Trauma Informed Community of Action

A summary for commissioners, services, practitioners and people with lived experience of trauma

Developing real world system capability in trauma informed care: learning from good practice

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Northern England
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Contents

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This is a very important and potentially game-changing report. I recommend it to anyone interested in or who has experience of trauma and its potential effect on the mental health and wellbeing of individuals and local communities. My own experience of mental ill health, over two decades, leads me to say with confidence that this trauma informed framework is the biggest thing to hit mental health and care services since the introduction of anti-psychotic medications and CBT. What is most exciting though is that the principles are very accessible, starting with one simple question: what's happened to you? Read it and be inspired.

John Lawlor OBE, Chief Executive, Cumbria Northumberland Tyne and Wear NHS Foundation Trust

"Child maltreatment is a leading cause of health inequality, with the socioeconomically disadvantaged more at risk, perpetuating social injustice. Though it is a priority in most countries of the WHO European Region, few devote adequate resources and attention to its prevention."

WHO (2013

The nature of the task

A Trauma Informed Approach is a system-wide approach to addressing the adversity that underlies much suffering and its impact on relationships. It is a system that is guided by knowledge of what is needed for healing from emotional and psychological wounds. It has relevance to everyone in the system through the promotion of safe, open trusting alliances. As such it works to create psychologically healthy and rewarding places of work that can adequately address the needs of people who come for help. It also focuses its efforts to prevent harm for people using the service, including that harm caused by services in their efforts to manage risk.

People who experience mental health problems have often been seen as presenting to services with a 'problem' within them that needs to be 'fixed' or managed. Our current approach aims for services to be delivered by people (staff) with an expertise that they offer to help to address these 'problems'. Importantly, staff delivering the service are not perceived as having problems to be 'fixed' or managed themselves.

A shift to a trauma informed lens requires everyone in the service to see a person in distress as reacting to the context of their experiences, and understanding that everyone in a service (staff and people using services) has unique and important wisdom about their own needs. It also requires acknowledgement that people who offer the help may also have been subject to traumatic contexts. Routes to healing would pay particular attention to physical and emotional safety; trust, clarity and boundaries; choices and control over what happens; collaboration and inclusivity; skills building and empowerment (Fallot and Harris, 2001).

Much work has been undertaken in the USA already: "Trauma Informed Care is a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization" (SAMHSA, 2014).

As UK services move to find and develop ways of embedding trauma informed practices, ways are needed of learning from each other's efforts to enable translation of the principles into effective action. The concept of practising in a way that is trauma informed, or delivering services within this value base, is beginning to gain momentum in the UK and is referenced as the direction of travel within the **NHS Long Term Plan for England.** It is also the focus of a national public health initiative in Wales, and in Scotland there is commitment to becoming a trauma informed nation. Locally, many passionate people are making efforts towards such trauma informed ideals in their own services too. The user movement and voices of people with lived experience of trauma and mental health issues has been pivotal in creating in the impetus. As efforts are made locally towards such changes in services, such collaboration and user leadership will be vital in mitigating against concerns that the ideals become co-opted by professionals and genuine co-production is compromised.

"We hope the NHS will look at the lack of provision of trauma-specific and focused support which address the root cause of these mental health problems."

Gabrielle Shaw, CEO of National Association for People Abused as Children (Januarv 2017)

The Northern England Clinical Networks and the North East and North Cumbria Academic Health Science Network hosted an event in Durham in March 2019 aimed at capturing the experience and wisdom of those innovators and early adopters in the UK. They worked with support from Northumbria University, Tees, Esk and Wear Valleys NHS Foundation Trust, and John Lawlor, Chair of the Mental Health Steering Group of the Integrated Care System for the North East and North Cumbria, to co-create a community, resources and a summary document to guide further developments. It was a privilege to hear about such great examples from people brave enough to be noticing and addressing a stark reality about the nature of mental health and our historical response to it. This document presents the learning from this summit with additional revision following an event in July 2019. It can be used as the basis for local discussions, including in England as local health and care systems draw up plans to respond to the NHS Long Term Plan challenge to create a new community-based mental health offer incorporating TIC. It will be used as an important reference point as we establish an England-wide national community of practice in TIC to support planning and implementation, funded by NHS England and NHS Improvement.

