ACEs

Adverse
Childhood
Experiences

Be the Change

Developing trauma informed practice in Northern Ireland: Key messages

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This report has been prepared for the Trauma Informed Practice Project of the Safeguarding Board for Northern Ireland.

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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 key messages report is part of a suite of papers which focus on trauma informed care in the child welfare system, the health system, the education system and the justice system. This report provides an overview of the principles of trauma informed care and summarises the findings from the evidence review across multiple systems and settings. Consideration is given to the extent to which there is evidence that TIC implementation has led to improved outcomes, as well as the ways in which individual initiatives have incorporated change across the key implementation domains of workforce development, trauma informed services and organisational change. The accompanying system specific reports provide a more detailed summary of the academic and policy and practice literature as they relate to health, child welfare, education and justice.

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.

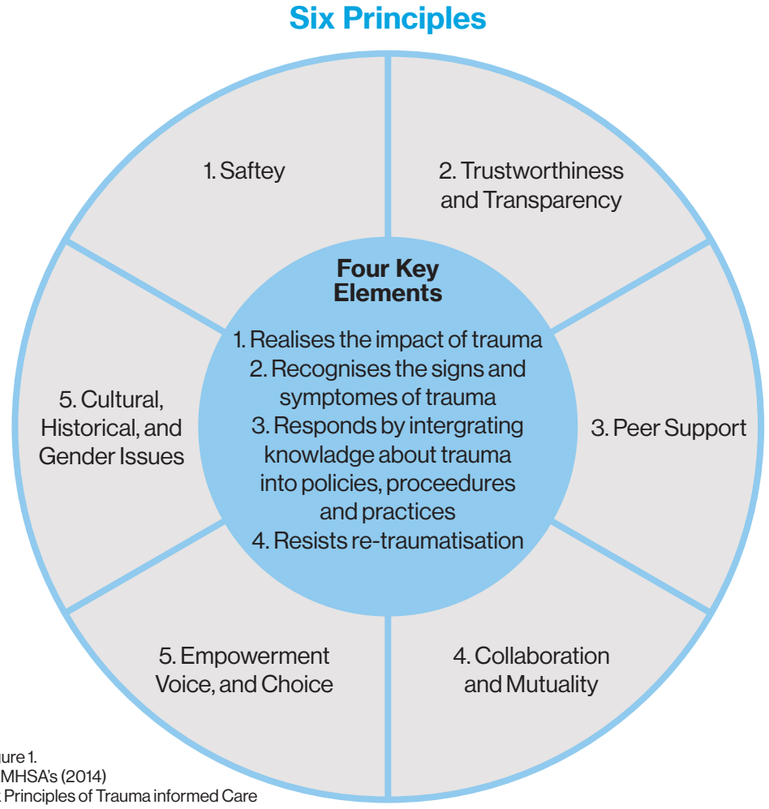

Figure 1.
SAMHSA's (2014)
Six Principles of Trauma informed Care

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.

How common are ACEs in Northern Ireland?

There has not yet been a population level prevalence survey of ACEs conducted in Northern Ireland (NI) which is urgently needed to accurately inform service development. Until NI specific data is available, it is necessary to use research from other countries to provide ACE prevalence estimates in NI. These estimates should, however, be viewed with caution as there are NI specific issues, including the number of areas with high levels of deprivation and the impact of the Troubles, which suggest NI prevalence may be higher than in other countries. The need for caution is further reiterated by the findings from a recent systematic review of 37 ACE studies (Hughes et al., 2017) which highlighted considerable variation in the number of adversities measured across individual studies. This, in turn, produced significant variation in the prevalence rates identified: an ACE score of 0 ranged from 12% to 67%, and an ACE score of 4 or more, from 1% to 38%.

