focusing on trauma-informed approaches or covering ways of working with certain groups of people (e.g. people with experience of homelessness) have attempted to define this upfront. Moreover, some studies have included a systematic review of existing literature to explore how the term is used and implemented in different settings (Hopper et al., 2010; Sweeny et al., 2016; Addis et al, 2022).

However, as indicated by the references included in this section, some of the key literature on trauma-informed approaches is more than ten years old. It should also be noted that many of the sources used are from the United States, where trauma-informed practice is more established.

3 Why is taking a trauma-informed approach important when supporting people experiencing multiple disadvantage

This section provides an overview of the available evidence on the impact of taking a trauma-informed approach.

3.1 Key findings

Although there is large body of literature showing how trauma relates to the experiences of people experiencing multiple disadvantage, such as mental health issues, there is less research measuring and evaluating trauma-informed approaches.

A range of positive individual outcomes (for both people accessing services and staff providing support) have been identified across sectors. Where a trauma-informed approach has been implemented there is much agreement that this improves experiences of services (in part because it reduces risk of harm) and helps contribute to positive changes in people's lives. However, overall, it is difficult to determine the precise contribution of trauma-informed initiatives and make recommendations about the specific elements that make a difference (Becker-Blease, 2017; Hanson et al., 2018).

A main reason for this is the lack of agreement on the definition of a trauma-informed approach (as explained in Chapter 2). Another is that a trauma-informed approach is a component of an organisation or intervention, so it is hard for evaluations to determine the specific contribution this approach has on outcomes. In addition, many studies included in this section were small-scale qualitative studies rather than those which have used more robust methodologies to attribute impact, such as RCTs.

Individual outcomes

There is evidence of positive individual-level outcomes across different sectors including the criminal justice system, mental health sector, women's sector and housing and homelessness sector. Studies have shown improved relationships (Prestidge, 2014; Cordis Bright, 2017), improved compliance with interventions (Miller and Najavitas, 2012; Cordis Bright, 2017) as well as more effective service use and appropriate behaviour which helped people move towards independence more quickly (Prestidge, 2014).

There is also evidence of reductions in reoffending (SAMHSA, 2010; Cordis Bright, 2017; University of Washington, 2017; McCartan, Harris and Prescott, 2019), reduced time to discharge for young people in secure care (Greenwald, et al., 2012) and a positive effect on housing stability (Hopper et al., 2010; Stergiopoulos et al., 2015). A trauma-informed service for women with multiple needs in the United States found improved clinical outcomes related to mental health and substance use problems (Chung, Domnio and Morrisey, 2009) and studies have shown how a trauma-informed approach can result in an

increased sense of safety, which is important for people with experience of trauma (Community Connections, 2003; Sullivan et al., 2017; McCarthy et al., 2020).

Many studies have found that trauma-informed interventions significantly reduced post-traumatic stress disorder (PTSD) symptoms and improved psychological outcomes, notably reductions in depression and anxiety (Han, 2021). Where mental health services in the United States have implemented a trauma-informed approach a range of outcomes including reductions in general mental health symptoms, increased coping skills, improved physical health, greater treatment retention and shorter inpatient stays have been noted (Sweeney et al., 2016).

Service integration has also been found to benefit individuals facing multiple needs and with a history of trauma as improvements to mental wellbeing, substance use and risky behaviours have been recorded (Domino et al, 2006; Hopper et al., 2010; Academic Health Science Network, 2021). PIEs have been found to improve housing outcomes and/or reduction in rough sleeping, improved behaviours, improved use of services, improved mental health and engagement with mental health services (Cockersell, 2016; Peddie, 2017).

However, there is a lack of evidence about how individuals may benefit from a trauma-informed approach in organisations that focus on addressing problematic substance use.

Service and system outcomes

There is less research on the impact on organisations and systems of taking a trauma-informed approach beyond the positive impacts on staff. Training and support provided in organisations implementing a trauma-informed approach or PIE give staff more confidence to work with 'challenging cases' (Prestidge, 2014; Moreton et al., 2018), can improve partnership working and morale (Hopper et al., 2010; Moreton et al., 2018), and create greater compassion towards clients and colleagues (Damian et al., 2017).

Studies have argued that the benefits of introducing a trauma-informed approach outweigh any costs because of the negative economic and ethical consequences created by the cycle of traumatisation and re-traumatisation that this can help to stop (Bowen & Murshid, 2016; Sweeney et al., 2016; Becker-Blease, 2017). However, overall, there is a lack of data on cost-savings created by adopting a trauma-informed approach (Hanson and Lang, 2016).

3.2 Overview of available evidence

There is a strong evidence-base demonstrating the link between trauma and the different needs that the Changing Futures programme is trying to address. For example:

- Traumatic events in childhood are linked to an increased risk of serious, persistent, and chronic offending in adolescence and throughout the life course (Baglivio et al., 2015; Craig et al., 2017; Wolff et al., 2017).

- Research has shown that individuals who are homeless are likely to have experienced some form of trauma in their past and/or when they were homeless and being

homeless increases the risk of further victimisation and re-traumatisation (Hamilton et al. 2011; Borysik 2019).

- 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 et al., 2015).

- Exposure to traumatic experiences, especially in childhood, has been linked to substance use disorders, including substance misuse and dependence, and substance use disorders are also highly comorbid with posttraumatic stress disorder and other mood-related psychopathology (Khoury et al., (2010).

- Rates of clinical depression and posttraumatic stress disorder are higher among abused versus non-abused women, particularly if victims have experienced other lifetime trauma (Warshaw et al., 2013).

- The impact of trauma and potential coping strategies used, combined with trauma survivors' difficulties in forming trusting relationships and engagement with services, can result in multiple disadvantage (Fisher, 2015; Watson et al., 2019).

However, as has been acknowledged by numerous authors, there is a scarcity of research on measurement and evaluation of trauma-informed approaches, which makes it difficult to quantify the impact of trauma-informed initiatives and make recommendations about the best way to implement these approaches (Becker-Blease, 2017; Hanson et al., 2018).

Only two studies included in this review applied a randomised control trial or quasi-experimental methods, and around half of the peer-reviewed academic articles included are more than five years old. Several journal articles built on secondary research to propose a policy position, rather than outlining findings from a primary research study where we could learn more about outcomes. When qualitative studies have been included these were often small-scale: those reported in academic journals were mainly conducted in the United States, while independent research and evaluation reports were mostly from the UK. More promisingly, we identified numerous systematic reviews exploring outcomes from trauma-informed services or key features of a trauma-informed approach.