Key goals of summit

- Use examples from the lived experience of people with trauma histories and people delivering services to extract important implementation themes.
- Integrate these with expert opinion, scientific research and practice-based experience at the event in March 2019.
- Outline drivers for change.
- Develop a summary from the emerging principles and standards setting out the core conditions for trauma informed services.
- Evaluate the usefulness of the Open Narrative Enquiry methodology to co-produce meaningful emergent themes from numerous first-hand experiences.
- Agree actions for developing trauma informed practice further.
- Collate written and spoken narratives about implementing trauma informed ideas.
- Ensure the guide is available for use by anyone wanting to consider ways to develop methods of supporting each other and communities through psychologically traumatic experiences or significant adversity.

Psychologically traumatic life experiences have potential to impact on key elements of mental health:

- Wellbeing and emotions,
- perception and thinking,
- relationships,
- physical health and functioning.

Psychological trauma can result from a range of experiences which may include:

- actual physical injury, fear of harm or acute pain,
- personal loss or bereavement,
- situations that exclude someone from other people, their culture or home,
- relationships which have inflicted harm,
- an absence of care or neglect of basic needs
- witnessing any of these either directly or indirectly through people close to us or the media or work.

Not everyone who has mental health problems identifies themselves as someone with a trauma history, although few would say that adversity does not accompany their mental health issues. Experiencing serious adversity does not always result in a person having mental health difficulties and, in fact, adversity can sometimes provoke personal growth. Using the term 'trauma' is in itself loaded with personal meaning and possible stigma and shame. Often trauma is defined quite narrowly as emerging only from risk to life and consisting of repeated intrusions or reliving of the event into the mind and associated with avoidance of cues linked with what happened. Such constrained definitions don't seek to include and appreciate the unique context in which each of us finds ourselves. Being complex social animals, we adjust to a diverse range of adverse experiences in diverse ways, hence the person-centred focus of 'trauma informed' approaches.

There are several current drivers for such a change:

1. Views of people with lived experience of trauma and mental health services:

There is a growing service user movement that is articulating its dissatisfaction with both what is delivered by mental health providers and about the way it is delivered. Services that are led by people who have previously used services are gaining increasing traction in conversations about needs-led, community-based and personalised responses to mental health problems – though significant concerns remain about their sustainability – and can address some of the concerns around powerlessness and stigmatisation. It is now good practice to have contributions from people who have used services at various levels of service delivery and design, which is enabling new models to be successfully supported.

"During the last twenty-five years in secondary mental health services, I have had little opportunity to have my story heard or the support to make sense of what happened and is still happening to me…This is the story of a non-person, of a walking diagnosis, of a set of 'symptoms'…. Someone who has been on a cocktail of toxic drugs with no informed consent…The childhood abuse talked about. I wanted to talk about it but no-one ever asked me the right questions, so I stayed silent… I hear rumours of something called Trauma Informed Care…. it seems this is the closest thing to care and compassion I might expect" Gary H (2018)

2. The evidence base:

Adverse childhood experiences (ACEs) increase the risk of an individual experiencing a range of mental health issues, including those leading to suicide attempts and voice hearing as an adult. It can contribute to poor physical health such as diabetes and heart disease and a significantly shorter life expectancy. It is associated with increased likelihood of being involved in violence and assaults. It is also linked to addictions and difficulties functioning in work or at home (Ashton et al, 2016). It can increase the population risk of severe mental health problems, such as psychosis, by approximately one third (Varese et al, 2012). It is important to acknowledge that adverse events are possible throughout a person's lifespan and a single event in adulthood can create problems that may match diagnostic criteria for Post-Traumatic Stress Disorder (PTSD) according to the DSM-V/ ICD-10. Evidence from the USA shows that trauma informed approaches can be effective in creating community resilience and promoting mental health recovery in different ways for those who come to mental health services for help.

One such example would be routine enquiry about trauma in primary care:

"When the use of comprehensive medical history, including routine inquiry into traumatic life experiences in the developmental years, ultimately penetrates clinical primary care, it may be one of the major public health advances of our time." Felitti and Anda (2014)

3. World view:

Trauma informed care may certainly be about emphasising the role of our social and environmental context in the development of a person's or community's mental health. However, it is not about negating any role of biology or genes. It is the relative emphasis between the two factors which leads to certain recovery routes being valued more than others. For example, the large number of prescriptions for psychiatric medications in the UK reflects one approach to seeking to manage distress based on biological hypotheses. A trauma lens may therefore lead to additional options that emphasise ways to create safer and better-connected communities as well as allowing individuals to gain greater personal control and self-worth. The first step is to reassess our working models of mental health, which may involve facing some challenging realities.

