Humber and North Yorkshire
Health and Care Partnership

Children and Young People's Trauma Informed Care Programme

A Trauma Informed Organisational Development Framework

Self and Peer Evaluation Toolkit

Introduction

Children and Young People's Trauma Informed Care Programme

Established in 2022 to deliver a ten-year programme of system change, the Humber & North Yorkshire Children and Young People's Trauma Informed Care Programme is a collaboration of a wide range of stakeholders including health, Local Authority, Education, Youth Justice, Police and Voluntary Services. The programme was developed collaboratively to ensure that all professionals working across the system with children and young people who have experienced trauma, can be supported to respond appropriately, consistently, and compassionately, so that the support these children and young people receive helps them to thrive.

This Trauma Informed Organisational Development Framework was initially developed and tested by a team of subject matter experts working within the violence reduction unit in Lancashire, who understand systems and processes. It has since been used across Lancashire with a range of organisations, as part of the Pan Lancashire partnership on Trauma Informed Care. The programme team have met with Lancashire to learn from their developments and have adapted this for use based on feedback from partners for use across our ICS.

By championing prevention and early intervention, we aim to intelligently use the data and evidence available to us, to improve and embed trauma informed practice across all organisations supporting vulnerable children and young people across Humber & North Yorkshire.

We hope that you and your teams find this resource useful and helpful and look forward to working with you to support this process.

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Foreword

To deliver the Humber and North Yorkshire (HNY) programme, we have created the Children and Young People's Trauma Informed Care Partnership. This partnership is made up of all statutory and non-statutory agencies/ partners across Humber and North Yorkshire that are involved in the provision of services for Children and Young People who are vulnerable. As part of the developing governance model, an operational Steering Group and a Strategic Alliance have been established. The partnership will work collaboratively to lead, plan and co-ordinate the 4 areas of the Trauma Informed Care framework. (Please see page 8).

Our Children and Young People's Trauma Informed Care (TIC) Programme is a collaboration of partners from across our six places within Humber and North Yorkshire. The model aims to build on existing infrastructure to strengthen pathways and collaborative working, while testing new models of delivery to improve outcomes.

As part of our HNY TIC core team offer, we will provide support on policy and practice to organisations working with Children and Young People. This includes working through Trauma Informed Care (TIC) toolkit with organisations working to progress from being Trauma Aware to being Trauma Informed so the culture of the whole system reflects a Trauma Informed Approach.

We will work with stakeholders to identify where training needs lie, and put together a timeline of training over the duration of the programme. All training will initially be delivered by our framework of trainers in a variety of ways and means to suit time constraints, different learning needs and is relevant to role and responsibility. There will also be support in developing your own organisations "ARC Champions" though a training for trainers' model so this training can be embedded and sustained within your organisation's own induction and training programme. The aim of our training is to help and support organisations to progress through the 4 stages highlighted in this document and ultimately become fully 'Trauma Informed'.

1 Rationale

Trauma is recognised as a profound, global, public health burden. The pervasive and harmful impact of traumatic experiences on individuals, families and communities, and the inadvertent but widespread re-traumatisation of children and adults within existing services and systems, has made it essential to rethink 'how we do business'. Although many people who experience trauma will progress in life without any long-term negative impacts, far too many others will experience more profound difficulties and traumatic stress reactions. That said, research indicates that with appropriate support, people can overcome traumatic events. However, many individuals and families have gone – and continue to go – without appropriate support or interventions. Left unaddressed, trauma can prevent achieving good health and wellbeing as well as impacting on wider outcomes e.g. education and employability. Over the years, a tendency to focus on the presenting symptoms (e.g. violence, criminality, or substance misuse), at the expense of addressing underlying issues, has led to huge human and economic costs to society. Now more than ever, there is an urgent need to tackle the impact of trauma and focus on how public systems can support people to prevent, as well as recover from traumatic events. Only by working together, across systems and with our communities, will we reduce the complex and interconnected social determinants and inequalities, which drive trauma. Consequently, this Trauma Informed Organisational Development Framework has been designed to cultivate collective, cross-sector learning, to support the ongoing development of trauma informed services and embed a Trauma Informed Approach across statutory and non-statutory organisations.