A key reason for this limitation in research findings is that there is currently no consensus-based definition on the particular practices or policies that comprise a trauma-informed approach for any service or system (Branson et al., 2017). This makes it challenging to compare different services and systems and identify factors influencing outcomes. It is also difficult to isolate the impact of a trauma-informed approach from the overall intervention being delivered, of which it is a component. Hanson et al. (2018) explain that more information is needed to be able to conclude whether trauma-informed programmes, organisations, and systems yield more positive outcomes than those that are not trauma-informed.

3.3 Individual-level impacts of taking a trauma-informed approach

Services working with those experiencing multiple disadvantage are in a unique position to provide lasting change to an often-overlooked group – supporting the healing from trauma, establishing relationships, and developing connections in the community (Hooper et al., 2010). If staff feel more empowered and confident in supporting people experiencing multiple disadvantage, this can lead to a reduction in the number of people being turned away from services on grounds of behaviour (DHSC, 2019).

Evidence on implementing a trauma-informed approach in the criminal justice system

The idea that the criminal justice system should be trauma-informed was described as novel and consequently quite underdeveloped by Randall and Haskell in 2013. Since then, several studies and programmes have focused on this, predominantly from the United States.

Many individuals who interface with the criminal justice system have been exposed to traumatic events across the life-course (Kubiak et al., 2017). SAMHSA (2010) outline that trauma-informed criminal justice responses can help avoid re-traumatising individuals and thereby increase safety for all, decrease reoffending, and promote and support recovery of justice-involved women and men with serious mental illness. Prisons that have implemented trauma-informed services have experienced substantial decreases in institutional violence and there is evidence to suggest that trauma-informed services resulted in a decrease of other behavioural and mental health situations (Kubiak et al., 2017).

The evaluation of the Enhanced Case Management (ECM) was the only example identified of evidence of a trauma-informed approach with people who have criminal justice contact in the community (rather than in prison) from the UK. The ECM approach to working with young people who were in contact with the youth justice system in Wales was grounded in the Trauma Recovery Model. This was designed to provide practitioners and managers with increased knowledge and understanding in relation to how early attachment, trauma and adverse life events can impact on a young person's ability to engage effectively in youth justice interventions. It also provided a psychology-led approach to multi-agency case formulation and intervention planning so that interventions could be tailored and sequenced based on developmental and mental health needs of the young people.

An evaluation of ECM found a range of improvements for the 21 people who participated in the trial (Cordis Bright, 2017). For example, the ECM approach helped to establish improved relationships and trust with young people which was, in turn, helping to improve engagement and compliance with interventions. There was also evidence of more tailored and flexible approaches to working with young people aimed at addressing their problems/needs rather than undertaking 'standard' offence-focused work. Hence, practitioners, managers, clinical psychologists, the project lead and young people all observed improvements to quality of life and quality of relationships with agencies, as well

as benefits for society, such as reductions in reoffending and reductions in severity of any reoffending.

Taking a trauma-informed and person-centred approach is considered important in supporting people to move away from the criminal justice system. A review of the available literature on delivering trauma-informed care in prison environments found evidence of increased responsiveness to evidence-based cognitive behavioural programmes that reduce criminal risk factors (Miller and Najavits, 2012). Taking a trauma-informed approach enables the individual to recognise that they are being heard, supported, and enabled to change, which means that they can own their desistance (Rowles and McCartan, 2019). Similarly, referring to people by their offence and/or as an offender increases the likelihood that they will always see themselves in this light and therefore be less likely to change and desist from future offending (McCartan, Harris and Prescott, 2019). Recognising people as more than their offence and believing that they can change are key in preventing reoffending in the future.

There is also evidence from the United States about the benefits of taking a trauma-informed approach to policing and in secure care settings. For example, evidence has suggested that taking a trauma-informed approach can reduce the time to discharge for young people in secure care (Greenwald et al., 2012). The study looked at outcomes of training in trauma-informed treatment in a residential treatment facility for people aged up to 21. It found that time to discharge was reduced by 39%, and rate of discharge to lower level of care was doubled compared to the year before the training. However, it was noted that it was difficult to identify the exact causes of these improvements because numerous interventions were delivered in this timeframe.

Let Everyone Advance with Dignity (LEAD) is a pre-arrest and at-the-point of arrest diversion approach in the United States, specifically designed for people who commit repeated low-level and non-violent crimes, often driven by a combination of mental ill-health, problematic substance use, homelessness, trauma and poverty. It is a whole system approach to harm reduction and law enforcement which utilises trauma-informed intensive case management. Case managers will aim to work with clients to address and understand underlying psychological trauma by listening to them and working to integrate their voices into their service delivery plan. Staff have small caseloads of about 15 people and are often knowledgeable about clients' situations because of their own lived experience. They can provide a range of support, such as assistance with house, treatment and employment.

An evaluation by the University of Washington (2017) looked at LEAD's success and compared the results of people on the programme to those who experienced the traditional justice system. They found that LEAD participants had 60% lower odds of arrest during the six months following, and 58% lower odds of arrest and 39% lower odds of being charged with an offence over the longer-term period

Evidence from the housing and homelessness sector

A review of quantitative, qualitative, and corroborative evidence regarding trauma-informed services in homelessness service settings found that people accessing homelessness services want providers who are empathic and caring, provide validation, and offer emotional safety — all characteristics of trauma-informed approaches (Hopper et al.,

2010). The review also found early evidence that trauma-informed care may have a positive effect on housing stability and may lead to a decrease in crisis-based services (such as hospitals).

A qualitative study that explored a trauma-informed approach across outreach, housing, and support services reported several benefits for individuals accessing these services and the staff supporting them (Prestidge, 2014). Firstly, staff and clients had improved relationships because of working in a trauma-informed way. This meant that staff increasingly considered the emotional needs of the people they were working with and used their knowledge of psychological trauma and the effects of this to create safe and supportive environments. Clients were also found to be using services more effectively, behaving more appropriately and consequently moving towards independence more quickly. Support to manage anxieties, understand thoughts and feelings and therefore build a sense of control over their lives was credited as a reason for this change. Likewise, focusing on clients' strengths and setting and reviewing small goals was felt to be important in such positive outcomes being achieved.

