Implementing Trauma Informed Approaches in Northern Ireland

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Abbreviations

ACE:	Adverse Childhood Experience
CYP:	Children and Young People
DSM:	Diagnostic and Statistical Manual of Mental Disorders
EPPOC:	Executive Programme on Paramilitary and Organised Crime
HSC:	Health and Social Care
REA:	Rapid Evidence Assessment
PTSD:	Post Traumatic Stress Disorder
SAMHSA:	Substance Abuse & Mental Health Services Administration USA
SBNI:	Safeguarding Board for Northern Ireland
TIA:	Trauma Informed Approach
TIC:	Trauma Informed Care
TIP:	Trauma Informed Practice
V/C:	Voluntary and Community
YJA:	Youth Justice Agency

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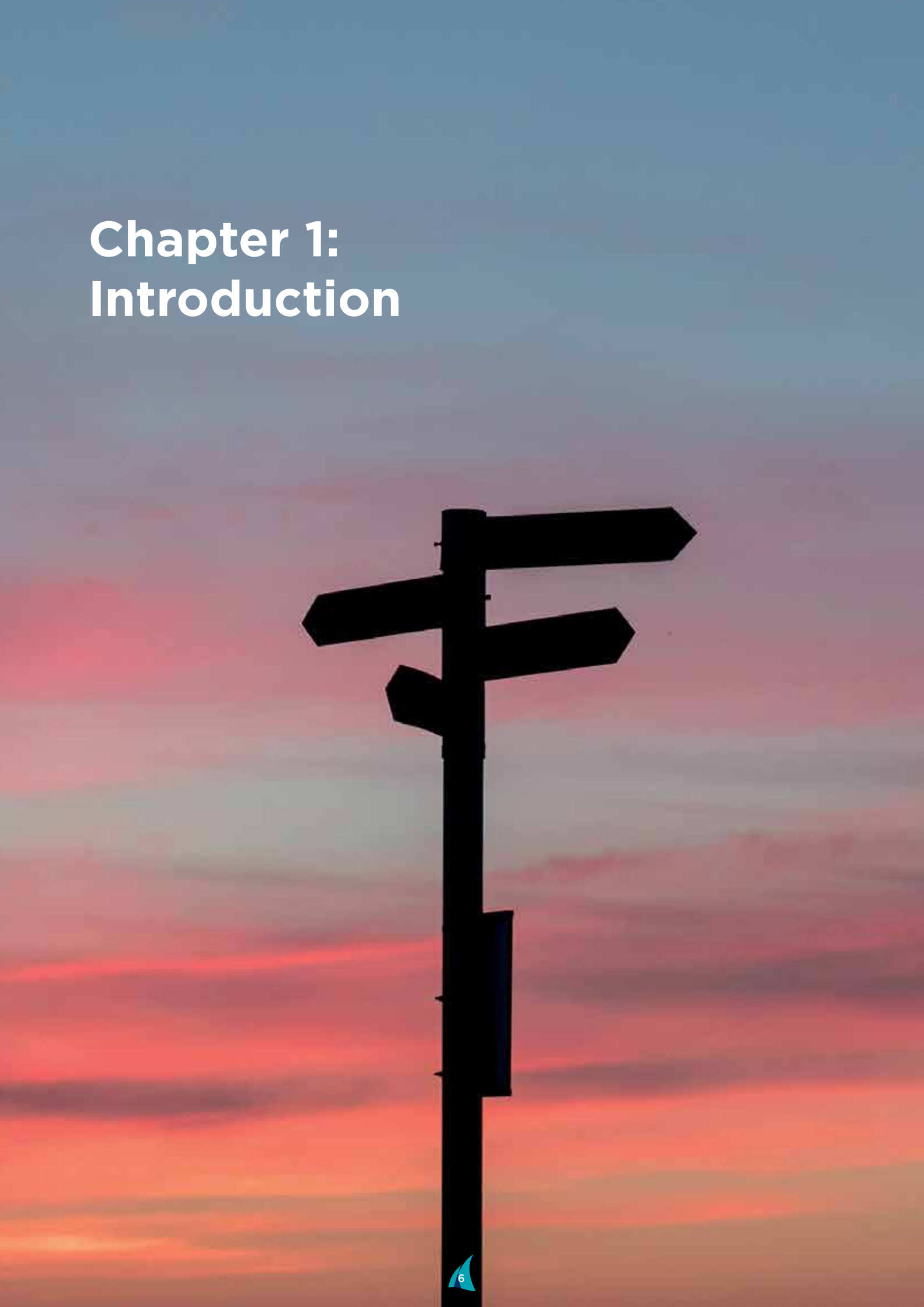


1.1 Introduction and Overview

This report presents the background and findings of an organisational review of the implementation of trauma informed approaches (TIAs) in Northern Ireland (NI) commissioned by the Safeguarding Board NI (SBNI). An Executive Summary Report has also been produced (Mooney et al., 2024b). The review was undertaken by a research team based at Queen's University Belfast (QUB), primarily made up of academics and researchers based at the School of Social Sciences, Education and Social Work (SSESW) (including Dr Suzanne Mooney, Principal Investigator; Dr Montse Fargas-Malet, Research Fellow; Professor Lisa Bunting; Dr Lorna Montgomery; Dr Mandi McDonald; Dr Colm Walsh; Professor Davy Hayes), in close collaboration with Ms Deirdre O'Neill in the QUB School of Nursing and Midwifery (SONM). This opening chapter **(Chapter 1)** clarifies adopted terminology and provides a brief overview of the development of trauma informed approaches within the UK. It concludes with a summary of the review methodology adopted by this study, outlining the different components which together make up this organisational review of TIA implementation in NI. **Chapter 2** presents the findings of a rapid evidence assessment of recently published literature on TIA implementation in diverse sectors and settings, followed by the findings from an online survey to map current developments in TIA implementation in NI in **Chapter 3**. **Chapter 4** presents the findings from a series of focus groups seeking to establish a strategic overview of senior managers and professionals' assessment of TIA implementation in their sector or area of expertise in NI. Four in-depth case studies of organisations and services implementing trauma informed approaches in NI are presented in **Chapter 5**. The report concludes with **Chapter 6** where conclusions and recommendations are detailed.

1.2 A brief note on terminology and conceptualisation

The overarching term of **Trauma Informed Approaches (TIAs)** has been adopted in this review to encompass Trauma Informed Practice (TIP) and Trauma Informed Care (TIC) as a means to reflect the relevance of TIAs for organisations which do not provide frontline service provision as well as those which do.

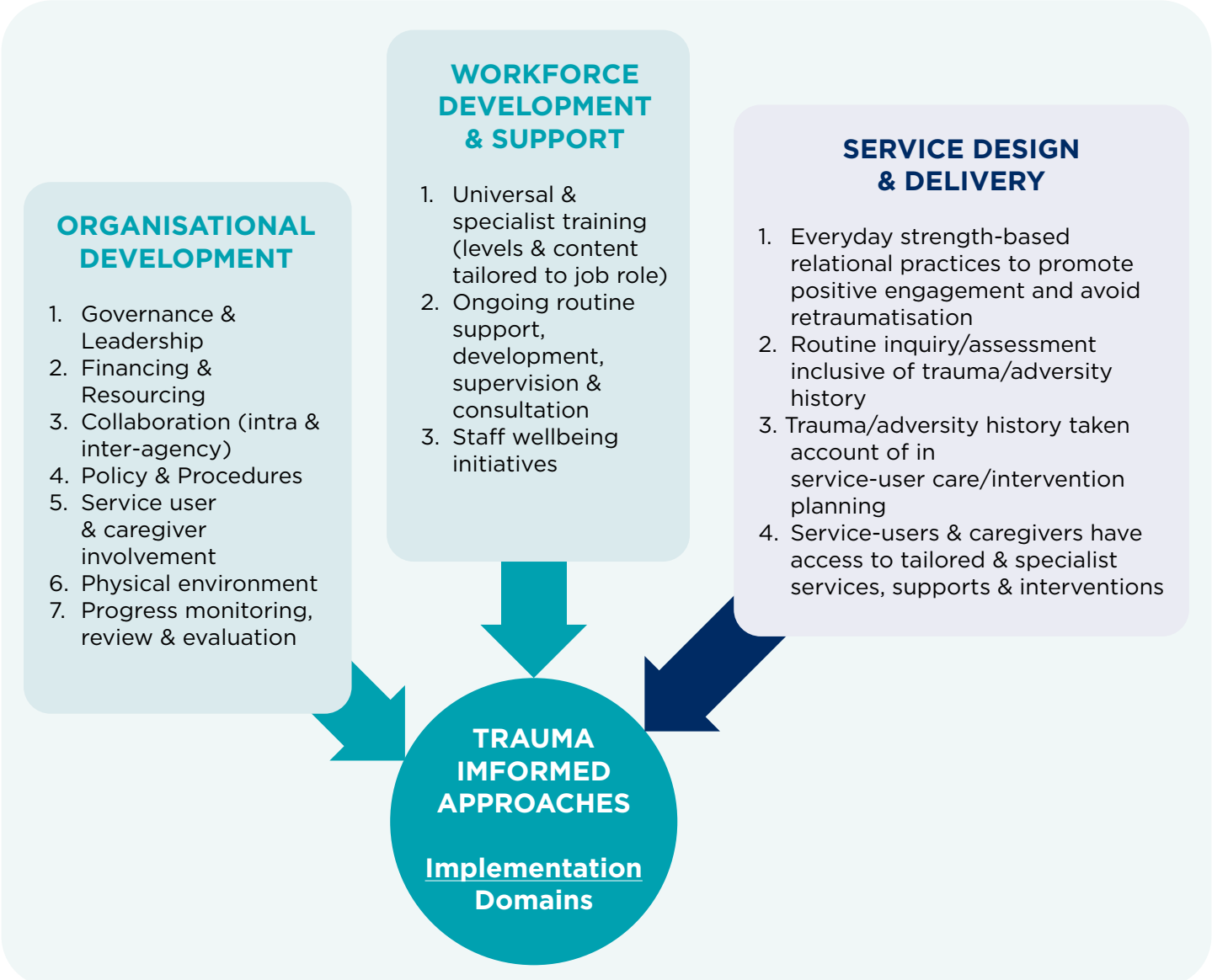
TIA Implementation domains: In the interest of achieving relevance for this cross-sector TIA organisational implementation review, we have sought to merge and adapt the primary implementation frameworks available i.e. SAMHSA's (2014) ten implementation domains; Hanson and Lang's (2016) implementation framework for child welfare and justice settings; and the Trauma and Learning Partnership Initiative (TLPI) framework (Cole et al., 2013), which considered the development of trauma-sensitive schools. The following overarching framework is thus proposed encompassing three core implementation domains (organisational development; workforce development and support; and service design and delivery). Within each overarching domain, there are a number of specific implementation foci or indicators which require attention. It is acknowledged that while whole system TIA implementation includes action across at least two of these core domains, not all implementation indicators will be relevant to every organisation, dependent upon their purpose and mandate. For example, the service design and delivery domain may have different resonance dependent upon whether the organisation is a frontline service provider or a support, regulatory, commissioning or governance body (See Figure 1.1).

1. **Organisational development:** a range of organisational developments including governance and leadership; financing and resourcing; review of policies and procedures; the physical environment; enhanced service user engagement and involvement; progress monitoring and evaluation.

2. **Workforce development and staff support:** Staff development initiatives directly related to support staff understanding the impact of trauma on service users and ongoing support/supervision/training to embed practice change; support for staff wellbeing.

3. **Service design and delivery:** initiatives which sought to embed trauma-informed practices in their universal service delivery (e.g. an intentionality towards enhanced relational connection with service users; reduced use of restraint etc.); integrating recognition of service users' trauma history into assessment, planning and intervention; or increased access to targeted trauma-specific services and interventions i.e.(specialist interventions for service user cohorts, such as group work or therapeutic modalities).

Figure 1.1: TIA Implementation Domains



1.3 Trauma Informed Approaches in the UK

Since Felitti and colleagues first published their seminal Adverse Childhood Experiences (ACEs) study in 1998, developments have been underway to address the growing international evidence of the stark detrimental impacts of multiple childhood adversities on health and wellbeing outcomes across the life course (e.g., Bellis et al., 2015; Hughes et al. 2017). These efforts led to the development of the concept of Trauma Informed Care [TIC] in the USA, first articulated by Harris and Fallott (2001) and further developed by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). TIC is a framework of care delivery transformation which uses trauma as a lens to understand common presentations in health, justice, education and social care settings, and support organisations to develop trauma-sensitive or responsive forms of service delivery. The growing body of international and national ACE research has been more recently accompanied by research which has established the high correlation between childhood adversity and socio-economic disadvantage (Metzler et al., 2017; Walsh et al., 2019). Together, these developments have captured the widespread attention of cross-departmental policy makers with all four UK nations adopting some form of ACE-related strategy to mitigate the challenges of childhood adversity and embed TIAs across diverse sectors and settings. The most significant strategic developments in Scotland and Wales are detailed in brief below.

Scotland has made significant progress in advancing TIA implementation at a national level, with the Scottish Government specifically mentioning its aim to mitigate childhood adversity in consecutive Programmes for Government since 2017-18. The Scottish Government has also sought to address the social and economic circumstances in which people live, acknowledging that social inequalities, such as poverty or gender inequality, can influence levels of childhood adversity and trauma along with people's ability to overcome such experiences. A trauma-informed and responsive approach has been officially recognised as crucial to ensuring all children, young people and adults in Scotland can lead healthy and fulfilled lives, with a governmental commitment to a shared vision of trauma-informed and responsive organisations, systems and workforces articulated. Preventing and more effectively responding to trauma and childhood adversity is seen as essential for Scotland's National Performance Framework's ambition of increasing wellbeing, creating opportunities to flourish, and improving outcomes for people and communities. Central to these developments was the design of the Knowledge and Skills Framework for Psychological Trauma, led by NHS Education for Scotland in 2017. This framework aimed to create a shared language and understanding around what a trauma-informed and responsive workforce looks like, and to clarify what was needed to achieve such goals. The Framework is considered to have allowed training to be developed consistently across the national workforce, developing the knowledge and skills of individual staff groups, depending on role and responsibilities. The National Trauma Training Programme was established in 2018 and rebranded to the National Trauma Transformation Programme (NTTP) in 2023 to reflect the need for a whole system approach towards trauma-informed culture, attitudes, policies and practice across the workforce, which requires long-term, transformational change. This NTTP is a major and long-term change programme, supported by the Scottish Government and COSLA (Convention of Scottish Local Authorities). Since 2018, the Scottish Government has invested over £9.6 million in the NTTP. This includes £1.6 million each year to work with Health Boards and community planning partners to further progress trauma-informed systems, organisations and workforces. For further information on TIA developments in Scotland, please see https://www.gov.scot/publications/adverse-childhood-experiences-aces/.

In ***Wales***, considerable progress has also been made in embedding TIA implementation in Government policy. Public Health Wales first published its ACE prevalence research report in 2015 (Bellis et al., 2015), prompting a call upon the Welsh Government to take action to prevent ACEs and subsequent research reports into the creation of resilience (e.g., Hughes et al., 2018). A range of policy and legislative developments followed with

the Welsh Government articulating a clear commitment to prioritise action to prevent ACEs through the creation of ACE-aware public services ('Prosperity for All: National Strategy', Welsh Government, 2017) and 'A Healthier Wales: our Plan for Health and Social Care' (Welsh Government, 2019). This policy and legislative framework recognised the lifelong importance of addressing early childhood adversity, and shaped the priorities of Public Health Wales of building resilience across the life course, addressing harmful behaviours, and protecting health. Initiatives included the establishment of the Adverse Childhood Experience (ACE) Support Hub Cymru in 2017 to support professionals, organisations, and the community to help create an ACE-aware Wales. Funded by the Welsh Government, their mission is to tackle, mitigate and prevent ACEs by sharing ideas and learning, and to challenge and change ways of working within youth justice, housing, local authority, health, education and sporting bodies, as well as the local community. The ACE Support Hub is hosted by Public Health Wales and is part of the World Health Organisation (WHO) Collaborating Centre on Investment in Health and Wellbeing. More recently, the Welsh Government has supported the development of a Trauma-Informed Wales Framework. The Framework (2023) was co-produced with an Expert Reference Group that included Welsh professionals and people with lived experience, and with people and organisations across Wales through a public consultation. It is considered an all-society Framework to support a coherent, consistent approach to developing and implementing TIP across Wales, providing the best possible support to those who need it most. The Framework is seen by the Welsh Government as an important aspect of its current Adverse Childhood Experiences (ACEs) Plan, conceived as helping to achieve the actions in the 'Together for Mental Health Strategy'. It also seeks to influence the delivery of wider Welsh Government policies, particularly those which support vulnerable people and communities.

1.4 Methodology Overview

The methodology for this organisational review of the implementation of trauma informed approaches in NI is based on an implementation science approach which aims to bridge research-practice challenges in real-world settings, integrating consideration of both process and outcomes, to accelerate the development, delivery and sustainability of public health approaches (Theobald et al., 2018). This methodology is in keeping with the Outcomes Based Accountability (OBA) approach, adopted by NI Executive in the Programme for Government, and integrated into previous SBNI EITP TIP Project Review Reports.

This organisational review consists of four distinct components:

(i) a rapid evidence assessment of national and international literature reviews about the implementation of TIA;
(ii) progress mapping of TIA implementation across key sectors and organisations in NI via an online survey;
(iii) a strategic overview of senior professionals' assessment of TIA implementation in their sector or area of expertise; and
(iv) in-depth case studies of selected cross-sector trauma-informed implementation initiatives in NI.

Each component of this organisational review builds on the findings of the other elements and concludes with a distinctive output. The outputs of all four components have been brought together in the final chapter of this report and in the Executive Summary Report (Mooney et al., 2024b) with recommendations for how SBNI and partner agencies can progress the implementation of TIA in NI.

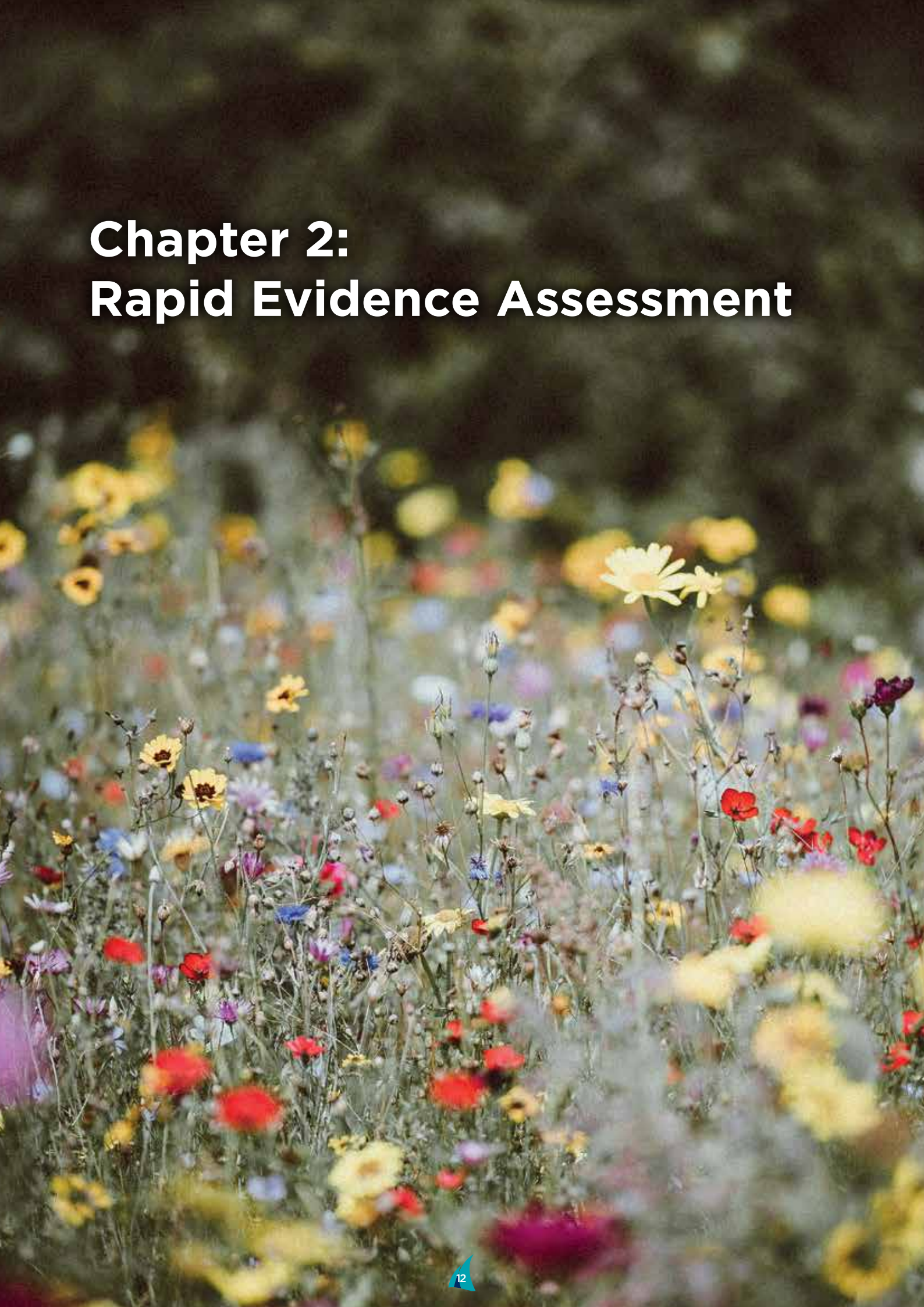
Part 1 - Rapid evidence assessment (REA): This REA builds on the findings of the systematic evidence review conducted by team members on behalf of SBNI in 2018-19 (Bunting et al., 2019a), identifying and synthesising data from publications in the intervening years which focus on the key components of effective TIA implementation to embed and sustain TI organisational developments in diverse real world settings; and methods for the evaluation of effectiveness.