"The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud."
Judith Herman (1992)

4. Impact of uninformed care:

Disturbingly, there is a concern that some kinds of contact with mental health services causes more traumatisation to some people, because the prevailing culture includes experiences that can threaten trust or safety. Such harms are called iatrogenic because they are caused by the solution to another problem. This concept of iatrogenic harm does not just apply to potential physical harm from some psychoactive medications, or the impact of being restrained or secluded but also the psychological impact of the way distress is managed. The impact of limited safety is felt by patients and staff.

Mersey Care NHS Foundation Trust has successfully reduced its use of control and restraint through a program of change called 'No Force First'. They used a collaborative approach that valued the personal stories of people who had been restrained, for which one of their service users won an MBE. The outcomes included an improvement in staff absence.

5. Care of staff:

There are many sources of burnout and trauma for staff working in mental health too. We know that working with people in severe distress can also have an impact on staff, who have their own human responses to such extreme distress. The nature of abuse that service users have been subjected to may be difficult to listen to. In some settings, staff are at risk of being involved in violent incidents. Staff also bring with them their own life experiences and adversity from outside of work. A trauma informed service could therefore 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.

The Blue Light campaign led by the MIND charity is an example of an attempt to support first responders and emergency personnel via training and workplace ambassadors. Improvements were noted in mental health awareness, wellbeing and resilience. There was also a notable change in workplace culture - it became acceptable to be more open about what each person felt they needed.

6. National policy:

The new **NHS Long Term Plan** calls for trauma informed practice to be a core component of service developments. The **Community Mental Health Framework for Adults and Older Adults** references the need for services to deliver trauma informed care and the Blackpool Better Start Partnership has been commissioned by NHS England to scope trauma informed practice in perinatal and maternity services.

We are now at a tipping point for action. Whilst the motivation to develop services that are trauma informed is high, the knowledge about how to do it is still developing in practice. Some services, however, responded early to the Department of Health call for routine enquiry of abuse over a decade ago. For example, the Early Intervention in Psychosis Service in Lancashire became a national demonstration site for their work in developing trauma informed access to psychological therapies with a group of service users that traditionally experienced poor access.

Psychologically informed care is already established in many services, often those groups led by people with their own experiences of adversity, such as charities working with homeless people or women who have experienced domestic abuse. The Centre for Mental Health has produced a recent directory of such service examples.
(Wilton & Wilson, 2019)

7. Major incident preparedness:

Trauma informed care principles can help better equip the population to respond to major incidents. Major incidents may involve a threat to the safety of large numbers of people and require the deployment of a large number of emergency personnel. In some cases there are large numbers of casualties caused by events such as large-scale flooding, rail crashes, or terrorist attacks. The availability of specialist trauma therapists in services ensures there is more capacity to address the likely increase in post-traumatic stress disorder after such an event. However, in addition, having trauma informed systems in place will also help ensure there is prior awareness about the psychological impact of such events, how awareness of how to support yourself or others through such events, better understanding of how people respond to and process these events, and how to spot signs you or someone else may need specialist help. In this way, trauma informed systems support community resilience.

After the Grenfell fire, a free NHS therapy service was set up and provided by the Central and North West London NHS Foundation Trust. It offers a wide range of therapies and self-referral is simple. It has formed an important response to the aftermath. www.grenfellwellbeing.com

Methodology for developing this report

The themes presented in this report represent the work of 85 participants at the national trauma summit in March 2019 using a method designed for collating themes from numerous examples of good practice. The invited attendees were made up of people with lived experience of trauma and clinicians, stakeholders, researchers, and policy makers from around the UK, as indicated on this map. They were invited on the basis of their experience in implementing trauma informed principles.