2 About this framework

This framework has been designed as a resource to:

- Promote discussion about how we respond to trauma.
- Reflect on current policies and practices.
- Identify what trauma informed policies, practices and resources organisations already have in place.
- Guide organisations to understand the process of embedding a trauma informed approach.
- Carry out self and peer evaluations against specific statements.
- Facilitate collaborative learning.
- Identify developmental needs and next steps.
- Develop a common language within and across multi-agencies,

Encourage leaders to:

- Think about their organisation through a trauma informed lens.
- Develop infrastructure to support cultural change.
- Incorporate understanding of trauma in all policies and practices.
- Develop reflective practice and critical thinking.
- Minimise the impact of vicarious and secondary trauma; and
- Provide effective supervision to the whole workforce.

Note 1. This framework has been written primarily for organisational development purposes (taking a 'whole systems' approach), however we encourage flexibility in its application; the framework might also be useful for the development of individuals and teams, although individual or team completion is not to be taken as representative of a whole organisation.

Note 2. The Trauma Informed Organisational Developmental Framework refers to the whole of this document, whilst the Self and Peer Evaluation Toolkit refers specifically to Section 6.

Note 3. This document forms one of a number of trauma informed resources being produced by the HNY TIC Programme. The document is not intended to be used in isolation; it is designed to complement existing trauma informed resources, training and processes that organisations are currently engaging in locally, nationally and transnationally.

Note 4. An existing understanding of trauma informed care, approaches and practices is essential to implementing this framework. Our programme has developed training to support this.

3 Background and context

What do we mean by trauma?

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (SAMHSA's (2014, p.7) definition)

What do we mean by Trauma Informed Care?

- Trauma Informed Care (see glossary for further information) originally emerged in healthcare settings, but has since been adopted by criminal justice systems, schools and other services for children, adults and families.
- A primary aim of Trauma Informed Care is to increase an organisation's awareness of how trauma can negatively impact on children and adults, so that they can adapt practices to avoid causing further trauma.
- Trauma Informed approaches have been defined as:

An organisational change process focused on preventing (re) traumatisation within services. (Sweeney and Taggert (2018, p.385)

Our Pledge:

We will work collaboratively to ensure that all professionals working across the system with children and young people who have experienced trauma, can be supported to respond appropriately, consistently, and compassionately, so that the support these children and young people receive helps them to thrive.

4 How to use the framework

The Four Phases

The framework is divided into four phases and has been designed to be highly flexible so that each organisation (programme, individual, team or department) can focus on what is most relevant depending on the services they provide. The aim is for all of the services, teams and departments within the organisation, to eventually reach phase 4, so the organisation is providing a consistent approach to Trauma Informed Care.

Phase	Definition
1) Trauma Aware	The organisation has a basic understanding of what trauma is, its prevalence and recognises how it can impact on people who use services and staff.
2) Trauma Sensitive	The organisation has begun to: explore the trauma informed principles in daily work; build consensus, consider the implications of embedding trauma informed practice; and is preparing for change.
3)Trauma Responsive	The organisation is readily responding to trauma, including support for both the people who use the service and staff, and has begun to change the culture to align with the trauma informed principles.
4)Trauma Informed	A trauma informed (TI) approach is the norm, accepted and embedded in the organisation so it no longer depends on a few 'champions', 'coaches' or 'leaders. The organisation continues to work with partners (people with lived experience, communities and multi-agencies) to strengthen and adapt its trauma informed approach. The programme or service has been rigorously evaluated and outcomes demonstrate the positive impact of changes made.

Note 1. It is possible to begin at phase 1 and move through all 4 stages. Alternatively, some organisations may find it more appropriate (depending on their journey) to begin at a later phase.
Note 2. Different individuals, teams and departments within organisations may be at different 'phases', at different points in time, along their trauma informed journey.

How to use the framework

Self-evaluation

The statements in each phase are intended to guide evaluation of current practice.
FD = Fully Developed, implemented / embedded/ evaluated, and currently operating as business as usual.
AP = Active Progress, partially implemented / readily responding/ culture change underway / support and resource in place.
PP = Planned Progress, beginning to explore/ building consensus / considering implications. Will move into 'active progress' within the next 6 months.
LP = Limited Progress / not started / delayed, basic understanding/ no plans and or operational activity at the current time/ progress delayed.
* Place a tick within the appropriate column, then write down what evidence you have to support each statement.