Research has shown that PIEs achieve significant positive change for people experiencing multiple exclusion/deprivation and with histories of compound trauma (Cockersell, 2016). This includes improved housing outcomes, improved behaviours, improved use of services and improved mental health. For example, data from St Mungo's (n=2,506) shows that PIE residents were two and a half times less likely than non-PIE residents of a similar profile to be evicted, and 20% more likely to have a positive move-on outcome (Cockersell, 2016). In addition, internal data analysis of a PIE pilot in a 19-bed hostel revealed that therapeutic interventions clinically and statistically reduced mental distress and incidents of aggression and alcohol use. Further, that there was a 51 per cent reduction in all types of criminal justice contact in a one-year sample (Rhodes, 2016).

The Psychology in Hostels Project operates in the Lambeth homeless hostel network. The service provides a Psychologically Informed Environment for residents and staff. It is delivered by psychologists based across three Thames Reach hostels. Between 2016 and 2018, over 200 residents engaged with the team and 1,650 therapy sessions were offered with a 78% attendance rate (London Housing Foundation, 2018). Evaluation findings showed that participation had resulted in individuals accessing mental health services, and that there had been a 62% reduction in people sleeping rough (Peddie, 2017). Key reasons underlying success were felt to be understanding resident needs and contact at a pace that suited the individual, using informal outreach activities to develop trust (Ibid.)

The Housing First model provides permanent housing for people experiencing homelessness without pre-conditions. It has been found to be complementary with trauma-informed principles. For example, where trauma-informed care was implemented in a Housing First programme for survivors of intimate partner violence most clients retained housing up to three-months after services ended and increased their sense of safety and knowledge of domestic violence (Ward-Lasher et al., 2017).

An RCT evaluated the effectiveness of Housing First with Intensive Case Management (ICM) among ethnically diverse homeless adults in an urban setting in Canada. This 24-month study (n=378) found evidence of positive individual outcomes. For example, over a 2-year period, Housing First participants spent a significantly greater percentage of time in stable residences compared to those in the control group (75.1% compared 39.3%, 95%

Confidence Interval). Similarly, community functioning improved significantly from baseline for Housing First participants compared to the control group (change in mean difference of MCAS scores = +1.67, 95% Confidence Interval). There was also a 53% reduction in the number of days spent experiencing alcohol problems among Housing First participants. (Stergiopoulos et al., 2015). ICM used a recovery oriented, trauma-informed approach and harm reduction principles.

However, as there is already a strong evidence-base in relation to the effectiveness of the Housing First model (Mackie, Johnsen and Wood, 2017; Miler et al, 2021), it is difficult to disentangle the contribution of taking a trauma-informed approach in achieving individual outcomes. Likewise, as described in Chapter 2, interventions taking a PIE approach have the flexibility to use different psychological frameworks and PIE and trauma-informed approaches are related but not the same, so again it is difficult to isolate the direct impact of trauma-informed ways of working in creating outcomes within services run as a PIE.

Evidence from the women's sector

Being able to choose the gender of practitioner and receive support in a women-only space has been cited as important for the recovery of women who have experienced abuse or violence (DHSC, 2018). When women's traumatic responses and behaviours are explained and normalised by practitioners, evidence suggests that this makes a significant difference to their recovery and feelings of safety (McCarthy et al., 2020).

Research into services working with women experiencing multiple disadvantage found that a trauma-informed approach is vital (Sharpen, 2018). Services that embrace 'resilience over pathology' are ones that women are much more likely to use and recommend. Women interviewed were very clear that practitioners needed to develop a more trauma-informed approach to be able to understand how behaviours may be a psychological defence or coping strategy, and to be able to respond accordingly.

Chung, Domnio and Morrisey (2009) investigated whether a trauma-informed integrated approach in treating women with co-occurring disorders and a history of violence. The approach aimed for clinical and organisational integration, through treatment for substance use, mental health and trauma being connected and organisations working in partnership to provide continuity of care.

The quasi-experimental study compared experiences of women who received an intervention with those who received similar comparison programme (n=2,087). By examining service recipients' self-reported data on service content, the study found strong evidence that the intervention increased the provision of trauma-informed and integrated services and improved clinical outcomes related to mental health and substance use problems.

A small study by Sullivan et al. (2017) explored the extent to which a trauma-informed approach, as experienced by domestic violence shelter residents in the United States, caused changes in thoughts and feelings. Survey results (n=57) found that residents' perception of the degree to which they received trauma-informed services was associated with improvement in their self-efficacy (mean scores on a four-point scale increased from 2.87 to 2.98) and safety-related empowerment (mean scores on a 13-point scale increased from 3.82 to 4.04) but had no impact on depressive symptoms. It was felt that

staff members' encouragement, empathy, and respect encouraged survivors to recognise their skills and strengths.

Evidence from the mental health sector

Many studies have found that trauma-informed interventions significantly reduced PTSD symptoms and improved psychological outcomes, notably reductions in depression and anxiety have regularly been identified (Han, 2021). In addition, where cognitive behavioural therapy was the main intervention, positive changes in relation to psychological outcomes emotional dysregulation, interpersonal problems and risky behaviours have been observed (Ibid.)

Furthermore, studies exploring the effectiveness of a trauma-informed approach in mental health services in the United States have identified benefits including a reduction in seclusion, reduced post-traumatic stress symptoms and general mental health symptoms, increased coping skills, improved physical health, greater treatment retention and shorter inpatient stays (Sweeney et al., 2016). For example, a study of 2,189 women with co-occurring disorders and a history of violence found that a trauma-informed approach to treatment led to improved physical health outcomes (Weissbecker and Clark, 2007) and a controlled pre-post study of 313 woman with mental health and substance use issues found that trauma-specific group treatment resulted in significantly better treatment retention over three months and greater improvement on post-traumatic stress symptoms and coping skills (Gatz et al., 2007). In addition, an RCT across 5 inpatient units in a psychiatric hospital found that over a 3.5-year period, restraints had reduced by 82.3% (Borckardt et al., 2011). However, substance use, use of emergency rooms, imprisonment and homelessness service use did not change (Sweeney et al., 2016).

Qualitative results from a pilot project in mental health services in the United States indicated that people accessing these services responded well to a trauma-informed approach. Findings included an increased sense of safety, better collaboration with staff, and a more significant voice. 84% of clients rated their overall experience with these trauma-informed services using the highest rating available, suggesting that they were very satisfied with trauma-informed changes in service delivery (Community Connections, 2003).