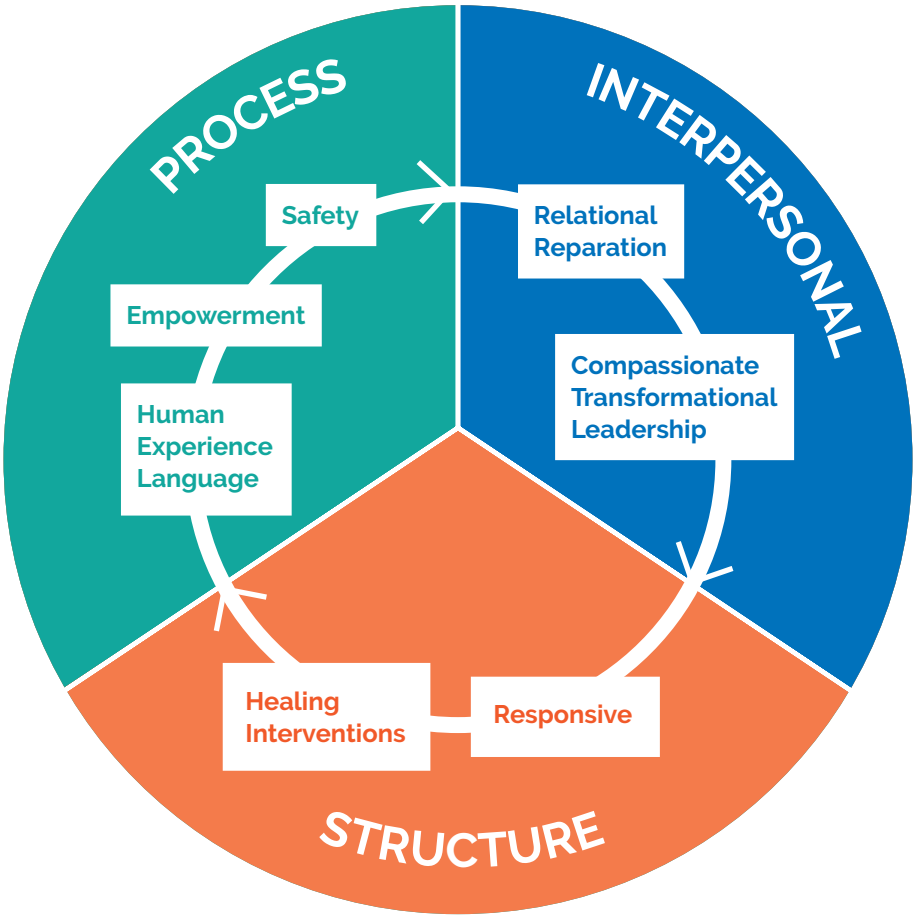
The process of engagement was developed between Petia Sice at Northumbria University, and Angela Kennedy at Tees, Esk and Wear Valleys NHS Foundation Trust. Open Narrative Enquiry (ONE) is a group-based method of extracting themes within a short timescale from many personal experiences and observations. It is a form of qualitative research based on Socratic dialogue (Bennett, Anderson and Sice, 2015) and world café (Jorgensen and Steier 2013) methodologies. The process asks for participants to prepare a narrative in advance according to a set structure that prompts their reflections and emotional memories but importantly asks participants to extract the actions and behaviours that were critical for success in their real-world example. Appreciative enquiry enables us to see what works well so we can do more of that.

Methodology for developing this report

Group work at the summit was used to extract key points from discussions, which are identified and then themed and prioritised. Groups of people then commented on and developed each other's themes until a consensus is reached. The method addresses issues of power by giving all examples equal weight and all identified ingredients for success are included in the resulting consensus. In addition, the groups work on random narratives rather than their own and then on the themes produced by other tables. The refinement of the themes continues around groups until consensus is reached. These themes created the framework presented in the diagram shown below.

It is good practice in qualitative methodology to review and refine the themes and descriptions with participants to ensure it represents their narratives. This was done at a follow-up event in July 2019. The themes that evolved from the narratives are detailed below. A visual model is presented and each theme then described. Themes are illustrated with a couple of examples from the anonymous examples of good practice from which the theme emerged and also by the practice points captured by the submitted examples.

A trauma informed framework for change



These standards relate to the way that care is delivered.

A1. Safety:

Trauma Informed Care needs the explicit promotion of environments, communities and practices which are physically, psychologically and socially safe for people who use services and staff. The conventional understanding of safety as the absence of physical risk of harm, which is often managed by other people or environments. Such safety often comes at a cost. Physical restraints or loss of choice are not always benign in their impact. Not everyone will become traumatised by being in an unsafe context, but an unsafe context does increase the risk of someone becoming traumatised. Safety involves being seen as of worth, with valid experience and opinion, safe from physical harm from others and feeling like one has a valid place in a group. Healing cannot begin until a person experiences safety in the present moment. Therefore, an emphasis on safety from both a user and staff perspective is not only a critical basis for the start of any healing, but it is also preventative for harms to both service users and staff by prevailing practices. It is certainly not envisaged that safety can ever be absolute and harm minimisation attempts to mitigate long term risks by short term empowerment are important. Safety in the long run is rarely achieved by restricting freedoms.