Part 2 – Progress Mapping: This element of the organisational review involves a structured ***online survey*** to map the progress of SBNI member agencies, partners and other organisations and services (across key sectors in NI) in implementing trauma informed approaches;

Part 3 – Strategic Overview: Analysis of a series of sector-specific and regional ***focus groups*** with senior professionals and managers seeks to establish a strategic overview of leaders' assessment of TIA implementation in different sectors and the region as a whole.

Part 4 – Case Studies: This element of the review adopts an integrated process and outcomes evaluation approach to establish a comprehensive understanding of the implementation of four selected trauma-informed initiatives specifically: *what was implemented; how it was implemented; what difference did it make and to whom; as well as perceived initiative enablers and barriers within the service context.* It seeks to capture important organisational learning, which can be applied to other service settings wishing to implement trauma informed approaches, helping provide a vision for ongoing development.

Chapter 2:
Rapid Evidence Assessment



2.1 Introduction and Overview

In this section, we present the findings of a rapid evidence assessment (REA) of the literature recently published on the implementation of trauma informed approaches (TIAs)[1] in a range of sectors and settings. Due to the burgeoning of trauma-informed initiatives in the intervening years (Purtle, 2020), a realist synthesis (Rycroft-Malone et al., 2012) has been undertaken of national and international TI implementation literature reviews published from 2018 to supplement the cross-sector trauma informed care (TIC) evidence reviews commissioned by SBNI and undertaken by QUB in 2018 (Bunting et al., 2018 a-e). This REA therefore aims to synthesise the contemporary evidence from TIA literature reviews undertaken in diverse sectors and settings since 2018, to examine 1) TIA conceptualisation; 2) how TIAs are implemented; 3) implementation enablers/facilitators and barriers; and 4) TIA outcomes and effectiveness.

2.1.1 Electronic searches

In February 2023, we conducted systematic searches of databases for this rapid review. Databases searched include Scopus, Medline, IBSS, PsychInfo, Web of Science and ERIC. The searches included keywords 'trauma informed' and 'literature review', 'scoping review', 'narrative review', 'evidence review' or 'rapid review'. The results of these searches are specified in Table 2.1 below.

The initial database search provided 557 references. After duplicates were removed, 214 references remained.

2.1.2 Review Selection: Inclusion and exclusion criteria

The 214 references obtained were screened by a small team of reviewers and inclusion and exclusion criteria developed. Screening was conducted to determine which documents were relevant to the project's aim. The title and abstract of all potentially relevant publications were screened according to the inclusion criteria below. Where any discrepancies or uncertainty existed between reviewers, full texts were sought and read to establish relevance.

[1] The overarching term of Trauma Informed Approaches (TIA) has been adopted in this review to encompass Trauma Informed Practice (TIP) and Trauma Informed Care (TIC) as a means to reflect the relevance of TIAs for organisations, which do not provide frontline service provision as well as those which do. Where papers explicitly use TIP, TIC or TIA, this is explicitly noted in the text.

Table 2.1: Database searches

Database	Date searched – 22/02/23	Results
SCOPUS	TITLE-ABS-KEY (("trauma-inform*" OR "trauma inform*") AND ("systematic review" OR "scoping review" OR "narrative review" OR "evidence review" OR "rapid review" OR meta*)) AND (LIMIT-TO (PUBYEAR , 2023) OR LIMIT-TO (PUBYEAR , 2022) OR LIMIT-TO (PUBYEAR , 2021) OR LIMIT-TO (PUBYEAR , 2020) OR LIMIT-TO (PUBYEAR , 2019) OR LIMIT-TO (PUBYEAR , 2018)) AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (SRCTYPE , "j"))	197
MEDLINE	(("trauma-inform*" or "trauma inform*") and ("systematic review" or "scoping review" or "narrative review" or "evidence review" or "rapid review" or meta*)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word] limit 4 to (english language and yr="2018 - 2023")	136
IBSS	noft(("trauma-inform*" OR "trauma inform*") AND ("systematic review" OR "scoping review" OR "narrative review" OR "evidence review" OR "rapid review" OR meta*)) Additional limits - Date: From 2018 to 2023; Source type: Scholarly Journals; Language: English	8
PSYCHINFO	(("trauma-inform*" or "trauma inform*") and ("systematic review" or "scoping review" or "narrative review" or "evidence review" or "rapid review" or meta*)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word] limit 1 to (all journals and english language and yr="2018 - 2023")	85
WOS	("trauma-inform*" OR "trauma inform*") AND ("systematic review" OR "scoping review" OR "narrative review" OR "evidence review" OR "rapid review" OR meta*) (Abstract) OR ("trauma-inform*" OR "trauma inform*") AND ("systematic review" OR "scoping review" OR "narrative review" OR "evidence review" OR "rapid review" OR meta*) (Author Keywords) Timespan: 2018-01-01 to 2023-02-22 (Publication Date)	142
ERIC	AB (("trauma-inform*" OR "trauma inform*") AND ("systematic review" OR "scoping review" OR "narrative review" OR "evidence review" OR "rapid review" OR meta*)) OR KW (("trauma-inform*" OR "trauma inform*") AND ("systematic review" OR "scoping review" OR "narrative review" OR "evidence review" OR "rapid review" OR meta*)) Limiters - Date Published: 20180101-20230231; Publication Type: Journal Articles; Language: English	9

Inclusion criteria:

(i) Trauma Informed Implementation: To meet inclusion criteria, the reviews had to include initiatives which had sought to implement a trauma informed approach (TIA) in at least one of the three core implementation domains adopted by this study (i.e. organisational development; workforce development and support; service delivery and practice change).

(ii) Systematic search and evaluative data: All forms of literature reviews were included such as systematic review, narrative review, evidence review, rapid review, scoping review or meta-analyses, providing they used systematic search strategies and included some evaluative data from which to assess outcomes or effectiveness related to TIA implementation, i.e.:

- studies that evaluated strategies, processes and outcomes related to TIA implementation;
- outcomes could include service user/ client outcomes and/or service-level outcomes (e.g. improved knowledge in response to training, improved staff well-being, increased identification of trauma etc.);
- studies that used systematic methods to report upon barriers and enablers of organisational/whole service trauma-informed implementation.

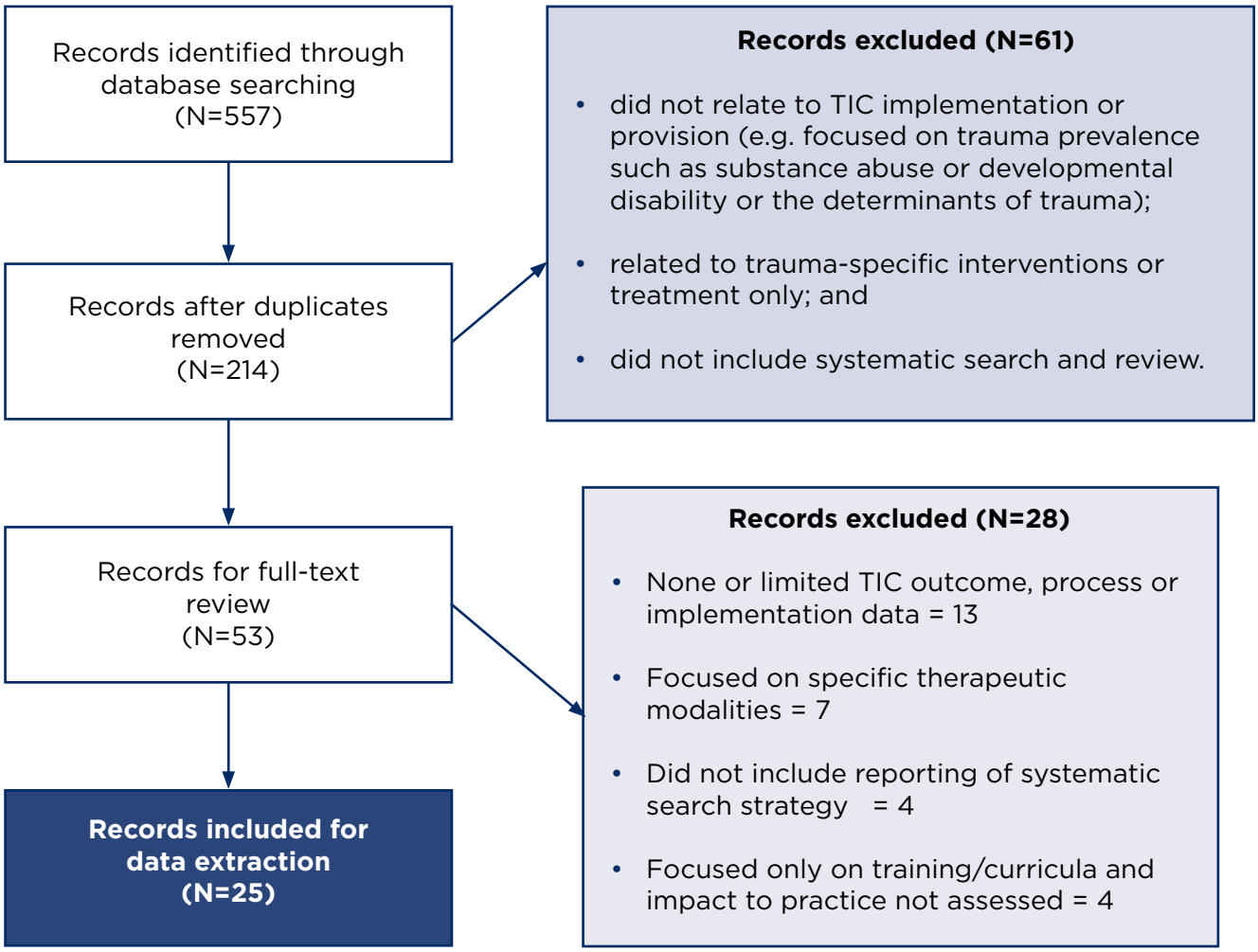
Exclusion criteria: We have excluded the following:

- Non-English publications;
- Non-academic or peer-reviewed publications such as books, theses, and conference proceedings;
- Reviews published before 2017 (to supplement prior TIC evidence review undertaken in 2018);
- Reviews with no systematic search strategy:
- Reviews containing no evaluation data e.g. conceptual papers only; and
- Reviews that focused solely on specific trauma-focused treatments (such as TF-CBT) with no reference to being part of a wider TI initiative.

As explained in Figure 2.1 (below), after applying the inclusion and exclusion criteria, 25 references have been included for data extraction.

In September 2023, we conducted another search of the literature using Google Scholar and Google. This search resulted in **a further five articles** (Huo, et al., 2023; Lewis et al., 2023; Lowenthal, 2020; Maynard et al., 2019; Thomas et al., 2019) being included in the review, as they fulfilled the inclusion criteria specified.

Figure 2.1: Flow Diagram Review Selection



2.2. Included papers overview

The 30 reviews included (see Table 2.2) in this REA are an eclectic mix. While some focused either primarily on the implementation/operationalisation of TIAs (including barriers and facilitators) or the effectiveness of TI initiatives, others attempted to straddle both implementation and effectiveness. The reviews also covered implementation in a range of settings. While some reviews focused on a specific setting (e.g. education, health), others included multiple settings. See Table 2.3 (below) for a brief overview of the setting and focus of included papers.

Table 2.2: List of references included [2]

Avery et al. (2021)[1]	Lewis et al. (2023)[16]
Bailey et al. (2019)[2]	Lowenthal (2020)[17]
Bargeman et al. (2022)[3]	Maguire & Taylor (2019)[18]
Bargeman et al. (2021)[4]	Mahon (2022)[19]
Bendall et al. (2021)[5]	Maynard et al. (2019)[20]
Berger (2019)[6]	McNaughton et al. (2022)[21]
Brown et al. (2022)[7]	Morton Ninomiya et al. (2023)[22]
Bunting et al. (2019)[8]	O'Dwyer et al. (2021)[23]
Cohen & Barron (2021)[9]	Oral et al. (2020)[24]
Davidson et al. (2022)[10]	Phung (2022)[25]
Fernandez et al. (2023)[11]	Procter et al. (2023)[26]
Fondren et al. (2020)[12]	Purtle (2020)[27]
Gundacker et al. (2021)[13]	Thomas et al. (2019)[28]
Huo et al. (2023)[14]	Wassink-de Stigter et al. (2022)[29]
Jackson & Jewell (2021)[15]	Zhang et al. (2019)[30]

Table 2.3: Records included for data extraction (n=30)

Settings		
Multiple settings	7	3, 4, 11, 15, 17, 19, 27
Schools/Education	8	1, 6, 9. 12, 20, 25, 28, 29
Health (including Mental Health)	12	5, 7, 10, 13, 14, 16, 18, 21, 22, 23, 24, 26
Child Welfare	3	2, 8, 30
Focus		
Effectiveness primarily	11	2, 6, 9, 11, 12, 13, 15, 16, 20, 26, 27
Implementation and/or operationalisation primarily	8	3, 5, 14, 18, 21, 23, 25, 29
Both Effectiveness and implementation	11	1, 4, 7, 8, 10, 17, 19, 22, 24, 28, 30

All included texts were closely reviewed and synthesised with a clear focus on the aim of this REA, i.e. to highlight the evidence from TIA implementation to date in diverse sectors and settings, and to identify recognised implementation barriers and enablers. The findings are presented below under the four main thematic areas which emerged from the review process, namely TIA conceptualisation; TIA implementation; implementation enablers and barriers; and TIA outcomes and effectiveness.

[2] Full reference details are in the subsection entitled 'Included References for the Rapid Review' (page 88-90). The superscript numbers beside each reference are used to indicate the specific articles in Tables 2.3-2.5.

2.3 TIA Conceptualisation

A number of the included papers reviewed (e.g. Bailey et al., 2018; Bargeman et al., 2022; Phung, 2022) make explicit reference to a lack of definitional consensus on the use of terminologies such as trauma, trauma informed care (TIC), or a trauma informed approach (TIA). This absence of conceptual clarity was noted as potentially problematic in a previous child welfare TIC evidence review conducted by a QUB research team (Bunting et al., 2019). Importantly, Bargeman et al. (2022) propose that to be able to define trauma informed care, the term trauma itself needs to be defined first in order to make the distinction. They note that the term 'trauma' has been defined in different ways, ranging from strictly biomedical individualised definitions to broader definitions which comprise much broader social and cultural elements. The most frequent definition of 'trauma' articulated in the papers reviewed is that put forward by the Substance Abuse & Mental Health Services Administration USA (SAMHSA) which produced the original internationally recognised definition of trauma informed care (TIC). This definition clearly orientates toward individual-level experience but understands trauma impact to be wide-ranging, including many far-reaching consequences in people's lives and relationships:

"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)

Indeed, the Adverse Childhood Experiences (ACEs) research (Felitti & Anda, 1997; Bellis et al., 2014) was also noted in a number of the papers reviewed (e.g., Avery et al., 2021; Bunting et al., 2019; Jackson & Jewell, 2021; Mahon, 2022). This body of research has drawn attention to the prevalence of childhood adversity and the detrimental impact of multiple adversities on an individual's outcomes across the life course. This seminal body of research critically influenced the emergence of the concept of TIC (Harris & Fallot, 2001; SAMHSA, 2014), drawing close attention to the relational nature of many adversities and the subsequent need for 'relational repair' in the helping relationship with every interaction considered an intervention with potential therapeutic benefit or indeed the risk of further harm (e.g., Frederick et al., 2021, Triesman, 2016).

There is a plethora of trauma-related terms in this field that are often, sometimes mistakenly, intertwined and conflated. These include trauma-informed, trauma-sensitive, trauma-responsive, trauma-focused and trauma-specific. A key distinction to be made is between ***'trauma-informed'*** and ***'trauma-focused'*** services or interventions. Trauma-focused or trauma-specific services refer to those services that work directly with individuals who have had particular experiences known to be traumatic in nature (such as domestic violence, political conflict related experiences etc.). Trauma-focused or trauma-specific interventions refer to particular treatments or therapies for specific trauma-related symptoms such as PTSD (e.g. EMDR, Trauma-CBT), or broader interventions that are tailored toward specific life experiences (e.g. group work with young people who have experienced domestic violence).

In contrast, ***TIP, TIC and TIA***, which tend to be used interchangeably in the literature (Bunting et al., 2018), "do not aim to elicit a description of trauma, nor address it directly" (Davidson et al., 2022, p. 3). Instead, the broader term of 'trauma informed' refers to a whole-systems organisational change framework that aims to develop coherent cultures, policies and practices across systems of service delivery to enhance service user engagement and provide more effective care (Bunting et al., 2018; DeCandia, 2014). 'Trauma-informed' approaches recognise that many service users, patients or clients of health, social care, education and justice services will have been impacted by potentially traumatic adverse experiences across their life course, and therefore a more responsive form of service delivery is required. SAMHSA (2014) thus articulated four assumptions which should underpin all trauma-informed service delivery, commonly referred to as the four 'R's:

[3] In the UK, the Government has adapted the original principles proposed by Harris and Fallot (2001) and SAMHSA (2014) to include safety, trust, choice, collaboration, empowerment and cultural consideration in their working definition of TIP.

"A program, organisation, or system that is trauma-informed *realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization*." (p.9)

In order to achieve these goals, organisational systems are advised to adopt the following six trauma-informed principles into all aspects of their service delivery as a means to redress previous adverse experience, building safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and addressing cultural, historical and gender issues (SAMHSA, 2014)[3].

Becoming a trauma-informed organisation is therefore considered not as a one-off activity (Lewis et al., 2023) or a "standalone intervention that can be delivered in silo" (Phung, 2022, p. 7). It is instead an organisational transformation process which requires systemic culture change and ongoing work at all levels of the organisational hierarchy, rather than simply training or screening (Lowenthal, 2020). As such it is recognised that implementing a trauma informed approach is complex, as organisations and systems differ widely. Therefore, what has been recommended is "a comprehensive, whole-system approach to the implementation process that is theoretically grounded, developmentally informed and is flexible enough to be adapted to each organisation's unique context" (Lowenthal, 2020, p. 188). Thus, a trauma informed approach has also been described as "a framework to guide complex systems" (Phung, 2022, p.7).

Some of the literature reviews included in this REA explored how (and indeed whether) different research studies defined and operationalised TIC, TIP or TIA (Bargeman et al., 2022; Bendall et al., 2021; Davidson et al., 2022; Morton Ninomiya et al., 2023). In general, review authors found that many (even most) studies did not specifically define or operationalise the approach adopted, while others simply employed popular definitions, in particular, SAMHSA's (2014) guiding principles and core assumptions noted above, which appear to be the most widely utilised (Bendall et al., 2021; Brown et al., 2022; Davidson et al., 2022). For instance, in their systematic review focusing on TIP in outpatient health services for young people, Bendall et al. (2021) found that of 13 included studies, most publications did not include a definition of the approach adopted; three used SAMHSA's definition; while another three gave alternative definitions closely aligned with the SAMHSA's definition. Davidson et al. (2022) reported similar findings in their scoping review of TIAs in cancer care. Interestingly, in the eight (out of a total of 13) studies that did not define or operationalise the TIA adopted, implementation was articulated as a community or medical intervention, a screening method or a form of psycho-education, all falling short of what might be defined as a whole system transformational approach. In addition, Morton Ninomiya et al.'s review (2023), focusing on TIAs when working with pregnant and/or parenting women who use(d) alcohol, found that some studies did not even use explicitly the term 'trauma-informed' and instead referred to phrases such as "relational, judgment-free, supportive, emotionally safe, culturally safe/responsive, harm reduction, holistic, women-centered, strengths-based, individualized, self-determination, and wraparound" (p. 5). Like the term 'trauma-informed', these terms were often not clearly defined or operationalised. Similarly, within the education sector, Maynard et al.'s (2018) systematic review argued that it was unclear what trauma-informed schools were exactly implementing, with no agreement on the operationalisation of what is essential to a trauma-informed school approach (Wassink-de Stigter et al., 2022).

2.4 TIA implementation

Similar to the absence of conceptual clarity re. definitions of TIAs noted above, a range of classifications are used to describe the different core areas involved in whole-system TIA implementation or operationalisation, some of which were utilised in the papers reviewed. In this section, we now discuss TIA implementation progress and limitations as reported in the papers reviewed on the implementation domains adopted by this study i.e. (i) Organisational Development, (ii) Workforce Development and Support, and (iii) Service Delivery and Practice Change.

