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Developing trauma informed practice in Northern Ireland: Health and mental health care systems

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Background

In September 2018, the Safeguarding Board Northern Ireland (SBNI) commissioned a rapid evidence assessment (REA) to facilitate and support the adoption of Trauma informed practice across health, social care, justice, education, and community and voluntary systems in NI. The REA sought, primarily, to explore the evidence pertaining to organisational change processes required to implement Trauma informed care at a whole systems level, and identify some of the complexities of implementing Trauma informed processes and associated evidence of effectiveness. A systematic search of the academic literature identified more than seventy papers reporting on evaluations of organisation wide Trauma informed implementation across a range of sectors and settings. This was supplemented by a search of on-line publications, which was used to identify Trauma informed international and UK policy and practice developments not published in academic journals.

This paper provides an overview of the principles of Trauma informed care, describing how service user experiences of adversity and/or trauma relate to health care systems and outlining international and national policy and practice developments in creating more Trauma informed healthcare systems. In discussing the findings from the evidence review and wider literature, consideration is given to the extent to which there is evidence that TIC implementation has led to improved outcomes for service users across systems and settings, as well as findings and examples from the healthcare specific literature. Consideration is also given to the ways in which individual initiatives have incorporated change across the key implementation domains of workforce development, Trauma informed services and organisational change, as well as the associated evidence of effectiveness.

This paper is part of a suite of papers which focus on Trauma informed care in the child welfare system, the healthcare system, the justice and the education system. It should be read in conjunction with 'Developing Trauma informed practice in Northern Ireland – Key Messages', which provides a more detailed summary of the key review findings across multiple systems and settings.

What is Trauma informed Care?

Trauma informed care (TIC) is a whole system organisational change process which seeks to embed theoretically coherent models of practice across diverse settings and roles, including child welfare, family support, justice, mental health and education. It emerged from the findings of the seminal Adverse Childhood Experiences (ACE) study in the US (Felitti et al., 1998) with subsequent international and UK research establishing the same, strong graded relationship between the number of childhood adversities experienced (inclusive of physical, sexual and emotional abuse; neglect; and household adversity), and a wide range of negative outcomes across multiple domains over the life course (Anda et al., 2006; Anda et al., 2010; Bellis et al., 2015: Hughes et al., 2017; Van der Kolk et al., 2005). In recognising the impact of childhood adversity on child and adult outcomes, Trauma informed services strive to build trustworthy collaborative relationships with children and the important adults in their lives, as well as improve consistency and communication across linked organisations and sectors, with the aim of mitigating the impact of adversity by supporting and enhancing child and family capacity for resilience and recovery, and reducing organisational practices that may inadvertently exacerbate the detrimental effects of severe adversity and constrain engagement. Although most widely implemented in the USA, TIC is gaining momentum as a comprehensive practice framework across the UK, Europe, Australia and New Zealand with a growing body of context-specific implementation guidance and associated evaluation generating some evidence of positive effect.

Understanding and defining Childhood Adversity, Trauma and Resilience

Adverse Childhood Experiences

While facing distressing experiences in childhood is common and normal, such as feeling stressed before exams or starting a new school, some children and young people grow up in environments or have experiences which are more emotionally distressing or difficult. These can be potentially traumatic and can have a long-lasting impact on their development, health and wellbeing. Such experiences include sexual and physical abuse and neglect within their home or community, the loss of a caregiver or sibling, and taking on adult responsibilities. These experiences can be exacerbated by wider social conditions and circumstances, such as poverty or discrimination on the basis of race, culture, gender or sexual identity. ACEs have been defined in a range of ways, depending on research foci. The following recent definition aims to expand more restrictive conventional definitions:

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust and bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.

Adaptations represent children and young people's attempts to survive in their immediate environment (including family, peer group, schools and local community), finding ways of mitigating or tolerating the adversity by using the environmental, social and psychological resources available to them, establishing a sense of safety or control, making sense of the experiences they have had, the community or family that they are growing up in and the identity they are forming (Bush, 2018, p.28).

Childhood Trauma There is considerable overlap in the terms 'adverse childhood experiences' and 'childhood trauma' which are often used interchangeably (Bush, 2018). The Substance Misuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services, moves beyond traditional trauma-related psychiatric diagnoses in its definition of trauma which has been adopted internationally by organisations and systems interested in transforming service delivery to better meet the needs of those who have experienced childhood adversity:

> Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and 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, 2014 p.7).

It is recognised that while children and young people who experience childhood adversity and trauma are negatively impacted by their experiences, not all will result in enduring mental health conditions or necessarily lead to a trauma-related diagnoses. This report uses the terms 'adversity and trauma' interchangeably to encompass this broader range of experiences and effects, and recognises that many of the risky and challenging behaviours displayed by children and young people in the context of adversity represent creative adjustments or adaptations to their circumstances and are attempts (out of their awareness) to survive, manage and make sense of their experiences.

Resilience However, it is important to remember that the effects of adverse childhood and traumatic experiences are unique to the individual and are mediated by a range of protective factors, which help children and young people develop resilience and manage their experiences, mitigating some of the worst effects of adversity and trauma. Important protective factors for children and young people include supportive relationships with caregivers, peers and extended networks. Resilience is recognised as not just a matter of individual traits and capabilities, but rather the child's access to a supportive network, raising the important challenge of how services engage and maximise the resources available to children within their informal and formal networks:

> [R]esilience is not, and should not, be viewed as an issue of individual resources and capabilities. Resilience arises through children's interactions with their social and physical ecologies, from families, through to schools and neighbourhoods. Scaffolding child development by supporting families, building healthy and happy school environments and communities, and addressing social inequalities in access to resources is crucial for enabling vulnerable children exposed to adversity to navigate their way to success. Resilience therefore depends on the structures and social policies that determine availability and access to resources (Bowes, 2018, p.89).

What are the Core Principles of Adversity/ Trauma informed Care?