In England, Tees, Esk and Wear Valleys NHS Foundation Trust, a large mental health provider in the North of England, developed a trauma-informed care pathway throughout its adult division, and training for staff to implement this. Findings indicated that there was a reduction in use of short-term/intermittent medication, though the level of reduction was not reported. This was because staff felt empowered to have meaningful discussions about trauma and used this to inform care plans whilst using skills developed in grounding and emotion regulation (Sweeney et al., 2016).

Service integration

Service integration has also been found to benefit individuals facing multiple needs and with a history of trauma. Research from the United States suggests that integrating services for traumatic stress, substance misuse, and mental health leads to better outcomes (Domino et al., 2006). For example, a meta-analysis of programme effects across nine sites found that sites with noticeably more integrated counselling services

produced more favourable results in mental health symptoms and both alcohol and drug use problem severity, and that this difference was statistically significant (Cocozza et al., 2005).

Another quasi-experimental study (n=2,026) of integrated provision found small but statistically significant improvements in trauma and mental health symptoms (such as distress and daily functioning) amongst those who received the intervention compared to the usual-care group. Reductions in hospitalisation and use of crisis services was also observed by a community behavioural health programme (n=3,800) that integrated trauma prevention and intervention into mental health and substance use services (Hopper et al., 2010).

In addition, self-harm rates and associated costs in a prison in England reduced significantly following a multi-agency change project aimed at positive risk taking. This included mental health first aid training, training delivered by prisoners to staff, mental health staff delivering specialist therapies to prisoners, offering creative opportunities to express emotion, and the building of a new sensory room (Academic Health Science Network, 2021). Hence, linked to the principle of collaboration, it could be argued that service integration is a trauma-informed way of working.

The Whole System Approach (WSA) to working with women with offending histories was introduced in Greater Manchester in September 2014. Key features included a multi-agency approach (across criminal justice, mental health, employment and housing agencies), built around a network of women's centres, a person-centred and gender-specific approach, and provision delivered across the region and at all stages of the criminal justice system. Overall, 17% (55 of the 316 women) were convicted of an offence in the 12-month follow-up period in 2014-15, which was considerably lower than the reoffending rates for women receiving support from women's centres throughout England (30% out of a cohort of 597 women) (Kinsella et al., 2018). However, these figures need to be treated with caution as it is not possible to verify the similarities between the two cohorts of women. Most women (79%, n=635) had experienced a positive change across the ten areas measured in the outcome star (Ibid.)

3.4 Impact on local services and systems of taking a trauma-informed approach

Although considering individual-level measures of impact are essential, systems-based measures offer opportunities not only to assess whether systems are equipped to support individual-level outcomes, but also whether they can support broader systems-level changes to improve the health of communities (Matlin et al., 2019). However, less research is available on how trauma-informed approaches impact organisations and local systems.

An exception to this is the evidence on the benefits of taking a trauma-informed approach for staff and volunteers. There is some evidence that people who work in support services have a high prevalence of ACE scores themselves (Esaki & Larkin, 2013). Training, supervision and support as part of a trauma-informed approach can therefore be just as important to staff wellbeing and healing (Menschner & Maul, 2016). Organisations taking a trauma-informed approach have reported increased collaboration with clients and external

agencies, and improved staff morale (Hopper et al., 2010). In a study of an organisation that had taken a trauma-informed approach, staff reported that they were less reliant on their managers because they were more understanding and therefore 'tolerant' of the people that they were working with (Prestidge, 2014).

A recent study on working with trauma in adult probation services in England and Wales identified several benefits for staff of working in a trauma-informed way (HMIP, 2022). In particular, trauma-informed approaches were found to feel intuitive, improve job satisfaction, help to overcome the dissonance between personal and professional values and organisational demands, help to create a meaningful working relationship between the practitioner and the person on probation, and provide a more humane lens through which to redefine the more punitive aspects of practice.

Staff have also been found to benefit from PIEs, alongside people accessing services. Research found that staff felt better able to manage challenging beneficiaries and tackle complex cases as a result of working within a PIE approach (Moreton et al. 2018). Other apparent benefits for the workforce included enhanced skills, improved morale, increased resilience and lower levels of staff sickness, absence and turnover. There is also potential for PIEs to reduce silo working because they can provide a common purpose, approach and language that can span diverse organisations and sectors (Ibid.) Hence, the national Fulfilling Lives evaluation identified Psychologically Informed Environments as promising practice emerging from the programme.

Damian et al. (2017) evaluated the training of criminal justice, social services, health and education professionals in Baltimore on how to utilise a trauma-informed approach across their organisations. Professionals participated in a nine-month multi-agency training programme, based on SAMHSA's Concept of Trauma and Guidance, which focused on educating those involved in how to implement trauma-informed principles throughout their organisations. Participants also received monthly technical assistance, coaching and feedback sessions from national trauma experts on how to apply trauma-informed practices at their organisations.

Provider and organisational level factors associated with the implementation of trauma-informed care were assessed before and after the training, with follow up at nine months. This found a significant improvement in organisational culture and climate as well as increases in compassion satisfaction and reductions in compassion fatigue. Interviews with 16 staff identified changes at the organisation and individual staff level. These included such agencies implementing more flexible, less-punitive policies towards clients and adopting trauma-informed workplace design, a heightened awareness of staff's own traumatic stress and the need for self-care, and a greater sense of camaraderie and empathy for colleagues.

Studies have also argued that the benefits of introducing a trauma-informed approach outweigh any costs because of the negative economic and ethical consequences of the cycle of traumatisation and re-traumatisation that this can help to prevent (Bowen & Murshid, 2016; Sweeney et al., 2016; Becker-Blease, 2017). Childhood trauma is linked to increases in social service cost and there is a range of information showing how much different needs (such as homelessness and mental health) costs per year in the UK. However, there is a lack of data on cost-savings created by adopting a trauma-informed approach (Hanson and Lang, 2016).

A study that examined the 12-month cost of the array of services used by women with co-occurring mental health and substance use disorders and a history of violence and trauma found no differences in cost between 'standard' care programmes and trauma-informed integrated services. As the women who were accessing trauma-informed integrated services were found to have improved clinical outcomes, these were judged to be cost effective and 'more efficient' than usual care (Domino et al., 2006).

Lastly, there is indirect evidence that trauma-informed therapies can potentially reduce violence through their effectiveness in reducing PTSD and other psychosocial symptoms (Black et al., 2012; Silverman et al., 2008), which has benefits for local communities and public services.