2.4.1 Organisational Development

Although TIA implementation and research has tended to focus predominantly on the domains of 'workforce development' or 'trauma-focused treatment' (Fernandez et al., 2023), the 'organisational development' implementation domain is considered to be of primary importance to the effective TIA implementation. Lowenthal's (2020) review of TIC in child/youth service sectors described a continuum of TIC implementation. At one end of the continuum, there were limited change initiatives, often consisting of one-off trainings and a few interventions to address the physical environment and/or policy or organisational culture, while at the other end, there were comprehensive change initiatives, which used multiple strategies over long periods of time to create and embed significant changes in the broader service system, organisational culture and policy. Such comprehensive change initiatives were noted to incorporate more components from the 'organisational development' implementation domain, with limited change initiatives less likely to show meaningful positive impact.

Successful TIA implementation has been specifically linked to reviewing and amending organisational ***policies and procedures***, following recommended TIC guidelines and adopting refinements, such as service user involvement, alongside activities within other domains (e.g. ongoing staff training) (Oral et al., 2020). According to Oral et al. (2020), "Most trauma-informed organisations begin by establishing a stakeholder group to look at the available policies, procedures, and practices to determine how they might better align with a TIC paradigm" (p. 909). In fact, Bargeman et al. (2022) identified clear policies and procedures at different levels (i.e. programme, organisation, system and inter-sectoral levels) as a key requirement for successful operationalisation of TIC. In Huo et al.'s (2023) review of TIA implementation in healthcare settings, several initiatives described strategies to build buy-in across the organisation, including aligning strategic planning, establishing teams responsible for implementation and monitoring, organising quality monitoring systems, etc. Similarly, within the education sector, strategic implementation planning was identified as a key factor affecting implementation, which included conducting a needs assessment, integrating a TIA into existing initiatives, appointing advocates within school and establishing implementation teams (Wassink-de Stigter et al., 2022). Indeed, the importance of adopting trauma-informed policy and procedures was seen as a key organisational change mechanism in schools, particularly in relation to disciplinary practices, as it helped reduce behavioural incidences and enhanced learning time for all (Avery et al., 2021). In the child welfare sector, as part of the TIA implementation process, some initiatives described making changes to policies, processes and/or data systems (Bunting et al., 2019). Bunting and colleagues (2019, p.15) gave an example from their included studies:

"In an effort to embed trauma-informed principles into decision-making processes, the Michigan Children's Trauma Assessment Centre developed a trauma-informed Court Report Checklist (CRC) to assist Family Court judges to understand a child's trauma history, the impact of the trauma on their functioning and the services being provided the child."

Leadership buy-in has also been shown to be required to make meaningful organisational changes (Lowenthal, 2020; Mahon, 2022; Phung, 2022). Indeed, securing leadership buy-in was identified as critical in a range of studies within various reviews in the health sector (Bendall et al., 2021; Brown et al., 2022; Huo et al., 2023), the child welfare sector (Bunting et al., 2019), and the education

sector (Phung, 2022; Wassink-de Stigter et al., 2022). This was reported to be achieved through offering initial training to directors and senior managers, establishing implementation teams and local champions (who mobilised resources), developing implementation plans, and examining organisation readiness (Bunting et al., 2019). In addition, it was noted in some papers that TIC implementation brought changes in leadership and management practices, sometimes being experienced as a flattening of the organisational hierarchy, particularly in terms of staff feeling empowered and enhanced collaboration in decision-making processes. This, in turn, was identified to improve organisational climate and staff satisfaction (Mahon, 2022).

Financing and resourcing were mentioned as key components of successful TIA implementation within the organisational development domain. In fact, in many reviews, lack of financial capacity was seen as a central barrier to implementation (e.g., Mahon, 2022) (see section below). Intra and inter-agency ***collaboration*** was also deemed a fundamental element of organisational development which is integral to successful TIA implementation in different sectors (e.g. Avery et al., 2021; Bendall, 2021; Brown et al., 2022; Mahon, 2022; Wassink-de Stigter et al., 2022). For instance, in Brown et al.'s (2022) review of TIA implementation in hospital emergency departments, eight of the 10 studies reviewed had initiated enhanced collaboration (e.g. collaboration across health professions or with community organisations), seen as vital to successful intervention. In five papers, they found that "Collaborations with community organisations were vital to addressing social determinants of health including housing instability, food insecurity, and economic insecurity" (p.339). Focusing on cancer care, Davidson et al. (2022) found that inter-professional collaboration in TIC, i.e. having inter-professional care teams, was likely to have positive impacts on service users, such as improving quality of life, maximising patient safety and developing a sense of trust between staff and service users. In reviews focusing on schools, collaboration was also mentioned as significant, particularly the need to engage with multiple key stakeholders, such as local agencies, mental health professionals and children's caregivers (Wassink-de Stigter et al., 2022). For example, Phung (2022) noted the need for "a strong cross-system collaboration among teachers, staff, and mental health professionals" (p. 8), while Avery et al. (2021) advocated the use of care co-ordination teams that provide family-driven and student-involved planning and practices. Thus, collaboration as a TIA implementation priority was understood to not only involve inter-agency collaboration, but also enhanced collaboration between staff and service users and families. For instance, focusing on acute psychiatric inpatient settings, O'Dwyer et al. (2020) highlighted the importance of collaboration between service users and staff, and how collaborative relationships led to "increased choice and a more flexible and confident nursing group" (p. 1063). However, it was also recognised that promoting enhanced collaboration with service users and families/caregivers raised challenges, with professionals struggling to balance organisational pressures to follow safety and risk management procedures while integrating TIC principles, and relinquishing control to service users, who they believed to be a risk to themselves and others.

Following on from the collaboration element of the organisational development implementation domain, some reviews also found that ***service user and caregiver involvement*** or the involvement of wider stakeholders through co-production (in the planning, design and delivery of services) was a key implementation domain in various sectors (Mahon, 2022), including the health sector (Bendall et al., 2021; Lewis et al., 2023), the child welfare sector (Bunting et al., 2019), and the education sector (Avery et al., 2021). For instance, in Lewis et al.'s (2023) review of primary care and community mental healthcare, six models (out of the eight identified in the six reported studies) included engagement and involvement of people with lived experience. Examples included involving people with lived experience of mental health problems in service development working groups/committees, and six models recruited people with lived experience as advisors and staff. Focusing on trauma-informed schools, Avery et al. (2021, p. 393) highlighted that pupil engagement and participation can lead to "modifications to classrooms that enhance the learning environment, reducing triggers and supporting relationships". Thus, engaging pupils, families and communities

was regarded as essential to trauma-informed planning and the effectiveness of interventions. Avery et al. (2021) also argued that gaining pupil views aligns with the United Nations Convention on the Rights of the Child (UNCRC) and statutory duties on education providers in this regard. In contrast, within the child welfare sector, in a range of initiatives reported in Bunting et al.'s (2019) review, parent and carers were noted as the primary targets of involvement, rather than children and young people. Relevant examples included involving parents/caregivers in trauma-informed training and community engagement initiatives or in leadership teams, and engaging family members and other supportive adults as part of permanence planning for children in foster care (Bunting et al., 2019).

Reviews exposed a general lack of ***progress monitoring and evaluation*** regarding TIA implementation, with a noted absence of measuring the outcomes of TIA initiatives (particularly clinical outcomes) and the impact on service users and families (Mahon, 2022). One notable exception was Lewis et al.'s (2023) review of primary care and community mental healthcare, where seven of the eight models reviewed reported monitoring progress and quality improvement strategies. However, overall, this component was less mentioned in many of the reviews included, as were considerations around the ***physical environment***. In Brown et al.'s (2022) review, for instance, in only two of their 10 included studies, interventions considered how the physical space of Emergency Departments could be evaluated and improved using a trauma informed framework; while in Bunting et al.'s (2019) review, none of the community-based child welfare projects included described changes made to offices or other facilities in line with a TIA. In contrast, in Lewis et al.'s (2023) review, seven out of the eight identified models included making changes in the physical environment (e.g., women-only spaces and activities with childcare provision, redesigning waiting rooms and offices).

2.4.2 Workforce Development and Support

Adequate ***workforce training*** is generally regarded as the foundation for the effective delivery of trauma-informed services (Bargeman et al., 2022) or the first step for an organisation to become trauma-informed (Purtle, 2020). Introductory TIA training to all staff has been recommended to precede full implementation (Mahon, 2022). In schools, staff training was found to help teachers reframe pupils' behaviours and decrease the potential of punitive practices (Avery et al., 2021). Similarly, in the child welfare system, as well as within healthcare, training was found to result in increased staff knowledge, awareness, and/or confidence in applying trauma-informed principles (e.g., Brown et al., 2022; Bunting et al., 2019) (see outcomes section for further detail). However, it is also recognised that workforce training alone, especially when it is short and one-off, is insufficient with regard to embedding lasting practice change and thus has limited impact (Lowenthal, 2020; Wassink-de Stigter et al., 2022). In their review of TIA implementation in multiple sectors, Jackson and Jewell (2021) found that TIC training practices varied significantly across sectors, despite arising from the same foundational context.

Within the healthcare sector, reviews found that most organisations/services (in the included studies) had implemented some sort of trauma-informed staff training or educational interventions, with universal training often complemented by other implementation strategies designed to embed TIC throughout the service (Bendall et al., 2021; Brown et al., 2022; Huo et al., 2023; Oral et al., 2020). In fact, some reviews argued that "training can result in a paradigm shift toward more TIC practices" (Oral et al., 2020, p. 910). For instance, in Lewis et al.'s (2023) review of TIAs in primary care and community mental health care settings, all six included studies (evaluating eight models) covered training and ongoing support for staff. Similarly, within the child welfare system, training has been found to be the most common and a vital component of TIC implementation (Bunting et al., 2018). Within the education sector, particularly when focusing on trauma-informed schools, reviews found that all studies included some element of training and professional development (Avery et al., 2021; Berger,

2019; Fondren et al., 2020; Phung, 2022; Wassink-de Stigter et al., 2022), which was considered a change catalyst and key to improve motivation to change school practice (Avery et al., 2021). However, in the oncology field in Canada and the USA, Davidson et al. (2022) highlighted a lack of formal training and guidelines for TIC implementation.

Workforce development initiatives mentioned in the literature reviewed often ranged from a single training session, train-the-trainer sessions, the provision of regular supervision and the delivery of ongoing training (e.g. Huo et al., 2023). In one of the reviews (of studies in Australia), training was limited to workshops and brief web-based training (McNaughton et al., 2022). The length of training provided also ranged widely (Bunting et al., 2019; Maguire and Taylor, 2019), as did the approaches used, which included role playing and coaching, motivational interviewing and a learning collaborative model, as well as specialist training for trauma-focused interventions (e.g. Jackson & Jewell, 2021). Within the healthcare sector, although the training content, format and the duration varied, Lewis et al.'s review (2023) found some common features, including being delivered by external experts, being tailored to particular organisational contexts and patient populations, and inclusive of booster sessions.

In some reviews, the way staff training is delivered was identified as either an enabler or a barrier to successful TIA implementation. Common elements of workforce development identified as having a positive impact were:

- ongoing staff training (including booster sessions) and development (as well as follow-up support), as opposed to single, one-off sessions (Bunting et al., 2019; Huo et al., 2023; Jackson & Jewell, 2021; Wassink-de Stigter et al., 2022);
- delivering training to a variety of staff at all levels of the organisation (Huo et al., 2023);
- practical learning elements (e.g. role plays) (Huo et al., 2023; Maguire and Taylor, 2019);
- including peer workers or staff with lived experience in the training delivery (Maguire & Taylor, 2019);
- training focus and structure to be delivered in partnership with the organisational leadership (Avery et al., 2021);
- space and time for staff to debrief and discuss difficulties on a regular and ongoing basis (Avery et al., 2021);
- a flexible format tailored according to needs (Huo et al., 2023);
- embedding training into orientation for new staff and making training compulsory (Huo et al., 2023); and
- on-site delivery (Huo et al., 2023).

In addition, Avery et al. (2021) argued that:

"enabling teachers to be active participants in their training along with encouraging staff to express the challenges and systemic barriers they experienced, showed benefits as part of the intervention design."
(Avery et al., 2021, p. 392)

In Purtle's (2020) review of staff training in multiple sectors, most studies did not identify a specific training curriculum, and considerable variation was found in the amount of information provided regarding the content of the trainings and their approach. Some of the included reviews in this REA explored how curricula have been developed and piloted for healthcare professionals in different settings (e.g. Oral et al., 2020). Gundacker's (2020) review of trauma-informed curricula for primary care services revealed that trauma-informed training in primary healthcare is an area which is still actively developing (with half of the curricula reviewed being pilots, feasibility studies or curricula in development). A review of Australian studies argued that TIP training content within the health and mental health sectors differs widely, with trauma being understood through different models, including neurobiological, neuro-biopsychological, cognitive and psychosocial approaches (McNaughton et al., 2022). In terms of topics covered in these curricula, Gundacker (2020) found that the most common elements were understanding the health effects of trauma exposure (94%), followed by topics related to patient-centred communication and care (71%), addressing interprofessional collaboration (53%), addressing trauma screening (47%), and addressing understanding of personal history (35%). In Brown et al.'s review

(2022), educational content varied from trauma epidemiology and health impact to TIC clinical skills, with their focus on specific populations (e.g., sexual violence survivors, pediatrics, patients experiencing mental health crises). In Bendall et al.'s review (2021) of TI initiatives in outpatient health and counselling settings for young people, training content focused on trauma screening/assessment (3 studies) and the impact of trauma responses (2 studies). In relation to targeted audiences, six studies made reference to system-wide training, which included clinical and non-clinical staff (Bendall et al., 2021).

However, this implementation domain is not just about the training. Although mentioned less frequently in the studies in the included reviews and probably requiring additional focus (Bunting et al., 2018), the critical importance of ***ongoing workforce development and support*** to staff delivering TIC was acknowledged (Bargeman et al., 2022; Bunting et al., 2019; Mahon, 2022), with increasing recognition that secondary or vicarious trauma among frontline staff needs to be properly addressed (e.g., Bargeman et al., 2021; Mahon, 2022). While self-care is noted as an important element of TIA implementation in some literature, it has also been argued that "the full onus on individual staff members to support their well-being in light of the known effects of secondary trauma is not sufficient" (Thomas et al., 2019, p. 447). In the child welfare context, strategies to provide ongoing staff support were considered crucial, and included the use of coaching, mentoring, learning collaboratives, and monitoring of fidelity to the trauma-informed model through supervision (Bunting et al., 2019). In clinical settings, despite its reported benefits, it was argued that opportunities for staff to engage with reflective practice were uncommon due to a lack of time and resources (Maguire & Taylor, 2019). In the education sector, mentoring and supervision (individual supervision or small group sessions or workshops), as well regular check-in protocols (to detect and respond to signs of stress), were forms of ongoing workforce development and support that were also considered essential to strengthening practice and organisational change (Avery et al., 2021). Coaching was found to enable staff to apply trauma-informed skills and strategies into their daily practices in the classroom, while regular peer consultation groups gave staff the opportunity to discuss, plan and practice these strategies, celebrate what went well and receive support from colleagues (Wassink-de Stigter et al., 2022).

2.4.3 Service design and delivery

Many studies in the included reviews, especially within the child welfare sector (Bunting et al., 2019) and healthcare sector (Bendall et al., 2021; Brown et al., 2022; Lewis et al., 2023; Oral et al., 2020), explored the implementation of ***universal screening*** processes (for history of adversity/trauma and/or mental health conditions/difficulties). Indeed, trauma screening has been considered an essential part of TIAs within multiple sectors, although there appears to be wide variation in how it is conducted (Bendall et al., 2021). Despite this, in a review focusing on primary care and community mental healthcare settings, Lewis et al. (2023, p. 15) concluded that "a universal trauma-informed approach does not have to include a screening component to improve patients' experiences and outcomes". In addition, various difficulties and barriers to screening have been identified, including resource allocation, time constraints, utility and appropriateness of screening instruments, as well as staff resistance due to not feeling suitably prepared and trained (Mahon, 2022). Staff were reported to be often reluctant to undertake trauma screening as they did not feel suitably prepared or qualified and were afraid to 'open a can of worms' (Mahon, 2022; O'Dwyer et al., 2020). It was reported that even when staff in clinical settings were confident in screening service users, some claimed that they did not know how to respond after a disclosure of trauma (Maguire & Taylor, 2019). As Bargeman et al. (2022) argues, across all systems, staff are resistant to trauma screening in the absence of a clear protocol on how to respond and if they perceive the system to be unable to respond appropriately by providing effective and accessible therapeutic services. For instance, in youth mental health settings, it was reported that staff avoided trauma screening and assessment for fear of retraumatising young people (Bendall et al., 2021). An additional challenge identified in the literature reviewed is in relation to the screening measures available, as it is argued that many may not be suitable (in terms of

evidence base or psychometric properties) or may not have the required utility and brevity for professionals to use them routinely (Mahon, 2022). However, routine screening has also been shown to have benefits for service users, improving the provision of integrated care. For example, in health settings, routine screening has been noted to result in identifying further need, which has led to some institutions "investigating how they might better integrate behavioral and mental healthcare services with primary care" (Oral et al., 2020, p. 909). Within child welfare settings, studies have explored the implementation of screening processes and routine inquiry, which have been described as being perceived favourably by professionals, despite reported challenges, such as inadequate IT systems, limited buy-in, poor availability of appropriate follow-up therapeutic interventions, and team cultures (Bunting et al., 2019).

Trauma-focused therapeutic interventions were reported in many of the studies in the reviews included in this REA, particularly in health and child welfare settings. For instance, in Bendall et al. (2021)'s review of TIA implementation in outpatient and counselling health settings for young people, many of the interventions reported referred to therapeutic interventions (e.g., provision of CBT, trauma-centred counselling, etc.) (11 out of 13 included studies). In child welfare, different services and initiatives were found to have trained some of their staff to deliver evidence-based treatments such as trauma-focused cognitive behavioural therapy, and child parent psychotherapy, with evaluations showing positive impacts (Bunting et al., 2019). Even in schools, trauma-focused interventions appeared to be delivered on some occasions (e.g. Cognitive Behavior Intervention for Trauma in Schools or Bounce Back), but it was widely recognised that these alone would not be able to create a school-wide trauma-informed environment able to reduce the impact of trauma and avoid re-traumatisation. Wassink-de Stigter et al., (2022, p. 2) note the pressing need for trauma recovery to be embedded in everyday school practices:

"Recovery of trauma also takes place in daily interactions with school staff members, as traumatized students are in need of a safe and nurturing environment that provides consistency."

In schools, ***everyday relational practices*** were transformed, as punitive reactive measures were replaced with restorative, strengths-based and skill-building approaches, which was strongly supported by evidence-based literature (Avery et al., 2021). In healthcare settings, Morton Ninomiya et al. (2023, p. 14) in their review of services and programmes supporting pregnant and parenting women using alcohol during pregnancy), showed how a sense of safety and trustworthiness (i.e., key TIC principles) was cultivated and achieved "when program and service staff were consistently non-judgmental, welcoming, and respectful with women accessing supports". The authors also found evidence of the use of routine strengths-based and skill-building approaches, with programmes being flexible around women's lives, for example not penalising them for missing appointments or offering to meet service users in their own homes or somewhere they felt comfortable. Indeed, approaches, programmes or services that included service user choice, in additional to everyday relational practices were found to be highly effective in terms of service user outcomes. Thus, in some reviews, how services were provided was also acknowledged as a crucial element of TIA implementation. It was recognised that TIA implementation in this service delivery domain could be achieved via holistic care of service users and their families, addressing need through relationship-based practice, as well as additional screening and referral to specialist services (Oral et al., 2020).

2.5 Implementation enablers and barriers

Enablers/facilitators and barriers to implementation were identified and categorised in several of the included reviews. For instance, Huo et al. (2023) described factors as relating to intervention characteristics (e.g., perceived relevance of TIC among staff or lack thereof); outer setting (i.e., influences external to the organisation); inner setting (i.e., culture of the organisation and climate for implementation); individual characteristics (i.e. staff openness or resistance); and the process of implementation (e.g., type of staff training delivery or engaging service users in implementation efforts). Bargeman et al. (2022) distinguished between infra-structural barriers (i.e., physical or organisational barriers) and ideological barriers (i.e., relating to ideas, perspectives and understanding). It has also been acknowledged that some of these factors could potentially be both a facilitator/ enabler and a barrier, depending on their presence or absence (e.g., Wassink-de Stigter et al., 2022). In this review, we have adapted these different classifications, and have distinguished between barriers and enablers that relate to individual factors, organisational factors and external or wider context factors (see Table 2.4).