With an awareness of the impact of childhood adversity and trauma on people's lives and behaviours over-time, TIC advocates developed a set of key assumptions and principles to help design responsive, holistic and effective systems of care. In bringing together a set of key principles, the effort is not to create a new set of rules, but rather to identify the core components of service culture, design and delivery that require attention (Figure 1). This includes paying attention to experience at all levels of the system, not only the service user/identified client, but also their caregivers (both families and professional caregivers), as well as practitioners, service managers and inter-agency interfaces.
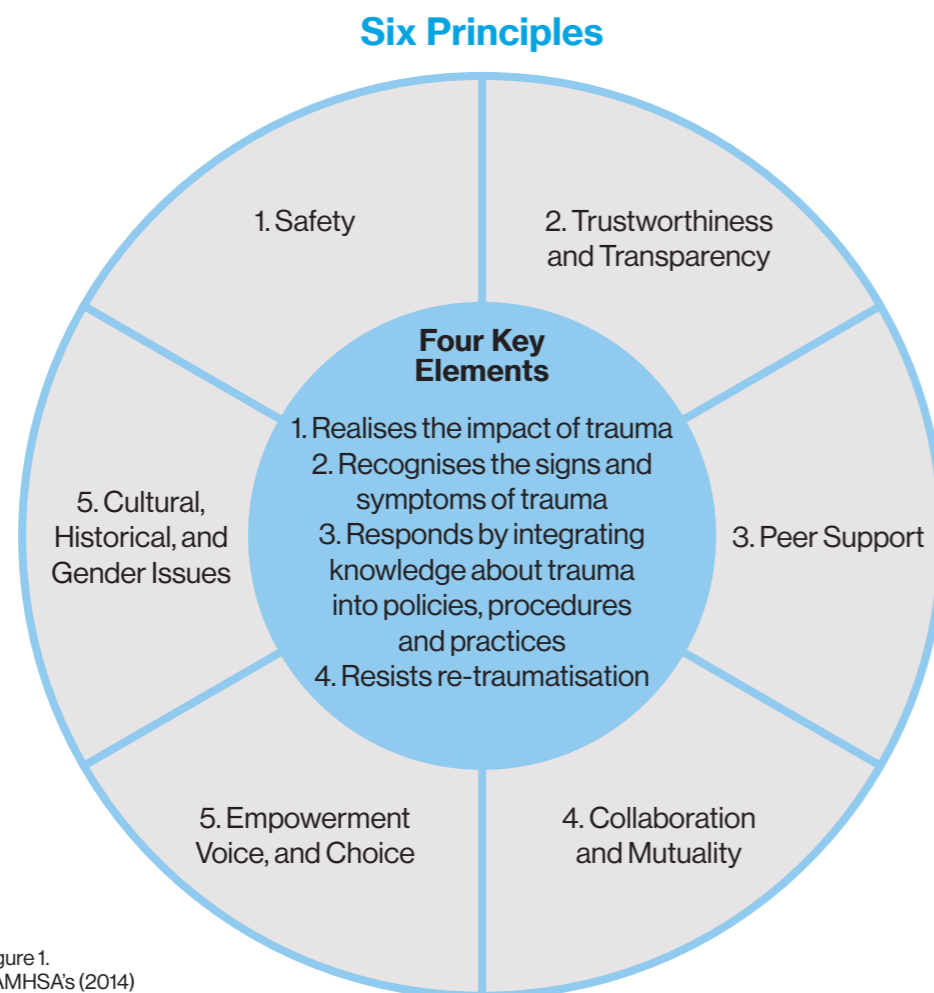
Six Principles

Figure 1.
SAMHSA's (2014)
Six Principles of Trauma informed Care

The Substance Abuse and Mental Health Services Administration (SAMHSA), has identified four key assumptions underpinning Trauma informed care - what they call the four 'R's:

(i) that all people at all levels within the system have a basic realisation about childhood trauma and adversity and how it can affect individuals, families, groups, organisations and communities

(ii) practitioners are able to recognise the signs of trauma and adverse childhood experiences, which may be manifest by people accessing services as well as those providing services

(iii) the system of care responds by applying the principles of adversity and Trauma informed care to all areas of functioning – from the receptionist to the chief executive – with policies, practices and language altered to appreciate the experiences of childhood trauma and adversity on service users and their families, and mitigate the risks of inadvertent re-traumatisation and secondary traumatic stress experienced by the staff providing services. TIC is inclusive of adversity and trauma-specific interventions (such as dedicated services and interventions for substance

misuse, domestic violence or post-traumatic symptoms), whether assessment, treatment or recovery supports, but also incorporates trauma principles into the organisational culture

(iv) adversity and trauma informed care seeks to resist re-traumatisation of service users and providers. Re-traumatisation is considered a significant concern, as people who have experienced multiple adverse life events often experience acutely exacerbated impact than those who have experienced a single trauma, resulting in decreased trust and willingness to engage with services (SAMHSA, 2014). Re-traumatisation can be present in any situation or environment that resembles an individual's original trauma experiences, literally or symbolically, which then triggers difficult feelings and reactions (SAMHSA, 2014).

While there are obvious practices that may be re-traumatising, such as restraint or isolation, the potential for re-traumatisation is thought to exist at all levels of care and is demonstrated through the use of oppressive and non-collaborative approaches to practice which violate the trust of service users and do not take account of their wishes and feelings.

Adversity, Trauma and the Healthcare System

Numerous studies confirm the association between experiences of childhood adversity and trauma with an array of physical and mental health difficulties. Individuals who experience multiple adversities in childhood are at increased risk of chronic illness including ischemic heart disease, liver disease, and chronic obstructive pulmonary disease and are more likely to be morbidly obese and to engage in health-harming behaviours such as smoking or drinking heavily (Felitti et al, 1998; Bellis et al, 2015). In terms of mental health, increased exposure to adversity in childhood has been linked to lower mental well-being and lower life satisfaction and to increased risk of suicide attempt in adulthood (Felitti et al, 1998; Bellis et al, 2015) and whilst still in childhood or adolescence (Devaney et al, 2012).

Replication of the American ACE study (Felitti et al., 1998) with UK populations indicate and 8% of English adults aged 16-64 years (Bellis et al., 2014 and 14% of Welsh adults aged 16-64 years (Bellis et al., 2015) have experienced 4 or more ACEs. In the absence of a Northern Ireland ACE population survey, the findings from the Welsh survey, arguably, provide the best comparison, sharing, as Wales does, similarly high proportions of deprivation. This would suggest that 1 in every 7 people in NI has experienced 4 or more ACEs, indicating a substantial minority of our population are potentially at risk of developing a range of

physical and mental health conditions. The impact of the Troubles is another important aspect of the Northern Ireland context which may directly and indirectly impact on the level of ACEs. Bunting et al. (2013a) have reported the very high levels of Post-Traumatic Stress Disorder specifically and of mental health problems more generally (Bunting et al., 2013b). Betts and Thompson have also reported that Northern Ireland "has higher levels of mental ill health than any other region in the UK with 1 in 5 adults and around 45,000 of children here hav(ing) a mental health problem at any one time" (2017, p.3).

Exposure to childhood adversity is therefore unsurprisingly related to increased health care utilisation over the long term (Ko et al., 2008). However, adults with a history of trauma can find health examinations particularly challenging and may be reluctant or hesitant to engage with preventative health care, routine screening or non-urgent services. Many traumatic events involve some physical violation and the necessity for close inter-personal proximity and physical contact in many health examinations or routine screening can prevent trauma survivors from seeking preventative health care (Raja et al, 2015).

While it is important to note that not all individuals exposed to childhood trauma will experience, or seek treatment for mental illness as an adult (Boyce and Harris, 2011), it has become apparent that those who have experienced trauma, and who may require Trauma informed care, are not a discrete sub-set but rather represent the greatest proportion of people accessing mental health services (Muskett, 2014). Routine health care appointments can be a gateway for identification of trauma exposure or traumatic stress reactions, therefore primary health care providers, such as GPs, accident and emergency staff and health visitors, often provide a point of entry to more specialist services mental health services (Ko et al, 2008).

