ACEs

Adverse Childhood Experiences

Be the Change

Developing trauma informed practice in Northern Ireland: The child welfare system

SBNI
Safeguarding Board for Northern Ireland

QUEEN'S UNIVERSITY BELFAST

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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 and evaluations 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 the justice system and outlining international and national policy and practice developments in creating more Trauma informed justice 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 to findings and examples from the justice 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 health system, the justice system and the education system. It should be read in conjunction with 'Developing Trauma informed practice in Northern Ireland – Key Messages' report 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, where first developed, 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.
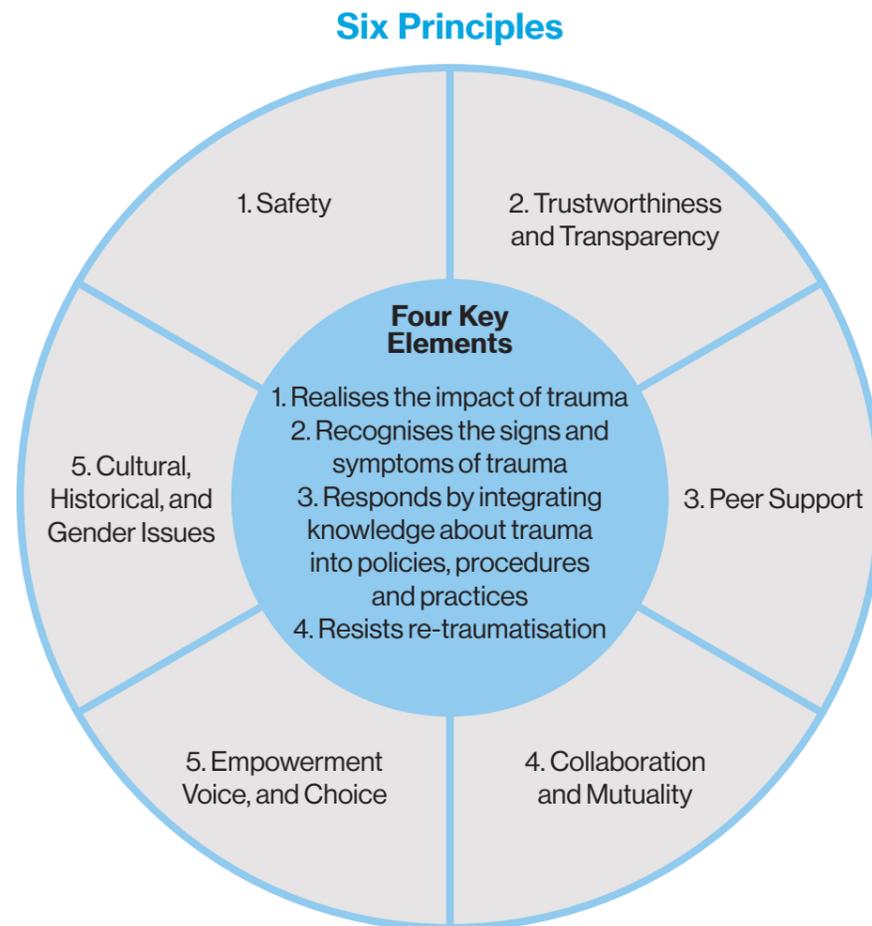
Six Principles

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 Child Welfare System

The child welfare workforce interfaces with children and adults who have experienced trauma on an everyday basis. Indeed, it can be argued that no other child-serving system encounters a higher percentage of service users with trauma histories, whether it be in family support, child protection, foster, kinship or residential care. Replication of the American ACE study (Felitti et al., 1998) with UK populations indicate that 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) had experienced 4 or more ACEs. In the Welsh study (Bellis et al., 2015), 23% had been exposed to verbal abuse, 17% physical abuse and 10% sexual abuse as children. Other household dysfunction was also common with 16% witnessing domestic violence in their household, 14% living with an adult with a mental illness, 14% an adult who abused alcohol and 5% an adult who abused drugs. 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.