Table 2.4: Main barriers and enablers

	Factors	Barriers	Enablers
INDIVIDUAL	**Staff engagement**	Staff resistance to change and uneven commitment from front-line staff or poor staff engagement [3,14,16,19,29]	Staff buy-in and openness to change [14,25,29]
	Staff perceptions of TIA	Lack of perceived relevance of TIA among staff [3,14]	High/growing level of awareness of perceived relevance of TIA among staff [1,3,14]
	Staff confidence	Staff fears and misconceptions [23,24]	
ORGANISATIONAL	**Leadership buy-in**	Lack of leadership buy-in	High levels of engagement, commitment and support from senior organisational leadership [14,16,17,19,29]
	Organisational culture of collaboration	Lack of collaboration between teams [14]	Culture of intra and interagency collaboration (with funding allocated to building relationships) [14,17,29]
	Staff Support	Unsupportive culture with high pressure environment & competing priorities and staff time constraints [8,14,16,19,28,29]	Culture of ongoing staff support and open communication [1,14,16,17,29]
	Staff Training	Insufficient or lack of adequate staff training [3,14,18,23,29]	Relevant, context-specific, ongoing staff training and development [1,14,25]
	Resourcing	Inadequate/insufficient financial resources allocated [3,14,16,17,19,29]	Allocation of adequate financial/staffing resources to promote TIA implementation [14]
	Policies & procedures	• Policies, funding & regulation incompatible with TIA [14,16,21] • Inadequate or absence of consistent and clear policies and procedures across all levels [3,19,23]	• Clear policies and procedures at all levels reviewed and adapted/changed for TIA relevance [1,3,14,18,29] • Alignment of TIA with existing strategic plans/policies [14,29]
	Service user involvement	Lack of service user engagement [14,25]	Involving service users in implementation efforts [14,29]
	Monitoring & Evaluation	Lack of data collection and evaluation on relevant outcomes	Mechanisms established to regularly collect, review and communicate data on relevant context-specific outcomes [14,29]
	Time	Lack of sustained involvement in change process	Sustained involvement in the change process overtime [17]
External and wider context	**Conceptualisation**	Lack of conceptual clarity and definitional consensus about TIA; difficulty in distinguishing TIA from current best practice [3,25]	Development of a shared TIA language and conceptualisation [17,23,28]
	Evidence	Lack of empirical research/data on the effectiveness of TIAs [3]	Growing body of empirical research evidencing positive TIA impact in different service settings [3]
	Legislative & regulatory environment	Legislative and regulatory environment where organisations are not facilitated or encouraged to be trauma-informed e.g. that does not actively promote inter-agency collaboration [19]	Legislative and regulatory environment where TIA implementation is facilitated, encouraged or mandated [19]
	Institutional legacy	Institutional policy legacies across all systems which are at variance with TIA implementation [3,17]	Implementation of TIA in other agencies with same service user population evoking precedence [14]

2.5.1 Individual factors

Individual factors identified in the literature reviewed tended to focus primarily upon staff characteristics and attitudes and the way they engaged or disengaged from TIA implementation. Negative staff/service provider attitudes, staff resistance or poor (as well as uneven) staff engagement and commitment were found to be barriers to effective TIA implementation (Bargeman et al., 2022; Huo et al., 2023; Lewis et al., 2023; Mahon, 2022; Wassink-de Stigter et al., 2022), while staff buy-in (Phung, 2022) and openness to change were seen as enablers (Huo et. al., 2023; Wassink-de Stigter et al., 2022). Staff resistance to change was often linked to a poor understanding of trauma, and perceptions of TIC as costly, not relevant or ineffective, which it was found could be addressed by adequate training (Bargeman et al., 2022). For instance, within schools, staff buy-in was reported to be hindered by certain teacher attitudes and beliefs (i.e. lack of awareness of the prevalence and impact of trauma among pupils; considering healing from trauma a home issue, not a school one; a belief about the need for punitive discipline to diminish disruptive behaviour; equating being trauma-informed with being 'soft' on disruptive behavior) (Wassink-de Stigter et al., 2022). It was argued that these issues could be mitigated or addressed through enhanced workforce development, and monitoring and evaluating progress, so staff became aware of the benefits of a TIA (Stigter et al., 2022). In healthcare settings, Huo et al. (2023) found that not being able to encourage staff buy-in could result in staff turnover and poor staff morale. To address these issues, they recommended a range of strategies to build staff buy-in, which critically included involving them in the TIA implementation design.

Staff reluctance to engage was also found to be related to the perceived relevance of TIC to the setting and target population (Bargeman et al., 2022). Thus, staff sometimes perceived that either TIC principles were not suitable for their organisation or that TIC delivery was not possible due to the diversity of service users (Huo et al., 2023). On the other hand, perceived relevance of TIC among staff was found to be a facilitating factor in four studies in a review focusing on healthcare settings (Huo et al., 2023). Similarly, in a review focusing on schools, it was found that the impact of implementing a TIA was dependent on teachers' perception of 'school-fit' and the acceptability of adopting a TIA (Avery et al., 2021).

Staff confidence, staff fears and misconceptions, as well as worries about their own inadequacies were identified as barriers in acute psychiatric inpatient settings (O'Dwyer et al., 2020). Staff fear 'to offend' service users was also reported as a barrier to trauma screening in another review in healthcare settings (Oral et al., 2020). The authors attributed these fears to staff's discomfort with their own trauma history and their desire to avoid secondary trauma, compassion fatigue and burn out. It was found that these issues could be addressed through some of the organisational factors specified below, i.e., ongoing workforce training, development and support initiatives (Bargeman et al., 2022; Bunting et al., 2019; Mahon, 2022; Oral et al., 2020).

To conclude this sub-section, it appears that much needs to be done to ensure that the content of workforce development initiatives is relevant to the service setting and engages proactively with staff concerns and reticence, including them meaningfully in implementation planning and review. Ongoing evidence collected through progress monitoring and evaluation processes also is needed to adequately promote the relevance of TIA to the specific service setting.

2.5.2 Organisational factors

Multiple organisational factors were identified as affecting TIA implementation, which were perceived as either barriers or enablers in the included reviews, dependent upon their presence or absence. Some of these were related to the TIA implementation domains mentioned in earlier sections, such as training, service user involvement or collaboration and are incorporated in the summary table above. Lowenthal (2020) reported the importance of sustained involvement in the change process overtime as well as engagement across the organisational hierarchy as a means to effect long-term and meaningful change:

"Meaningful change requires ongoing work and the participation of all levels of the organisational hierarchy to be sustained, especially in complex service systems where change is difficult and where the dominant service delivery paradigm may be incompatible with TIC principles" (Lowenthal, 2020, p. 184).

Leadership buy-in was a key implementation facilitator and change driver highlighted in many of the reviews (Avery et al., 2021; Huo et al., 2023; Lewis et al., 2023; Lowenthal, 2020; Maguire & Taylor, 2019; Mahon, 2022; Wassink-de Stigter et al., 2022). This element consisted of high levels of involvement, commitment, accountability and support from senior organisational leadership, which appeared fundamental as a starting point in the implementation process to ensure that policy and procedural change is implemented, and practice developments established on a long-term basis.

Changes in policies and procedures also featured as key organisational enablers noted within a range of reviews (e.g., Avery et al., 2021; Huo et al., 2023; Lewis et al., 2023; Maguire & Taylor, 2019; McNaughton et al., 2022). In contrast, a lack of consistent and clear policies and procedures across all levels (Bargeman et al., 2022; Mahon, 2022; O'Dwyer et al., 2020) or policies that were too rigid or not compatible with TIA, e.g., policies giving limited flexibility to how staff delivered services and how service users engaged with the service (Huo et al., 2023) were found to be significant barriers to TIA implementation. In addition, it was argued that any fragmentation between interventions and procedures could elicit staff perceptions of having to constantly adopt new innovations, detrimentally impacting staff buy-in (Wassink-de Stigter et al., 2022). On the other hand, clear policies and procedures at all levels (Bargeman et al., 2022), the alignment and integration of TIA with existing strategic plans, programmes, interventions, policies and improvement plans (Huo et al., 2023; Wassink-de Stigter et al., 2022) were found to be implementation facilitators. These included policies promoting flexibility in care protocols and offering service users more choice and control over their care plans (Huo et al., 2023). In the education context, Avery et al. (2021, p. 393) also mentioned the importance of school readiness for successful engagement, "along with consideration of how the intervention aligns with the core values and needs of the school and infra-structure such as policies and procedures".

Another key element mentioned in a number of reviews was the resourcing of TIA developments. In the literature, this was described mostly as a barrier or on occasion an enabler when present. Thus, while inadequate/insufficient financial resources allocated was considered a barrier to implementation (Bargeman et al., 2022; Huo et al., 2023; Lewis et al., 2023; Lowenthal, 2020; Mahon, 2022; Wassink-de Stigter et al., 2022), the allocation of adequate financial/staffing resources to promote implementation was seen as a key organisational enabler (Huo et al., 2023).

A supportive organisational culture for staff was another key element found to be central to successful TIA implementation across settings. Thus, while an unsupportive culture within a high-pressure environment (Lewis et al., 2023), coupled with competing priorities and staff time constraints (Bunting et al., 2019; Huo et al., 2023; Lowenthal, 2020; Mahon, 2022; McNaughton et al., 2022; Thomas et al., 2019; Wassink-de Stigter et al., 2022) acted as strong barriers to change, a culture of staff support, open communication, and evidence-based practice (Huo et al., 2023; Lewis et al., 2023; Wassink-de Stigter et al., 2022), involving provision of ongoing mentoring, modelling and expert consultation (Huo et al., 2023) or ongoing staff support (Lowenthal, 2020) enabled change. In schools, for instance, certain teaching coaching models – including regular individual supervision and small group sessions, workshops, and in-class in the moment support from a specialist – were found to be particularly effective in terms of translating knowledge into practice and supporting staff development (Avery et al., 2021). In health settings, review authors called for staff "to be regularly and consistently supported through reflective practice" (O'Dwyer et al., 2020, p. 1065) as a means to facilitate engagement with practice change. In terms of staff development, the design and delivery of staff training programmes was considered either as an enabler or a barrier to implementation (see previous section on Workforce Development and Support). Insufficient or lack of adequate staff training (Bargeman et al., 2022; Maguire &

Taylor, 2019; O'Dwyer et al., 2020; Wassink-de Stigter et al., 2022) was found to be a barrier to implementation, whereas relevant and ongoing staff training and development (e.g. Avery et al., 2021; Phung, 2002) was perceived as a key organisational enabler.

Including service users in diverse aspects of the implementation process was also seen as an important organisational enabler, while a lack of engagement of service users was noted as a barrier (Huo et al., 2023; Phung, 2022). Service user involvement included a range of strategies, such as seeking regular service user feedback (the most common strategy mentioned); involving service users in the delivery of training programme; having service users in leadership positions and/or implementation teams; and even involving them in the design of initiatives or interventions (Huo et al., 2023). It was noted that in order to engage service users, adequate resources and flexibility had to be embedded into the service/initiative, e.g., paying for involvement or giving service users choice and control over schedules (Huo et al., 2023). In addition, it was found that 'a culture of interagency collaboration' was an important enabling factor for TIA implementation (Huo et al., 2023; Lowenthal, 2020; Wassink-de Stigter et al., 2022), especially when administrative support to coordinate and monitor the collaboration was properly funded, while a lack of collaboration between teams was seen as a barrier (Huo et al., 2023) (See previous section on TIA implementation).

Finally, another key enabler reported in several studies in different reviews was the establishment of mechanisms to regularly collect and review data on uptake and outcomes (Huo et al., 2023), thus monitoring and evaluating progress and outcome data (Wassink-de Stigter et al., 2022). This meant that successes could be celebrated, building staff confidence and motivation (Wassink-de Stigter et al., 2022). On the other hand, a lack of data collection and evaluation was identified as an organisational barrier to successful TIA implementation and sustainability (Huo et al., 2023).

2.5.3 External factors and wider context

Factors relating to the wider or external context in which organisations or services are embedded surfaced as significantly impacting upon successful implementation of trauma informed approaches (TIA) (Mahon, 2022).

The lack of definitional clarity regarding TIA was highlighted as a barrier by Bargeman et al. (2022) who argued that this conceptual confusion led to great variability in how TIA is interpreted, adopted and implemented in various settings and organisations. It was thought that these disparities in implementation can also cause service user concerns, but can be alleviated by developing a shared understanding and accountability within services (O'Dwyer et al., 2020). In addition, review authors argued that this lack of consensus on the use of terminologies has made assessment, analysis and evaluation of the empirical evidence of TIA in different settings considerably more challenging (Phung, 2022), and has negatively influenced the acceptance of ideas regarding TIA (Bargeman et al., 2022). On the other hand, the development of a shared language and understanding of TIAs (Lowenthal, 2020) has been argued to facilitate implementation.

Bargeman et al. (2022)'s review also emphasised the importance of empirical evidence about the efficacy of TIAs, as either an enabler or a barrier to implementation respectively, dependent upon its existence or lack thereof. They argue that the lack of empirical research on TIA effectiveness is hindering its operationalisation, whereas a growing body of empirical research is starting to offer relevant insight and evidencing positive impact acting as a primary enabler of TIA implementation (Bargeman et al., 2022). In the context of trauma-informed schools, Phung (2022, p. 8) pointed out the importance of programme fidelity when collecting evidence for TIA:

"extra attention to program fidelity and research design (i.e., power of studies, larger sample sizes, longitudinal studies, reducing the risk of bias, etc.) is paramount in the pursuit of scaling programs and generating high-quality strong empirical evidence for TIAs."

Bargeman et al. (2022) also highlighted institutional policy legacies across all systems (health, child welfare, education, justice and social services) as significant barriers to progress. Such policy legacies noted included the health system's strong legacy and tendency to pathologise symptoms and provide care based on diagnostic criteria; child welfare's legacy of standard operating procedures, including child removal from family home and heavy reliance on the use of short term foster homes; the legacy of educational policy and pedagogy to narrowly define the scope of a teacher's role in the classroom; the justice system's legacy of punitive justice and correction facilities' procedures; and the legacy of social services as siloed programs. For instance, it is argued that a trauma-informed approach to youth mental health can sometimes clash with the conventional approach based on the DSM system of pathologisation, and when that happens, practice is thought to revert to conventional biomedical approaches (Lowenthal, 2020). In the context of psychiatric inpatient units, some argued that it was useful to reflect on the dominance and hierarchy of the biomedical model, speaking up against that system in order to foster TIA implementation (O'Dwyer et al., 2020). According to Bargeman et al. (2022), "addressing the impacts of policy legacies across systems of care as they relate to the operationalization of TIC will be critical moving forward" (p. 810).

The need for inter-agency cooperation with regard to TIC implementation was noted by Huo et al. (2023) who reported that in one study, the implementation of TIC within one service acted as a precedent and generated some pressure for other organisations to do likewise. These authors found that TIC implementation in agencies delivering care to the same service users was found to be crucial for implementation success in their own organisation, as when this was not the case, TIC implementation could be 'undermined by other agencies delivering care that reduced client trust and sense of safety with healthcare providers' (p. 10).

2.6 Outcomes and Effectiveness

In this final section, we examine the evidence related to the outcomes and effectiveness of TIA implementation in different fields of practice as noted in the papers reviewed. Different types of outcomes are distinguished. These include service user and family/caregiver outcomes; staff outcomes; and service or system-level outcomes (see Table 2.5). Although in general, TIA implementation has been found to generate positive outcomes, as well as a few mixed results in particular areas, review authors note significant methodological limitations to the evidence gathered, in terms of study design (e.g. lack of longitudinal designs, small sample sizes, high attrition rates, etc.), measurement (e.g. validity and reliability of outcome measures and instruments) and analysis (Bailey et al., 2018; Bunting et al., 2019; Fernandez et al., 2023; Lowenthal, 2020; Maynard et al., 2021; McNaughton et al., 2022; Purtle, 2020).

Outcome measures used to assess TIA effectiveness in the literature reviewed were varied but tended to include mostly self-report instruments completed primarily by staff (e.g., ARTIC, COPE and TIOT), but with some also completed by service users and families (e.g., CBCL) (Fernandez et al., 2023). Table 2.5 lists the outcomes reported upon in the included reviews. Common ***staff outcomes*** measured across settings included: training satisfaction; staff's trauma-informed knowledge; staff's understanding of service-user behaviours; self-reported trauma-informed responses and practices, etc. ***Service-user and family/caregiver outcomes*** measured in the studies reviewed included service user satisfaction; service user trauma-related symptoms and indicators of family functioning, psychological functioning, health and social functioning. Finally, common ***organisational outcome*** variables included the frequency and duration of seclusion and restraint episodes as well as community level outcomes (e.g., number of successful linkages) (Fernandez et al., 2023).

[4] ARTIC refers to the Attitudes Related to Trauma-Informed Care Scale; COPE refers to Coping Orientation to Problems; and TIOT refers to the Trauma-Informed Organizational Toolkit.
[5] CBCL refers to Child Behavior Checklist

Some outcomes were very much sector-specific, as Bargeman et al. (2021) noted. For instance, in the youth justice system, practices focused on minimising triggers in the court system and distress caused by restrictive measures, which had led to reductions in violent behaviour, the reduction or elimination of coercive forms of intervention (e.g., use of seclusion and restraints), and reduction in depression and PTSD symptoms among service users (Bargeman et al., 2021). Many of these outcomes were also linked to cost savings (Lowenthal, 2020). In child welfare, outcomes focused on placement stability, reducing distress caused by frequent placement changes, and providing birth and foster families with TIC knowledge and strategies (e.g., Bargeman et al., 2021; Bunting et al., 2019). Studies identified a decrease in mental health symptoms, drug use, emotional/behavioural difficulties, and an increase in engagement and satisfaction within mental health treatment programs (Bargeman et al., 2021). Thus, as Bailey et al. (2018) argued, despite limited evidence, TIA implementation appeared to have a significantly positive impact on the lives of children and young people living in out-of-home care. In addition, a meta-analysis focusing on children involved with the child welfare system found that trauma-informed interventions showed a moderate positive impact on a range of child wellbeing indicators, including PTSD symptom reduction, behavioural problem reduction and other psychological wellbeing improvements (Zhang et al., 2021).

In the schooling system, in general, positive outcomes were reported, including fewer suspensions, expulsions and disciplinary referrals, and improved academic performance (Cohen & Baron, 2021). However, in education settings, reviews revealed a scarcity of assessment of the overall impact of trauma-informed schools (Maynard et al., 2021; Phung, 2022). In fact, Maynard et al. (2021) did not find any evaluations rigorous enough to be included in their systematic review of TIAs in schools.

In health care settings, studies have found TIA implementation to have led to better access to mental health services, reduced health care costs, and a significantly decrease in the use of seclusion and restraint, including chemical restraint and prescribed sedative medications (e.g., Lowenthal, 2020; Oral et al., 2020).

Other positive outcomes reported for service users in healthcare systems were increased quality of care, increased outpatient referral follow-up rates, and less time spent in restraints for patients experiencing mental health crises (Brown et al., 2022). Procter et al.'s (2022) review focused on outcomes of TIAs for suicide prevention. They found limited evidence, however, to draw conclusions on the impact of trauma-informed suicide prevention strategies, as evaluations were in their infancy and showed inconclusive impacts on suicidality at that point. Most studies focused instead on feasibility and implementation. Regarding outcomes for staff in health settings, many studies in the included reviews reported positive outcomes following TIA training (e.g., trauma-informed knowledge, attitudes, and beliefs; confidence and staff readiness; self-reported practices; satisfaction with training, etc.) (Bendall et al., 2021; Brown et al., 2022; Gundacker, 2020; Lewis et al., 2023; Maguire & Taylor, 2019; McNaughton et al., 2022).

In general, however, as in other settings, in healthcare settings, most reviews found limited, mixed and sometimes conflicting evidence on outcomes and effects (or perceived effects) of TIP, TIC or TIA, usually leaning towards some improvement and positive outcomes (Lewis et al., 2023). In particular, there appears to be scarce evidence on the impact of TIP, TIC or TIA implementation on the outcomes for service users and their families or caregivers, which were much less likely to be reported upon (3 studies out of 13 did in Bendall et al., 2021; Oral et al., 2020). However, despite methodological limitations in the evidence, Oral et al. (2020) concluded that "promising TIC interventions have started to emerge in mental health and paediatric and adult primary healthcare settings" (p. 912).

Table 2.5: Outcomes

OUTCOME TYPE	SPECIFIC OUTCOMES
Service user & family/ caregiver outcomes	Service user satisfaction (including students' views of teacher supportiveness) [1,2,5,9,10,16,24]
	Service user/caregiver clinical, health, psychological, behavioural and/or educational outcomes (including quality of life, family functioning, self-esteem and trauma symptoms) [1,2,5,10,11,15,16,17,22,24,28,30]
	Engagement with services (including rates of attendance) and compliance with treatment [1,5,9,11,24]
	Service user perceived safety [9,16]
	Parenting and family outcomes, e.g. parenting confidence, caregiver strain/stress, family safety and caregiver capacities, likelihood to retain custody of children, etc. [8,11,17,22]
Staff outcomes	Staff trauma-informed knowledge, beliefs and attitudes [5,7,8,9,11,13,15,17,18,19,21,24]
	Staff readiness and confidence; comfort discussing trauma with service users [5,7,8,9,11,13,16,17,19,21,24]
	Staff trauma-informed self-reported practices [9,13,15,17,19]
	Feeling supported and valued [16]
	Staff perceived safety [16]
	Staff satisfaction [5,11,17]
	Staff stress [9]
Service/System level outcomes	Seclusion and restraint rates [2,7,11,17]
	Staff injury rates [11]
	Recidivism [4]
	Improvement in quality-of-service ratings [7]
	Number and/or consistency of referrals [5,7,15,17,24]
	Cost savings [17,24]
	School suspension rates [9,11]
	Number of behavioural incidents; and critical and violent incidents [1,2,11,17]
	Out-of-home placement stability/disruption [2,8,15,17]

2.7 Key messages

This Realist Evidence Assessment aims to synthesize contemporary evidence from TIA implementation literature reviews undertaken in diverse sectors and settings since 2018, with thirty papers reviewed following systematic search strategies. Included reviews in this REA tended to focus either primarily on TIA implementation/operationalisation or effectiveness, while others attempted to straddle both implementation and effectiveness. The reviews also covered implementation in a range of settings. While some focused on a specific setting (e.g. education, health, child welfare), others included research from multiple settings. The following key messages emerged from detailed analysis:

- There remains a lack of definitional consensus or conceptual clarity on trauma informed care (TIC) or a trauma informed approach (TIA) in the literature reviewed. This proves problematic when advancing systematic research to evidence effectiveness.