Developments in Trauma informed Health Systems

Trauma informed Care has been defined by Raja et al (2015) as every part of a service having 'a basic understanding of how trauma impacts on the life of an individual seeking services'. It is important to draw a distinction between trauma-specific services, which are specialised to the treatment of trauma symptoms with specifically targeted interventions and therapies, and Trauma informed services, which focus on wider systemic or organisational change aimed at integrating Trauma informed principle across various levels of the system and/or various professional groups. Raja et al. (2015) have conceptualised this distinction between Trauma informed and trauma-specific care as a pyramid (see Figure 2). At the base of the pyramid is patient-centred communication and care, intended to reduce anxiety, increase patient choice and control and help establish rapport for all patients. This does not require screening patients for a trauma symptoms or knowledge of an individual's trauma history, but rather, involves small changes both to provider behaviour and to health system practice, that can be employed with all patients but may be particularly helpful for those with a trauma history and who may be more anxious during medical appointments. For example, in the case of physical examinations, this may involve the medical practitioner clearly outlining what parts of the body will be involved, allowing the patient to ask questions and offering choices that will not hinder the examination but could increase patients' sense of control.

The next level of the pyramid is educating practitioners to understand the health effects of trauma, to promote more insightful and empathic engagement. For example, when discussing life style choices that impact on health such as smoking or substance misuse, practitioners could recognise that this might be part of a set of coping behaviours linked to traumatic histories. The third level of the pyramid involves inter-professional collaboration. This can entail maintaining a list of referral sources across disciplines for patients, keeping referral and educational material on trauma readily available to all patients in the waiting room, as well as making appropriate referrals to specialist services, thereby allowing the healthcare practitioner to acknowledge a patient's trauma history and needs without going beyond the boundaries of their own competence and role. Moving up the pyramid, health care practitioners should be helped to understand their own history and reactions, and the stress this can generate. Finally, at the top of the pyramid is screening for trauma, accompanied by the appropriate resources to offer those who are then assessed as needing specific support.

Proponents of TIC note that some aspects of mental health care can be counter-therapeutic and even re-traumatising to trauma survivors. Trauma informed care in mental health services should aim not only treat trauma symptoms but be founded on the commitment to doing no further harm to trauma survivors (Muskett, 2014). Organisations that prioritise risk management can encourage the development of coercive relationships which in turn can reinforce the trauma survivor's sense of helplessness. Controlling or coercive practices such as the use of seclusion, restraint or pressure to accept medication, and inpatient environments with locked wards, search protocols and mixed-sex populations can be perceived as emotionally unsafe, unsupportive and disempowering by trauma survivors. This, in combination with trauma symptoms, can establish a pernicious

loop which is a barrier to effective treatment and care (Muskett, 2014). Controlling practices such as seclusion and restraint can also conflict with professional ethics of care and compassion potentially leading to stress and burn-out for practitioners.

Thus, it is imperative that mental health services become Trauma informed, organised and delivered in ways that enable safety and trust, to guard against perpetrating 'institutional re-traumatisation' (Sweeney et al., 2016). Health care settings tend to have well-established process for quality assurance and continuous quality improvement which can help facilitate assessment and integration of Trauma informed practices within existing frameworks (Ko et al., 2008). However, as with other systems, any drive to develop a more Trauma informed health care system and workforce needs to be mindful that a climate of continuous reorganisation and upheaval in the context of scarce resources and low staff morale will likely make staff engagement challenging. Acknowledgement that childhood adversity and abuse plays a role in adult mental illness also requires a broadening of the lens to understand mental distress not just in medical and pharmacological terms, but also as a familial and social issue. Trauma informed mental health services should seek to create environments that are physically and psychologically safe, building trusting collaborative relationships with service users, and reducing or eliminating coercion and control. Thus, there is a need for more than an expectation that individual practitioners will engage differently with service users' Trauma informed care requires system-wide change and commitment, with specific policies that allow services to move toward more Trauma informed practices supported by identified champions and mentors (Sweeney et al., 2016).
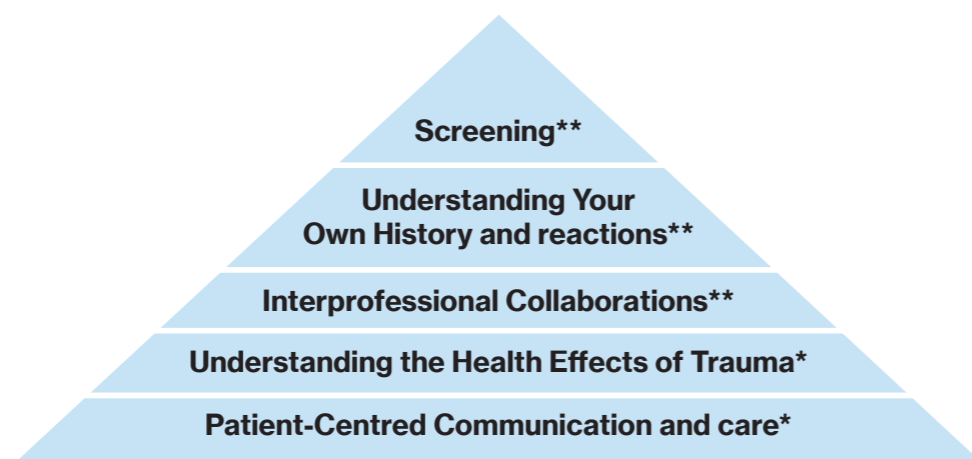

Figure 2.
The Trauma informed Care Pyramid (Raja et al, 2015).

While much of the impetus for Trauma informed approaches has come from the USA, there have been associated policy developments in the UK. More than a decade ago the English Department of Health (2003) published recommendations regarding routine enquiry about abuse in mental health settings, although it is not clear what extent this has become a routine part of current practice. Other examples of a move toward Trauma informed mental health care include the recognition of inclusion of trauma in some NICE guidelines (2014) and Scotland's Mental Health Strategy 2012-2015 (Scottish Government, 2012), which established a key priority that general services, including primary health care and mental health services, should be aware of the impacts of psychological trauma. The Scottish Adverse Childhood Experiences Hub, hosted by NHS Scotland is currently considering the embedding routine enquiry about adverse childhood experiences in all health and social care assessments in order to promote more individualised intervention plans that address both the root cause of presenting issues as well as the symptoms.

The growing evidence and discourse about the detrimental impact of early adverse social experiences on children's life chances has influenced social policy developments in NI. the Think Family NI initiative was introduced in 2009 and is currently governed by the Children and Young People's Strategic Partnership (http://www.hscboard.hscni.net/partnerships/think-family-northern-ireland/). This approach recognises that mental illness has an impact on family members as well as on the individual with the actual diagnosis or difficulty. In particular, parental mental illness can have an adverse effect on children, while the stress of parenting can be deleterious to adult mental health. The approach embraces Trauma informed tenets of choice and communication, both between the individual service user and worker, and across the various services that support the family. This approach enhances partnership and communication across adult and children's statutory and voluntary sector agencies working with different members of the one family, and equips practitioners across multiple systems with a common set of questions to frame family conversations. The Think Family project has established an infrastructure of relationship and communication channels around the topic of mental illness and its potentially adverse impact on family members. This existing approach is a potential vehicle for developing Trauma informed planning and service delivery to families impacted by mental illness.