Children & Young People's Trauma Informed Care – Core Team Support Offer

- One to one support to be offered via the Community of Practice Manager to work through the self-evaluation toolkit.
- Regular planned reviews with Community of Practice Manager to acknowledge successful movement through the phases of trauma.
- Support to be given via the Community of Practice Manager to resolve any barriers that organisations are facing preventing movement forward.

Peer Evaluation

Once you have completed the self-evaluation, you can then contact the Children and Young People's Trauma Informed Care Programme's Core Team who will suggest a peer evaluating organisation.

- The peer evaluation should be a supportive, developmental process, where learning is shared (not a process of critique).
- The peer evaluating organisation should provide feedback under the 'Plan of action / Reflective comments' heading.

Next Steps

If you choose not to take part in a peer evaluation, then you can make notes under the 'Plan of action / Reflective comments' heading yourself.

- Continue to work through each phase in order to progress along a continuum of being Trauma Aware > Trauma Sensitive > Trauma Responsive > Trauma Informed.
- Organisations are continually evolving and therefore it is important to see the development of trauma informed approaches as an ongoing process (i.e. there will be new recruits, new challenges, and a need to continually review policies and practices in the context of a changing landscape).

Note 1. The Peer and Self Evaluation Toolkit is not a formal evaluation or certification process.
Note 2. Further details about the peer review process will be provided on the HNY Children and Young People's Trauma Informed Care (TIC) Programme website in due course. In the meantime, or alternatively, please contact the CYP TIC Team (contact details provided on the back of this document).

5 What do we mean by a phased approach?

By taking a phased approach we:

- Anticipate that different organisations will be at different points along their trauma informed journey.
- Also recognise that different people within organisations, are likely to be at different points along the phased continuum.
- Encourage you to refer to the most appropriate phase depending on your (individual, team or) organisation's current practices.
- Take into account that implementing a trauma informed approach takes time; it is a gradual process of continual development (not a training package or a tick-box exercise) and requires 'buy-in' throughout the whole system.

6 The Self and Peer Evaluation Toolkit

Phase 1: Trauma Aware

Trauma Aware

	FD	AP	PP	LP	Peer Evaluation	Evidence
Most workers are aware of what trauma is and its prevalence	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
Most workers have an individual understanding of shame – developing shame competence	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
We are working towards having an organisational understanding of shame	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 1: Trauma Aware *(Continued)*

Most workers recognise the different ways in which trauma can affect people ('service users' and staff)

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

We have identified a TI lead and have begun raising awareness of TI practice within the organisation

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Most workers (frontline, management and senior leadership) are committed to TI practice

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 1: Trauma Aware *(Continued)*

	FD	AP	PP	LP	Peer Evaluation	Evidence
Most workers can recognise when people are affected by trauma	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
The leadership team are beginning to explore the implications of adopting the TI principles and are preparing for change	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
The organisation's TI approach works in collaboration with people with lived experience to develop and improve the service provided and share learning (applies throughout)	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 2: Trauma Sensitive

Trauma Sensitive	**FD**	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
Workers have attended trauma awareness training	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
Workers are sensitive to trauma and its impact on people (i.e. individuals, communities, colleagues and themselves)	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
Workers are committed to the principles of TI practice (see Appendix 1)	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 2: Trauma Sensitive *(Continued)*

	FD	AP	PP	LP	Peer Evaluation	Evidence
Workers have sought out opportunities to implement trauma learning and skills	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
The organisation has considered the implications of adopting the TI principles	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
Most workers (frontline, management and senior leadership) are committed to TI practice	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 2: Trauma Sensitive *(Continued)*

	FD	AP	PP	LP	Peer Evaluation	Evidence
Resources (e.g. time and staffing) have been allocated to support TI cultural change	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
TI agents of change are starting to influence other staff and are able to call into question non-TI practices and policies	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	AP	PP	LP	Peer Evaluation	Evidence
Workers (frontline, management and senior leadership) value and are committed to TI practice	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 3: Trauma Responsive

Trauma Responsive	**FD**	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
The organisation has identified current strengths based on the TI principles	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
Organisational strengths are being captured and celebrated to create a positive movement and drive further change	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
The organisation can demonstrate a change in culture towards being TI	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 3: Trauma Responsive *(Continued)*

People are supported to safely disclose experiences of trauma where appropriate

FD	AP	PP	LP	Peer evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

People affected by trauma are signposted / referred to the appropriate services to enable safe disclosure and ensure their needs are met