4 Factors that prevent trauma-informed services and systems

This chapter explores the factors that have been shown to make implementing a trauma-informed approach more difficult.

4.1 Key findings

Mapping work by Sweeny et al. (2016) suggested that despite evidence of increasing interest in trauma-informed approaches in the UK, there was not yet a 'critical mass' needed for this to be implemented widely. As with the enablers of a trauma-informed approach, several common challenges to taking a trauma-informed approach have been highlighted across systematic reviews, academic research and other evaluation and research reports, which are applicable regardless of geography.

The main barriers

The lack of consensus on a definition of a trauma-informed approach is considered a significant barrier in the implementation and evaluation of this (Branson et al., 2017). As trauma-informed approaches have been understood and implemented differently, it is hard to compare ways of working and assess impact. For example, there are no benchmarks for what trauma-informed training should entail (Bendall et al., 2021) and research has found that staff sometimes consider good practice and taking a trauma-informed approach as the same (Hanson and Lang, 2016). Such issues are exacerbated by the importance of tailoring provision to individual and organisational needs and the local context as what works will differ by organisation (Kubiak et al., 2017).

Furthermore, the context of austerity and the way in which services are commissioned, such as the use of payment by results mechanisms and focusing on outcomes, can be barriers to services taking a trauma-informed approach (Bear et al., 2019; Revolving Doors, 2015).

Resistance to change has been highlighted as another barrier, especially at a time when there appears to be a constant cycle of new initiatives (Sweeney et al., 2016; Wilton and Williams, 2019) or because it could involve staff being confronted by their own role in cultures or organisations that have caused harm to others (Wilton and Williams, 2019). This is a particular challenge as 'traditional' ways of working risk causing additional harm by implementing practices, such as rigid rules, lack of confidentiality, and systems of punishment/coercion that mirror past trauma (Jennings, 2004; Prescott et al., 2008; HMIP, 2020).

Lastly, there remains a lack of solutions to address staff turnover and limited capacity that also prevent trauma-informed ways of working which is problematic as much ongoing thought and effort is required to fully adhere to trauma-informed principles (Bloom and Farragher, 2013).

4.2 Barriers preventing a trauma-informed approach

The lack of an agreement on what constitutes a trauma-informed approach and how this should be implemented is a problem. As discussed in Chapter 2, there is not an agreed definition of a trauma-informed approach. Numerous authors have identified the lack of consensus on the definition as a primary barrier to creating trauma-informed systems (Branson et al., 2017). A reason for this is that training is currently being delivered without benchmarks as to what this should entail (Bendall et al., 2021).

Linked to this, research has shown that staff sometimes fail to identify what makes a trauma-informed approach unique or see the value of this because they sometimes perceive good practice and taking a trauma-informed approach as the same thing (Hanson and Lang, 2016).

Being able to demonstrate the impact of taking a trauma-informed approach has also been difficult (as discussed in Chapter 3). The lack of a definition makes comparing success across different services challenging. This gap in the evidence is likely to make it more difficult to obtain buy-in with this approach across services and local and national systems.

The local and national context, organisational values, the organisation's profile and characteristics of people accessing a service can all affect training effectiveness and service delivery. For example, what helps one individual might not help another, and changes that have worked for one organisation might not work for another (Kubiak et al., 2017). It is difficult to easily understand how to put trauma-informed principles into practice when this needs to be tailored to individual, organisational and local contexts.

'Traditional' ways of working risk causing additional harm by implementing practices that mirror past trauma. This includes rigid rules, lack of confidentiality, and punitive discipline practices (Jennings, 2004) as well as a culture where force or coercion may occur to ensure compliance (Prescott et al., 2008; Jennings 2004). Such experiences can create distrust of systems and services. These issues were reflected in a recent study on working with trauma in adult probation in England and Wales, which identified significant barriers to probation becoming a trauma-informed organisation (HMIP, 2020). These included the challenges of reconciling a trauma-informed approach within a system of punishment, the continued dominance of the risk management paradigm and the professional culture which encourages work practices that can result in vicarious trauma and compassion fatigue, such as processes being prioritised over people.

Resistance to change. Professionals are often reluctant to let go of accepted models or theories that are familiar, and systems are strongly resistant to change (Lorenzi and Riley, 2000). A reason for this resistance highlighted in the literature is the challenge of getting buy-in with new initiatives at a time when public services in England face continuous change and upheaval (Sweeney et al., 2016). Staff/volunteers may be sceptical about devoting energy and resources to this way of working, when they have regularly seen initiatives replaced by something new every couple of years (Wilton and Williams, 2019).

Furthermore, acknowledging the role of trauma in people's lives, and the role that services and systems can play in creating and embedding this, can result in resistance. It challenges the idea of a safe and just society, and for many this means being confronted

by their own role in cultures or organisations that have caused harm to others (Cohen, 2013).

Several studies have highlighted that trauma-informed approaches need to be well resourced to be implemented successfully. For example, Tompkins and Neal (2018) suggest that there is a need for financial resources to pay, train, support, and retain staff – especially in services where care is provided 24 hours a day. However, the context of **austerity** means that such resource is increasingly limited. The **commissioning landscape** often means services are accessing multiple short-term funding streams to deliver a service, which makes delivering a coherent organisation-wide trauma-informed approach more challenging (Bear et al., 2019). Concerns identified around creating needs that cannot be met (Moses et al., 2003) are relevant here.

As highlighted by IPPR (2015), socially excluded adults have increasingly been subject to mechanisms like payment by results in employment support programmes, homelessness services and drug and alcohol treatment which have limited scope for service users to shape the way support is provided; this goes against the principle of collaboration. Other concerns raised about this type of support include that it focuses on volume and outcomes rather than quality of support, which can result in those with more complex needs finding it harder to access and be prioritised for support, going against the idea of equality of access (Bear et al., 2019; Revolving Doors, 2015).

This is exacerbated by **capacity issues and staff turnover**. Limited time for staff to attend training sessions and limited supervisory and clinical capacity (e.g. for structured supervision) can present real barriers to delivering a trauma-informed approach (Sweeney et al., 2016). For example, if staff are unable to attend training, they could lack confidence in their ability to work in a trauma-informed way. Limited resource to dedicate to working in a trauma-informed way seems particularly problematic when there is much ongoing thought and effort required to wholeheartedly adhere to trauma-informed principles (Bloom and Farragher, 2013).