Current strategic drivers in NI clearly embed Trauma informed principles, with growing attention to early intervention, relationship-based practice, and whole family and systemic approaches. This is particularly apparent in the four work streams of the Early Intervention Transformation Programme (EITP, 2014), a cross-departmental initiative (DoH, DE, DoJ, DfC and DfE) developed in collaboration with Atlantic Philanthropies, which seeks to deliver improvement in long term outcomes for children and young people across NI via early intervention. Other inter-related policies include 'Making Life Better' NI Public Health Framework (DHSSPSNI, 2014); Infant Mental Health Framework (Public Health Agency, 2016); Protect Life Strategy (DoHNI, 2016; and the Children and Young People's Strategy Consultation Document 2017-2027 (DENI, 2017). Awareness of the critical impact of adverse experiences in childhood (in particular domestic and sexual violence, child and parental mental health, and neglect) are explicitly set out in the strategic plan of the Safeguarding Board NI (2018-22) [SBNI, 2018] with a clear direction toward embedding Trauma informed care principles through the introduction of strength-based, safety-orientated approaches to stabilise and strengthen a child and family's situation.

How Can Trauma Informed Care Benefit Those in Contact with Healthcare Systems?

Out of the seventy plus academic papers evaluating organisation wide Trauma informed implementation, more than half focused on child welfare and many did not specifically evaluate child or family outcomes. Where data was available, with a few notable exceptions, the generalisability of study findings was often limited by the use of non-randomised designs, lack of a control or comparison group, small sample sizes and/or lack of standardised, validated measurement tools. In spite of these limitations, the review highlighted a growing body of evidence pointing to the positive impact TIC can have on service users across various settings through improved child mental health outcomes, improved patient-provider rapport, reductions in the use of seclusion and restraint, fewer substantiated child maltreatment reports, reduced caregiver stress, decreases in school disciplinary offences and suspensions, and reduced youth aggression (see 'Developing Trauma informed Practice: Key messages' report).

The review identified 27 empirical peer-reviewed studies pertaining to Trauma informed care in health care and mental health systems. Seven papers reported on health initiatives in either primary or secondary care, four papers described Trauma informed initiatives in the area of substance abuse, thirteen papers reported on Trauma

informed mental health initiatives (primarily inpatient services), and three reported on multi-professional initiatives including health professionals. There were also two relevant systematic reviews pertaining to TIC in psychiatric inpatient facilities (Muskett, 2014) and similar facilities for youth (Bryson et al., 2017), as well as a third systematic review focused on TIC implementation using a training component across multiple service systems (Purtle, 2017).

Outcomes were more frequently measured with regards to TIC initiatives in mental health treatment settings with a strong emphasis on the reduction of physical coercion in routine psychiatric and residential care evident. One systematic review highlighted this as the central aim of nine out of the thirteen studies reviewed (Bryson et al., 2017), with all nine studies demonstrating reductions in the use of seclusion and/or restraint. A much smaller number of studies evaluated treatment related outcomes, demonstrating significant increases in youth functioning (Boel-Studt, 2017). reductions in treatment time and increases in positive discharges (Greenwald et al., 2012), decreases in overall PTSD symptoms, aggression, anxiety, attention problems, rule breaking, depression, thought problems, and somatic complaints (Hodgdon et al., 2013), and reductions in aggression towards staff, property destruction, and incidents of running away (Izzo et al., 2016). Additionally, one of the few studies assessing residential addictions treatment (Hales et al., 2018), found that multistage TIC implementation increased both client satisfaction and the number of planned discharges. A longitudinal evaluation of a 6-year collaborative community project for female youth at risk in-Hawaii (Suarez et al., 2014) involving mental health, education, juvenile justice, and child welfare professionals, produced significant improvement on measures of youth strengths, competence, depression, impairment, behavioural problems, emotional problems as well as decreased levels of caregiver strain. Financial analysis indicated that these outcomes were obtained with a minimal overall increase in costs when compared to standard care alone (365,803 USD vs 344,141 USD).

How has Trauma informed Care been implemented?

Given that TIC requires change at multiple levels of an organisation, advocates have developed guidance for implementing a Trauma informed approach. Building on Harris and Fallot's (2001) preliminary work, SAMHSA's (2014) identified ten implementation domains and proposed a series of questions to consider in each domain (see Table 1). Similarly, Branson et al. (2017) and Hanson & Lang (2016) have identified multiple implementation domains as the basis of Trauma informed systems. These centred around the broad implementation categories of clinical services, agency context and system level changes (Branson et al., 2017) and workforce development, Trauma informed services and organisational changes (Hanson and Lang, 2016). These echo tiered approaches to TIC in health care systems (Raja et al, 2015) which support trauma-sensitive awareness and practice with all patients and students, and more targeted approaches for those displaying some level of trauma-related need, moving towards screening for childhood adversity and trauma and referral to trauma-specific services for those with identified trauma symptomology. While the specific components of TIC are context-dependent, and there are minor variances in articulation and structuring between the different frameworks, the rapid evidence review identified considerable commonality with the broad implementation domains of workforce development, trauma-focused services and organisational change (Hanson & Lang, 2016) reflected across all settings. Key implementation components within each domain and associated evidence of effectiveness specifically in relation to healthcare systems are discussed below.

Workforce Development

Training - The most commonly evaluated element of TIC implementation across initiatives and settings was, by far, training. Although limited by the preponderance of pre and post-test designs with short follow-up periods and a reliance on self-report measures, studies invariably demonstrated increases in staff knowledge, awareness and confidence in Trauma informed principles and practice. Similarly, much of the work on TIC within health settings took the form educating staff about trauma and its effects, and was provided to range of professional groups including dentists, nurse, doctors and primary care practitioners, psychiatrists and mental health practitioners, substance misuse providers and residential care staff. Training typically covered topics such as the neurobiological impact of traumatic stress, implications for childhood development and for physical and mental health, the social consequences of trauma, and indicators of traumatic stress or PTSD. Most of the training was delivered in brief one-off sessions producing the same positive results

observed in child welfare initiatives but, likewise, beset with the same methodological difficulties.

However, one study evaluating delivery of the 'Risking Connections' training programmes for health care workers, was particularly robustly evaluated through use of a randomised control trial design (Green et al., 2015; 2016), albeit with small numbers (see Box 1). The trial produced significant increases in patient-centeredness as measured by observed simulated visits with actors playing standardised patients, as well as a significant increase in patient's self-reported perceptions of patient-provider shared decision-making. This is important given that patient choice and empowerment are key elements of TIC in health care and that this is one of the few studies which linked training with observable and independently evaluated changes in practice. Similarly, Palfrey et al.'s (2018) 12-month follow up of training delivered to mental health professionals was an exception to the brief follow-up periods used in most training evaluation designs. There was evidence of continued interest in TIC at follow-up, with 80% having gone on to receive further training in trauma-specific interventions, suggesting the potential for a relatively small investment of staff and trainer time to deliver some longer-term benefits.