Examples:

One forensic service has badged its development towards safer cultures and trauma informed care as "Nurturing Safer Futures". By using resources differently and with no extra investment, they created more reflective spaces, used a trauma lens in treatment planning and engagement. This was supported by a move to collective leadership. Service improvements have been significantly noted by regulators.

Another unit noticed that new people during admission often ended up restrained quickly. Noticing that they had arrived after custody tired, hungry and expecting a cigarette but not being allowed one, staff changed the intake procedure. Handcuffs were removed more quickly, and the person offered something to eat and drink and asked, "You have had a hard day. What do you need from us?". Use of restraint at intake reduced to zero.

Practice points: Trauma informed safety

- A reflective learning culture around safety is required, including learning from serious incidents as well as positive outcomes.
- A trauma informed approach to harm minimisation towards self and others is needed.
- Harm to long term recovery and healing from current safety plans need to be considered as well as physical safety from harm.
- The building of trust and ensuring dignity and privacy are paramount to psychological safety.
- Social safeness, where attachment security is expressed in the connectedness within groups, is an expression of inherent value and belonging, promotes productivity and buffers the impact of work stress.
- Services require 'integrity', where they have the capacity to deliver healing interventions and then communicate their accessibility to create hope.
- Safe contexts also enable difference to be tolerated, disagreement to be openly managed, facilitate cooperation and allow for risk taking that focuses on what people can do rather than what they can't.
- Proactive planning around safety is desirable, including how addressing the underlying issues, can reduce potential harm to others and self and how collective reflective learning can help over time.
- Staff can be proactive around safety if they feel they are trusted by their employers.
- Risks need to be understood as connected to people's lives and not just an expression of illness or behaviour. Underlying issues need addressed for risks to be minimised.

These standards relate to the way that care is delivered.

A2. Human Experience Language:

The way we describe and talk about services and mental health reflects and drives culture within services and in wider communities. Current services can be accused of labelling people and jargonising human experience. The professionalization of language around distress, which has emerged from both psychiatric and psychological models, can feel reductionistic, can feel imposed and can exclude and invalidate first person understandings. Ways of understanding and discussing mental health that uses everyday language would be of value. This will promote a more equal and inclusive discussion around mental health. It will reduce stigma. It will allow for multiple valid opinions. It will open up understandings and potential ways forward. Such language would frame the meaning of mental distress within the socio-cultural context in which the it evolved and how it comes to be expressed. The workgroups felt that a broader narrative than PTSD needed to be heard from the submitted case examples. Issues of complexity needed to be included in the dialogue, which would then inform the kind of services required. The notion of trauma informed services cannot be reduced to addressing the diagnosis of PTSD.

Examples:

"The term 'treatment resistant patient' could be rephrased as 'our treatment is not working, what we can do to help them maintain hope?'"

"I sit alongside as far as possible and listen"

One person's family member had long struggled with voices. A new practitioner did not discuss labelling the symptoms and chose to avoid a treatment approach that emphasised getting rid of voices. Through listening to the voice hearer's perspective of their experiences, trust and emotional safety were built which enabled the person to discuss their childhood experiences that had led to them hearing voices for the first time.

Practice points: Trauma informed language

- Presentations to services by people with mental health problems need to be approached as potentially meaningful reactions to current or historical circumstances.
- 'Symptoms' and 'risks' are therefore understandable in the wider context of people's lives.
- There is greater clarity and screening for physical health issues that may underlie some mental health presentations. E.g. neurologically based psychosis, autism, dementia, thyroid problems can all produce mental health symptoms but may require medical diagnosis and intervention. A trauma informed approach would promote thorough assessment of all causes.
- Experiences that are currently viewed as 'problems' could be reframed to emphasise the survival value of many trauma related reactions. For example, dissociation is a logical way for the mind to cope with severe trauma, because it allows for it to be compartmentalised and avoided so that the person can in many ways continue to function.
- A trauma informed culture seeks to allow for multiple narratives around distress, and includes some gender specificity and cultural context e.g. responses to racism.
- Service delivery options need to include responses suitable for Complex Type II (ongoing/ multiple experiences) trauma, which are different from type I (single incident) trauma.
- Staff and services users should be supported to make meaning from accounts of distress in a helpful and evolving way as the basis of care interactions.
- Understanding the way that trauma impacts on the sense of self and the way that experiences manifest in the body can guide services to address the actual level of impact that trauma can cause at an earlier stage. This may include early screening for dissociation.
- Services should understand that staff bring with them their own experiences that influence their approach and a trauma informed lens is applicable for staff too. There is a theme of common humanity that should underpin the organisational culture in services.