Newell and MacNeil (2010) explain how finding out more about the trauma someone has experienced and regularly working with people who have experienced suffering in their lives can result in professional burnout, secondary trauma, vicarious trauma and/or compassion fatigue. **Staff will therefore face challenges** and require adequate support to address their own wellbeing. Robust systems and processes to provide this may be more difficult for smaller organisations to provide (Wilton and Williams, 2019b).

5 Factors that enable trauma-informed services and systems

This chapter provides a summary of the evidence on what cultural, contextual and practical factors can support the design and delivery of trauma-informed services and systems.

5.1 Key findings

Overcoming barriers to a trauma-informed approach

A psychometrically tested instrument, the TICOMETER, has been used by some studies to assess the extent to which a service is trauma informed. This tool could be used to support evaluation and address evidence gaps. In addition, trauma-informed champions, education opportunities and local toolkits have been suggested to address resistance to change by improving understanding of the benefits of a trauma-informed approach (Bear et al., 2019).

Joint-commissioning and applying a trauma lens to commissioning have also been suggested to ensure that services are able to take a trauma-informed approach (McCarthy et al., 2020). For example, Bush and Brennan (2018) suggest that trauma-informed models of commissioning should be (amongst other things) knowledgeable about trauma in local communities, flexible in response to this and integrated through data-sharing agreements and co-commissioning services so that people have continuity of care.

Key enablers

Several enablers to a trauma-informed approach have been regularly identified across systematic reviews, academic research and other evaluation and research reports, and these are relevant across different geographies.

Firstly, there is agreement that leaders can help to drive a trauma-informed agenda forward by setting an example and inspiring staff (Holly, 2017; Academic Health Science Network, 2021). Covington (2016) also recommends that organisations appoint Trauma and Gender Champions. Organisational policies and procedures that reflect trauma-informed principles are also considered important (Addis et al., 2022; DeCandia and Guarino, 2015). This could include policies such as mandatory staff training on trauma and procedures such as involving clients in their care. Other examples identified in the literature included maintaining open communication with clients, keeping consistent appointments and giving sufficient notice if change is necessary (Menschner and Maul, 2016).

The literature also highlights the need for the physical environment to promote safety and collaboration to enable a trauma-informed approach. Suggestions made include consideration of comfort, privacy and choice (Elliot et al., 2005; Covington, 2011) as well as keeping areas well lit, having welcoming language on signs and ensuring clients can easily exit rooms if needed (Menschner and Maul, 2016).

One of the most common factors discussed in literature that considers enabling factors of a trauma-informed approach is support and training for staff. It is suggested that training should be organisation wide (SAMHSA, 2014; Covington, 2016; Holly, 2017) and ongoing (Maguire and Taylor, 2019). However, a systematic review of trauma-informed approaches that included staff training in healthcare settings and a study evaluating a trauma-informed training programme for staff working with individuals experiencing multiple disadvantage concluded that training is most effective when accompanied by other factors such as organisational policy changes (Purtle, 2020; Burge et al., 2021).

Screening and assessment tools are often used to identify past and current experiences of trauma and related problems and to tailor support to meet individual needs (Addis et al., 2022), but there is less available evidence on trauma screening practices and how they support a trauma-informed approach (Chaudri et al. 2019; Hopper et al., 2010).

It is also acknowledged that adequate financing structures are necessary to resource a trauma-informed approach. Ongoing monitoring can help track progress and, if evaluation occurs, it is suggested that this reflects trauma-informed principles so it can safely involve people with experience of trauma (SAMHSA, 2014).

5.2 Enabling factors

Guidance published by the Substance Abuse and Mental Health Services Administration (2014) outlines ten implementation domains, drawn from change management literature and trauma-informed frameworks.

The first is **governance and leadership** that support/invest in the implementation of a trauma-informed approach within an organisation, and an identified point of responsibility who is leading on and overseeing the work.

Holly (2017) explains that developing a person-centred and trauma-informed organisation requires commitment from those at the top because leaders set the tone for the entire organisation. Recent guidance developed by the Academic Health Science Network (2021) outlines several reasons why authentic and compassionate leadership is required in trauma-informed approaches. This includes because leaders can set an example and inspire collective action through their areas of influence and leadership is key in supporting the motivation and job satisfaction of staff to work in a trauma-informed way.

To support the implementation of cultural change, Covington (2016) recommends that organisations appoint Trauma and Gender Champions. These are individuals tasked with the day-to-day delivery of trauma-informed services and who might serve as role models for all staff on the practical aspects of becoming trauma-informed in a manner consistent with overall culture change goals. Bear et al. (2019) also suggested than buy-in from staff can be achieved through service 'champions' who act as influencers, as well as informal education programmes on the benefits of trauma-informed working and the development of local toolkits.

Policies that establish a trauma-informed approach underpinning an organisation's work and **procedures** reflecting trauma-informed principles (such as involving clients in their care and acknowledging experiences of trauma) are considered important. For example, it is argued that a trauma-informed approach is enabled by an organisation-wide

commitment to translate trauma-informed principles into tangible practices (DeCandia and Guarino, 2015). A literature review exploring key language in trauma-informed programmes/organisations found aligning policy, procedures and programming with trauma-informed principles was linked to success of implementation (Addis et al., 2022). This included policies and/or procedures to promote a safe environment and eliminating or reducing harsh/coercive practices, mandatory trauma training for all staff, universal screening of all clients and procedures for consumer engagement and input in service planning and development of a trauma-informed system (Ibid.)

Guidance on successful trauma-informed care implementation (Menschner and Maul, 2016) suggests:

- welcoming clients and ensuring that they feel respected and supported
- ensuring staff maintain healthy interpersonal boundaries and can manage conflict
- keeping consistent appointments
- offering sufficient notice and preparation when changes are necessary
- maintaining communication that is consistent, open, respectful, and compassionate
- being aware of how an individual's culture affects how they perceive safety and privacy

Where the **physical environment** promotes safety and collaboration it is adhering to trauma-informed principles and enabling a trauma-informed approach. Considerations could include sufficient space for comfort and privacy and ensuring that available reading materials or images used on the walls are not triggering (Elliot et al., 2005). Spaces should be designed to give service users a sense of belonging and normalisation (Walker et al., 2021). A calm atmosphere that respects privacy and maximises the choices a someone can make will promote healing (Covington, 2011).