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

People affected by trauma have their immediate needs for safety identified at the earliest possible opportunity so they can be protected from further harm

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

The needs of workers exposed to trauma, whether directly or indirectly, are recognised and addressed (e.g. staff supervision and trauma therapy)

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 3: Trauma Responsive *(Continued)*

There are processes in place for gathering feedback and meaningful input from 'service users' and staff

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Language used considers the TI principles (Appendix 1)

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Workers can apply TI knowledge in practice and reflexive practice is supported

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Reviews of outcomes, policies and procedures, and organisational development plans incorporate change through a TI & shame lens

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 4: Trauma Informed

Trauma Informed	**FD**	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
Changes in the organisation's TI journey are clearly evidenced through data collection	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
Workers feel supported to deliver TI practice	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

	FD	**AP**	**PP**	**LP**	**Peer Evaluation**	**Evidence**
Reflective practice is considered an essential tool and effective supervision is embedded into routine practice	☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 4: Trauma Informed *(Continued)*

People affected by trauma are supported to access timely interventions and recover

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

The needs of people affected by trauma are prioritised over systems and procedures to reduce the risk of re-traumatisation

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Outcomes, procedures and policies are aligned to a TI approach and embedded in practice

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Phase 4: Trauma Informed *(Continued)*

New recruits, volunteers and promoted staff demonstrate a commitment to the TI principles (Appendix 1)

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

All aspects of the organisation have been reviewed and revised through a TI & shame lens

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

The organisation's TI practice has been independently evaluated (processes and outcomes) and uses evidence and data to inform decision making

FD	AP	PP	LP	Peer Evaluation	Evidence
☐	☐	☐	☐	☐	☐

Plan of action / reflective comments

Appendices

Appendix 1: Trauma Informed Principles

What are the key principles of trauma informed approaches?
Sweeney and Taggert (2018) consolidated information from a number of different organisations and resources to produce the following 10 principles. We refer to these principles as those cited by the Early Intervention Foundation (2020).

1. Seeing through a trauma informed lens, meaning that there is an **understanding and acknowledgement of the links between trauma and mental health**.
2. **Adopting a broad definition of trauma** extending beyond PTSD, including recognising social trauma and the intersectionality of multiple traumas.
3. Making trauma enquiries sensitively and with **knowledge about how to respond**.
4. Referring people to **evidence-based, trauma specific support**, where indicated.
5. **Addressing vicarious trauma and re-traumatisation**.
6. **Prioritising trustworthiness and transparency in communications**, such as limiting the professionals a person is required to repeat their traumatic history to.
7. Moving towards **collaborative relationships** and away from helper-helpee roles, based on trust, collaboration, respect and hope.
8. Adopting **strengths-based approaches** that reframe symptoms as coping adaptations, such as dissociation as an adaptive strategy to escape unbearable experiences.
9. **Prioritising emotional and physical safety** for service users and workers.
10. Working in **partnership with people** who have experienced trauma, for example to design, deliver and evaluate services.

Note 1. Other organisations and resources cite different numbers of principles. For example, SAMHSA (2014) refers to the following six principles: (1) safety; (2) trustworthiness and transparency; (3) peer support.
(4) collaboration and mutuality; (5) empowerment and choice; and (6) cultural, historical and gender issues.
Meanwhile, the NHS Education for Scotland (2017) refer to the following five principles: (1) choice; (2) empowerment; (3) safety; (4) trust; (5) collaboration.
Note 2. Many of the principles overlap with other ways of implementing good practice, such as co-production with experts by experience, collaboration within and across agencies, shared decision making, having a positive and safe environment and strengths-based services. Hanson (2013) argues that there is nothing specific about trauma informed care that is specific to a history of trauma; the need to be sensitive and humane is just good care.
Adapted from Sweeney and Taggert (2018)

Appendix 2: Trauma Informed Guidance

What is the guidance for implementing a trauma informed approach?
Sweeney and Taggert (2018) consolidated information from several different organisations and resources to produce the following 10 principles. We refer to these principles as those cited by the Early Intervention Foundation (2020).

The Three E's of Trauma

Events: Events and circumstances may include the actual or extreme threat of physical or psychological harm or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stress or-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

Experience: The individual's experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic.