Both research and practice experience indicate that experiences of maltreatment and neglect, parental mental ill health, domestic violence and substance misuse often co-occur. In the context of child welfare, removal from the family home and multiple placement moves can also present additional stressors, potentially exacerbating existing trauma. Although professionals are often very aware of the trauma that has precipitated contact with the child welfare system, they may be less aware of the complex trauma history of parents and children, may not always link this with current behavioural or emotional problems or have access to appropriate resources to address these needs. In order to be Trauma informed, child welfare systems not only need effective trauma screening and assessment protocols at every level, but also access to research-based trauma treatment services beyond generic mental health services (Ko et al., 2018). A wider systems approach that recognises the important role foster parents, adoptive parents, and courts can play in facilitating post-trauma recovery, is also necessary.

Nonetheless, it is important to acknowledge that the use of Trauma informed approaches within child welfare engenders certain tensions, particularly within social work. Much of the writing on Trauma informed social work positions the worker in a facilitative role, yet more often in child protection work, they are 'uninvited intruders' whose intervention may itself be experienced as traumatic. Parents often have complex trauma histories and the statutory social work duty to assess parenting practice, ensure the safety of children and, where necessary, remove children from parental care, causes particular difficulties with the Trauma informed principle of creating a safe emotional environment for service users and avoiding re-traumatisation (Atwool, 2018). Focusing on presenting problems without appropriate attention to parental history can further exacerbate the situation, leaving trauma related needs unaddressed, parents' feeling ignored and less likely to engage with support services as a result.

Developments in Trauma informed Child Welfare Systems

In an effort to develop more Trauma informed child welfare systems, various national initiatives, practice and training models have emerged. Of particular note is the work of the National Child Traumatic Stress Network (NCTSN) in the United States. Established by Congress in 2000, the 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. The development of Trauma informed practice in child welfare has also seen substantial federal funding with the Administration for Children and Families (ACF), a division of the United States Department of Health and Human Services

(HHS), funding five-year demonstration grants in 2011 to develop and evaluate a range of strategies for improving care for children in the child welfare system suffering from exposure to trauma. Strategies included workforce development, trauma screening and referral, dissemination of trauma-focused EBTs, and improved collaboration between child welfare and behavioural health.

Within the NCTSN, there are multiple committees designed to address specific topic areas related to the field of child trauma. In particular, the Child Welfare Committee (CWC) of the NCTSN was created to support the development of products, interventions, and services for children involved in the child welfare system (Walsh et al., 2018). This CWC has been instrumental in recognising the importance of developing a Trauma informed curriculum for child welfare professionals, creating the first version of the Child Welfare Trauma Training Toolkit (CWTTT) in 2007. The CWTTT was updated in 2012 and comprises 14 modules, with the first six focused on providing an overview of trauma and its effects, with the remaining modules focusing on the 'essential elements' of Trauma informed care and encouraging participants to identify concrete strategies that they can integrate into their daily practice (Box 1). The CWTTTT is currently being revised.

Box 1. Child Welfare Trauma Training Toolkit (CWTTT)

Child Welfare Trauma Training Toolkit identifies essential elements of Trauma informed child welfare practice to guide caseworkers to: (a) maximise the child's sense of safety, (b) assist children in reducing overwhelming emotion, (c) help children make new meaning of their trauma history and current experiences, (d) address the impact of trauma and subsequent changes in the child's behaviour, development, and relationships, (e) coordinate services with other agencies, (f) utilise comprehensive assessment of the child's trauma experiences and their impact on the child's development and behaviour to guide services, (g) support and promote positive and stable relationships in the life of the child, (h) provide support and guidance to the child's family and caregivers, and (i) manage professional and personal stress.

The CWTTT is both didactic and experiential and includes lecture elements as well as multiple activities to assist the participant in better integrating the material into their daily practice.