On-going staff support – Various initiatives stressed the importance of on-going staff support as crucial to maximising the impact of initial training and embedding TIC in practice. Across settings, this included the use of learning collaboratives, coaching, mentoring and monitoring of fidelity to the Trauma informed model through supervision, on-going consultation and coaching from model developers/trainers or other experts and continuous staff training, booster sessions and/or recertification processes. In health, for example, implementation of an adapted model of Six Core Strategies and Risking Connections for residential youth treatment focused on creating internal trainers and supervision leaders who provided ongoing trainings and reflective practice groups (Barnett et al., 2018). Participation was incentivised by offering a raise in hourly pay rate to staff who met specific training criteria. Similarly, a multistage TIC project in a non-profit residential addiction treatment agency in the USA (Hales et al., 2018) involved the recruitment of mentors and trainers responsible for training all staff on trauma and TIC, as well as reflective conversations facilitated by a senior advisor and program directors during staff meetings and ongoing, real-time staff coaching provided in group and one-to-one formats

**Box 1.
Risking
Connections
- Green et al.
(2015; 2016)**

Preparation

- Adaptation of the Risking Connections manual based on input from targeted providers and patients

- Training content and materials were piloted and refined in collaboration with practitioners

- Focus groups with providers reviewed draft training content and analysed feedback from a two-session training pilot at a local primary care site

Content

- responses to trauma

- use of screening tools

- the importance of relationships

- the role of self-awareness and self-care

Delivery

- The curriculum entailed a 6-hour programme, delivered in two half-day sessions to primary health doctors (GP equivalents)

- Training sessions were separated by one week of implementation and encouraged reflective learning

- Training approaches included use of group exercises, and case studies throughout to illustrate training points

Self-care - Self-care also featured as a component of TIC implementation in a number of initiatives, although it was not as widespread as the practice related supports discussed above. In some cases, this included the creation of specific teams to provide peer support to colleagues (Lang et al., 2016; Caldwell et al., 2014), but more often took the form of emphasising self-care in TIC training (Brown, Baker, & Wilcox, 2012; Barnett et al., 2018; Wilson and Nochajski, 2016; Green et al., 2015; Green et al., 2016). For example, implementation of Six Core Strategies in in-patient psychiatry, secure residential and group home settings (Caldwell et al., 2014) involved establishing a team of staff, called the ASAP Team, who provided peer support and immediate support for staff who experienced trauma. In some residential settings, including psychiatric facilities, systematic debriefings following staff use of seclusion and restraint were also introduced (Hummer et al., 2010; Caldwell; 2014).

Specific evaluations of the impact of TIC initiatives on staff trauma or stress were more limited and findings somewhat mixed. Baker et al. (2017) noted that residential staff's experience of vicarious traumatisation actually increased after TIC training but also highlighted qualitative findings suggesting this was potentially due to increased awareness. Barnett et al.'s (2018) evaluation of the impact of the ARC model indicated that it had no effect on residential staff turnover and that frequency of participation in the trainings and supervision groups were not significantly correlated with job satisfaction or felt safety. However, the 'Healing Baltimore' nine-month initiative (Damian et al., 2017) (Box 2) found that, post-training, health, social services, education and legal professionals reported significant improvements in organisational culture and climate (as measured by Safety Attitudes Questionnaire) and as well as increased compassion satisfaction, being able to derive pleasure from your work (as measured by the Professional Quality of Life Scale (PROQoL). Nonetheless, scores on the compassion fatigue scale of PROQoL also significantly increased, suggesting that training heightened awareness of providers' burnout and secondary traumatic stress. This was supported in qualitative interviews which confirmed heightened awareness of participants own traumatic stress and need for self-care and but also pointed to a "greater sense of camaraderie and empathy for colleagues".

Box 2. 'Healing Baltimore' initiative – training programme (Damian et al., 2017)

- A 9-month training programme developed by the Baltimore City Health Department in collaboration with SAMHSA's National Center for Trauma Informed Care (NCTIC) and the Behavioural Health System Baltimore (BCHB).

- Training was provided to law enforcement, Social Services, Health and Education professionals in Baltimore.

- SAMHSA's Concept of Trauma and Guidance for a TIA provided the framework the training. NCTIC consultants conducted the monthly training at the BHSB office, and focused on educating and providing technical assistance to participants in implementing the six TIC principles of 1) Safety, 2) Trustworthiness and Transparency, 3) Peer Support, 4) Collaboration and Mutuality, 5) Empowerment, Voice and Choice, and 6) Cultural, Historical and Gender Issues.

- Participants received a series of monthly technical assistance, coaching and feedback sessions from national trauma experts on how to utilise Trauma informed practices at their agencies.

Trauma Focused Services

Screening and Assessment – Review findings involving implementation of trauma screening within the child welfare and health systems (Lang et al., 2017; Lotzin et al., 2018; Miller et al., 2017; Decker et al., 2017; McGee et al., 2015), found that screening was generally perceived favourably by professionals, leading to increased identification of adversity/trauma exposure amongst service users and increasing service user perceptions of support and confidence in providers. In health, a randomised controlled trial (Lotzin et al., 2017) evaluating the impact of one-day Trauma informed 'Learning how to ask' training provided to substance misuse providers in outpatient clinics, demonstrated increases in frequency of asking patients about exposure to traumatic events. These increases were retained at 6-month follow-up. Implementation of the ARCHES (Addressing Reproductive Coercion in Health Settings) model in family planning clinics (Miller et al., 2017; Decker et al., 2017) also involved the introduction of universal screening to support the recognition of abuse (see Box 3). Qualitative interviews (Miller et al., 2017) indicated that the intervention increased provider confidence in discussing intimate partner violence, while patients described how the intervention gave them important information and made them feel supported and less isolated. Quantitative evaluation (Decker et al., 2017) indicated that patients found the interpersonal violence (IPV) assessment helpful, irrespective of their IPV history, while those who received the intervention

reported greater caring from providers, greater confidence in provider response to abusive relationships, and greater knowledge of IPV-related resources at follow-up, compared to those who did not.

However, various challenges related to routine inquiry and assessment were also noted in the child welfare literature. This commonly included systemic issues such as the size and scope of the system, the number of staff, competing demands, staff turnover etc., as well as specific issues around buy-in, local availability of evidence based treatment/services and problems with information technology systems (Akin et al., 2017; Lang et al., 2017). In one UK study, three services across North West England; a Child and Adolescent Mental Health Service (CAMHS); a drug and alcohol service; and sexual violence support service, piloted routine inquiry through the use of a standalone Implementation Pack (Quigg et al., 2018). However, these services eventually decided not to continue the initiative post pilot. Although reasons for this were multi-faceted, it was noted that the Implementation Pack, and potentially the academic literature, did not provide sufficient information on how to use the information gathered from routine enquiry on ACEs to inform service provision and the support offered to clients, particularly within the types of services included in the pilot. Overall, it was felt that clearer theoretical foundations, more developed guidance on responding to disclosures, particularly from children, and broader approaches beyond the provision of a standalone Implementation Pack, were required to ensure services and practitioners were ACE-informed.