- It is argued that a TIA is best understood as a framework to guide an organisational transformation process to enhance service user engagement which requires systemic culture change and ongoing work at all levels of the organisational hierarchy.

- A range of classifications are used to describe the different core areas involved in whole-system TIA implementation in different service settings. These can be summarised via the three implementation domains adopted by this study, i.e. (i) Organisational Development, (ii) Workforce Development and Support, and (iii) Service Delivery and Practice Change.

- The different components within the Organisational Development implementation domain (governance and leadership, policy and procedures, service user involvement, physical environment, collaboration, monitoring and review) are considered to be of primary importance to effective TIA implementation with multiple strategies utilised over longer time periods to embed sustainable changes in the broader service system, organisational culture and policy.

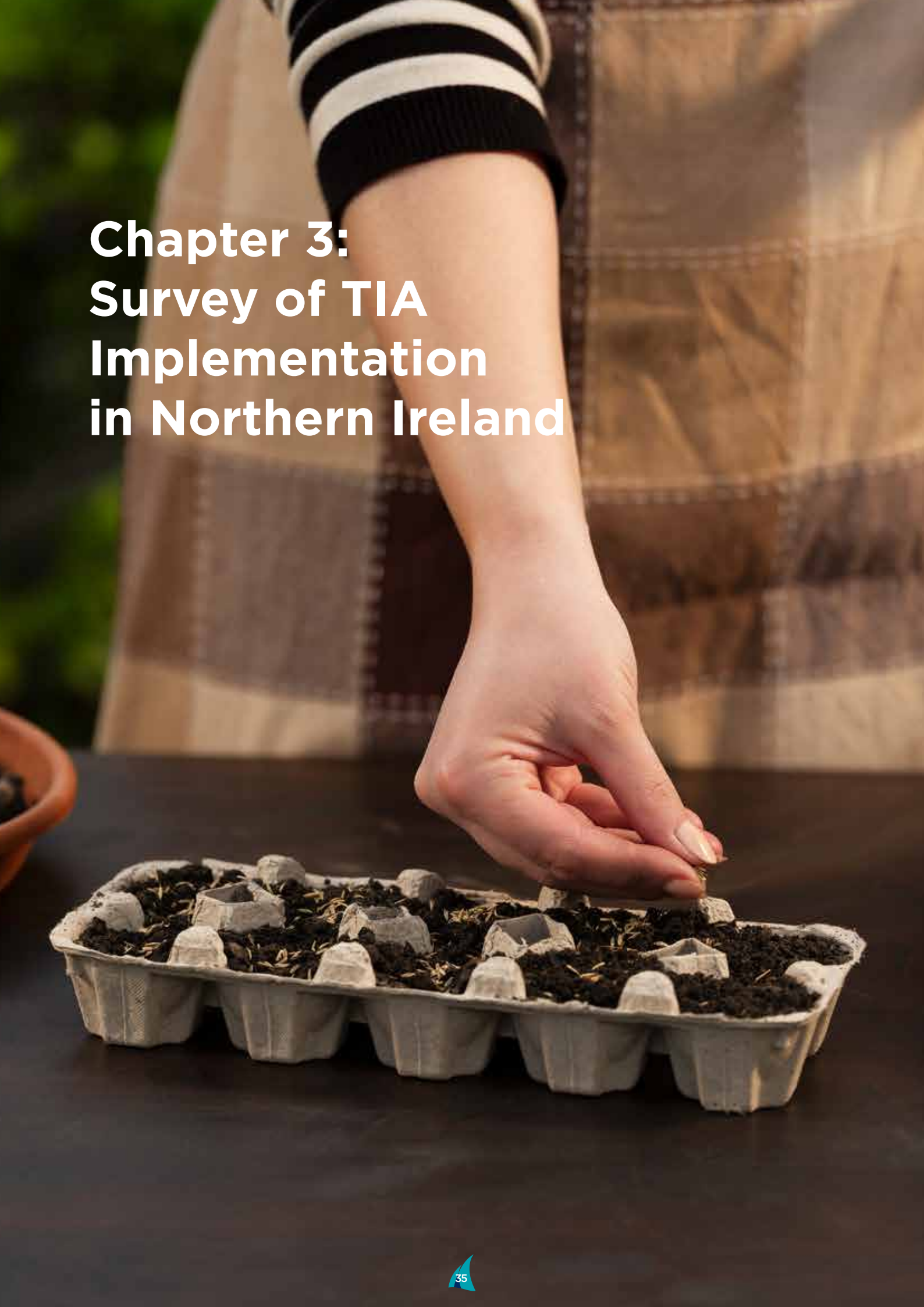
- Workforce training is generally considered one of the first implementation steps for an organisation to become trauma-informed. However, training alone, especially when short and one-off, has been found to be insufficient to embed lasting practice change, with the critical importance of ongoing support strategies to frontline staff required to enhance staff wellbeing and practice development. Research indicates that TIA training practices and curricula varied significantly across sectors and settings, despite arising from the same foundational context.

- While access to specialist trauma-focused services and interventions should be facilitated where appropriate, research highlighted the importance of enhancing everyday relational practices as central to improving service user outcomes across settings.

- A number of enablers and barriers to TIA implementation are identified in relation to individual factors (such as staff buy-in, knowledge and skills), organisational factors (such as the provision of staff training and ongoing workforce development) and external or wider context factors (alignment with the wider political, strategic and financial context).

- Outcome measures used to assess TIA effectiveness are varied across settings. They commonly include staff outcomes (such as knowledge, skills and wellbeing); service-user and family/caregiver outcomes (such as service satisfaction; symptoms; family functioning, wellbeing) and organisational outcome variables (such as use of seclusion and restraint; critical incidences; suspension/exclusion; service engagement).

- Although TIA implementation has in general been found to generate positive outcomes across services and settings, research notes significant methodological limitations to the evidence gathered, in terms of study design, measurement and analysis.



Chapter 3: Survey of TIA Implementation in Northern Ireland

3.1 Introduction and Overview

In this section, we present the findings of an online survey to map current developments in the implementation of trauma informed approaches (TIAs) in Northern Ireland (NI). This survey aimed to: 1) explore progress made by SBNI member agencies, partners and other service providers in NI in developing and implementing integrated trauma informed approaches across diverse sectors and services; and 2) identify barriers and enablers to progress, and 3) any known benefits or disadvantages. The survey was designed to give a broad overview of current TIA implementation developments in NI, identifying strengths as well as areas of under-development, and act as a resource to envision how TIA development may be progressed in the future.

3.1.1 Survey design

The online TIA implementation survey was designed by the QUB Research Team in collaboration with SBNI TIP Advisory Group and key stakeholders to ensure utility and accessibility across contexts, and conducted via Qualtrics, an online survey platform which is GDPR compliant. To ensure alignment with SBNI Trauma Informed Practice (TIP) project support materials, which had originally adopted SAMHSA's (2014) 10 TIC implementation domains, the questionnaire included Likert-scale questions on TIP implementation within each particular agency/organisation/project, as well as free-text options to allow participants to give some detail about their particular project/initiative and upload any relevant documentation. SAMHSA's (2014) original 10 TIC implementation domains[6] were brought together into eight subsections (governance, leadership, financing and resourcing were combined, as was progress monitoring and evaluation). These composite domains were used to frame the questions in the survey, with organisations invited to: *identify which TIA components they had sought to adopt and the level of progress in each; briefly describe any initiatives/efforts; explore to what extent this initiative/effort has been achieved; describe any identified outcomes; identify enablers and barriers to implementation progress; and current priorities for development.* An accompanying diagram of the SAMHSA TIC implementation domains and key indicators was developed by the research team and sent to participants as an aide to survey completion. The survey was deliberately kept broad and used drop down options and Likert scales with minimal qualitative responses requested to ease completion and accommodate responses from cross-sector agencies, with respondents invited to forward any relevant additional documentation. An initial draft of the survey was piloted with a small number of organisations to ensure utility with respondent feedback informing minor alterations.

3.1.2 Recruitment process

An invitation to the online survey was sent to senior professionals in projects, organisations or services which were known to have implemented a TIA, and it was promoted to a wider audience via social media. The SBNI TIP team assisted in the initial identification of contacts who were provided with the survey invitation and encouraged to share the survey invitation with others. In addition, social media (i.e., X, formerly known as Twitter) was used to further advertise the survey to agencies and services who may not have had a connection with the SBNI but who may have sought to implement a TIA at some level in their organisation or service.

3.1.3 Response overview

In total, by the time the survey closed in mid-September 2023, 84 responses had been received. Of these, fifty were completed in full. Twenty-eight submissions were completed only minimally, so were excluded from further analysis. A further six, although also partially completed, have been included in the analysis as only a few questions were missing. Of these 56 submissions included for analysis, six responses were about the same three initiatives. These participants were invited to review their submissions and consider a combined response. All subsequently submitted a joint response. Thus, in total, we have included 53 cases for analysis.

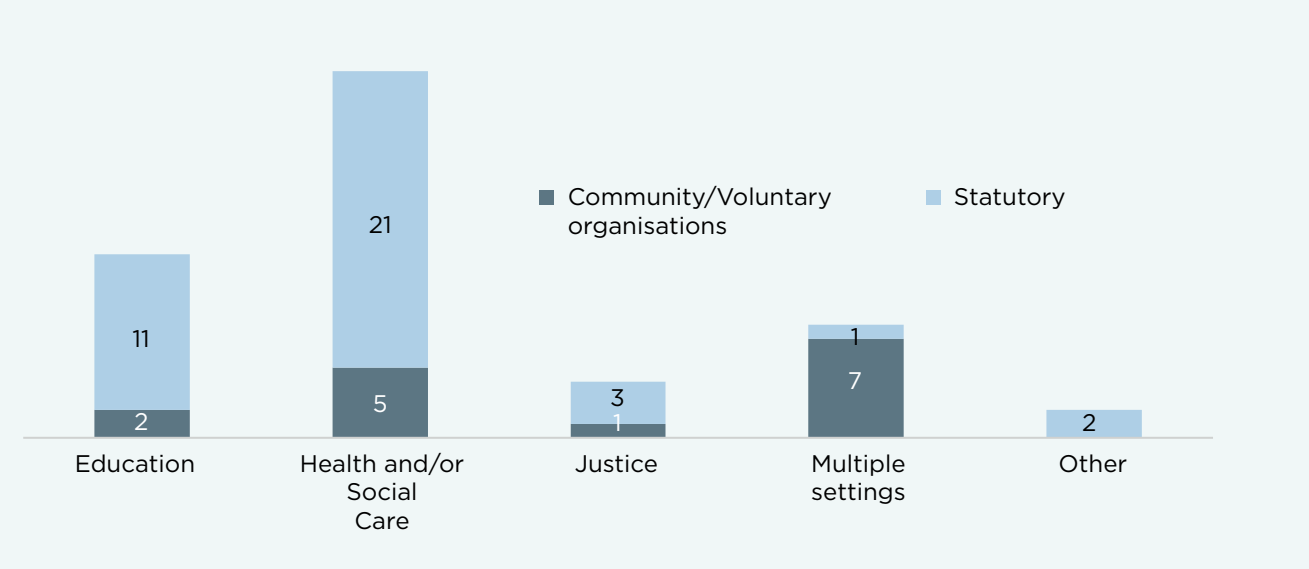
[6] 1. Governance and leadership; 2. financing and resourcing; 3. policies and procedures; 4. the physical environment; 5. service user involvement; 6. collaboration; 7. progress monitoring and service improvement; 8. evaluation; 9. workforce development and support; and 10. assessment and intervention.

3.2 General description of the TIA survey submissions

3.2.1 Description of the organisations/agencies/services

Survey submissions were diverse, having been completed by professionals working in a range of organisations within different sectors (i.e. statutory; voluntary/community organisations) and settings (i.e., education, health and social care, justice, multiple settings, other) (see Figure 3.1).

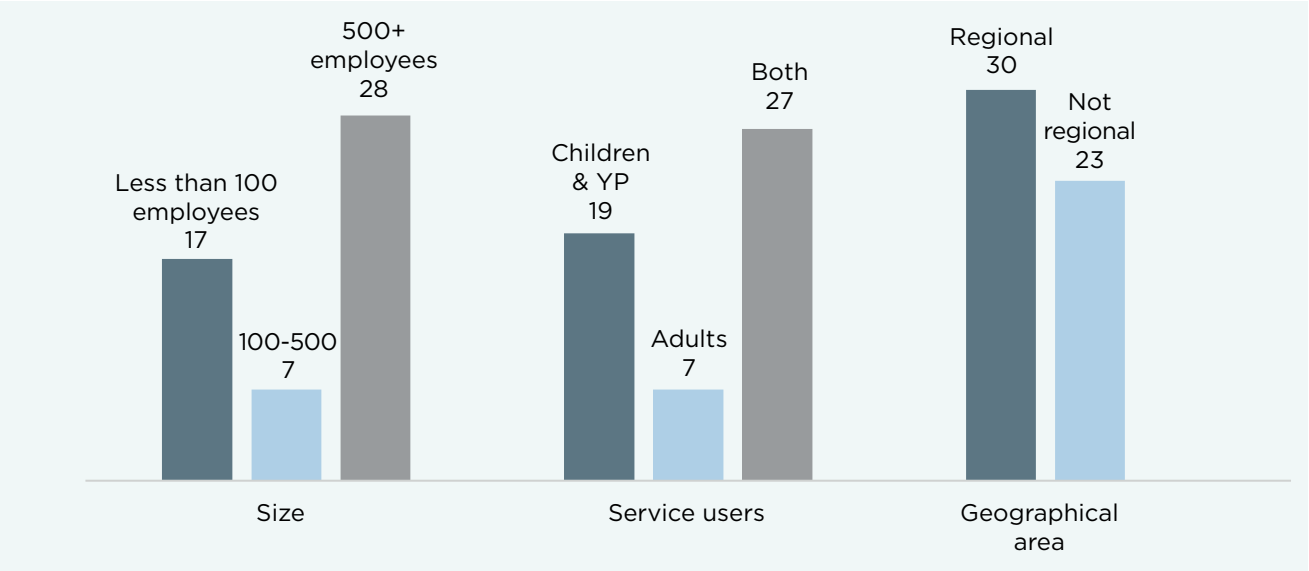
Figure 3.1: Organisations' sector and setting (n=53)



Health and/or Social Care was clearly the largest setting represented (n=26/53), followed by Education (n=13) and those submissions that indicated that they worked in multiple settings (n=8). Two submissions reported they worked in 'other settings' which included a wide range of community services provided by voluntary and community sector organisations. Although only four submissions reported that they worked exclusively within a Justice setting, Justice was noted by six of the multiple setting organisations. Within the Health and/or Social Care submissions, 11 were clearly Health (including mental health) organisations or projects. Of these 11, nine survey submissions were from statutory agencies and two were from voluntary/community organisations. However, of the organisations who reported they worked in multiple settings, seven of the eight submissions were from the voluntary/community sector.

Organisations and services represented in survey submissions were also diverse in terms of size of organisation, target populations and geographical area served (see Figure 3.2). Adult services were a clear minority of survey submissions received, representing only seven of the total 53. In contrast child services (n=19/53) and organisations which work with both children and adults (n=27/53) represented the large majority of survey submissions. Submissions were received from both regional (n=30/53) and non-regional services (n=23/53), with over half of the submissions reporting on TI implementation in large organisations of over 500 employees (n=28/53).

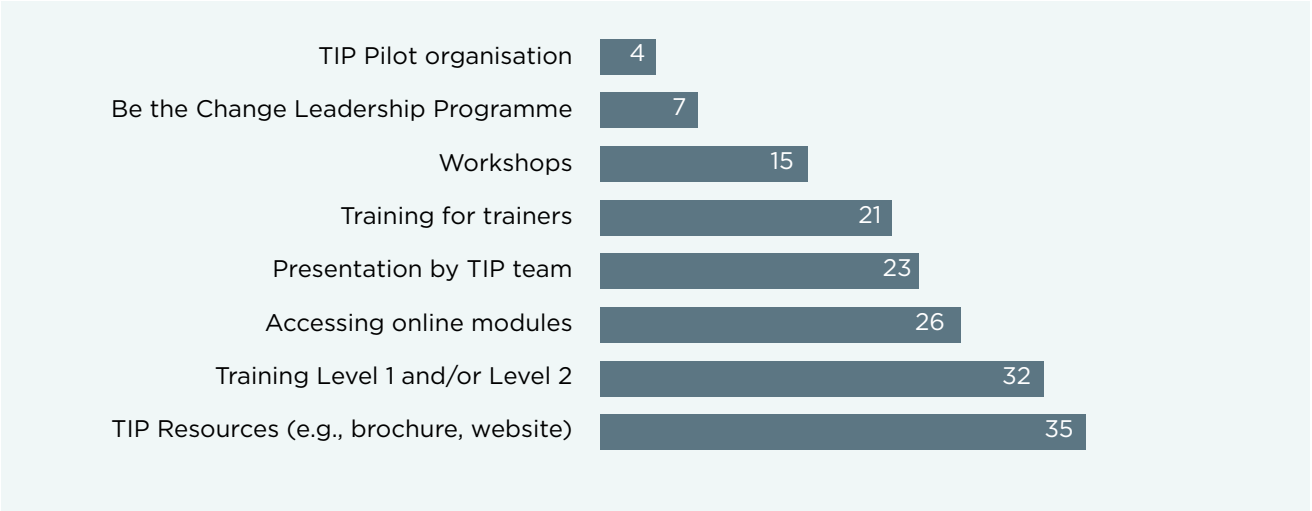
Figure 3.2: Size of organisation, service users and geographical area (n=53)



3.2.2 SBNI TIP Project Support

The large majority of survey respondents (n=40/53) reported having received some sort of support from the SBNI TIP project as part of their TI implementation, while the remainder indicated that they had either not accessed such support or were unsure. The range of supports utilised varied (see Figure 3.3), with general SBNI TIP resources being the most common support accessed, followed by Training Levels 1 and Level 2. While caution regarding the numbers is recommended given the uncertainty articulated by some respondents, it would appear that different levels of the SBNI TIP project training resources and supports were well utilised by many of the organisations who responded to this survey.

Figure 3.3: Forms of support received from SBNI TIP project



3.2.3 Submission categorisation

Finally, the 53 survey submissions received described a variety of types of trauma informed implementation initiatives. While the majority were from projects, services or organisations which could be described as 'frontline', i.e., where staff worked directly with the public, there were others from organisations which performed a support, advisory, strategic, commissioning or governance role and were thus classified as 'non frontline' (n=12). Of the frontline submissions received, a number referred to TIA implementation (or a particular aspect of TIA implementation such as workforce development or child participation) across a whole organisation (e.g., schools, voluntary/community organisations, HSC Trusts) (n=23), while others described more specific trauma informed or trauma-focused projects, initiatives or services set within a larger organisation or agency context (n=18). The following submission categories were therefore used to group similar types of implementation initiatives and thus provide some level of overview of implementation progress:

1. Frontline organisations - whole organisation TIA implementation;

2. Frontline services or projects - TIA implementation initiatives within wider organisations;

3. Non frontline organisations – TIA implementation in support, advisory, strategic, governance or commissioning organisations.

3.3 TIA Implementation

This section describes how the different TIA implementation domains (based on SAMHSA's 2014 classification) were perceived to have been progressed for each of the three types of submission categories identified above. Table 3.1 shows how the domains were operationalised within the survey questionnaire. For each indicator, respondents identified their assessment of implementation progress based on a 5-point Likert scale, i.e., whether the indicator had not yet been considered; had been considered but not progressed; implementation had begun; the indicator had been partially implemented; or it had been fully implemented. The options of not relevant and unsure were also provided. N.B. Detailed TIA implementation survey graphs on each domain in each of the organisational categories are provided in the Appendix.