The NCTSN has adapted the quality improvement methodology of the Breakthrough Series Collaborative (BSC), for use in the child trauma field. The BSC is a quality improvement model developed by the Institute for Healthcare Improvement (2003) to help health care organisations make 'breakthrough' improvements in quality while reducing costs. It was designed to help organisations close the gap between evidence and practice by creating a structure in which interested organisations could easily learn from each other and from recognised experts in topic areas where they want to make improvements. Typically, BSCs involve a short-term (6 to 15-month) learning system that brings together a large number of teams to seek improvement in a focused topic area. In 2010, the NCTSN, with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), launched the Trauma informed Child Welfare Practice Breakthrough Series Collaborative (TICWP BSC), which brought together nine teams from across the USA with a focus on developing Trauma informed child welfare practices (decisions, actions, policies, procedures, staffing, and supports for children and caregivers) that increased the probability that children who need out-of-home placement remain in a single, appropriate, and stable home whenever possible (Conradi et al., 2011).

Various specific Trauma informed models aimed at changing practice in specific settings have also been developed in recent decades This is particularly evident within residential, group care and treatment settings where models such as Sanctuary, the Attachment, Self-Regulation, and Competency Framework (ARC) and Risking Connections have been commonly utilised as therapeutic treatment models as well as organisational frameworks to support Trauma informed care within service systems (Bryson et al., 2017, Bailey et al., 2018). Sanctuary, for example, is described as an evidence-supported, Trauma informed, whole system organisational change process comprised of a number of components organising around the 'Four Pillars' of shared knowledge, shared values, shared language, and a shared practice. The model provides a variety of training inputs and skill building tools including on-site consultation, implementation manuals, practice-based learning materials, fidelity checklists, toolkit lessons and psychoeducation manuals (Esakai et al. 2013). A range of therapeutic models including both Sanctuary (see Box 2) and ARC, as well as the Model of Attachment Practice (MAP), Social Pedagogy, and the Children and Residential Experiences (CARE) model, are currently used in children's residential care across NI (MacDonald et al., 2012).

Within the UK, there have also been significant interest in ACEs research and developing Trauma informed approaches across different systems and service settings. The 2017/18 Scottish Programme for Government made a commitment to prevent ACEs and support children and adults in overcoming early life adversity (Scottish Government, 2017a). Similarly, the Welsh national strategy Prosperity for All (Welsh Government, 2017) aims "to create ACE-aware public services which take a more preventative approach to avoid ACEs and improve the resilience of children and young people" (p.23). The Scottish Government has subsequently developed a National Trauma Training Framework for those who have contact with survivors of trauma across all parts of the Scottish workforce (Scottish Government, 2017b) and both Welsh and Scottish Governments have funded national ACE Hubs.

There have been also efforts to implement routine ACE screening in England with the Local Authority of Blackburn and Darwen piloting the Routine Enquiry about Childhood Adversity (REACh) initiative with child and family services, health services and a range of community organisations (McGee et al., 2015). The REACh training programme aimed to increase health professionals' and practitioners' knowledge about the potential consequences of childhood adversity as well as increasing their confidence in routinely asking and responding to disclosures. Following the initial scoping and pilot, the Department of Health commissioned Lancashire Care NHS Foundation Trust (LCFT) to develop a standalone Implementation Pack to support services in developing, implementing and embedding routine enquiry (amongst clients aged 14+ years). Similarly, in NI, the SEHSCT ACE pilot initiative (2015-16) utilised an adapted 15-item ACE questionnaire as a means of routinely inquiring about and considering ACEs during initial child and family social work assessment processes. This was accompanied by the development of a Family Life Stories practice workbook and guidance (Mooney et al., 2018), to facilitate practitioners to use ACEs research and embed associated Trauma informed care practice principles in longer to term work with families to enhance service user-practitioner engagement.

Box 2.
The Sanctuary Model

The Sanctuary Model represents a theory-based, Trauma informed, trauma-responsive, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organisational culture. The model is-informed by four knowledge areas: the psychobiology of trauma, actively creating nonviolent environments, social learning principles, and understanding complex system change.

Core components: The Sanctuary model combines trauma theories, an enhanced therapeutic community philosophy and strategies to address post-traumatic symptoms, unhelpful coping strategies and disruptions to children's development.