Box 3. ARCHES (Addressing Reproductive Coercion in Health Settings) Model (Miller et al., 2017; Decker et al., 2017)

A Trauma informed intervention addressing intimate partner violence and reproductive coercion to all women seeking care at family planning clinics, regardless of exposure to violence. The intervention sought to educate women about available resources and harm reduction strategies. ARCHES has three major elements:

1. Universal assessment: screening with all clients to support recognition of abuse including for those who may not recognise it

2. Harm reduction counselling: to minimise the health impact of abuse

3. Supported referrals: provision of information about violence support providers and offering to connect patients with domestic violence advocates in real time

Evidence-based, trauma-focused interventions – there is a wealth of literature providing evidence of the effectiveness of various trauma-focused interventions and therapeutic approaches. In the rapid evidence review of TIC implementation, a number of child welfare (Fraser et al., 2014; Kramer et al., 2013; Lang et al., 2016; Henry et al., 2011) incorporated collaborative, multi-agency strategies to increase access to evidence-based treatments. For example, in an Arkansas state-wide initiative (Kramer et al., 2013), Trauma informed training for child welfare staff was conducted following dissemination of trauma-focused cognitive behavioural therapy (TF-CBT) to more than 150 mental health professionals across the state to maximise capacity for assessment and treatment referrals once child welfare workers were better informed about the effects of trauma on children.

In residential psychiatric care, the majority of implementation initiatives adopted specific Trauma informed models such as Trauma informed psychiatric residential treatment (TI-PRT) (Boel-Studt, 2017), Six core strategies (Barnett et al., 2009, Caldwell et al., 2014), Risking Connection (Barnett et al., 2018), Safe and Positive Approaches (SPA) (Russell et al., 2018) and the ARC model (Hodgdon et al., 2013) (see Box 4). These were commonly utilised as therapeutic treatment models as well as organisational frameworks to support and embed Trauma informed care across multiple system levels. In some studies, a range of other Trauma informed support services were provided in addition to specific therapeutic models/treatment. For example, as well as individual trauma-focused therapy such as Eye Movement Desensitisation and Reprocessing (EMDR) and Trauma Focused-Cognitive Behavioural Therapy (TF-CBT), implementation of TI-PRT in a large Mid-Western Behavioural Health Agency in the USA (Boel-Studt, 2017) also included trauma recovery group-based education for patients, alongside trauma education and skills training for caregivers. Similarly, in addition to evidence-based treatments, a collaborative community project provided intensive case management, community supports by paraprofessionals (i.e. peer support for young people and caregivers) and structured group activities as well as evidence-based treatments (e.g., Trauma-Focused Cognitive Behavioural Therapy and Girls Circle psychoeducational support groups) (Suarez et al., 2014).

Core Components Of Treatment Models

Attachment, Self-Regulation, and Competency Framework (ARC)

ARC is designed as both an individual level clinical intervention, to be used in treatment settings for youth and families, and as an organizational framework, to be used in service systems to support Trauma informed care. ARC principles can be applied in many settings that do not include individual therapy and/or as systemic points of intervention that go beyond individual therapy.

Core components: The model developers describe ARC as a strengths-based and component-based framework designed to deal with the problems and vulnerabilities that result from overwhelming stress (trauma) in children's earliest experiences of care. ARC is not a model per se, but a flexible framework which enables practitioners to choose from a menu of sample activities and interventions built around ten building blocks or key treatment targets, organised around one of the three domains: attachment, self-regulation and competency.

The three domains focus on: (a) building healthy attachments between children and their care-givers, particularly family members, (b) supporting children to develop skills to manage their emotions and physiological states, and thus increasing the child's self-regulation, (c) building the child's competency, by increasing their capacity and skills, and (d) working with children to integrate experiences of trauma, thereby increasing their self-understanding. https://arcframework.org/

Six Core Strategies (6CS)

Six Core Strategies is a prevention-oriented and trauma informed care framework aimed at reducing the use of restraint and/or seclusion. Its six components are:

1. Define and articulate a goal for the reduction of restraint.

2. Reflect upon the use of restraint and personal communication styles (Root Cause analysis)

3. The use of measures (surveys) to ascertain needs and challenges with regards to aggression on the wards.

4. Consumer Roles in inpatient settings

5. Workforce Development- (trauma informed care and training)

6. Debriefing Techniques

https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use

Risking Connection (RC)

Risking Connection is based on the premise that the therapeutic relationship is the foundation for psychological growth and change. This concept is drawn from a considerable body of literature, which theorizes that the quality of the therapeutic relationship is paramount to successful treatment.

The components of such a therapeutic relationship are described in RC as RICH: Respect, Information, Connection, and Hope. This model emphasizes:

- A framework for understanding common trauma symptoms

- A common inclusive language

- Relationships as the primary agent of change

- Respect for, and care of, both the client and the service provider (vicarious traumatization) as critical to healing

- Strategies and tools to support adoption of the model in clinical, social, and organizational processes

    http://www.riskingconnection.com/

Trauma informed psychiatric residential treatment (TI-PRT)

TI-PRT is an enhanced form of traditional psychiatric residential treatment grounded in trauma knowledge and Trauma informed principles of care and includes both clinical and organizational components:

Organizational components: all TI-PRT staff receive orientation, ongoing training, and supervision in understanding trauma and in working effectively with trauma-affected youth; all members, including the staff and youth, engage in safety planning and each member documents his or her safety plan and keeps it with them at all times; members identify a mission (i.e., goals and objectives that they hope to accomplish); member check-ins occur daily among youth and staff to discuss any issues or red flags

Clinical components: Young people receive individual trauma-focused therapy including EMDR or TF-CBT and participate in a trauma recovery group-based curriculum 2 times per week. The groups are led by staff who are trained in the curriculum and are comprised of approximately 8–10 youth matched by age. Program staff and therapists also work with caregivers to provide trauma education and teach skills to help them support their child's treatment. A family-centred approach focused on the inclusion of families in decision-making and treatment planning is also used.

Source: (Boel-Studt, 2017)

Organisational change

Leadership buy-in and strategic planning - Many of the initiatives reported were part of broader, organisation wide Trauma informed implementation strategies aimed at changing organisational culture and practices. Key elements of implementation across settings focused on establishing leadership buy-in, often through providing initial training to agency directors and senior management, establishing implementation teams, developing strategic implementation plans and structures, and assessing organisation readiness (Fraser et al., 2014; Kramer et al., 2013; Lang et al., 2016; Henry et al., 2011; Hendricks et al., 2011; Elwyn et al., 2015; Elwyn et al., 2017). In psychiatric care, for example, initial implementation of the ARC model in residential treatment program entailed identification of key stakeholders, completion of an organisational Trauma informed needs assessment and establishment of an implementation team. Likewise, implementation of an adaption of Six Core Strategies and Risking Connection (Barnett et al., 2018) in psychiatric care involved an initial needs assessment with staff and leaders and emphasised the importance of leadership buy-in and planning with agency administrators from the outset.