Effects: The long-lasting adverse effects of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognise the connection between the traumatic events and the effects.

The Four R's of a Trauma-Informed Approach

Realisation: In a trauma-informed approach, all people at all levels of the organisation or system have a basic realisation about trauma and understand how trauma can affect families, groups, organisations, and communities as well as individuals. People's experience and behaviour are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past, whether they are currently manifesting, or whether they are related to the emotional distress that results in hearing about the first-hand experiences of another.

Recognition: People in the organisation or system are also able to recognise the signs of trauma. These signs may be gender, age, or setting-specific manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

Respond: The programme, organisation, or system responds by applying the principles of a trauma-informed approach to all areas of functioning. The programme, organisation, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organisation, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviours and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realises the role of trauma in the lives of their staff and the people they serve.

Resist Re-Traumatisation: A trauma-informed approach seeks to resist re-traumatisation of clients as well as staff. Organisations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the wellbeing of staff and the fulfilment of the organisational mission. Staff who work within a trauma-informed environment are taught to recognise how organisational practices may trigger painful memories and re-traumatise clients with trauma histories.

Source: SAMHSA (2014)

Appendix 3: Trauma Informed Activities and Components

In a search of published literature, websites, national (U.S.) resources and feedback from professionals, Hanson and Lange (2016) identified a variety of strategies for becoming trauma informed. Hanson and Lange's (2016) mapping found 15 components, across three domains: workforce development (WD); trauma focused services (TFS); and organisational environment and practices (ORG). In the table below, we highlight the activities and components that were most identified as important elements of trauma informed care.

WD	TFS	ORG
Training all staff in awareness and knowledge on the impact of abuse and trauma	Use of standardised, evidence-based screening/assessment measures to identify trauma history and trauma-related symptoms or problems	Collaboration, service coordination, and information sharing among professionals within the agency and with other agencies related to trauma informed services
Measuring staff proficiency in defined criteria to demonstrate trauma knowledge/practice	Inclusion of child's trauma history in child's case record/file/service plan	Procedures to reduce risk of client re-traumatisation
Strategies/procedures to address/reduce secondary trauma stress among staff.	Availability of trained, skilled clinical providers in evidence-based, trauma focused practices	Procedures for consumer engagement and input in service planning and development of a trauma informed system
Knowledge/skill in how to access and make referrals for evidence-based trauma focused practices		Provision of services that are strengths based and promote positive development
		Provision of a positive, safe physical environment
		Written policies that explicitly include and support trauma informed principles
		Presence of a defined leadership position or job function specifically related to trauma informed care

Appendix 4: What have we learnt from evaluations?

A report published by the Early Intervention Foundation in February (2020) provides information on current evaluations of trauma informed care (summarised below).

What have we learnt from evaluations so far?

While it is reasonable to assume that increased client choice and trust represent improvements in services, the extent to which these improvements will also reduce symptoms of trauma, anxiety and other forms of stress, or lead to sustained improvements in outcomes, has not yet been rigorously tested' (p.78).

Most evaluations of trauma informed approaches currently lack rigour, and the findings are mixed:
Overall, most findings from less rigorous studies are positive and include improvements in:

i. Practitioners' knowledge.
ii. Increased placement stability for children.
iii. Reductions in reports of depression, family difficulties and child behavioural problems.