Table 3.1. Domains and Indicators

1. Governance, Leadership and Financing
1.1. Senior managers have received TIP training
1.2. A specific TIP implementation group/ groups has been set up
1.3. Specific TIP goals/targets have been identified
1.4. A TIP implementation plan has been developed
1.5. There is an identified TIP leadership position or positions related to progressing TIP in the organisation/ agency
1.6. TIP is specifically mentioned in organisational/ agency strategic plans
1.7. Financial resources are identified and ring-fenced to progress TIP initiatives
1.8. Personnel resources are made available to progress TIP initiatives
1.9. A trauma informed approach is taken account of when funding or commissioning services/work
2. Physical Environment
2.1. Service user/caregiver perspectives on the physical environment are regularly sought
2.2. Staff perspectives on the physical environment are regularly sought
2.3. A review group has been set up to consider the physical environment from different perspectives
2.4. Changes to the physical environment have been made as a result of feedback
2.5. The entrance to the service is welcoming for service users and their caregivers
2.6. Mission statements are visible which highlight diversity & inclusion, & commitment to TIC
2.7. 'Safe spaces' are created where service users/caregivers and frontline staff can go to allow tensions to de-escalate

3. Policy and Procedures
3.1. Key areas of potential re-traumatisation of service user and family/caregiver have been discussed and identified
3.2. Written policies and procedures have been developed to reduce service user re-traumatisation
3.3. Written policies and procedures have been developed to promote the provision of strength-based services
3.4. Previous policies and procedures have been screened and updated to reflect TIP principles
4. Engagement and Involvement
4.1. Efforts are made to decrease service user-agency power differentials and maximise engagement
4.2. Service user and caregiver perspectives are integrated into TIP implementation initiatives and evaluation processes
4.3. Written policies or procedures have been developed for enhancing service user and caregiver involvement in their own care/intervention plans
4.4. Written policies or procedures have been developed for enhancing service user/caregiver involvement in wider service planning and development
4.5. Service user and caregiver feedback is routinely sought and used to enhance service provision
4.6. Service users and families/caregivers are involved in TIP training, either directly or via integrating their perspectives in training materials
4.7. Opportunities are created for service users and their families/caregivers to meet with others experiencing similar circumstances to promote shared learning and mutual support
4.8. People with lived experience are actively sought to be involved in the work of agency/organisation as volunteers or staff

5. Workforce Development & Support

5.1. Universal TIP training is provided for all staff

5.2. Enhanced/specialist training is provided for some staff to enable them to act as TI champions/mentors

5.3. Ongoing workforce support/reflective practice/reflective supervision/ consultation opportunities are provided

5.4. Frontline practitioners have regular access to TI consultation and supervision

5.5. Frontline staff have regular access to staff/team debriefing, learning and support forums, in particular after significant incidents

5.6. Relevant staff receive training/support to understand the impact of the work on staff

5.7. Workforce wellbeing initiatives have been developed to support staff wellbeing

6. Collaboration

6.1. Collaboration and service coordination has been promoted within the agency

6.2. Inter-agency collaboration and service coordination has been promoted

6.3. Clear intra-agency (i.e. internal to organisation) referral pathways and information sharing protocols have been developed

6.4. Clear inter-agency/sector referral pathways and information sharing protocols have been developed

6.5. Collaborative multi-disciplinary case conferences/network meetings are facilitated

6.6. Cross-sector partnerships have been developed with relevant statutory & community organisations

6.7. Service users/caregivers are helped to access other services when appropriate

7. Assessment and Intervention

7.1. Methods of routine inquiry are developed to enquire about service users' life histories

7.2. Staff receive initial assessment training & ongoing support to mitigate potential for service user re-traumatisation

7.3. A person's history is taken account of in their care plan/service/intervention planning

7.4. Trauma assessment is integrated into data systems

7.5. Service users/ caregivers are supported to access relevant trauma-focused interventions

8. Progress Monitoring, Service Improvement & Evaluation

8.1. Targeted priorities and practice change goals are identified

8.2. Measures have been identified to monitor service-level change

8.3. Data systems are utilised or adapted to audit, monitor progress and evaluate TIP implementation/service development priorities

8.4. TIP implementation progress and on-going learning is communicated regularly with staff & service users

8.5. Clear goals and measures are established with regard to targeted service user (and caregiver) outcomes

8.6. Quality assurance or governance processes take account of TIP progress

8.7. External evaluations re. TIP progress have been conducted

3.3.1 Frontline organisations

Submissions overview: In total, 23 survey submissions included frontline organisations seeking to implement TIA *across a whole organisation*. Most of these were statutory agencies (n=14/23) and the remainder were voluntary or community organisations (n=9). Just under half of the organisations in this category delivered services to both children/young people and adults (n=11/23) with the remainder delivering services exclusively either to children and young people (n=9) or adults (n=3). These organisations reported their delivery of services across a range of settings including education (n=6), multiple settings (n=6), health and social care (n=6), health (including mental health) (n=3) and justice (n=2). The six education submissions in this category included whole schools and colleges across primary, post-primary and further education sectors as well as one youth club. Those organisations which indicated that they were delivering across 'multiple settings' were made up of relatively large regional voluntary/community sector organisations which encompassed a wide range of projects providing services in relation to family support; child welfare; early years; social care; education; justice; housing/ homelessness; refugee support; substance use; mental health. While three submissions related specifically to health/mental health service provision, there were six which spanned health and social care. These tended to be largely made up of Trust-wide initiatives to embed TIA in their service delivery. The two justice submissions encompassed large regional organisations with a statutory remit. Organisations in this submission category were fairly evenly split between those delivering services across the whole of Northern Ireland (n=11/23) and those that were not (n=12), with a range of sizes in terms of numbers of employees. Of the organisations delivering services regionally, about half had over 500 employees (n=5/11), three had 100-500 employees, and three had less than 100 employees. In contrast, of the non-regional organisations represented in survey submissions, most had 500+ employees (n=7/12), one had 100-500 employees, and four had less than 100 employees.

Implementation progress overview:
Duration of whole service TIP implementation by frontline organisations ranged from 1 month to 48 months. The majority of organisations (n=17/23) indicated that they had received some level of support from the SBNI TIP project with only four reporting that they had not, and two respondents not completing this question. In relation to the extent to which the specified aims of the TIP implementation initiative had been achieved, eight organisations in this category stated to a moderate extent, seven to a large extent, and eight to a small extent.

While there was significant variability in the perceived progression of domain indicators, in general, based on the respondents' perceptions, the TIA implementation domains most progressed in this category of survey submissions included collaboration, workforce development and support, and some elements of governance and leadership. In contrast, the domains which were least progressed included the physical environment and progress monitoring and evaluation.

Regarding the composite domain of ***Governance, Leadership and Financing***, a mixed picture emerged in terms of implementation of the various elements. TIP being specifically mentioned in organisational or strategic plans (ind. 1.6) was the strongest element reported upon with 14 submissions stating that this had been fully implemented (n=14/23), five indicating partial implementation, and only three stating this had not yet been considered or progressed. This was closely followed by having an identified TIP leadership position within the organisation (ind. 1.5) (14 full implementation; 3 partial; 6 not considered/progressed) and senior managers having received TIP training (ind. 1.1) (13 full implementation; 7 partial; and only 2 indicating that this had not been considered/progressed). These implementation strengths were well captured in free text comments:

"The Board of Trustees and Senior Leadership Team have adopted the principles of TIO. The COO [Chief Operating Office] has been appointed to lead out an implementation plan, and this will be included in the new organisational strategy. Training has been completed with all Senior Managers including corporate services, and a group developed across the organisation to lead on TIP planning."
(Frontline organisation, Multiple Settings, V/C sector)

"The college has TIP built into its vision and mission statements... This approach has been bought in at every level – BoGs [Board of Governors], SLT [Senior Leadership Team] MLT [Middle Leadership Team] and all staff. Children are supported, and have a role to play in the trauma informed approach of supporting each other also, and assembly time is used to provide inspiration for doing so."
(Frontline organisation, Education, Statutory)

The least well-developed element in this domain was in relation to TIP financial resources being identified and ring-fenced (ind. 1.7), with over one-third of the organisations (n=8/23) stating that this had not yet been considered/progressed, five reporting partial implementation, and six stating that it had been fully implemented. Similarly, personnel resources being made available was noted as challenging by some:

"Whilst there is a TIP leadership group, there is no finance/commissioning attached. This is a challenge as embedding TIP into a large organisation requires commissioned posts to ensure... that implementation can occur. The staff involved are enthusiastic and see the value/need for the workforce to be trauma informed however they are promoting TIP in addition to completing the other roles/responsibilities they hold."
(Frontline organisation, HSC, Statutory)

In relation to the ***physical environment*** domain, there was again a variable response from frontline organisations regarding implementation of the various elements. The elements more robustly implemented were that the entrance to the service was welcoming (ind. 2.5) (11 full implementation; 5 partial) and that 'safe spaces' had been created (ind. 2.7) (10 full; 5 partial). The least well implemented element was that a review group had been set up to consider the physical environment (ind. 2.3), with 11 respondents stating that this had not yet been considered or progressed, six noting partial implementation, and only four indicating full implementation. The regular seeking of staff and service user perspectives on the physical environment (ind. 2.1 & 2.2) was more likely to be reported as partially implemented (10 and 9 organisations respectively) as was that changes to the physical environment were made as a result of feedback (ind. 2.4) (3 full; 10 partial), with seven organisations reporting that they had not yet considered or progressed any changes. There were indications in the comments that the process of consulting on and improving the physical environment was at a relatively early stage for some, with challenges noted for large organisations with a variety of facilities:

"A baseline survey has just been completed with staff and included contributions from a very small number of service users and volunteers. A more comprehensive environment checklist with recommended actions for implementation will need to be carried out...[organisation] has a number of different services operating in various locations/venues such as Head Office (used by talking therapies clients), housing units and day centres, therefore all will need to have inspections before recommendations can be made."
(Frontline organisation, Health, V/C sector)

"Parents, staff and students have given verbal feedback on the physical environment...There have not been any surveys carried out to get written feedback."
(Frontline organisation, Education, Statutory).

Some qualitative comments provided insight to the change in working patterns brought about through the COVID pandemic, with re-thinking required with regard to the use of physical spaces:

"Prior to Covid we did have a plan to turn one of our rooms into a more welcoming space for meetings with children, young people and families with a particular emphasis on a Trauma Informed environment... however with the event of Covid, the office was not used and plans fell by the wayside. Since returning to a more hybrid way of working, the office space for families is no longer required."
(Frontline organisation, Multiple settings, V/C sector)

The weakest indicator in the ***Policy and Procedures*** domain was that previous policies and procedures had been screened and reviewed to reflect TIP principles (ind. 3.4), with only five of the organisations reporting this had been fully implemented, seven stating partial implementation, and seven reporting it had not yet been considered or progressed. The other elements in this domain were mostly reported to be either fully or partially implemented. For example, only three organisations stated that policies and procedures to promote the provision of strengths-based services (ind. 3.3) had not been considered/progressed and three stated they were unsure. In relation to the existence of written policies and procedures to reduce re-traumatization (ind. 3.2), only three organisations stated this had not yet been considered or progressed, although a further three reported that they were unsure. In relation to key areas of potential re-traumatization being discussed and identified (ind. 3.1), most organisations in this submission category reported that this had either been partially (n=9/23) or fully implemented (n=6). Written comments provided some insight into the challenges of progressing trauma informed policy and procedural change in large organisations with multiple projects and sites, with progress thought to be advanced by human resources senior representation:

"... developments within the one service... are very advanced. Procedures, signages, wording, processes etc. have been reviewed and improved. Organisation wide however, this progress is slower. The fact that the HR director however is now coming onto the review team, will enable significant changes to be made to major organisational policies."
(Frontline organisation, Multiple settings, V/S sector)

A number of other comments indicated that there remained work to be done to understand the connections between trauma informed policy and procedures and other relevant policy development initiatives:

"There are HSC [Health and Social Care] areas where policies such as reducing restrictive practice, MCA [Mental Capacity Act] legislation etc. are very pertinent, and therefore adhered to. Whilst this is TIP, I don't think that they would be perceived under that heading."
(Frontline organisation, HSC, Statutory sector)

Varied progress was reported by responding organisations in the ***Engagement and Involvement*** domain. Most progress appears to have been made in relation to service user and caregiver feedback being regularly sought and used (ind. 4.5) with 16 organisations (n=16/23) reporting that this had been fully implemented and six partial implementation. In four of the other elements (ind. 4.1-4.4), implementation was more likely to be reported as partial rather than full, with a small number of organisations stating that these elements had not yet been considered or progressed. The three remaining elements regarding people with lived experience actively sought to be involved in the work of the agency (ind. 4.8), opportunities for service users to meet with peers (ind. 4.7), and service users/caregivers involved in TIP training (ind. 4.6) had more variable implementation, especially the latter with only two organisations stating that this had been fully implemented, 9 reporting partial implementation, and 7 stating that it had not yet been considered or progressed. Some comments from organisations reflect their ongoing work in relation to this domain, which was noted as a priority area in a number of submissions:

"...there is much progress ensuring that clients and their families are involved and have the opportunity to contribute to the organisation...However there is still much work to be done to ensure that clients/service-users have a wide range of opportunities to safely influence the way we operate and what we can offer."
(Frontline service, Health, V/C sector)

"...we have come a long way in hearing from and responding to and directly involving the service user. However, there is still a way to go before we reach co-production and the service user is involved in the design and development of services."
(Frontline service, Justice, Statutory).

Example 1: Children's Court Guardian Agency

Aim: "To increase the engagement with and participation by children and young people in the Children's Court Guardian Agency."

Steps taken: "Increasing engagement with children and young people in the Agency has taken place both through the development of a Youth Forum and the provision of a platform for children and young people to have their voice heard and to influence the practice, as well as through promoting and integrating into practice a focus on children and young people's lived experience and the impact this has on their welfare."

Developments achieved:

- "This has included providing ***Top Tips for Judges*** on meeting with children and the importance of sibling contact to promote their sibling relationships, as well as telling us what matters to them when they meet a Guardian.

- We have incorporated into the ***guidance for our court reports***, children and young people's experience of trauma to ensure this will be embedded in the ***Guardian assessment***. This includes guidance from children and young people in the Forum who wanted us to reflect what they said verbatim, "do not dilute my words".

- This guidance is also integrated into the ***Recording Policy***. Additionally, as a direct result of a young adult who had a Guardian in the past accessing her file - we have highlighted in the policy that the child who is the subject now, will be the adult reader in future, and the impact of the content on the adult reader should be to the fore when records are compiled. Recent learning and improvement sessions to implement recording systems and Recording Policies have reinforced the voices of children and young people.

- Children and young people have been involved in the ***re-design of our feedback form*** and have previously been involved in the ***development of tools and resources for Guardians*** to engage with children and young people including the content and images.

- The Youth Forum influenced and contributed to ***the Agency's conferences***, by making contributions, using the platform to have their voices heard and influence the audience.

- Our current project with young people on ***rebranding*** has enabled the recent group of young people to convey their sense of hope in their choice of colour for the branding and a positive sense of their identity in the images chosen.

- Young people have been involved in updating the suite of characters in the ***About Me/ About Court engagement tools***, to make them relevant and appealing. The young people involved recently attended a Board meeting to share their work, as a further step to embedding participation structures within the Agency.

- Additionally, we are piloting an app called "This is Me" designed to ***engage with pre-school children and children with learning needs***. Changes currently being made to the app (which will go live in January 2024) are as a result of feedback on what is working with the children in the pilot group."

Submission responses indicated good implementation progress across the organisations in the ***Workforce Development and Support*** domain in relation to most of its indicators, including the advancement of universal training (ind. 5.1) and specialist training for staff to act as trauma informed champions (ind. 5.2). Particularly substantial progress was reported in relation to workforce wellbeing initiatives having been developed to support staff wellbeing (ind. 5.7), which was reported to have been either fully or partially implemented by all organisations in this submission category (16 full, 6 partial). Additional comments indicated significant investment in such wellbeing initiatives as well as the frequent use of external organisations:

"Staff have been able to apply for health and wellbeing funds to promote staff wellbeing and value. The Trust's workforce plan has a strong emphasis on staff wellbeing and development."
(Frontline service, Health/Social Care, Statutory).

Opportunities for ongoing workforce support and development, e.g. reflective practice or supervision (ind. 5.3), was also reported as progressing relatively well with 21 organisations reporting either full (n=10) or partial (n=11) implementation. Some education organisations noting the benefits of an 'open door' to senior staff:

"... we also ensure that all staff know that supports are in place to support their SEMHW [social, emotional, mental health and wellbeing]. The Principal has an open door Policy, and all of the staff are encouraged to seek out support in times of need. The Safeguarding Team are also available for staff who seek out support.... For staff who prefer, there is also an external support which has been arranged..."
(Frontline organisation, Education, Statutory)

A weaker area of implementation in this domain was in relation to frontline practitioners having regular access to TI consultation and supervision (ind. 5.4), with six organisations stating that this had not yet been considered or progressed. While appreciating the progress made in this domain, several comments highlighted the work still to be done, as well as the challenges of bringing change in large organisations:

"...we have come along way but there is always room for improvement. We are developing TI supervision policy and practice and sourcing training in this for frontline managers."
(Frontline service, Justice, Statutory)

"Significant developments in this area have taken place across the organisation over the last 2 years. Reflective practice has been implemented and is now an essential part of each service's budget. A 'Wellbeing for All' group has been established to provide oversight for staff wellbeing. A TI lead post has been created which will provide a central source of support and contact for all teams. Senior leadership are really getting behind this TI journey. With such a large organisation however, progress will be slower and takes sustained effort from those driving it."
(Frontline service, Multiple settings, V/C sector)

The ***Collaboration*** implementation domain appeared to be the domain with the most progress as reported by organisations in this submission category. It should be noted, however, that a number of organisations did not respond fully to the elements in this domain and qualitative comments indicated a level of uncertainty about how collaboration was actioned in different parts of large organisations. That being said, most organisations reported that each of the elements had been fully or partially implemented with only two indicating, in relation to intra-agency collaboration and service coordination being promoted (ind. 6.1), that it had not been considered or progressed. Some respondent comments reflected their assessment that this domain is reasonably well advanced with examples of inter-agency and multi-disciplinary training and efforts made to ensure 'warm handover' to other services when required:

"There has been collaboration with HSC Trusts when considering learning and improvement around trauma and also shared training with solicitors. Interagency collaboration and co working is part of the [organisation] role."
(Frontline service, Social Care, Statutory).

"[Organisation] works in partnership with services users and relevant others including the statutory sector and community and voluntary organisations to ensure access to relevant services and ongoing help and support where required."
(Frontline service, Justice, Statutory).

Once again, the challenges of advancing collaboration in large organisations was noted:

"Collaborative referral panels have been set up between the organisation and the statutory teams referring clients in. Across agency collaboration is advanced, effective and respectful. Across the wider organisation however, there is room for further progress and development in this area."
(Frontline organisation, Multiple settings, V/C sector)

While acknowledging some missing responses, some progress was reported on the indicators in the ***Assessment and Intervention*** domain. In relation to a person's history being considered in their care or service planning (ind. 7.3), for example, 12 organisations stated that this had been fully implemented and six that it had been partially implemented. Responses in relation to the other elements were more mixed, reflecting a split between full and partial implementation, and a small number of organisations reporting that the indicators had not been considered or progressed as yet. Qualitative comments provide further insight into the development of these practice-change indicators in diverse service settings:

"Re-integration plans and Support Plans are put in place for students in need. Specific measures are put in place for individual students. These are reviewed and amended in line with need."
(Frontline organisation, Education, Statutory)

"Understanding of trauma is key to the [...] role. There has been training on ACEs [adverse childhood experiences] and trauma both with HSC Trusts and with solicitors, in order to have an integrated approach to understanding of the impact of trauma. Trauma is also integrated into [...] reports and associated guidance. Children and young people's needs for trauma informed services are routinely identified and empathy with the trauma of parents and their experiences of ACEs is reflected by the [staff member] in their response to parents."
(Frontline organisation, Social Care, Statutory sector).

The ***Progress Monitoring, Service Improvement and Evaluation*** composite domain appeared to be the weakest overall in terms of the implementation of the various elements, further hampered by some missing responses. Most of the indicators received a high number of responses stating that they have not yet been considered or progressed, most notably in relation to external evaluations of TIP implementation being conducted (ind. 8.7) and data systems being used/adapted to monitor and evaluate TIP priorities (ind. 8.3). The strongest progress reported in this implementation domain was in regard to clear goals and measures being established regarding targeted service user/carer outcomes (ind. 8.5), with 15 organisations stating this had been fully (n=5) or partially (n=10) implemented. Comments from several organisations indicated that, whilst some progress had been made in this domain, implementation was at an early stage and required further development:

"A baseline survey has been completed for staff and some services which will be repeated on an annual basis. Development of a client and volunteer specific survey is in consideration. Further work is required on monitoring of services and improvement."
(Frontline organisation, Mental Health, V/C sector).

"Whilst this area has been identified as a requirement in initial stages, the goals are being developed for the next stage....The next phase of the project will help to build on progress made to date and embed this work."
(Frontline organisation, Multiple settings, V/C sector).

Other comments drew attention to the use of external specialists to advance articulation and measurement of key outcomes, and the role of Quality Improvement projects in promoting service development:

"Developing children and young people's feedback processes and a culture of feedback was a Quality Improvement project, and continues to be an area for learning and improvement."
(Frontline organisation, Social Care, Statutory sector).