In order to provide estimates for NI, three important ACE studies (Felitti et al., 1998; Dube et al., 2003; Bellis et al., 2015) have been used and a range of estimates for children, adults and the total population are provided in the main report. It should be noted that these studies focused on the adult population, but their findings have been used to estimate the number of children who have or will experience ACEs. Together, they suggest that between 36-53% of the NI population will have experienced 0 Aces, accounting for 672,231 - 986,933children and adults in the NI population, and that between 6-14% will have 4 or more ACEs, accounting for 115,452 - 260,699 children and adults in the NI population.

Arguably, the findings from the Welsh population survey (Bellis et al., 2015) provide the best comparison with NI, sharing, as Wales does, similarly high proportions of deprivation. Taking Welsh statistics as a baseline, we would anticipate 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.

How Can Trauma informed Care Benefit Children and Families?

As part of a rapid evidence review using systematic search and screening methods, more than seventy papers evaluating organisation wide Trauma informed care implementation across child welfare, health, education, justice and social care were identified. The studies were mainly American, 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 Box 1).

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 are discussed below.

Evidence Review-Developing Trauma informed practice in Northern Irelan Key Messages

BOX 1. Child And Family Outcomes

Child Welfare

- One state-wide initiative, the Massachusetts Child Trauma Project (MCTP), reported significant decreases in substantiated maltreatment reports among families serviced by the MCTP (Barto et al., 2018)
- Three organisational/agency level child welfare initiatives highlighted 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 participation in a community project for at risk female youth (Suarez et al., 2014)
- In residential group care/treatment, a systematic review (Bryson et al., 2017) found that 9 studies reported significant reductions in the use of seclusion/restraint
- Four residential group care/treatment studies showed reductions in treatment time and increases in positive discharges (Greenwald et al., 2012), improvements in mental health (Hodgdon et al., 2013) and reductions in aggression towards staff, property destruction, and incidents of running away (Izzo et al., 2016)
- Two studies evaluating TIC initiatives in fostering and/or adoption services reported improvements in children's mental health, reduced caregiver stress and improved placement stability (Hodgdon et al., 2016; Murphy et al., 2017)

Health

- There was considerable overlap between the residential child welfare literature and the literature pertaining to in-patient psychiatric care, with both showing significant reductions in the use of restraint and/or seclusion across multiple studies (Bryson et al., 2017), with a smaller number demonstrating improvements in residents' mental health functioning
- Two studies reported on outcomes in primary care, demonstrating: significant increases in patient-centred practice, patient reported increases in patient-doctor rapport and shared decision-making, as well as increases in women's perceived caring from family planning clinic providers, confidence in provider response to abusive relationships, and knowledge of related resources

BOX 1. Child And Family Outcomes

Education

- Findings from four school based TIC initiatives pointed to positive impact in terms of better understanding of the effects of trauma , coping strategies and/or resilience among children who participated in whole classroom interventions (Perry and Daniels, 2016; Ijadi-Maghsoodi et al.,2017); improvements in trauma symptomology and/or emotional and behavioural functioning among children who participated in school based therapeutic interventions (Dorado et al., 2016; Shamblin et al., 2016, Perry and Daniels, 2016), and decreases in disciplinary offences and suspensions (Dorado et al., 2016)

Justice

- In keeping with the literature on residential care/treatment, evaluation of TIC implementation in residential juvenile justice or secure accommodation was associated with reduced youth misconduct and reduced assaults on youth by peers (Elwyn et al., 2015), reduced staff and youth grievances (Elwyn et al., 2015), improved youth mental health and greater levels of optimism and hope (Marrow et al., 2012), fewer threats toward staff (Marrow et al., 2012) and fewer incidents of restraint or seclusion (Elwyn et al., 2015; Caldwell et al., 2014: Marrow et al., 2012)