Schroeder et al. (2021) argue that a trauma-informed built environment may promote wellbeing at the individual-level (e.g. increased feelings of safety), improve the social environment (e.g. greater community connectivity), and complement traditional person-centred efforts to address trauma. Menschner and Maul (2016) recommend the following factors to create safe physical environments:

- keeping car parks, common areas, bathrooms, entrances, and exits well lit
- ensuring that people are not allowed to smoke, loiter, or congregate outside entrances
- monitoring who is coming in and out of the building
- positioning security personnel inside and outside of the building
- keeping noise levels in waiting rooms low
- using welcoming language on all signage
- making sure service users have clear access to the door in rooms and can easily exit

In addition, it is recommended **that staff, clients and their family members have significant involvement**, voice, and meaningful choice at all levels across the design and delivery of a service. Wilton and Williams (2019) explain that concerns and scepticism should be taken seriously and engaged with in a meaningful way. An organisation taking a

trauma-informed approach will listen, understand and respond to both people accessing services but its staff as well.

Some studies emphasise the importance of staff and/or volunteers having lived experience or direct personal experience of recovery as well as prior experience of working with the client group (McCarthy et al., 2020; Tompkins and Neal, 2018). Elliot et al. (2005) concluded that having equal regard for the value of consumer and professional staff supports trauma-informed working. Fallot and Harris (2008) state that the programmes which have been most successful in developing significant and lasting trauma-informed approaches have engaged frequently underrepresented groups — administrators, support staff, and consumers — in all aspects of the change process. Service user involvement is also acknowledged as a reason behind services exploring and embedding trauma-informed approaches (Academic Health Science Network, 2021). **Cross-sector collaboration** is also considered important. Guarino (2012) highlights the need for commitment and a coordinated effort at all levels to be able to change the practices, policies, and cultures of whole organisations within and across local systems towards trauma-informed approaches.

Training and workforce development is one of the most referenced enabling factors in the literature. Studies have found that resistance to creating trauma-informed services often stems from a lack of knowledge about the impact of trauma, uncertainty of appropriate service responses, and for some staff unresolved personal traumas (DeCandia and Guarino, 2015). Early guidance on trauma-informed approaches outlined that all staff members can benefit from general training to help them understand that trauma is the expectation, not the exception (Brown, Harris and Fallot, 2013). The literature also highlights the importance of support and supervision for staff (Maguire and Taylor 2019; Wilson et al., 2021). For example, in a study about how services were working with women who had experienced multiple disadvantage, it was noted that for an organisation to be truly trauma-informed, it needs to recognise the signs of secondary trauma amongst staff and provide appropriate support and clinical supervision from the outset (Sharpen, 2018).

Available guidance also suggests that training should be organisation-wide rather than just for the professionals working one-to-one with people so that all staff and volunteers feel empowered and comfortable responding to trauma survivors (SAMHSA, 2014; Covington, 2016). Holly (2017) explains that it will be difficult for a service to take a trauma-informed approach until everyone involved is willing and able to make the connection between people's experiences and the difficulties they face. Furthermore, a review focused on staff training in mental health settings highlighted that training needs to be ongoing rather than a one-off (Maguire and Taylor, 2019).

A review of trauma-informed approaches that included staff training across a range of healthcare organisations (Purtle, 2020) found the training resulted in short-term improvements in staff knowledge, attitudes, and behaviours related to trauma-informed practice. However, it was less clear whether these changes were sustained or whether they translated into client outcomes. The review concluded that trauma-informed approaches appeared most effective when training was accompanied by other factors such as organisational policy changes linked to trauma-informed principles (Ibid.).

A trauma-informed care training programme for health care workers in the United States, Risking Connections, was evaluated by Green et al. (2015; 2016). Impact was assessed using randomised control trial design, albeit with small numbers. This found significant increases in patient-centredness, as measured by observed simulated visits with actors playing standardised patients, and a significant increase in patients' self-reported perceptions of shared decision-making between the patient and staff.

In England, a study evaluating a trauma-informed training programme for staff working with individuals experiencing multiple disadvantage found modest improvements in the degree of trauma-informed care, which were sustained 12 months later (Burge et al. 2021). The provider (which worked with people experiencing homelessness) employed two clinical psychologists to develop psychologically- and trauma-informed practice. The study examined group and individual level changes before the training, six months after and one-year after the training. The degree of trauma-informed care was measured by the TICOMETER, a psychometrically robust organisational measure of a trauma-informed approach.

The findings showed that at a group level, scores in three of five domains improved following training: knowledge and skills, relationships, and policies and procedures. However, two domains did not improve: service delivery and respect, which the authors thought may require wider culture changes to achieve. Furthermore, individual level analysis showed that some participants' scores decreased following the training. The authors concluded that it is important that organisations do not simply see the provision of training to staff as indicative of being trauma-informed; they may be more informed about trauma, but they might not act differently as a result (Burge et al. 2021). Other factors therefore also need to be considered – such as those that are discussed in this chapter.

To enable a trauma-informed approach, SAMHSA (2014) recommend **ongoing assessment, tracking and monitoring of trauma-informed principles** and effective use of evidence-based trauma-specific screening, assessments and treatment. The guidance explains that **evaluation methodology** should use research tools that are appropriate and **reflect trauma-informed principles**. Working with people with lived experience of trauma to co-produce materials can support this process.

On the issue of evaluating trauma-informed approaches, Champine et al. (2019) argue that organisations need psychometrically sound tools to measure the extent to which they are trauma-informed, to identify strengths and needs, and to monitor progress toward improvement. The TICOMETER [4] is a brief measure that can be used in organisations wanting to assess their trauma-informed approach levels, identifying areas for future training, and track their changes over time (Bassuk et al., 2017).

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[4] www.ticometer.com

The TICOMETER

The TICOMETER measures the level of trauma-informed care in an organisation's working practices. It is a psychometrically tested tool that has 35 items considered to be indicators of trauma-informed care across the following five domains:

- Building trauma-informed knowledge and skills
- Establishing trusting relationships
- Respecting service users
- Fostering trauma-informed service delivery
- Promoting trauma-informed policies and procedures

It can be completed online and takes around 15 minutes. However, it only captures staff perceptions of organisation's needs and progress, not the views of service-users.

It is designed as organisational assessment and monitoring tool, rather than outcome measure, and can be used to determine training needs and trauma-informed policies (Bassuk et al., 2017).

Some studies have implemented this to examine the implementation of a trauma-informed approach at an organisation (Burge et al. 2021).