"The [organisation] has been working with its Impact and Evaluation specialist in London to look at ways in which TI initiatives can be measured. TIP is now part of the agenda on service and regional reviews and the independent inspections (reviews) undertaken twice yearly in each service across the UK."
(Frontline organisation, Multiple settings, V/C sector)

Future priorities: The frontline organisations in this submission category outlined a range of short-term priorities. While some simply noted their intention to provide refresh or further training and learning opportunities for all staff, for others this appeared to be related to enhancing staff understanding, buy-in and competence for advancing a trauma informed approach in their service:

"Identify available best-practice resources, training and support to help with implementing informed and responsive approaches...set out the knowledge and skills that will support colleagues in all roles to help people affected by trauma and adversity."
(Frontline organisation, Multiple settings, V/C sector)

"For all staff to have a basic awareness of trauma and its impact on children and adults. For all staff to understand what a trauma-informed approach means. For all staff to understand the value of the [organisation] becoming trauma-informed for those accessing the services and for staff across the organisation."
(Frontline organisation, Multiple settings, V/C sector)

"To continue to use Restorative Practice and ensure that staff are confident in and comfortable with its implementation."
(Frontline organisation, Education, Statutory)

In addition to advancing workforce training and development, organisations identified a broad range of organisational development goals, such as developing or updating policies, action plans, physical environment developments, establishing a project implementation team, or securing funding for a dedicated TIP role as a means of maintaining momentum by building upon existing areas of development. In relation to advancing policies, action plans and priorities, some organisations stressed the importance of engaging service users and staff in creating or revising these:

"Project team developed with a range of service users, staff and volunteers. Framework with actions developed and agreed."
(Frontline organisation, Health, V/C sector)

"...ensuring that our review of estates, policies, and standards all reflect a trauma informed approach. We are currently developing our work with service users through our service user forums to take on board their views and ideas."
(Frontline organisation, Justice, Statutory sector)

Longer-term priorities identified by responding organisations were to further embed trauma informed approaches within and across their services. While some discussed developing TIP implementation plans, others articulated a desire to continue to develop and embed existing trauma informed provision and extend this across the whole organisation, seeking additional funding, resources and supports to do so:

"TI implementation plans to be considered and developed across each service area within the Family and Childcare Sub directorate initially. Engage with SBNI to develop Trust implementation plans... learn from others who are on the journey."
(Frontline organisation, HSC, Statutory sector)

"We are committed to implementing TIP within [organisation] and are aware this needs dedicated people and resources and wider organisational understanding. We are working towards this."
(Frontline organisation, Justice, Statutory sector)

"Commissioned funding to create a multidisciplinary team of staff including admin who can focus purely on embedding TIP across the Trust."
(Frontline organisation, HSC, Statutory sector)

Example 2: Southern Health and Social Care Trust TIP Working Group

Aim: "The Trauma informed practice (TIP) leadership working group has been established within CYPS [Children and Young People's Services] to provide leadership and oversight of the promotion and development of a trauma informed Directorate. The working group will seek to promote trauma informed practice, share the learning from TIP projects and create opportunities to support staff to build trauma informed practice into all aspects of service delivery. The TIP Leadership Working Group will:

- Provide a forum for staff to share knowledge and experience of TIP with the aim of enhancing knowledge and developing the culture.
- Provide a forum for sharing learning from TIP projects/initiatives both within the Trust and beyond.
- Agree an action plan in relation to progress the development of a Trauma Informed Directorate.
- Seek opportunities to engage the wider Trust in the development of a Trauma Informed organisation."

Short-term priorities: "Attention to the physical environment; Time and Space for reflective practice; trauma informed supervision included in implementation of new Social Work supervision policy; Implementation of the Framework for Integrated Therapeutic Care (FITC) training strategy across residential and LAC [Looked After Children] service areas; Leadership group to meet regularly and identify existing good practice and areas for development."

Long term priorities: "The aim of enhancing knowledge and developing the Leadership culture. Provide a forum for sharing learning from TIP projects/initiatives both within the Trust and beyond. Development of a Trauma Informed Directorate. Seek opportunities to engage the wider Trust in the development of a trauma informed organisation. Plan Trust wide events to share the message and celebrate best practice."

3.3.2 Frontline projects and services

Submissions overview: In total, 18 frontline projects and services were described in the survey responses. These were usually smaller TIA projects, services or initiatives that were developed or operated within the context of a larger organisation or agency. Most of the projects and services described were within statutory agencies (n=14/18), with the remainder of the submissions taking place in voluntary/community sector organisations (n=4). Over half of the submissions in this category delivered services to both children, young people and adults (n=10/18) while the remainder delivered services exclusively either to children and young people (n=5) or adults (n=3). Most of the projects/services were delivered in Health and/or Social Care settings (n=14), while three were located within Justice settings, and one in an Education setting. Within the broad Health and/or Social Care category, eight projects were designated as healthcare provision (inclusive of projects with a mental health, trauma-focused, primary care and physical healthcare focus), while the remaining six submissions spanned health and social care (inclusive of child/family support; care experienced children services; learning disability). Five respondents in this submission category described initiatives taking place in inpatient or residential settings, while the remainder related to community provision. A wide range of activities were described in these survey submissions including direct service provision to children, adults and families; staff training, consultation and support; and service development initiatives. The majority of these frontline projects or services were housed within large organisations of 500+ employees (n=11/18), whereas six were in small organisations of less than 100 employees. Seven submissions reported the delivery of regional services (n=7/18) with the remainder describing projects with a Trust-wide (n=9) or more local remit (n=2). Implementation of the same new trauma-informed service model was described across two different Trust settings.

Implementation progress overview: Duration of TIA implementation in each of the projects or services ranged from four months to 48 months, with a total of four projects having indicated their project or service had been involved in TIA implementation for 48 months (n = 4/18) and a further seven indicating either 24 months (n = 4/18) or six months (n=3/18). All projects/services that reported the length of TIA implementation to be 48 months were projects or whole services offering support to specific target populations (care experienced children, families on the edge of care, homeless population, traumatic bereavement), two within the statutory sector and two within the voluntary and community sector. The large majority of projects or services in this submission category indicated having received some level of support from the SBNI TIP project (n=17/18).

In general, according to respondents, the Policies and Procedures and Physical Environment implementation domains were the least developed across all projects/services with Collaboration, Workforce Development and Support, and Assessment and Intervention domains the most progressed.

Reponses in the ***Governance, Leadership and Financing*** domain were mixed with relatively few projects/services reporting each indicator to have been either fully or partially implemented (n=5/18). One initiative which reported very limited progress in this domain (all indicators assessed as either not yet been considered or not progressed), describing a perceived lack of understanding of the different TIA domains, bar training:

"TIP is talked about but I feel there's a lack of full understanding with a focus on the one domain of training which isn't at the level our staff work at. Financing happens for services within our sector such as the trauma team with small pockets of monies but no regular consideration in financing, population, culture, governance, leadership."

(Frontline project/service, Health, Statutory)

In this composite domain, governance and leadership indicators were much more likely to have been fully/partially implemented than those related to resourcing. For instance, a specific TIP implementation group being set up (ind. 1.2) was reported to have been either fully (n=7) or partially implemented (n=6) by 13 of the 18 submissions, with similar, relatively progressed, reports of senior management having received TIP training (ind. 1.1) (partial n= 9; full n=6). In contrast, only seven submissions reported that financial resources had been identified and ringfenced for TIP implementation (ind.1.7) (full n=2; partial n=5) with the remaining eleven submissions reporting that these matters had not yet been considered/ progressed (n=8). Limited progress was also reported in relation to personnel resources having been made available (ind 1.8) (full n=2; partial n=7; not considered/ progressed n=8). For those most progressed in this domain, the projects/ services were usually part of a larger initiative which had already received senior management approval (and thus some level of resourcing), or were running a bespoke service within a larger entity:

"The [new service model] Trust Implementation Team... is responsible for ensuring the Governance, Leadership, Financing of implementation in residential care is progressed as required."
(Frontline project/service, HSC, Statutory)

"Each [new service model] Implementation Lead has a Trust Implementation Plan developed."
(Frontline project/service, HSC, Statutory)

"This service is fully supported from senior management throughout all areas of the service including commissioners. Financing is dictated by larger government systems and supported via [organisation's] voluntary funds."
(Frontline project/service, Health, V/C sector)

Overall, the ***Physical Environment*** was one of the weaker implementation domains for this submission category. Seeking service user/caregiver and staff feedback on the environment (ind 2.1& 2.2) were the indicators where most progress was reported with twelve and eleven respondents noting either full or partial implementation respectively:

"When we host training, events and activities, we always include feedback on the physical environment as part of our evaluative process. We only know an environment is truly inclusive, nurturing and accessible if those utilising it feel that it is. When we receive suggestions, we seek to implement those."
(Frontline project/service, Social Care, V/C sector)

We have gathered feedback from the team to establish a safe space for staff and clients. – Victim support."
(Frontline project/service, Justice, V/C sector)

Example 3: Step Up Step Down (The Fostering Network UK)

Project Aim:

- To support children to remain safely at home with their birth families, rather than coming into care.
- To work collaboratively, with a statutory and voluntary partnership, and foster carers wrapping around whole families to see effective outcomes for families.
- To provide trauma-informed, nurturing, solution-focused and dignifying support to families, led by them.
- To connect children, young people and their families with wider community supports that feel supportive for them.
- Build an understanding of attachment frameworks and the impact of trauma, in order to provide opportunities for post-traumatic growth and nurturing relationships to flourish.

Trauma Informed Initiative: "In addition to the above, SUSD has sought to grow awareness of trauma and adversity for all involved in the project - birth families, foster carers, voluntary sector partners, statutory sector partners, informal partners and wider communities. Moreover, we have grown trauma-responsiveness within the project, and have altered policies, processes, paperwork, meeting formats, language and so on accordingly. We are always seeking to be more trauma-informed, nurturing and responsive, and believe that this is not a static place at which to arrive, but rather is a process that continues to move and grow. The learning from this project is being disseminated across the whole of The Fostering Network, and the organisation is on a journey to develop a full, trauma-informed framework within our context."

Steps taken: "We are a multidisciplinary team operating a trauma responsive service. Staff are from a variety of initial training backgrounds including social work, youth work, play therapy, integrative counselling, human givens training and art therapy. Alongside this, staff are trained in Solihull, trauma informed and responsive practice and supported via monthly line management, monthly external clinical supervision and monthly team meetings as well as being offered CPD opportunities such as Trauma Recovery techniques, Certificates in complex trauma, Kidsnet training and rapid rewind."

Engagement & Involvement: "The families we work with are within the fabric of all that we do. They inform and shape the service, regularly providing feedback and sharing their experiences (with psychological safety strongly considered). They have met with senior leadership on many occasions, and have been involved in sharing TIP learning and implementation more broadly, e.g. presenting at conferences, engaging with universities and research, sharing with other families and organisations, and indeed volunteering and working on specific projects."

Assessment & Intervention: "Family history and potential triggers for retraumatisation are understood from the beginning of a family's involvement with SUSD and we have effective mechanisms in place to gather this information. SUSD staff are well trained, supported and supervised on an ongoing basis to respond effectively to the families. Support-based team meetings are in place monthly for the family support foster carers, and peer-support events for the families, as well as specific psychological and therapeutic supports when required. Counselling and wellbeing support is available for staff also. We are currently reviewing our database and equipping the system to hold all relevant information safely, and a trauma-informed lens is being used within this process..."

Collaboration: "... Within SUSD specifically, excellent partnerships have been formed between ourselves and the statutory agencies we work with, as well as schools, health provision, social care, community groups, voluntary sector organisations and so on. External organisations have been involved with our TIP process, equipping and enabling us to embed and sustain the learning, such as Connected for Life, Karen Treisman, Lisa Cherry, June Onyekwelu and others. We work with a range of other organisations in terms of identifying community supports for families, and very much support with this engagement process."

Progress Monitoring & Evaluation: "We have clear aims and progress monitors within SUSD which we report on. A wide range of evaluative tools are used, such as surveys, focus groups, interviews and observations. The new database that is being developed will support with recording relevant information and monitoring progress even more... In terms of the wider organisation, KPI's are being developed by lead managers and senior leadership and we expect trauma-informed practices and processes to be reflected in those."

Future priorities:

- "To implement the vision, mission and new strategic plan at all levels of the organisational culture and work.
- To broaden the learning from SUSD to the wider organisation, across all four countries and teams... opening up more opportunities for networking and sharing good practice across the whole sector.
- To fully review and evaluate our trauma-informed practice and frameworks, and embed and implement any learning and recommendations thereafter....

Working with foster carers, birth families, care experienced young people and young adults, and families with children on the edge of care, we engage with trauma and adversity every day. We value lived experience immensely and consider inclusivity and accessibility to be of the upmost importance. We take a non-judgemental, holistic approach and recognise how vital it is for genuine trauma-informed practice to be at the core and centre of how we live, share and work."

The remaining indicators however reported limited progress by the majority respondents (ind. 2.3-2.7). Some respondents noted the challenges in this area related to multiple sites and limited access to finance:

"Physical environment stands out as requiring attention and bureaucracy of estate management not helpful."
(Frontline project/service, HSC, Statutory)

"Multiple physical environments need to be considered. Some services do not have identified accommodation."
(Frontline project/service, HSC, Statutory)

In spite of challenges related to limited space or working out of community facilities, respondents spoke of being resourceful and creative to make their environments user-friendly:

"As a service we would use community buildings so are very limited in terms of what we can do/change with regards to the physical environment, however, we try within the limitations we have to create a safe, user friendly space."
(Frontline project/service, HSC, Statutory)

"This is a sublet premises with restricted space... we have been resourceful and creative in how we can improve and adapt the environment to meet some [service user] needs."
(Frontline project/service, Health, Statutory)

"... is only one service of several housed in a larger premises... We have specific child and young person friendly spaces, however we do not for example have a waiting room for caregivers. We do make full use of the spaces we do have and are sometimes reliant on partners' premises to support our work."
(Frontline project/service, Mental Health, V/C sector)

Interestingly, one respondent spoke of how trauma-informed training was being delivered to those responsible for the estate as a means of enhancing awareness of potential changes needed to the physical environment as well as a collective initiative to help consider smaller changes that might be brought to children's residential environments to make them more home-like:

"TIP [new service model] training is being rolled out to Estates as another strand of developing knowledge and awareness of [new service model] requirements... Homes have been through a 'Making Homes Homely' project which was successful"
(Frontline project/service, HSC, Statutory)

Overall, the ***Policy and Procedures*** domain showed limited implementation progress, with relatively high levels of not considered/progressed and unsure or not relevant responses to all indicators. However, some responses from projects/services with implementation groups established indicated that change in this domain was a work-in-progress with clear plans apparent:

"The [new service model] is driving another review of processes/ policies - the Implementation groups will be progressing this - there has been a lot of work done on Restrictive Practices in secure setting in particular, this is on the plan."
(Frontline project/service, HSC, Statutory)

Another respondent however reported these issues to be at an early stage of implementation in an adult services initiative:

"... brought up to the [initiative] group, TIP is not just training and awareness. Policies and regional guidance considered but not implemented."
(Frontline project/service, HSC, Statutory)

A number of other responses indicated that projects/services operated within the policy framework of the wider organisation to which they belonged, with some reports of change across both and mutual influence:

"Policies within the Trust generally are beginning to take a more obvious TIP focus. In terms of setting up my own service, all policies and practice are embedded in a TIP perspective."
(Frontline project/service, HSC, Statutory)

"[The project/service] specific policies and procedures have been written/ edited to reflect TIP principles. The [wider organisation] are in the midst of a strategic vision and mission review, and the new strategic plan should have these principles embedded."
(Frontline project/service, Social Care, V/C)

In general, more implementation progress was reported in the ***Engagement and Involvement*** domain particularly in relation to service user/caregiver routinely sought and used (ind.4.5 – full n=7; partial n=9); efforts to decrease power differentials and maximise engagement (ind. 4.1 – full n=4; partial n=10) and service user/caregiver perspectives integrated into TIP initiatives/ evaluation processes (ind. 4.2 – full n=3; partial n=9). Some progress was also reported in relation to supporting service users/caregivers to meet with peers to promote shared learning/support (ind. 4.7 – full n=4; partial n=6) although for many this remained an area that had not considered or progress (n=5).

Overall, involving service users/caregivers in TIP training (ind. 4.6) or having people with lived experience involved in the work of agency/organisation as volunteers or staff (ind. 4.8) were reported as less well developed overall, although clearly some thoughtful engagement with the complexity of issues involved in achieving such goals was apparent in the responses received:

"The involvement of young people / families re. training materials etc. - this has been commenced at a regional level re. [new service model] implementation - however, at our Trust level, the [...] working group needs to develop this in ways that are relevant locally. We have involved a few people in the Trust in the [...] workshops - got their feedback / supported them... This is a very small start that needs further thinking and work within [new service model] implementation going forward."
(Frontline Project/service, HSC, Statutory)

"We have a process of supporting/ employing people who have lived experience of care, we have staff working in the homes with experience also (but this was not part of their recruitment or in the recruitment process as it currently stands, either in Trust or regionally)... this could and should be enhanced... but there is a change of thinking/culture needed re. specifically and openly looking for/ recruiting to post/encouraging openness from workforce for those who have experience."
(Frontline Project/service, HSC, Statutory)

The indicators related to policy development with regard to service user/ caregiver involvement in their own care (ind. 4.3) as well as service planning (ind. 4.4) were also less well progressed.

However, despite the disparity in responses, free text comments clearly indicated that some projects/services had made good progress in embedding service user involvement in their direct practice and service development processes:

"The families we work with are within the fabric of all that we do. They inform and shape the service, regularly providing feedback and sharing their experiences (with psychological safety strongly considered). They have met with senior leadership on many occasions, and have been involved in sharing TIP learning and implementation more broadly, e.g. presenting at conferences, engaging with universities and research, sharing with other families and organisations, and indeed volunteering and working on specific projects."
(Frontline Project/service, Social Care, V/C sector)

"The wellbeing shelf was co-produced with students – with wellbeing ambassadors and peer mentors."
(Frontline Project/service, Education, Statutory)

"[New service model] Health & Wellbeing Planning implementation is supporting involvement – [young people in care] being explicit and evidencing their involvement in their planning - as this embeds and spreads, it will definitely improve our organisation's capacity / accountability re. our young people/ families involvement."
(Frontline Project/service, HSC, Statutory)

Other qualitative responses indicated a number of challenges with regard to 'meaningful' engagement and involvement with particular service user groups in relation to learning disability or those with 'chaotic lifestyles', but respondents were clearly thinking carefully about how to take these ideas forward in their setting:

"[it is] difficult to identify meaningful ways to engage with service users."
(Frontline Project/service, HSC, Statutory)

"This is a complex diverse service users group and engagement requires a high level of sensitivity in service delivery and service user involvement. Often due to substance use and chaotic lifestyle the servicer user may not have the capacity or confidence and are not ready to engage in formal groups."
(Frontline Project/service, Health, Statutory)

Some respondents also noted the challenges in engagement and involving families or caregivers if children were in the care system:

"more professional corporate parents as many of [service users] if not all are in the care system."
(Frontline Project/service, Health, Statutory)

"We have discussed a parent group [for both families of children in the care system]- or ways where people in similar situations could meet together etc. - it is an area that needs further thinking and work."
(Frontline Project/service, Health, Statutory)

In these frontline projects and services, significant progress was reported across all indicators in the ***Workforce Development and Support*** TIA implementation domain. Qualitative responses indicated that many projects/services had received universal TIP training rolled out by their wider organisation (often SBNI Level 1 and 2 training), with some indicating that more specialist training is available for those involved in trauma-focused service provision:

"We are strong in this area as staff are considered our most valuable resources... As an organisation, [the wider organisation] rolled out trauma informed practice to all staff at its basic level, however [this service] operate at a level of trauma responsive practice to enable us to contain the levels of vulnerability that children and their family present."
(Frontline Project/service, Health, V/C sector)

Other responses from projects embedded within large statutory organisations drew attention to the significant progress made regarding understanding the impact of the work on the staff and focused attention to the availability of staff support and wellbeing resources. There was recognition in a number of responses that further work was required to address gaps and progress consistency in the delivery of workforce development and support processes such as reflective practice:

"The Trust has many processes/resources and training re. Staff Support and Wellbeing and a growing awareness of the impact of the work on the staff etc... however, the [new service model] implementation... will help consolidate existing processes and drive work needed for gaps i.e. consistency in provision of supports/reflective practice across the homes at all levels - this is partially done but work still being progressed."
(Frontline Project/service, HSC, Statutory)

"Support-based team meetings are in place monthly for the family support foster carers, and peer-support events for the families, as well as specific psychological and therapeutic supports when required. Counselling and wellbeing support is available for staff also."
(Frontline Project/service, HSC, V/C sector)

Overall, the ***Collaboration*** TIA implementation domain was perceived as well progressed with the large majority of respondents reporting that all indicators (ind. 6.1-6.7) had either been fully or partially implemented. Those reporting most favorably in this domain worked in services that clearly necessitated multidisciplinary and inter-agency cooperation given the complex needs of their service users, which appeared to have led in one instance to inter-agency pathway development:

"This is a health and social care service that requires multi agency multi-disciplinary collaboration to address the complex health and social care needs of those experiencing homelessness. These range from strategic departmental level, Public Health Agency to community and voluntary sector agency level. The service is involved in new homeless initiatives such as Complex Lives and has developed pathway initiatives with our secondary care services."
(Frontline Project/service, Health, Statutory)

"Links established between MHPs [mental health professionals] and other agencies for handover of care."
(Frontline Project/service, Health, Statutory)

"MDT [multidisiciplinary practice] collaboration regularly takes."
(Frontline Project/service, HSC, Statutory)

Other responses however indicated that while progress had been achieved, further work was needed as an awareness of gaps were identified. Specific limitations noted were related to warm handover and more generally in adult services:

"... some services do this better than others, generally collaboration is good across CYP [child & young person] services, and perhaps less so in adult services."
(Frontline Project/service, Health, Statutory)

"Warm handover started, unsure if it is fully implemented ... lack of evidence of this practice routinely as good practice."
(Frontline Project/service, Health, Statutory)

"All the processes and systems for Collaboration etc. are in place in Trust - however, I have put partially implemented as [the new service model] is bringing an awareness of gaps and areas that could be enhanced."
(Frontline Project/service, HSC, Statutory)

One respondent noted the sharing of sensitive information sharing as an added complexity to inter-agency collaboration: "At times SS [Social Services] do not share some sensitive patient information outside of social care meetings, (which cannot always be attended by [this service] therapists due to appointment-led service and length of notice given), but [this service] may need to know as it may impact cognition."
(Frontline Project/service, Health, Statutory)

Perhaps unsurprisingly, responses to the ***Assessment and Intervention*** TIA implementation domain by frontline projects and services indicated good progress when considering how to integrate attention to service users' history of trauma and adversity into their service delivery. Thus, most projects/services reported full or partial implementation across all indicators. A few responses noted the potential for service user re-traumatisation with measures in place to support staff with this sensitive and skilled work:

"Family history and potential triggers for retraumatisation are understood from the beginning of a family's involvement with [the service] and we have effective mechanisms in place to gather this information... staff are well trained, supported and supervised on an ongoing basis to respond effectively to the families."
(Frontline Project/service, HSC, V/C sector)

"All service users have assessments and all contacts are recorded via the Trust IT system, manual notes and diaries. The service has regular team huddles, team meetings and case reviews using the trauma informed lens."
(Frontline Project/service, Health, Statutory)

Some qualitative responses indicated how assessment processes had been adjusted or developed to take account of service user's histories, with case trauma-informed formulation increasingly used:

"[large service] created their own assessment document which... specific references to trauma history. Case Formulation has been and continues to be used by most teams."
(Frontline Project/service, Mental Health, Statutory)

"Within the rollout of the [new service model], we have a tailored assessment process so that each young person [in care] has a Health & Wellbeing Plan. This highlights the assessment process, including the completion of a formulation."
(Frontline Project/service, HSC, Statutory)

Other qualitative responses indicated that although some progress had been achieved, there was more work to be done, including integrating trauma assessment within data systems (ind. 7.4), the least progressed indicator in this domain:

"[routine inquiry] implemented in specialist areas but only minor questions in regional initial questionnaire, no reference to number of ACES, no questions about e.g troubles related trauma. Formulation training done but implementation has been lacking... IT systems and practices will enable staff to be more person-centred allowing service users to tell their story and not have to repeat it continuously in re-assessments. Feel people are being missed e.g addictions, lack of TIP considering trauma history and access to treatment within services..."
(Frontline Project/service, Health, Statutory)

"We are currently reviewing our database and equipping the system to hold all relevant information safely, and a trauma-informed lens is being used within this process."
(Frontline Project/service, HSC, V/C sector)

Once community services respondent also noted their assessment of the lack of specialist services to refer to which could respond relatively swiftly:

"Trauma focus is always taken into account at time of assessment/intervention but onward services are not always available in a timely fashion."
(Frontline Project/service, Health, Statutory).