1. Trauma theories – A Trauma informed community recognises our inherent vulnerability to the adverse effects of trauma and organises system-wide interventions aimed at mitigating these (Bloom, 2005). Sanctuary recognises that trauma can arise from discrete events and the impact of cumulative and less tangible experiences such as poverty. A Trauma informed culture can make sense of children's behaviour and, by using trauma-specific approaches, can help children to recover or heal.

2. Enhanced therapeutic community philosophy – Like the individuals they aim to help, organisations and the staff within them can misapply survival skills and produce dysfunctional (defensive) ways of behaving. This can result in environments that exacerbate children's problems. Sanctuary therefore addresses the need for systemic level change (the so-called parallel process). It has adopted a set of values (seven commitments), based on UK therapeutic community standards, to help individuals and organisations avoid trauma-reactive behaviours and to develop the organisational context necessary to provide a therapeutic environment for children.

3. The Sanctuary toolkit – This refers to a portfolio of skills designed to help teams and individual staff members work more effectively, particularly in difficult situations. They include community meetings, team meetings, safety plans, psycho-educational groups and SELF – a framework that equips staff and children with a non-technical language that provides a more helpful perspective on the recovery process.

Source: http://sanctuaryweb.com/Home.aspx

How Can Trauma informed Care Benefit Children and Families?

Out of the seventy plus academic papers evaluating organisation wide Trauma informed implementation, more than half focused on child welfare: 16 empirical peer-reviewed papers evaluated state-wide/regional and organisational/agency level child welfare initiatives involving frontline social workers and family welfare staff; 15 reported on the implementation of Trauma informed frameworks and models in residential care and/or residential treatment; two

systematic reviews reviewed effective strategies for implementing Trauma informed care in youth inpatient psychiatric and residential treatment settings and out-of-home care; and six papers reported on TIC implementation in foster/adoptive care initiatives. An additional two reports evaluating the implementation of routine enquiry in the UK were also identified through on-line searching of the policy and practice literature.

Despite the large number of Trauma informed papers identified, 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 in Northern Ireland: Key messages' report).

Only a small number of state-wide/regional and organisational/agency papers reported specifically on outcomes for children and/or their families. The Massachusetts Child Trauma Project (MCTP) was the most comprehensively evaluated of these and the only state-wide initiative which presented data on case outcomes, reporting significant decreases in substantiated maltreatment reports among families serviced by the MCTP (Barto et al., 2018) (see Box 3 for an overview of TIC components implemented). Three organisational/agency level initiatives also evaluated case outcomes highlighting: a reduction in child behaviour problems following implementation of the ARC model in a community trauma treatment centre (Arvidson et al., 2011); increased family safety, caregiver capabilities and child well-being following participation in Trauma informed family preservation services (Lucero & Bussey, 2012) and after participation in a community project for at risk female youth (Suarez et al., 2014). With the exception of the MCTP outcome evaluation (Barto et al., 2018), most studies lacked a control or comparison group and were based on small sample sizes. As such, while there were positive trends observed, the effectiveness of large scale, system wide initiative remains an area requiring significant further evaluation.

Outcomes were more frequently measured with regards to TIC initiatives in residential care and 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 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).

While the literature on TIC implementation in foster/adoptive care services was much more limited, service user outcomes were reported in two studies. The ADOPTS program, a 16-week brief outpatient intervention with adoptive children and their families found that the intervention reduced child anxiety, depression, post-traumatic stress, dissociation, and anger, as well as reducing care-giver stress (Hodgdon et al., 2016). Similarly, system wide implementation of Trauma Systems Therapy (TST) in KVC, a private out-of-home-care organisation in Kansas, produced significant improvements in functioning, emotional and behavioural regulation and placement stability (Murphy et al., 2017).

Box 3.
Core Trauma informed Care Components of the Massachusetts Child Trauma Project

- Basic and advanced child trauma trainings with CW staff using the National Child Traumatic Stress Network (NCTSN) Child Welfare Training Toolkit

- Workshops for foster parents (Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents)

- State-wide dissemination of three trauma treatments with empirical support via community-based mental health organisations: ARC, Child-parent psychotherapy and trauma-focused cognitive–behavioural therapy.