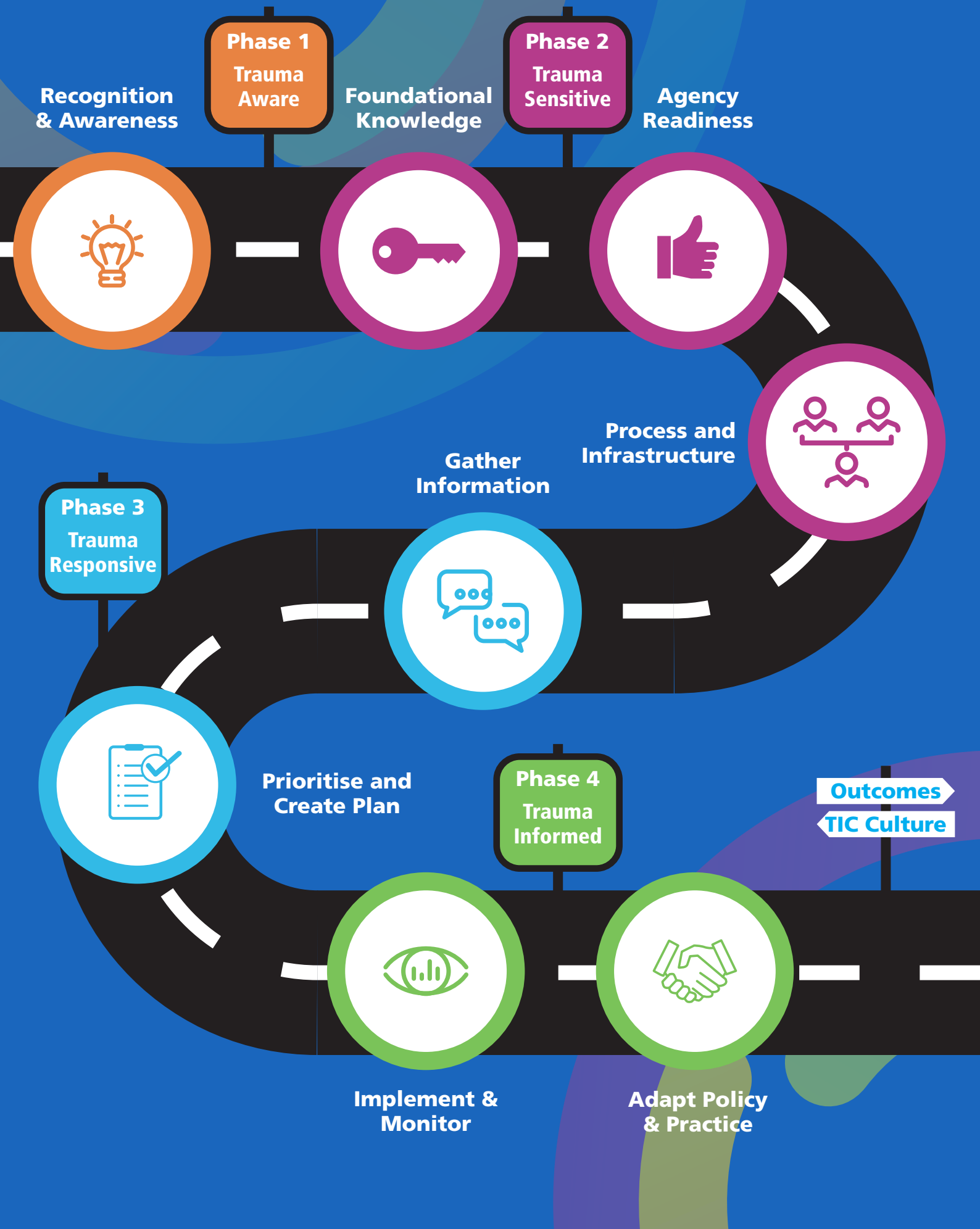
Trauma informed practices that have been evaluated often lack a comparison group, which means that their findings are still preliminary.
'Findings from the first randomised trial of trauma informed care are less positive'; the study found little difference in outcomes (p.78).

What needs to happen next?

Many trauma informed activities overlap with existing practices, so it is important to clearly outline how each activity is expected to add value over current practices, to improve short- and long-term outcomes.

More rigorous evaluations of the impact of trauma informed care on child and adult outcomes are needed 'before trauma informed care can be considered a proportionate and evidence-based response to childhood trauma and adversity' (p.79).

Appendix 5: A Trauma Informed Journey



Appendix 6: Glossary

Adverse childhood experiences (ACEs): The term ACEs was first coined in 1998 by a landmark population study (Felitti et al., 1998) to refer to 10 categories of abuse, neglect and family dysfunction in childhood used to predict a variety of poor adult outcomes. Since the original study was published, there has been widespread debate regarding the approaches used to prevent ACEs. It is also important to note that there are other negative child circumstances, beyond the original 10 listed, that can predict negative adult health outcomes (e.g., low birth weight, childhood disability, bullying and social discrimination). Furthermore, the link between ACEs and poor adult outcomes is not deterministic.

Critical thinking: Consideration of deeply held assumptions and questioning of accepted 'norms' and 'rules', not only the impact of our own roles, but also society's impact on people we work with and our practices.