Screening and assessment tools are often used in services that aim to apply a trauma-informed approach to identify past and current experiences of trauma and related problems, and to tailor support to meet individual needs (Addis et al., 2022). However, some studies have highlighted the limited evidence around trauma screening practices and suggested further research on this (Chaudri et al. 2019; Hopper et al., 2010).

Lastly, **financing structures** can also support a trauma-informed approach through providing resources for training, developing appropriate physical spaces, encouraging collaboration and funding high-quality assessment and support options. It is argued that it will be important for commissioners to recognise the value of a trauma-informed approach so that this way of working filters down into national and local policy, which will in turn create training and funding opportunities that enable this way of working (Wilton and Williams, 2019).

McCarthy et al. (2020) suggest moving towards commissioning through a 'trauma lens' and joint commissioning models as potential solutions to address some of the barriers that current commissioning structures create. Similarly, a report that called for an innovative commissioning pathway for child abuse and sexual violence survivors highlighted the need for commissioning bodies to consult with people who have been harmed by services and recommended co-commissioning models whereby pathways or services are co-produced or led by survivors and service users so that services 'help rather than harm' (Lomani, 2022). While Bush and Brennan (2018) propose that adversity and trauma-informed models of commissioning and care should be:

1. Prepared – by prioritising the causes and consequences of trauma, analysing data on local need and embedding this knowledge in commissioning pathways.

2. Aware – by ensuring local organisations have a good understanding of adversity and trauma, a common framework for identifying trauma and responding to cultural, identity and gendered contexts of people and the communities that they live.

3. Flexible – providing models of care that enable alternative and more flexible forms of access and engagement (e.g. street outreach) and providing targeted models of care to excluded groups who live in adverse and traumatic environments.

4. Safe and responsible – intervening early and having policies that prevent exposure to further trauma and models of coordinated support by well-trained staff who are supported to address vicarious trauma.

5. Collaborative and enhancing – engaging service users in decisions about their treatment and adopting a strengths-based approach.

6. Integrated – enabling effective communication and data-sharing between agencies and co-commissioning services to ensure that there is a continuity of care and consistency of pathways across, and within, the services people will receive.

A systematic literature review on trauma-informed care in youth inpatient psychiatric and residential treatment settings identified five factors that were instrumental in implementing a trauma-informed approach across a range of initiatives. These reflect the domains outlined above and included senior leadership commitment, sufficient staff support, amplifying the voices of patients and families, aligning policy and programmes with trauma-informed principles, and using data to help motivate change (Bryson et al., 2017). Likewise, a recent study exploring trauma-informed practice in probation services in England and Wales found that formal training, clinical supervision, knowledgeable and committed line management and buy-in from senior leaders were important in providing support to staff taking a trauma-informed approach (HMIP, 2022).

6 Conclusions

This REA has provided an overview of the available evidence on the benefits of taking a trauma-informed approach to address the different needs of people experiencing multiple disadvantage. The review has also considered what factors can enable or prevent a service or system from working in a trauma-informed way.

Availability of evidence

The review process identified several systematic reviews that had either summarised the evidence in relation to trauma-informed ways of working in a specific sector or attempted to understand how this has been understood and implemented. However, there is a lack of evidence on outcomes and impact from studies that have implemented RCTs or QEDs which are considered most robust. Instead, much of the academic and grey literature draws on qualitative studies that are relatively small-scale and several sources included in this review were policy papers or guidance documents about why and how a trauma-informed approach should be implemented. It should also be noted that the evidence-base is more developed in the United States and the search had to be expanded beyond the initial remit of sources within the last ten years as many prominent papers were authored before this.

Evidence of outcomes

It is difficult to determine the effectives of a trauma-informed approach or understand how best to implement this because there is a limited amount of research evaluating trauma-informed programmes and services. A significant reason for this is that there is not agreed definition of a trauma-informed approach, so it is challenging to compare ways of working and isolate the impact of taking a trauma-informed approach from wider interventions.

Individual outcomes have been most commonly identified in the criminal justice system mental health sector, women's sector and housing and homelessness sector. This includes impacts on relationships, engagement with services, improvements to behaviours (such as reoffending and violence) and better mental health. There is some suggestion that service integration can help to further such outcomes. There is less research on the impact on organisations and systems of taking a trauma-informed approach. The exception is evidence of the positive impacts on staff from studies that have explored how trauma-informed training and ongoing support has influenced ways of working. Although it is acknowledged that preventing trauma can help systems to reduce cost, there is a lack of data on cost-savings created by adopting a trauma-informed approach.

What helps and hinders a trauma-informed approach

Several enablers and barriers to a trauma-informed approach have been regularly identified across academic and grey literature.

When moving towards taking a trauma-informed approach, governance and leadership that advocate for and support this way of working and effective use of evidence-based

trauma-specific screening, assessments and treatment can enable this. However, change fatigue and limited capacity to implement new/additional tools can prevent this.

Organisations and systems trying to work in a trauma-informed way can support this through implementing policies and procedures that enable trauma-informed principles to be put into practice, having a physical environment that promotes trauma-informed principles, ensuring collaboration between staff and clients and providing training and workforce development opportunities. However, this will be made more difficult through staff turnover, resistance to change, funding cuts and commissioning models. Furthermore, not addressing secondary trauma amongst staff is problematic.

Other enablers include ongoing assessment, tracking and monitoring of trauma-informed principles, an evaluation methodology that reflects trauma-informed principles and sufficient resourcing. Other barriers include the lack of consensus on what constitutes a trauma-informed approach and how this should be implemented, and the context of austerity.

Implications for Changing Futures Programme

The Changing Futures programme has the potential to contribute to the evidence-base, which is limited in England. It will be important for the national programme evaluation to try and address some of the different questions raised in this review. For example, capturing how a trauma-informed approach is understood and adopted across the different funded areas, and how such perceptions compare to views in national government. There would also be benefits in exploring what individual, service and system-level factors are supporting and preventing trauma-informed practice (e.g. workforce skills and approaches to risk management) and improving understanding of how trauma-informed approaches can be embedded within services and systems more widely. Lastly, to contribute to the evidence base it would be helpful to capture any perceived and tangible outcomes from working in this way, such as impacts on engagement with services and improved experiences of services.

In the future, DHLUC and other government departments may want to consider developing a definition of a trauma-informed approach that can be adopted on a programme to ensure consistency in how this is recognised and implemented across different organisations.

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