- Dissemination involved comprehensive training and consultation in the form of a learning collaborative (LC) model which brings together senior manager, clinical supervisors, clinicians and data managers who commit to a 1-year learning period and involved face-to-face learning sessions and intensive EBT consultation.

- Creation of Trauma informed Leadership Teams (TILTs), focused on installing and supporting a structure for TIC systems integration at the community level. They rely on leadership by CW management and participation by social workers, consumers, mental health providers, and other community service providers and stakeholders.

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 justice and child welfare 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). Education and health-based frameworks (Dorado et al., 2016; Shambin et al., 2016; Raja et al., 2015) have incorporated similar features and components, emphasising tiered approaches to TIC 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 or other specific issues (such as having witnessed domestic violence or experienced sexual violence). 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 across systems, as well as specifically in relation to the justice system, 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. Training models used across child welfare initiatives varied in terms of duration, ranging from 1hr training on the use of trauma screening tools (Denison et al., 2018) to involvement in year-long learning collaboratives (Fraser et al., 2014). Training generally targeted senior managers followed by front-line staff and was often based on training content developed by the National Child Traumatic Stress Network (NCTSN), with particular reference to the Child Welfare Training Toolkit, developed in conjunction the Chadwick Trauma informed System Project (Fraser et al.,

2014; Bartlett et al., 2016; Kramer et al., 2013; Conners-Burrow et al.,2013; Lang et al., 2016; Hendricks et al., 2011). Training content commonly included understanding the types of trauma experienced by children and families, how this can impact child development, levels of stress and behaviour, the principles of TIC and how to apply them in child welfare settings.

Results were primarily based on self-assessment, with a number of studies utilising validated measures such as the Evidence-Based Practice Attitudes Scale (EBPAS), the Trauma informed System Change Instrument (TISCI) and the Trauma System Readiness Tool (Fraser et al., 2014; Bartlett et al., 2016; Lang et al., 2016; Henry et al., 2011, Hendricks et al., 2011) to assess changes in practitioner attitudes and practice. Although none of these measures involved independent observation of practice, they did demonstrate that practitioners were positive about evidence-based practice, had strong intentions to consistently engage in Trauma informed practice (Fraser et al., 2014; Hendricks et al., 2011) and felt that their practice had become significantly more Trauma informed as a result of training (Henry et al., 2011). Similarly, a large-scale evaluation of 'Training for Adoption Competency' provided to 855 professionals employed in mental health, adoption, family service and residential care agencies across 16 States (Atkinson and Riley, 2017) also found that those who received training showed substantial gains in TIC knowledge while a group of comparably qualified professionals experienced little gain (Atkinson and Riley, 2017).

On-going staff support – Various child welfare initiatives stressed the importance of on-going staff support as crucial to maximising the impact of initial training and embedding TIC in practice. Strategies to address this included the use of learning collaborative (Fraser et al., 2014; Lang et al., 2016; Hummer et al., 2010), coaching, mentoring and monitoring of fidelity to the Trauma informed model through supervision (Redd et al., 2017, see Box 6 for an overview of TIC components implemented), on-going consultation and coaching from model developments/trainers or other experts (Deveau & Leich, 2015, Izzo et al., 2016; Hodgdon et al., 2016; Atkinson & Riley (2017), and continuous staff training, booster sessions and/ or recertification processes (Redd et al., 2017; Barnett et al., 2018, Holstead et al., 2010). For example, after an initial five-day training for residential staff in the CARE model, consultants provided quarterly onsite technical assistance to implementation teams and other agency staff through observation and feedback, training and coaching for front-line supervisors, developing routines for reflective practice, and addressing organisational barriers to creating a more therapeutic milieu (Izzo et al., 2016). 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. While there were no empirical evaluations of the effect these additional supports had on TIC implementation or staff and service user outcomes, qualitative findings indicated that staff valued the multiple training modes and additional supports that were provided.