Intersectionality: A term first coined by American scholar Kimberlé Crenshaw, that asserts that people are often disadvantaged by multiple sources of oppression, such as their race, class, gender, sexual orientation, religion and other categories of identity. Intersectionality theory argues that most sociological theories make the mistake of examining only one variable at a time (e.g., gender oppression or race oppression and so forth). The basic premise is that variables are not isolated but work in groups to create an intersecting or interlocking system of oppression.

Reflection: process of learning from experience and using it to inform future actions. Using reflection in a professional setting helps to develop and improve future practice.

Reflexivity: In contrast to reflection, reflexivity involves more than just recognising the importance of the past. Reflexivity can happen before, during or after events. It involves self-reflection to interrogate our beliefs, values and practices 'before and in action'.

Resilience: The notion of 'bouncing back' (Pooley and Cohen, 2010) or 'Ability to develop positively despite exposure to significant threat, severe adversity, or trauma that typically constitute major assaults on the processes underlying biological and psychological development' (EIF, 2020, p.22). The concept of resilience has been challenged by those who argue that we should take pro-social action to prevent trauma and change inequalities (e.g., poverty, social exclusion and poor housing) rather than mitigating their effects.

Strengths-based (or assets-based) approach: 'explores, in a collaborative way, the entire individuals' abilities and their circumstances rather than making the deficit the focus of the intervention' (Department of Health & Social Care, 2019, p.24).

Supervision: 'An accountable process which supports, assures and develops the knowledge, skills and values of an individual, group or team' (Skills for Care, 2007, p.5).

Case Supervision: 'with workers or groups of workers to enable and support quality practice. A key aspect of this function is reviewing and reflecting on practice issues. This may include reviewing roles and relationships, evaluating the outcomes of the work and maximising opportunities for wider learning' (Skills for Care, 2007, p.5).

Clinical Supervision: 'In some professions and occupations, alternative titles may be used, such as "peer supervision", "developmental supervision", "reflective supervision" or just "supervision", but generally clinical supervision is seen as complementary to, but separate from, managerial supervision, which is about monitoring and appraising the performance of staff. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice' (CQC, 2013).

Continuing Professional Development Supervision ensures workers 'have the relevant skills, knowledge, understanding and attributes to do the job and profess their careers. Constructive feedback and observation in practice should be part of the learning process for workers and supervisors' (Skills for Care, 2007, p.5).
Line management supervision: 'is about accountability for practice and quality of service. This includes managing team resources, delegation and workload management, performance appraisal, duty of care, support and other people-management processes' (Skills for Care, 2007, p.

Trauma: 'Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well being' (SAMH 2014, p.7). Sometimes 'trauma' is subdivided into 'single incident trauma' and 'complex trauma'. The term 'single incident trauma' is used to describe 'one off' events (e.g. a rape, assault or serious accident). On the other hand, complex trauma involves exposure to and the impacts of multiple traumas or trauma that persists over time (e.g. child neglect or domestic abuse).
Secondary trauma: is when another person's experience of trauma starts to affect you.

Trauma Informed Care: This term and way of working originated in healthcare organisations. 'The primary aim of trauma informed care is to increase practitioners' awareness of how trauma negatively impacts children and adults and reduce practices that might inadvertently re-traumatise clients. Trauma informed care also aims to increase practitioners' sensitivity so that users perceive them as trustworthy and feel safe to disclose traumatic experiences' (EIF, 2020, p.22).

Trauma Informed Approaches: Over the years, the terminology of trauma informed approaches has evolved, reflecting the wider relevance of trauma informed ways of working beyond healthcare services. Trauma informed approaches is a wider umbrella term for integrating understanding of trauma and its potential impact into policies, procedures and practices in schools, social care, the criminal justice system and other frontline services.

Trauma Informed Practices: These are about applying trauma informed knowledge in our daily work, how we conduct ourselves and the decisions we make.

Vicarious trauma: This can occur when a professional's perception of the world becomes distorted as a result of their area of work. Care' typically refers to the provision of what is necessary for health, welfare, safety and protection. An 'approach' is about a way of dealing with a problem or situation. 'Practice' is about the application of knowledge about trauma.

Trauma Informed Care, Approaches and Practices: Often the phrases trauma informed care, trauma informed approaches and trauma informed practice are used interchangeably, although there are subtle differences in their meanings.

Appendix 7: References

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If you would like to find out more information about the work of the Children & Young People's Trauma Informed Care Programme please get in touch.

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