These standards relate to the way that care is delivered.

A3. Empowerment:

The process of becoming more confidently in control of one's life is an important element of healing and recovery. A key aspect of much traumatisation is a feeling of powerlessness: events have happened beyond a person's control, the impact is not of their choosing, and they may not feel they can control their thoughts or emotions. Services then need to be supportive of regaining a sense of control over one's mind, reactions and life. This would include the choices over treatment in services. Empowerment is the process by which confidence is gained through owning efforts towards change and feeling the outcome is of value to you and a result of your own choices. Empowerment relates to staff too so that they are motivated towards service change and so that they can remain a sense of wellbeing about work.

Examples:

Young people in an area with a population experiencing higher than average poor sexual and reproductive health found it difficult to disclose safeguarding issues face to face. The young people helped design an online service to promote self-assessment and management of their sexual health by paying attention to potential triggers for those with trauma, such a smear tests and genital examinations. This empowered young people to take control over their sexual health and behaviours. Safeguarding questions were completed online as part of the assessment which flagged those in need of signposting to a clinical support helpline. All safeguarding issues are discussed in team peer review meetings.

One service was delivering training on self-harm but decided to have this delivered to staff by people who self-harm rather than other staff. This shows a very different emphasis of power.

Practice points: Creating empowered individuals and communities

- Empowerment requires collaboration, co-production and co-design with people with lived experience of trauma that extends across care to include support for service planning, teaching, resource development, peer support, interventions, writing of policy, service leadership, business prioritisation, governance and evaluation.
- It requires explicit mitigation of the role of power differences in relationships that could re-traumatise people or limit their sense of control.
- Services should allow creative innovation by all stakeholders that promotes choices and flexibility in services enabling power to be distributed fairly.
- Empowerment would start with an organisational approach to trauma informed transformation which has been co-produced with service users who have a range of views.
- Direct peer support in all clinical services would give hope for recovery, minimise stigma and allow for lived experience voices in staff.
- Shared decision making and genuine co-production in developing and agreeing personalised care and support plans.
- Acknowledgement of power dynamics at play between staff, between professional groups and between staff and services users is critical. Understanding how people may experience power dynamics and how this can be balanced needs to be considered.

These standards relate to the way that services are organised.

B1. Healing Interventions:

Services need to deliver a range of trauma informed and trauma specific interventions that address the multi-level impact of trauma on wellbeing and functioning. Trauma specific interventions are those that have been devised to specifically target traumatisation. Such interventions often require specialist staff and training and may include things such as Eye Movement and Desensitisation Reprocessing (EMDR), which processes the emotions and cognitions attached to distressing memories so that the memories no longer make the person react as if they were still under threat. Trauma informed interventions might be any level of support that is delivered in a way that appreciates the impact of trauma and minimises any further harm. Pathways need to be flexible to enable choices and interventions based on unique personal need.

Examples:

A birth reflections service trained whole teams of midwives. This training enabled staff to have confidence in routinely enquiring about trauma and supported them to ensure the impact of birth trauma would not go unnoticed by services and be left unaddressed.

Children in a refugee camp took part in music making over a period of time which resulted in them becoming calmer and more engaged, so they could study better and begin to express joy again even whilst living under difficult circumstances.

Practice points: Interventions that heal the impact of trauma

- Being trauma informed in delivery needs availability of a range of interventions relating specifically to trauma recovery, matched to need, timely and available for long enough to make a difference.
- Support for creating the conditions where healing can begin is necessary, e.g. help with housing, income or getting out of an abusive relationship.
- Pathways to healing should be flexible and bespoke, and include approaches in addition to 'talking', with a focus on bodily wellbeing.
- Specialist therapies, including but not limited to EMDR and other evidence-based NICE-recommended therapies, need to be available, especially for those with complex traumatisation or dissociation.
- Some innovation and expansion of the evidence base may be useful over time.
- Sensitive single routine enquiry, documentation and sharing of the trauma context with consent help create continuity for the healing journey.
- More interventions need to be pro-active and preventative rather than reactive after severe crises.
- Shared decision making of the interventions offered is critical to success, particularly around medication.
- Such interventions need to be delivered in a co-ordinated way as part of a coherent plan where staff and agencies have a shared understanding.