**Box 4.
Core Trauma informed Care Components of The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT)**

- Creation of a core team and subcommittee to guide Trauma informed systems change

- Development of a cohort of 40 'trauma champions' who organised 1 in-service training about trauma every month

- State-wide mandatory preservice and in-service trauma training for child welfare staff, involved implementation of the NCTSN Child Welfare Trauma Training Toolkit - Training was provided to 487 managers and supervisors in the spring of 2013 and to 1,164 caseworkers and clinical staff in late 2014

- 'Worker wellness' (i.e. self-care) teams created and quarterly trainings in self-care provided

- Revision of agency policies for alignment with Trauma informed practice

- Training in trauma-focused cognitive behavioural therapy for community-based service providers

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. The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) created 'Worker wellness' teams who provided quarterly trainings in self-care (Lang et al., 2016) [see Box 4 for an overview of TIC components implemented]. In other child welfare initiatives, training in TIC included an emphasis on self-care and (Brown, Baker, & Wilcox, 2012; Barnett et al., 2018; Green et al., 2015; Green et al., 2016). For example, training in the ARC model of residential care emphasised 'the self of the treater,' focusing on vicarious traumatisation and countertransference (Brown et al., 2012), while Wilson and Nochajski 's (2016) social work curriculum contained teaching in clinical self-care with the aim of avoiding or

properly managing vicarious traumatisation among practitioners. 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 staff turnover and that frequency of participation in the trainings and supervision groups were not significantly correlated with job satisfaction or felt safety. The 'Healing Baltimore' nine-month initiative (Damian et al., 2017) found that, post-training, social services, health, 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). However, 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".

Trauma Focused Services

Screening and Assessment – Five States in the USA were involved in state-wide implementation of trauma screening for children within the child welfare system; Massachusetts, Colorado, Connecticut, Montana and North Carolina (Lang et al., 2017). The target groups and processes varied between states with some opting to screen children in all open cases, others opting to screen children coming into care (see Box 5). Screening was generally perceived favourably by child welfare workers and mental health professionals (Lang et al., 2017) and implementation led to significant increases in screening, although there were wide variations in the number of children screened. For example, in Massachusetts, the average rate of screening increased from 40.3% to 75.0%, while in Colorado, 53% of open cases were screened over a 16-month period. Routine Enquiry about Childhood Adversity (REACh) was also introduced in the English Local Authority of Blackburn and Darwen (McGee et al., 2015) and included NHS and statutory children and family health services as well as range of community organisations with a total of 110 staff members receiving the training. By February 2015, almost 2,000 screens had been completed, with the bulk of these administered by health visitors and school nurses (n=1500), followed by social services staff (n=180).

Box 5. Five State Screening Initiatives

Colorado
Aimed to provide universal screening for all children aged birth to 18 involved in the CWS who had an open case for ongoing services, including voluntary and court-ordered child protective services (CPS) involvement (excluding children seen only in intake/investigations)

Tool: Child Trauma Assessment Center (CTAC) screen

Connecticut
Collaborative on Effective Practices for Trauma (CONCEPT)
Aimed to screen all children aged 6 to 17 who were entering the care of the CWS following removal from the family of origin

Tool: Child Trauma Screen (CTS)

Massachusetts
Plan to screen all children aged birth to 18 following a CPS report that has been flagged for further assessment.

Tool: the NCTSN-adapted Child Welfare Referral Tool (later incorporated into the Family Assessment and Action Plan)

Montana
The implementation plan was to screen all children that were in contact with the Bureau of Indian Affairs CWS

Tool: Child Trauma Assessment Center (CTAC) screen

North Carolina
Aimed to screen children from birth to age 18 entering foster care. Screening children in other units (e.g. intake/investigations) was optional

Tool: 6 and 11-question versions of the Project Broadcast Screening Tool

However, further development of this initiative as a standalone Implementation Pack piloted with a children's mental health service, a drug and alcohol service, and a sexual violence support service highlighted significant challenges (Quigg et al., 2018) with the three services eventually deciding 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. Other challenges related to routine inquiry and assessment noted in the literature included common systemic issues such as the size and scope of the child welfare 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).