Developing policy, procedures and data systems - A number of papers drew attention to the specific changes made to policies, processes and data systems as part of the implementation process (Lang et al., 2016; Hummer et al., 2010; Caldwell et al. 2014; Akin et al., 2017). In health/mental health settings this entailed: reviewing and modifying psychiatric unit policies with a view to reducing or eliminating unit rules that were too restrictive (Borckardt et al., 2011); revising policies and procedures to ensure service users were aware of program expectations and developing policies to identify child and youth preferences regarding de-escalation (Hummer et al., 2010); supplementing staff training in de-escalation techniques with daily leadership reviews of the use of seclusion and restraint with monthly analysis of S&R data by an established safety committee (Goetz & Trujillo, 2012); encouraging service leaders to set goals to eliminate use of seclusion and restraint and keeping this as a standing agenda item at organisational meetings while dashboards of seclusion and restraint for each unit/facility were shared in real time (Caldwell et al., 2014). Goetz & Trujillo's (2012) account of implementing a Patient-Focused Intervention (PFI) Model in a behavioural health services hospital for adolescents and adults offered a particularly compelling account of assessment and data driven procedural changes made to increase patient safety and reduce the use of restraint. Efforts included: the introduction of 'Caring Rounds' i.e. a multidisciplinary set of rounds with the specific intent of assessing each patient's feeling of safety, pain

control, and medication response; establishing a management and safety committee which analysed monthly data on the use of seclusion and restraint; and daily leadership reviews of seclusion and restraint initiated to involve more staff. Another initiative in a residential addictions treatment agency (Hales et al., 2018) introduced reflective conversations facilitated by a senior advisor and programme directors during staff meetings with the aim of reviewing policies, practices and procedures to mitigate potential re-traumatisation

Changes to the Environment - Bryson et al.'s (2017) systematic review of in-patient and youth residential treatment noted that in the therapeutic community model, the environment and culture of the organisation are seen as therapeutic tools in themselves. Thus organisations were encouraged to make changes to the physical environment of the unit to make the treatment/residential space feel safe and welcoming for both patients/service users (both children and adults) and staff; and to include Trauma informed principles in mission and vision statements and to post these visibly to act as reminders for staff and service users of TIC goals. For example, Creating Trauma informed Care Environments Curriculum Hummer et al (2010) used a Learning Collaborative model to enable provider teams to engage in self-assessment to identify specific practices that they could implement to promote a more Trauma informed environment within their particular unit. This was accompanied by increased choice and control for young people and more collaboration, power sharing, and caregiver involvement. Borckardt et al. (2011) reported on an approach implemented across 5 paediatric psychiatric inpatient units which involved making inexpensive physical changes, including repainting walls with warm colours, placement of decorative throw rugs and plants, and rearrangement of furniture to facilitate increased patient-patient and patient-staff interaction. Interestingly, a multiple-baseline evaluation with random implementation of intervention components, found that these environmental changes were uniquely associated with a significant reduction in the rates of seclusion and restraint (Borckardt et al., 2011) suggesting that fairly minor and inexpensive changes can make a significant difference.

Engaging with Youth and Families - Engagement with children, young people, parents/ caregivers and extended networks was also an important element of the implementation process in a number of initiatives. Service user involvement took a variety of forms across systems and settings: including patients/young people and/or caregivers in training initiatives; parent/caregiver

involvement and systematic debriefing of young person following the use of seclusion or restraint; getting service user perspectives, employing a peer specialist to act as a patient advocate; engaging family members/supportive adults and patients/young people in case/treatment planning; conducting focus groups with service users as part of a community Trauma informed site assessment; and including service user representatives (young people and families/caregivers) in TIC leadership teams. Caldwell et al. (2014), in particular, highlighted the effective and meaningful use of service user involvement to bring about organisational change in residential psychiatric and secure settings. In this initiative, young people were invited to share their experiences of restraint with staff, highlighting how restraint resulted in a loss of self-respect and dignity, and in feeling less safe when witnessing peers being restrained. It was reported that this initiative, together with the involvement of family members and significant others, was central to the project's success in reducing seclusion and restraint by 67-100% across sites.

What might adversity and Trauma informed care look like in Northern Ireland?

The complexity and range of TIC initiatives makes comprehensive evaluation a difficult task and, generally, the literature was not able to isolate which implementation elements contributed to implementation success. However, various systematic reviews, (Purtle, 2018; Bryson et al., 2017), point to Trauma informed organisational interventions which incorporate multiple components as having the most meaningful impact upon service user and caregiver outcomes. Initiatives identified in the rapid evidence review commonly targeted the implementation domains of workforce development, the provision of trauma focused services and organisational change. Consistency was evident with regard to implementation components within these domains, although the extent to which they were incorporated within individual initiatives varied. Table 2 summarises these cross-system implementation components with a view to offering a framework for developing and benchmarking Trauma informed initiatives within the NI context.

WORKFORCE DEVELOPMENT

Training
- Basic and/or advanced training dependent upon staff role
- 'Train the Trainer' as a method of cascade training
- Use of group forums (such as Learning Collaboratives) to embed models of reflective practice, and consolidate learning and practice change
- Team access to on-going Trauma informed consultation and supervision
- Evaluation processes are embedded within TIC training initiatives

Staff Safety and Wellbeing
- Relevant staff training to understand vicarious traumatisation and promote self-care strategies
- Access to staff wellbeing support services
- Availability of regular staff/team debriefing, learning and support forums, in particular after significant incidents

TRAUMA-FOCUSED SERVICES

Screening and Assessment
- Where appropriate, develop appropriate methods of routine inquiry about adverse childhood experiences and trauma, including availability of protective factors
- Staff receive initial training and ongoing support in utilising trauma screening tools or assessment models
- Frontline practitioners are clear why and how routine screening information will be used and how to discuss ongoing need with service users
- Availability of local trauma and adversity-specific services, and referral processes are considered
- Incorporation of TIC screening/assessment results into existing data systems or assessment processes e.g. systematic recording of current or past adverse experiences of child/young person and key resources and relationships
- TIC screening/assessment is routinely discussed at team meetings and senior management fora, identifying service challenges and developments

Table 2. Key Components Of Cross System Trauma Informed Implementation

Evidence-Based Treatment/ Trauma-focused Services
- Dissemination of selected evidence-based treatment models in residential settings
- Increasing availability of trauma specific treatment services to meet identified need
- Developing trauma-focused support services (e.g. training/mentoring services for young people and parents/caregivers, group/classroom-based psychoeducation, Trauma informed intake and family assessments or embedding TIC expert/clinician within agencies)

ORGANISATIONAL CHANGE

Leadership buy-in & Strategic Planning
- Deliver leadership TIC training
- Development of implementation plans
- Creation of multidisciplinary implementation teams, including identification of TIC champions
- Identification of specific goals/targets depending on agency setting/context/priorities
- Assess and strengthen organisational preparedness Review TIC fit with policies and procedures and revise accordingly
- Identify key areas for change where practices risk child and family/care-giver re-traumatisation e.g. where/when restraint happens, removal of children
- Review and revise data systems to facilitate the storage, retrieval and sharing of pertinent childhood adversity/trauma information
- Ensure necessary resources are available to facilitate new initiatives e.g. workforce development etc.