These standards relate to the way that services are organised.

B2. Responsive System Design:

Multi-agency partnerships and other models of integrated provision need to be commissioned so that access to services and flow through and between them is seamless and timely, especially for stigmatised groups. Without this people cannot access help for their needs or suffer iatrogenic harm from this struggle and service gaps.

Examples:

One geographical area invested in EMDR therapy training across its primary care, secondary care mental health and physical health care staff including specialties other than adults. A strategic focus enabled local partners to draw on centralised funding and establish peer supervision, while special interest groups supported EMDR delivery.

Self-harm rates and associated costs in a prison 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, including via the building of a new sensory room.

Practice points: Designing trauma informed system capabilities

- Funding from services needs to support trauma informed practice as core business and this approach needs to be sustained.
- Trauma informed outcomes are monitored, which would be decided by people with lived experience. This needs to be culturally sensitive.
- Dedicated resources are needed for an adequately skilled and supported trauma informed workforce with sufficient staffing to maintain productivity and meaningfulness of the work.
- Commissioning contracts need to build in time for trauma informed skills development, reflective supervision and indirect work.
- A range of trauma informed and trauma specific services need offered, including those delivered and run by people with lived experience of trauma.
- Clear pathways are needed so people can access the services that meet their needs. A whole systems approach to managing population mental health needs will be required so that people with more complexity do have services available that are skilled to meet their needs. Strict access criteria are not suitable for all services.

C. Intrapersonal standards

These standards indicate the kinds of relationships that make a service trauma informed.
C1. Compassionate and Transformational Leadership:

Authentic, mindful, compassionate leadership that is committed to prioritising wellbeing and safety across the system is required to set an example and inspire collective action. This approach to leadership needs to apply to all levels: the wider system across health, care and other public agencies, particular mental health services, or care pathways and by members of a multi-disciplinary team co-developing an individual's care and support plan with them.

Examples:

"Focusing on engagement and process, rather than the end result".

A staff member decided to speak to a senior manager about a difficult work issue. The manager acknowledged the distress the member of staff was experiencing and found a practical solution to make the person feel safe. This led to the person being able to function well in a different role and an increased the sense of trust and confidence in the manager.

Practice points: Trauma informed leadership

- Systems of care need a capability to manage demand in a way that promotes helpful trauma informed outcomes for people that use the service.
- Leadership must support the motivation and job satisfaction of staff to deliver trauma informed practices.
- Supervision is seen as a vital space for reflection and learning but perhaps new models of reflective spaces could be utilised where the supervisor may not necessarily be more senior and may be an expert by experience.
- Having a culture where it is safe to raise and resolve difficulties in the moment is critical and trust would play out in the way leaders hold such a space and facilitate remedial action without micromanaging.
- Leaders also need to focus on a transparent and destigmatising culture that acknowledges that adversity can limit all of us. Modelling trauma informed values by examples is critical.
- Leaders at all levels have a responsibility through their influence to explicitly support trauma informed developments and integrate it into all their areas of influence.

These standards indicate the kinds of relationships that make a service trauma informed.

C2. Relational Reparation:

The way that people are related to creates a context where healing takes place. As social animals it is through a striving towards connectedness, clear boundaries, attuned relationships and social safeness that we learn about safety and inherent worth. There is a particular need to focus on human therapeutic relationships based on trust and collaboration when people are suffering because their trust or value has been breached. Whilst it is inevitable that our human nature makes can make encounters with others feel uncomfortable or dangerous, creating a motivation and intention towards repair through compassion helps keep the goal in mind. Learning respect for difference and finding ways of maintaining respect after difficult encounters is the basis of a trauma informed model.

Examples:

One woman on probation was helped to find a new home after she had been terrorised as a hostage in her previous home. Staff helped her to seek police protection from her abuser and supported her in ending her illicit drug use. The client re-established a relationship with her son and completed some education. One person described being admitted to an emergency department with chest pains but in a fugue state and mute. The staff accepted her written communications with kindness and respect. They showed curiosity to learn about the nature of her difficulty, which speeded up her recovery and eased her sense of isolation.

A peer-led crisis service in which services are delivered by people who themselves have had similar crises themselves.