Evidence-based treatment, adversity and trauma-focused services – The Massachusetts Child Trauma Project (Fraser et al., 2014), the Arkansas state-wide initiative (Kramer et al., 2013), CONCEPT in Connecticut (Lang et al., 2016) and Michigan Children's Trauma Assessment Center (CTAC) [Henry et al., 2011), all incorporated strategies to build treatment capacity through training and dissemination of evidence-based treatments such as Trauma-focused CBT, child-parent psychotherapy and the ARC model. In the Arkansas project, 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 group care, treatment and secure juvenile justice settings, the majority of implementation initiatives adopted specific Trauma informed models such as Six core strategies, Risking Connection, Collaborative problem solving (CPS), the Fairy tale model, ARC and Sanctuary (Bryson et al., 2017; Bailey et al., 2018; Elwyn et al., 2015; Elwyn et al., 2017; Caldwell et al., 2014: Marrow et al., 2012). Implementation of the Fairy Tale model in a residential unit in New York also involved training in EMDR and treatment was conducted by a multi-disciplinary team including residential direct care staff as well social workers who typically led the treatment teams, provided case management, as well as some individual and family therapy (Greenwald et al., 2012).

Other Trauma informed services provided as part of the implementation process included intensive permanence services for young people in foster care delivered in four phases (Hall and Jones, 2018); in residential care, the use of sensory tools such as pet therapy, visits to animal shelter, music therapy, cooking and swimming (Caldwell et al., 2014); behaviour management training for caregivers, a caregiver mentoring program and Trauma

Systems Therapy for caregivers (Akin et al., 2017); intensive case management, peer support for youth 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); and strengths-based, culturally appropriate, Trauma informed intake and family assessments accompanied by concentrated and family-focused case management services and referrals for material resources (e.g., housing, food, legal, transport, etc.) (Lucero and Bussey, 2012).

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 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). For example, both qualitative and quantitative evaluations highlighted the importance of establishing Trauma informed implementation leadership teams focused on installing and supporting a structure for TIC systems at the community level, as integral to the success of the MCTP (Fraser et al., 2014). Projects like the Michigan Children's Trauma Assessment Centre (CTAC) and the Chadwick Trauma informed System Project emphasised more 'grassroots' approaches centred on developing community partnerships and implementation strategies based on extensive collaborative community assessments and consultation (Hendricks et al., 2011). Hendricks et al. (2017) used the Trauma System Readiness Tool (TSRT) to assess the strengths and barriers of existing policies, procedures and service provision and inform the development of implementation plans. Leadership was less commonly emphasised in residential care initiatives, although the adoption of organisation wide Trauma informed models, by their nature, involved leadership buy-in. The Sanctuary Model, in particular, was emphasised as a model which targeted key leaders in initial training phases, who then returned to their agency to form a Core Team of representatives across all levels and departments who would act as the primary change agents (Middleton et al., 2015).

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). The CONCEPT initiative in Connecticut (Lang et al., 2016) involved a multidisciplinary core team which reported directly to the Department for Children and Families (DCF) and provided leadership oversight of planning and implementation. Several subcommittees reported to the core team including data/evaluation, screening/workforce development, policy, and trauma-focused EBP implementation. A qualitative case study evaluation of the TIC implementation process in out-of-home care facilities in three states (Akin et al., 2017), highlighted how embedding adversity and Trauma informed screening and assessment in practice required the development of electronic systems to collect and share data as well as policy amendments to facilitate information sharing between agencies. This presented various challenges which, although eventually overcome, caused significant revision of initial implementation plans.

In residential/treatment facilities, policy and procedural changes took the form of integrating TIC principles into the residents' handbook and treatment plans; and posting signs detailing the TIC principles around the facility (Elwyn et al., 2017); developing policies to identify child and youth preferences regarding de-escalation (Hummer et al., 2010); and amending procedures to include systematic debriefings following staff use of seclusion and restraint, (Hummer et al., 2010; Caldwell; 2014).