Collaboration
- Identify clear intra and inter-agency/sector referral pathways and data sharing where appropriate
- Establish shared understanding of adversity and TIC across systems, staff levels and disciplines
- Establish collaborative multi-disciplinary case conferences/care team meetings, including and prioritising service user engagement (both child and parent/family/caregiver)
- Establish partnerships with community and voluntary sector organisations

Physical Environment	• Establish a shared multidisciplinary staff/service user/caregiver team to undertake a review of the physical space and relevant residential unit policies/procedures • Use staff/service user/caregiver ideas to create a welcoming physical environment where peer and patient/service user/caregiver-staff interaction is encouraged • Publicly post mission statements which highlight awareness of service user adversity and trauma, and commitment to TIC principles • Create 'safe spaces' were services users/care-givers and frontline staff can go to calm down and allow tensions to be de-escalated
Service User Involvement and Peer Support	• Establish a commitment to decreasing agency-young person/caregiver power differentials and maximising service user involvement (children/young people and their parents/caregivers) in all agency policies and procedures Include young people and parents/families/caregivers in TIC training, either directly or via integrating their perspectives in training materials • Involvement of service user perspectives (both children/young people and their families/caregivers) in Trauma informed organisational assessment, leadership/implementation teams, service development initiatives and evaluation processes • Establish routine service user (young person and family/caregiver) feedback mechanisms • Create opportunities for young people and their families/caregivers to meet with others experiencing similar circumstances to promote shared learning and mutual support
Monitoring and Review	• Establish clear goals with regard to practice/outcome changes desired • Utilise or adapt current systems to audit, monitor progress and evaluate TIC implementation/service development priorities to address practice challenges and capture critical practice learning • Regular communication with staff and service users about TIC implementation progress and on-going learning • Monitor model/implementation fidelity (dependent upon TIC initiative)

Table 2. Key Components Of Cross System Trauma Informed Implementation Cont.

Such developments need to acknowledge and build on existing work and recent NI initiatives, which, while not necessarily emanating from TIC discourses, have much in common with TIC principles. While TIC offers an opportunity to bring purposeful theoretical and practice coherence across service settings, with enhanced outcomes for children and their parents/caregivers, it should be recognised that effective TIC implementation is not without challenges, which require close consideration in the development phase of any proposed implementation strategy. Leadership commitment is required from the outset to support organisational level culture and systems change, embedding meaningful service user and practitioner involvement in Trauma informed service design and development, and establishing routine research and evaluation processes to drive change. Reviewing system and organisational level policy and procedures to ensure 'fit' with adversity and Trauma informed principles is also required to provide the necessary framework to support changes in service delivery.

Evidence from the rapid evidence review highlighted that effective ACE routine screening/enquiry implementation requires the support of fit-for-purpose IT and data-sharing systems, and critical buy-in of all staff through dissemination of a sound theoretical and empirical rationale (Quigg et al., 2018). Assessment of the availability of evidenced-based trauma/adversity treatments/services and Trauma informed support services is another key consideration. Lack of support services to meet identified need can act as a significant barrier to staff engagement. Successful initiatives, particularly at the state-wide level, all made significant effort to build capacity amongst community mental health and other service providers.

Given that a lack of understanding of the experience and impact of childhood trauma (Sweeney et al., 2018), and reluctance to ask about early adversity (Huntington et al., 2005; Quigg et al., 2018; Read et al., 2017; Xiao et al., 2016) are identified barriers to TIC, it is essential to equip the NI workforce with effective, professionally relevant and comprehensive childhood adversity and trauma-awareness training. The evidence suggests that while one-off training sessions can deliver some gains, staff will be enabled to maintain interest and more effectively embed TIC principles in their everyday practice if offered repeated and ongoing supportive reflective practice learning opportunities. TIC represents a significant shift in thinking and practice for many agency contexts and, to be effective, training needs to take account of the 'needs and norms' of specific professional groups. Professional reluctance to shift from dominant biomedical causal

models of mental health or normative use of control-orientated coercive practices (such as restraint and seclusion) in group care and justice settings (Sweeney et al., 2018) need to be recognised and addressed in training content. Involving staff and service users in the design and delivery of training content is one of a number of ways this might be achieved.

Additionally, more generic system pressures such as high caseloads, workload pressures, lack of quality supervision, high staff turnover and underfunding all require consideration in TIC implementation planning. These pressures, if unaddressed, will inevitably mitigate against the sort of relational practice proposed by TIC frameworks and the amount of time staff have to commit to new initiatives (Atwool, 2018; Sweeney at al., 2018). Indeed, time itself is arguably the most important consideration of all. Funders, commissioners and senior managers need to be aware that the kind of whole system change envisaged by TIC will take some initial investment of time and energy, and that "allocating process time for the slow and organic changes that must take place to accommodate the new way of practicing should be factored into TIC implementation plans" (Bryson et al., 2017, p.12). However, with the right resource and a commitment to thoughtful planning and ongoing review, this rapid evidence review demonstrates that adversity and Trauma informed systems of care offer potentially valuable gains not only for children and young people, their extended networks and communities, but also for practitioners, service managers and commissioners, and indeed, society as a whole.

Resources

SAMHSA - https://www.samhsa.gov/

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioural health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. It offers a variety of free resources and guidelines:

- Understanding Child Trauma - https://www.samhsa.gov/child-trauma/understanding-child-trauma
- SAMHSA's Concept of Trauma and Guidance for a Trauma informed Approach - https://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf
- Alternatives to Seclusion and Restraint - https://www.samhsa.gov/trauma-violence/seclusion
- Trauma informed Care in Behavioural Health Services - https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816_LitReview.pdf https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf

National Child Traumatic Stress Network (NCTSN) - https://www.nctsn.org/

NCTSN is a group of 70 treatment and research centres from across the United States that has been instrumental in implementing Trauma informed child welfare initiatives not just in the USA, but internationally. Free access to range of online training resources and guidance can be obtained through registration with the 'NCTSN Learning Center for Child and Adolescent Trauma'. Resources include:

- The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families
- Child Welfare Trauma Training Toolkit
- Resource Parent Curriculum (RPC)
- The Child Trauma Toolkit for Educators
- Working with Parents Involved in the Child Welfare System

Chadwick Trauma informed System Project- https://ctisp.org/

The Chadwick Trauma informed Systems Dissemination and Implementation Project (CTISP-DI), and its predecessor the Chadwick Trauma informed Systems Project (CTISP), promote creating Trauma informed child welfare systems. It provides free access to training and implementation guidance:

- Free Downloadable: CTISP's Trauma informed Child Welfare Practice Toolkit - https://ctisp.org/Trauma informed-child-welfare-practice-toolkit/
- CTISP-DI Trauma informed Child Welfare Resources and Webinars - https://ctisp.org/ctisp-Trauma informed-child-welfare-resources-and-webinars/

The Health Care Tool Box: https://www.healthcaretoolbox.org/

Provides information on Trauma informed health care including access to research summaries, education materials and other tools and resources

NHS Health Scotland - Adverse Childhood Experiences (ACEs) - http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

Provides access to an overview of ACES in Scotland and Scottish national Strategies:

- Tackling the attainment gap by preventing and responding to Adverse Childhood
- Experiences – http://www.healthscotland.scot/media/1517/tackling-the-attainment-gap-by-preventing-and-responding-to-adverse-childhood-experiences.pdf
- 'Polishing the Diamonds' - Addressing Adverse Childhood Experiences in Scotland - https://www.scotphn.net/wp-content/uploads/2016/05/2016_05_26-ACE-Report-Final2.pdf
- Routine Enquiry Seminar Report - http://www.healthscotland.scot/media/1556/routine-enquiry-seminar-report.pdf

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