Practice points: Trauma informed relationships

- Resilience against adversity is based on collaborative and positive working alliances between individuals, teams, families, communities and agencies.
- The nature of the relationships between staff; between departments and agencies; and between staff and people is critical in preventing iatrogenic harm and finding a route towards individualised progress on a person's own terms
- Being trauma informed requires an acknowledgement that both individual and system resilience is influenced by social contexts.
- Values of compassion, wisdom and respect can be communicated nonverbally in interactions, even when the encounters are challenging.
- Placing a central value on the role of relationships is supported by reflective practice and, importantly, actions that seek to repair breaches in respect or trust and the capacity to think non-critically about the motivations behind the actions of others.
- Policies and targets could include a focus on 'patient' and staff experience. Such a social emphasis supports staff to feel safe and perform well without becoming burned out or experiencing vicarious trauma.

"The core experience of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivors and the creation of new connections"
Judith Herman (1992)

Participants were asked what activities would support the development of trauma informed practices. The following themes capture their ideas and what action a potential community of practice could do to begin addressing the ideas. These are not intended as must dos for services but rather tideas for further discussion and potential collaboration:

Recommendations from participants

- Create an open access national framework to guide service developments and good practice.
- Work with NHS England and NHS Improvement to promote trauma informed practice expectations with a particular emphasis on local implementation of the **Community Mental Health Framework** and access to services indicated by both the **NHS Long Term Plan** and **NHS England and NHS Improvement's existing national programme** for the development of psychological therapies.
- Launch a platform for collating and sharing information, news, ideas and narratives.
- Ensure greater collaboration between groups and services with similar values (including those outside NHS).
- Promote training for senior leaders.
- Establish locality/ speciality working groups and partnerships.
- Encourage mental health service providers to review their internal policies against trauma informed principles.
- A continued nationally mandated direction from government that encourages co-designed local solutions.
- Support improved access to specialist trauma related interventions and psychological therapies.
- Further engage a range of lived experience perspectives on trauma informed care and its implementation.
- Develop a growing evidence base for trauma informed care and its associated system change.

Issues, gaps and concerns

Participants were asked to identify potential barriers and worries to productive trauma informed care that may need to be addressed:

- Addressing blockers/laggards in the system.
- Engagement from all mental health professions, including psychiatrists.
- Carers and families also need knowledge and therapeutic work relating to their trauma histories not only signposting.
- Staff viewing the needs of everyone equitably and providing care free of discrimination.
- Increased availability of psychological therapies for complex trauma. Refine our understanding of trauma informed services over time: Delineate any limitations of trauma informed care and define its essential distinguishing components.
- Promote and develop a model of 'resilience' that does not blame those who are unwell for not being 'resilient' enough to overcome an issue or cope.
- Statutory professional training and continued professional development that is health or social care related (midwifery, paramedics, nurses, etc.) needs to be trauma informed.

Final remarks

This document contributes to our evolving understanding of trauma informed practice in the UK. The themes represent the factors that together contributed to the success of good practice examples. Whilst some factors may not seem specific to trauma, each factor was important to the delivery of trauma informed care and therefore are important cultural factors. Opposing cultures to the emergent themes would not allow for the more obvious trauma work to be delivered in ways that worked. Such cultures create safe and flexible places of work for all who participate in it.

Much work is needed to implement and refine the themes and also a need to evidence which aspects have most value. Different settings will require different practices and hence trauma informed care is not a fixed and universal endpoint. It is a multi-layered concept that needs to reflect complexity and as such our standards and evaluations need to adapt to the complexity of the different settings in which relevant principles are applicable.

These themes compare favourably to many of the other trauma informed frameworks that have originated in other countries. However, as trauma informed practice in the UK is still a work in progress, the narratives (and hence the themes) may be limited by the somewhat limited real-world experience that we have had so far. However, further efforts to promote mental wellbeing and community cohesiveness can be developed from such learning. As the NHS Long Term Plan in England drives a greater emphasis on trauma-informed care in community mental health models in England over the next 5 years, we will generate even more 'homegrown' learning along with continued efforts in the other devolved administrations. The new **Community Mental Health Framework** hopefully will provide a clear basis for clear system level commissioning for this approach across the NHS in England.

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Serious Media gathered the wisdom of participants on film.

Side Gallery in Newcastle offered some images from Jim Mortram, photographer, as a backdrop. https://smalltowninertia.co.uk/

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Appreciations from the March 2019 Event

Trauma Informed Community of Action

Academic Health Science Network North East and North Cumbria

NHS Northern England Clinical Networks