Box 6.
Core Trauma informed Care Components of a System wide implementation of Trauma Systems Therapy (TST) in an organisation providing out-of-home care to children (KVC)

Staff training - formal TST trainings for all staff and supervisors were conducted in early 2012. Training included an in-person training session (with overflow staff receiving training via video conference) and a follow-up training on the use of assessments—the UCLA-Post Traumatic Stress Disorder [PTSD]-Reaction index in particular. Attendees were required to complete assigned readings of the book written by TST developers (Saxe et al., 2007) and participate in book reviews (conducted via WebEx) prior to the in-person training.

Coaching, mentoring, and continuous quality improvement - All staff were afforded coaching and mentoring in TST through supervision. During weekly case consultations, supervisors mentored staff and provided instruction on TST. KVC, in conjunction with the TST developers, constructed fidelity measures that were administered quarterly by supervisors. Other efforts to ensure staff received support included the development of a sustainability team consisting of 12 staff members who provided oversight to the TST implementation effort. Additionally, staff in the residential and hospital program developed a number of different training 'boosters'.

Foster parent training - In addition to providing opportunities for foster families to attend formal training sessions, KVC developed an online training component, aligned with a specialised workbook, which families could use in their own homes.

Case consultation calls - Regularly scheduled conference calls involving all members of the child's team (case managers, supervisors, therapists, and family service coordinators, birth parents, resource parents and, when applicable, school personnel, state social workers, and the child's attorney).

TST tools and assessments- KVC staff worked with TST developers to provide tools to help staff and foster parents apply their knowledge of TST into daily practice e.g. the Moment by Moment Assessments for Caregivers, the Emotional Regulation Guide, and the Priority Problem Worksheet. Also used a number of child assessment and wellbeing measures.

Community partners training - originally TST training was provided for community partners on a child-specific basis to interested partners but over time this developed and in 2013, KVC provided its first formal training of community partners.

Birth parent training – Expanding TST knowledge and training to birth parents is the last step to full implementation. KVC has developed the birth parent curriculum with intended roll out in Autumn 2016.

Changes to the Physical Environment - Bryson et al.'s (2017) systematic review of inpatient 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 patients/ service users (both children and adults) and staff. For example, changes made to physical environment in a paediatric psychiatric hospital included repainting walls with warm colours, placement of decorative throws, rugs and plants, and rearrangement of furniture to facilitate increased patient-patient and patient-staff interaction (Borckardt et al., 2011). TIC teams (including staff at different levels of seniority/role and service users) were also established for each unit and tasked with reviewing and modifying unit rules and policies to be less restrictive to patients/service users or eliminating unit rules that were too restrictive. 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 Young People and Families - Engagement with children, youth and caregivers was also an important element of the implementation process in a number of initiatives, although it was not as widespread as it could have been, particularly in state level child welfare initiatives. Service user involvement took a variety of forms with the inclusion of residents and/or caregivers in training initiatives being the most common (Fraser et al., 2014; Holstead et al., 2010, Redd et al., 2017; Murphy et al., 2017). Implementation of Trauma Systems Therapy (TST) in an organisation providing out-of-home care to children (KVC) provided one of the most comprehensive examples of a systems wide training which targeted staff, foster parents, birth parents and community partners (see Box 6 for an overview of TIC implementation components). Other methods of engaging with young people and families included: caregiver involvement and systematic debriefing of youth following the use of seclusion or restraint (Hummer at al., 2010; Caldwell et al., 2014); getting service user perspectives on the use of restraint (Holstead et al., 2010; Caldwell, 2014); engaging family members and other supportive adults as part of permanence planning for youth in foster care (Hall & Jones, 2018); conducting focus groups with

service users as part of a community Trauma informed site assessment (Hendricks et al., 2011); and including service users in leadership teams (Fraser et al., 2014). While Akin et al. (2017) noted that, in the context of an out-of-home care, efforts to engage with service users were largely unsuccessful, Caldwell et al. (2014) highlighted the effective and meaningful use of service user involvement to bring about organisational change. In this initiative youth 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 watching peers be restrained. It was reported that this input, together with the involvement of family members, was central to the initiative'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 et al., 2017; 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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