GENERIC SAMHSA (2014)	JUSTICE Branson et al. (2017)	CHILD WELFARE Hanson & Lang (2016)	EDUCATION (Dorado et al., 2016; Shambin et al., 2016)	HEALTH
	Clinical Services:	**Workforce Development:**	**Universal**:	
Governance & leadership	Screening and assessment	Training of all staff on the impact of abuse or trauma	School policies, increasing teacher awareness and capacity	Patient-centred communication and care - reducing anxiety, increasing patient choice and control and help establish rapport for all patients
Policy	Services and interventions	Measuring staff knowledge/ practice	Developing a strengthened social-emotional curriculum	Educating practitioner to understand the health effects of trauma
Physical environment	Cultural competence.	Strategies/ procedures to address staff traumatic	Ongoing mentoring practices for all teachers.	
Engagement and involvement	**Agency Context:**	Knowledge/ skills in accessing evidence-based services		
Cross sector collaboration	Youth and family engagement			
Screening, assessment and treatment	Workforce development and support			

GENERIC SAMHSA (2014)	JUSTICE Branson et al. (2017)	CHILD WELFARE Hanson & Lang (2016)	EDUCATION (Dorado et al., 2016; Shambin et al., 2016)	HEALTH
Training and workforce development	Promoting a safe agency environment	**Trauma-focused services:**	**Selective:**	Inter-professional collaboration - keeping referral and educational material on trauma readily available to all patients
Progress monitoring and quality assurance	Agency policies, procedures	Screening/ assessment to identify trauma history and symptoms	consultation to help teachers develop strategies and behavioural plans to address challenging behaviours in class	Practitioners understanding their own history, reactions, and stressors this can generate
Financing	**System-level:**	Child's trauma history included in case record/plan	preventing secondary traumatisation or burnout.	Screening and referring to appropriate trauma specific services/ treatment for
Evaluation	Cross-system collaboration, System-level policies and procedures	Availability of evidence-based trauma-focused practices	**Targeted**:	
	Quality assurance and evaluation	**Organisational Change:**	Mental health assessment of specific children	
		Collaboration, coordination, and information sharing (internal and external)	Appropriate, evidenced based Trauma informed interventions for children and their families	
		Procedures to reduce risk for client re-traumatisation		
		Promotion of consumer engagement		
		Provision of strength-based services		
		Safe physical environment		
		Written policies that include/support TIC principles		
		Presence of a defined leadership position or job function specifically related to TIC		

Table 1. TIC Implementation Frameworks

Workforce Development

Training - Training has been, by far, the most commonly evaluated element of TIC implementation across initiatives and settings with studies commonly demonstrating increases in staff knowledge, awareness and confidence in Trauma informed principles and practice. Training provision and content varied considerably in terms of duration, ranging from one-hour training (Denison et al., 2018) to involvement in year-long learning collaboratives (Fraser et al., 2014), and often targeted senior managers followed by front-line staff. Evaluations of Trauma informed training were limited by the preponderance of pre and post-test designs with short follow-up periods and a reliance of self-report measures. However, one study evaluating delivery of a 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. The trial produced significant increases in patient-centredness 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 contexts 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 across settings 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 collaboratives (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), on-going consultation and coaching from model developments/trainers or other experts (Deveau & Leich, 2014, 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; Dorado et al., 2016). 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.

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. For example, the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) created 'Worker wellness' teams who provided quarterly trainings in self-care (Lang et al., 2016) while, in other initiatives, training in TIC included an emphasis on self-care (Brown, Baker, & Wilcox, 2012; Barnett et al., 2018; Wilson & Nochajski, 2016; Green et al., 2015; Green et al., 2016). In some residential units, systematic debriefings following staff use of seclusion and restraint were introduced (Hummer et al., 2010; Caldwell; 2014). Specific evaluations of the impact of TIC initiatives on staff trauma or stress produced mixed findings with both Baker et al. (2012) and Damian e al. (2017) noting that experiences of vicarious traumatisation increased after TIC training, likely 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 was not significantly correlated with job satisfaction or felt safety. Similarly, evaluation of an eight-week university course on trauma, delivered to gang intervention workers, as part of a strategy to develop Trauma informed juvenile justice systems (Dierkhising & Kerig, 2018), found that no significant differences in levels of secondary traumatic stress in comparison with a group of similar professionals who did not complete programme. However, in addition to increases in secondary traumatisation, Damian et al., (2017) also found that, post-training, social services, health, education and legal professionals reported significant improvements in organisational culture and climate, as well as increased compassion satisfaction (being able to derive pleasure from your work).

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. 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. In health, one of the most robust studies (Lotzin et al., 2017) involved a cluster-randomised controlled trial of 'Learning how to ask' training provided to professionals working in outpatient services for people with substance use disorders. At 6-month follow-up, the intervention reported higher self-reported frequency of asking patients about exposure to adverse or traumatic events than the control group, although findings were based on self-report. Introduction of universal assessment to support the recognition of domestic abuse and reproductive coercion in family planning clinics (Miller et al., 2017; Decker et al., 2017) indicated that the intervention gave patients important information, made them feel supported and less isolated, and increased confidence in providers. 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).

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 – Various child welfare (Fraser et al., 2014; Kramer et al., 2013; Lang et al., 2016; Henry et al., 2011) and schools-based initiatives (Dorado et al., 2016; Perry and Daniels, 2016; Shamblin et al., 2016) incorporated strategies to build treatment/intervention capacity in-house or increase access to evidence-based treatments via referral to other agencies. In residential group care, group treatment and secure juvenile justice settings, the majority of implementation initiatives adopted specific Trauma informed models of practice 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). While there was no specific evaluation of the treatments offered in state-wide child welfare initiatives, a variety of initiatives across residential settings, including group care, mental health treatment and juvenile justice settings, indicated that implementation of therapeutic models led to a significant reduction in the use of restraint and/or seclusion (Bryson et al., 2017, with a small number demonstrating improved mental health outcomes for residents (Greenwald et al., 2012; Hodgdon et al., 2013; Izzo et al., 2016), as well as children in the foster care system (Hodgdon et al., 2016). School based initiatives were also particularly well evaluated and pupils who received these trauma specific interventions showed significant improvements in symptoms, including adjustment to the trauma/adverse life experiences, affect regulation, and decreases in intrusive images and dissociation (Dorado et al., 2016), improved resilience (Shamblin et al., 2016) and reduced PTSD symptoms (Perry & Daniels, 2016). In addition to trauma/adversity-specific treatment, a range of other Trauma informed support services were provided as part of the implementation process:

- intensive permanence services for young people in foster care (Hall et al., 2018)

- 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, 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)

- 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 & Bussey, 2012)

- embedding clinicians in the school's Coordinated Care Team to provide a adversity/Trauma informed lens to the development of behavioural support plans for at-risk students (Dorado et al., 2016)

- whole class psychoeducation in classrooms with identified difficulties and challenging behaviours (Perry & Daniels, 2016; Ijadi-Maghsoodi et al., 2017)

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; Elwyn et al., 2015; Elwyn et al., 2017). 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 going forward (Elwyn et al., 2017; Elwyn et al., 2015; 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). Goetz & Trujillo's (2012) account of implementing a Patient-Focused Intervention (PFI) Model in a behavioural health services hospital centre 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 Physical 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, 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 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, although not as widespread as might have

been, particularly in state-level child welfare initiatives. Service user involvement took a variety of forms: including patients/young people and/or caregivers in training initiatives (Fraser et al., 2014; Holstead et al., 2010); parent/caregiver involvement and systematic debriefing of young person 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); employing a peer specialist to act as a patient advocate and liaison with the treatment team and administration (Goetz & Trujillo, 2012); engaging family members and other supportive adults as part of permanence planning for young people in foster care (Hall et al., 2018); engaging psychiatric patients/young people and their parents/caregivers in treatment planning (Borckardt et al., 2011); conducting focus groups with service users as part of a community Trauma informed site assessment (Hendricks et al., 2011); and including service user representatives (young people and families/caregivers) in TIC 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 service young people and parents/carers were largely unsuccessful, Caldwell et al. (2014) on the other hand highlighted the effective and meaningful use of service user involvement to bring about organisational change. 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 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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