Responses presented a more mixed picture in the ***Progress Monitoring, Service Improvement and Evaluation*** TIA implementation domain. For example, while some indicators such as targeted priorities and practice change goals identified (ind. 8.1) and clear goals and measures established with regard to service user (and caregiver) outcomes (ind. 8.5) were relatively positively reported (12 and 15 projects/services respectively reporting either full or partial implementation), others such as external evaluations having been conducted (ind. 8.7), and quality assurance processes developed to monitor TIP progress (ind. 8.6) received significant not yet considered/no progress responses. The indicator related to the use of data systems to monitor TIP progress also received mixed responses. Qualitative responses resonated with this mixed picture with clear evidence of interest in taking these issues forward reported. The significance of leadership, personnel, clear goals and data systems to assist with these tasks were highlighted:

"... we are in the early stages of implementation of TIP but there has been some areas of improvement in our work that takes into account TIP. It is positive we now have a lead for TIP so we can develop this in all areas of practice moving forward and will ensure evaluations take place."
(Frontline Project, Social Care, Statutory)

"Again there are processes in place re. service evaluation and evidencing outcomes for our Trust - these processes are a significant part of the role now for staff, however... there is more work to be done. We have made small steps in this... We have not yet had an independent TIP assessment... [the new service model] brings awareness of areas of further development and areas where new work is needed also."
(Frontline Project, HSC, Statutory)

"We have clear aims and progress monitors within [the service] which we report on. A wide range of evaluative tools are used, such as surveys, focus groups, interviews and observations. The new database that is being developed will support with recording relevant information and monitoring progress even more... KPI's [key performance indicators] are being developed by lead managers and senior leadership and we expect trauma-informed practices and processes to be reflected in those."
(Frontline Project, HSC, V/C sector)

Future priorities: Finally, respondents reporting on frontline projects/services described their short-term and long-term priorities for TIA implementation. While some respondents tended to simply mentioned continuing their TIA implementation work in terms of their short-term priorities, others were more detailed on where they aimed to concentrate their efforts in the immediate future:

"We are focusing on six key areas within the residential implementation. These include: Health and Wellbeing Planning; Staff support and reflective practice; Alignment of the peripatetic service; Staff development; Narrative & Life Story work; and Reflective governance"
(Frontline Project, Social Care, Statutory)

Some projects/services appeared to focus on 'awareness raising' and staff training, either by continuing their current workforce development practices or introducing new ones (as they all appeared to be at different stages on their TIA implementation journey):

"To share awareness and learning across all staff at all grades."
(Frontline Project/service, Justice, Statutory)

"Embed ACES and trauma awareness within safeguarding and other training."
(Frontline Project/service, Health and Social Care, V/C sector)

A few projects/services reported their intention to re-visit or draw new implementation plans and appoint implementation groups or coordinators, while some others mentioned developing working relationships between the statutory and voluntary sectors and co-producing and co-designing projects with service users. Regarding long-term priorities, responses were varied and sometimes rather vague. Priorities reported mostly related to developing implementation plans and strategies, as well as raising awareness and understanding of TIA principles:

"Have greater focus on implementation of TIP and greater buy-in from the organisation."
(Frontline Project, Health and Social Care, V/C sector)

"Increase understanding of trauma and skills to help traumatised children and young people within children's services in the Trust"
(Frontline Project, Health, Statutory)

3.3.3 Non frontline organisations

Submission overview: The remainder of the survey submissions (n=12/53) referred to organisations and projects that did not deliver frontline services. These were varied, including two from voluntary/community sector organisations and ten statutory agencies/organisations, which operated within various service settings: Education (n=6), Health and/or Social Care (n=2) and Multiple settings (n=4). Almost all the education initiatives (n=5/6) were involved in supporting schools, although initiatives differed in their central focus (e.g. behaviour support; looked after children; nurture; child protection; school leadership). The remaining education initiative was focused on governance. Within Health and Social Care, both submissions reported on TI implementation in relatively large statutory organisations with a focus on regional strategic development and governance. For those organisations which reported operating in multiple settings, submissions were received from two governmental departments, one District Council, and a voluntary sector organisation that provides workforce training.

Implementation progress overview: Half of the respondents in this category of submissions considered that the aims of their initiatives, projects or services reported upon had been achieved to a moderate extent (n=6/12); three reported they had been realised to a large extent; two to a small extent; and only one stated that they had not been achieved at all. The latter was because they had only started TI implementation less than a month previously. Overall, implementation timeframes ranged from less than one month to over 4 years. Not surprisingly, those who considered the aims had been achieved to a moderate or large extent had been implementing TIP/TIA for a longer period of time.

In general, based on the respondents' perceptions, the domains in which there appeared to have been more progress were workforce development and support; governance and leadership; and collaboration. On the other hand, the domains that were least progressed were assessment and intervention; and policy and procedures.

In terms of ***Governance, leadership and resourcing***, there was a mixed picture of development. Some of the projects/services which had been involved in TIA development for a longer period appeared to have progressed particularly well in this composite domain, whereas others who were at the early stages of implementation had only started to consider most of the indicators specified. Two such respondents provided further explanation of the limited progress:

"As highlighted previously, we are at the very early stages of developing and embedding a TI approach across the organisation. Our main focus is centred on raising awareness of the approach and obtaining buy-in at a senior leadership level. While there are champions within the organisation adopting a TI approach where possible, an overall organisational position has not yet been appropriately considered and/or endorsed at a senior leadership level."
(Non-Frontline, Health, Statutory)

"[Organisation] have been experiencing similar financial constraints to other organisations and although [management team] are keen to progress the project it has not been able to prioritise full implementation at this point."
(Non-Frontline, Social Care, Statutory)

Of the indicators in this domain, those most likely to have been fully implemented were in relation to TIP being specifically mentioned in organisational strategic plans (indicator 1.6., see Table 3.1) (n=5/12) as well as identified TIP leadership position/s (ind. 1.2.) (n=5). It was a mixed picture in terms of resourcing (as mentioned in above comment). Whereas four respondents felt that indicator 1.7 (i.e., financial resources were ring-fenced to advance TIA development) had been fully implemented, four others felt this element had not been considered or progressed, and four were unsure or felt it was not relevant. Similarly, four respondents stated that personnel resources had been made available (ind. 1.8.) (fully implemented), whereas four did not, and three were either unsure or felt it was not relevant. In terms of senior managers receiving TIP training (ind. 1.1.), four respondents felt this had been fully implemented, while five reported it had been partially implemented. Only three respondents reported that senior management training had not yet considered this or made progress.

In terms of the ***physical environment***, a considerable number of these non-frontline survey respondents reported that these indicators were either irrelevant or that they were unsure. For instance, one of the respondents explained that their staff worked from home, thus most of the indicators were irrelevant. Another respondent reporting on a governmental department initiative explained why they might not have in-depth knowledge of these environmental indicators in the services they support:

"[governmental department] fund a number of projects which are delivered by the VCS [voluntary & community sector] across various sites. The sites we visited are very welcoming. Unsure if all of them have a specific safe space identified."
(Non-Frontline, Multiple Settings, Statutory)

In general, some of the physical environment indicators were more likely to have been implemented whereas others were considered to have received little attention. Nearly half of respondents considered that indicator 2.1. (service user/ caregiver perspectives sought) had been fully implemented (n=5; and 1 had been partially implemented). Similarly, seven respondents considered that indicator 2.6. (mission statements visible) had been either fully or partially implemented (n=5 and 2 respectively). Respondents reported that staff perspectives had also been relatively regularly sought (ind. 2.2.), with four respondents reporting this indicator as fully implemented, and a further two as partially implemented. The indicator that had been least implemented was regarding the availability of 'safe spaces' (ind. 2.7.), with five respondents reporting that it had not yet been considered/progressed.

Regarding the ***Policy and Procedures*** domain, some respondents felt unsure about the indicators or considered them irrelevant to non-frontline organisations. This was especially the case in relation to written policies/procedures to reduce re-traumatisation (ind. 3.2.), with more than half of respondents in this submission category (n=7/12) answering either not relevant or unsure. However, for a few, the work on this domain was thought to be in progress with one respondent reporting it to be variable across the programme. One of the school support initiatives specified the work they had been doing in this area:

"The Service promotes relationship-based practices within schools and supports those schools to implement the Service model. Personal Education Plans (PEPs) have been revised... to support trauma informed, interagency plans for children Looked After. Training and implementation support is provided to schools and social care staff to ensure trauma and attachment informed practices. All policies and processes within the Service are based on the principle of reducing re-traumatisation."
(Non-Frontline, Education, Statutory)

Having written policies/procedures to promote the provision of strengths-based services (ind. 3.3) was one of the indicators in this domain which appeared more likely to be implemented fully (n=3/12) or partially (n=6/12). In contrast, nearly half of the initiatives (n=5/12) had not yet considered/progressed the indicator regarding previous policies/procedures being screened and updated to reflect TIP principles (ind. 3.4.).

In relation to the ***engagement and involvement*** domain, as in many of the other domains, there were some submissions that did not consider the indicators to be relevant. Indeed, three of the submissions marked all the indicators in this domain as either not relevant or unsure. However, other initiatives gave interesting details on their work in this domain:

"As noted before our service users are staff members from other organisations... we have been actively involving experts with experiences in our training delivery."
(Non-Frontline, Multiple Settings, V/C sector)

"The service was developed from a piece of research involving the views and experiences of key stakeholders, including other services, partner organisations, carers, social care staff, education staff, and most importantly, children. This engagement continued through the [University] Design and Implementation Study. It is increasingly difficult to get ethical approval to include the voice of the child. Processes include capturing and enabling the voice of the child to be included in their Personal Education Plans (PEPs), and for them to be included in the creation of their trauma and attachment informed space, and for school staff to actively seek the child's voice in relation

to the service model (e.g., the choice of their key adult). Our Service training incorporates videos created by our partner agency [...] with children in care. Further participation groups are planned for children, carers and parents to support the implementation of the service."
(Non-Frontline, Education, Statutory)

In general, some of the indicators in this domain appeared to be more developed than others. For instance, routinely seeking and using service user/caregiver feedback (ind.4.5.) was deemed as fully implemented by half of the submission responses (n=6/12) and partially implemented by a further four. On the other hand, indicators 4.6-4.8. were a lot less likely to have been implemented.

Particular attention seemed to have been paid to the ***Workforce Development and Support*** implementation domain, with not as many unsure or not relevant responses. Five of the submissions reported that their initiatives or organisations had either fully or partially implemented all of the indicators in this domain. Additional comments further highlight the progress in this domain:

"All staff within the Service have received a range of relevant trauma and attachment informed training, including enhanced training, ongoing service development days, regular supervision, case formulation meetings, staff survey to gauge wellbeing, and reflective practice."
(Non-Frontline, Education, Statutory)

"All staff have access to SBNI level 1 TIP training. Senior Staff have accessed level 2 TIP training. Some staff have accessed TIP Train the Trainers. Staff are signposted to Take 5 Framework, High Five Resources, EA Healthwell and Inspire. Regular H&WB [health and wellbeing] activities are planned for staff throughout the year."
(Non-Frontline, Education, Statutory)

"For some Services, all of these aspects are included in the Service delivery / support for staff through one to ones / supervision / de-briefings etc. In some cases, this 'peer support' is also made available to school staff. All organisational staff have access to well-being initiatives."
(Non-Frontline, Education, Statutory)

The provision of enhanced/specialist training to some staff to act as TI champions/mentors (ind. 5.2.) was one of the indicators that appeared to be most likely to be fully (n=7) or partially implemented (n=3). Universal TIP training for all the workforce (ind. 5.1.) was reported to have been partially implemented by most initiatives (n=8), with three reporting it as fully implemented. In terms of staff wellbeing, the majority of respondents indicated that the development of workforce wellbeing initiatives (ind. 5.7.) had been either fully (n=5) or partially (n=5) implemented. Although to a lesser extent, most respondents reported that regular access to staff de/briefing (ind. 5.5.) had been either fully (n=4) or partially (n=3) implemented.

Example 4: Controlled Schools Support Council Ethos & Leadership Programme

One of the Controlled Schools Support Council's (CSSC) key function areas is support for ethos development. Its Ethos and Leadership programme recognises the role of leaders in enabling a positive school ethos and, in alignment with the Department of Education's vision for teacher professional learning, acknowledges the role of school leaders, teaching and non-teaching staff in leading ethos, learning and school improvement.

Governance, Leadership & Financing

"... the Head of Education Support completed the SBNI TIP Be the Change Leadership programme in 2019 and disseminated this learning to the Education Team. (...) The three-year-programme of work in which TIP delivery features requires DE approval and is aligned with the Draft DE Corporate Plan. (...) Personnel resources such as officer time, travel expenses, which support in-school delivery of all training are made available to progress TIP initiatives and support the relationships with schools on a face-to-face basis whether this is in the context of delivering Level 2, other TIP informed modules or leadership coaching in schools."

Physical Environment

"Staff views regarding the physical environment are sought on a needs' basis, for example, views were specifically sought in relation to the physical environment during the pandemic and a commitment to supporting the hybrid model of working was also made and continues to be supported. (...) Recently, the removal of specific precautions such as dividing perspex screens was achieved through thorough consultation with all staff.

There are no designated safe spaces due to resource considerations (the organisation has had to relinquish its meeting room which would have been used by staff to meet in smaller groupings or to regulate during busy/overwhelming times). However, there are on-site lunch facilities where staff can engage with each other."

Policy and Procedures

"The organisation has a strong code of conduct and expectation of the service provided by officers to schools. During the pandemic, officers assumed the role of Continuity of Leaning Officers (COLO) and the role of COLO - a cross-organisational approach to supporting school leaders - this role involved providing the leaders of controlled schools with the necessary information required to lead their school communities during this period of time and included a strong pastoral support element for school leaders who were feeling under considerable pressure."

"CSSC's coaching support for school leaders is informed by TIP principles (...) Relevant documentation is provided to coaches ahead of a coaching commitment (...) Internally CSSC's Human Resources policies and procedures promote a family friendly approach which is emphasised in our current recruitment exercises with the hybrid model of working and family friendly policies evidenced in our promotion of these employment opportunities."

Engagement and Involvement

"On the whole, it was deemed that this implementation domain was not relevant to CSSC's work, however, we would take the opportunity to note the following: - Schools are meaningfully engaged with on a face-to-face capacity in meetings conducted with their designated School Support Officer and in engagement events which seek the views of school leaders and governors on the priorities of CSSC. Bi-annual surveys are also used to seek the views of school leaders. Each phase of education is represented on our Board of Directors with at least one serving school leader representing the views of nursery, primary, post-primary (selective and non-selective) and special ensuring that CSSC is conscious of the views of each phase of education within the controlled sector."

Collaboration

"One of CSSC's key strategic objectives is the intention to engage and collaborate with partners to ensure equitable support for the controlled sector. (...) Where support required is outside our remit, we signpost to the appropriate organisation/agency. We are also committed to building new and strengthening existing partnerships to support the development of controlled schools and the controlled sector. We have a Memorandum of Understanding in place with Stranmillis University College, which allows for collaboration on specific research projects such as the research into Play in Practice during the pandemic (led by Playboard NI), and a workshop on co-participatory approaches to anti-bullying and emotional health and wellbeing interventions in schools is in the planning stages for late September 2023. Other collaborations with external stakeholders take place on a less formal basis with the organisation committed to working with any external stakeholder to promote any programmes with the potential to impact positively on the controlled sector. Our presence on the EA TIP Steering Group and willingness to work with SBNI is an example of our willingness to collaborate, share our learning and benefit from the learning of others for the benefit of controlled schools."

Workforce Development and Support

"All team members received the L1 and L2 training from SBNI and three officers subsequently completed the Train the Trainers programme and are now equipped to deliver the training to controlled schools. In 2020, (...) all members of the Education Team completed the Chartered Management Institute's L7 Leadership and Management programme which built the capacity of the team to offer coaching and mentoring support to the leaders of controlled schools and has informed how team members work together with a coaching approach to problem solving often employed."

"TIP Lead on Education Team has led an awareness raising session of Trauma Informed Practice in schools for all staff which includes those with no direct engagement with schools. The implications of trauma informed approaches to support staff was also covered during this awareness-raising session. The organisation resources access to the Inspire Support Hub and staff are able to refer themselves for counselling. (...) every member of the Education Team benefits significantly from an open-door policy with access to our Line Manager facilitating ongoing reflective practice to support our role in schools but also our personal development and wellbeing. During the pandemic, staff benefited from weekly debriefing opportunities and after significant incidents (...), senior management have provided opportunities for staff to come together, to be supported and engage in collective reflection."

Assessment and Intervention

"(...) our delivery of L2 TIP, the TIP modules for governors and our coaching support is committed to ensuring that the service user, i.e those who receive our training/coaching support are not re-traumatised and the L2 training is especially careful to highlight that staff should take breaks where necessary if they feel that any of the content is triggering and staff are signposted to relevant external supports for emotional health and wellbeing both during and after the session (in the form of a follow up email which provides additional resources)."

Progress Monitoring, Service Improvement and Evaluation

"Our active presence on the TIP Steering Group allows for targeted priorities and practice change goals to be identified (...) Within the organisation, our understanding of governors' vital roles in supporting a positive school ethos has led to specific TIP content to raise their awareness of how trauma sensitive approaches to practice can enhance a school's ethos. Our goals and measures are specifically about the service we provide to schools. All training, as well as coaching support, is evaluated by participants and our impact is measured on a quarterly basis according to an Outcomes Based Accountability process. Governor evaluations of the TIP provision during delivery of the 2022/2023 Ethos and Leadership programme identified a willingness to engage with more learning on TIP and this has informed additional content for the 2023/24 Ethos and Leadership programme."

The ***Collaboration*** domain was another domain where more work appeared to have been undertaken. However, some respondents considered some of the indicators as not relevant (i.e. respondents from four initiatives/organisations answered not relevant/unsure for four or more indicators). This perhaps points to the challenge of language, and how common TIA implementation indicators may need to be articulated differently in specific service settings to ensure relevance. Our case example respondent explained their response:

"Overall, the statements in relation to collaboration are interpreted by CSSC as having a clinical feel to them and seem to refer to an individual 'patient.' CSSC therefore deems this implementation domain to be irrelevant to this project but will take this opportunity to outline how CSSC has collaborated with external stakeholders for the benefit of controlled schools."
(Non-Frontline, Education, V/C Sector)

However, despite the wording of the indicators, over half of the initiatives/organisations (n=7/12) reported to have fully or partially implemented most of the indicators in this domain. Most respondents (n=10) considered that collaboration and service coordination within the organisation had been promoted within their initiative/organisation (ind. 6.1.), with six considering it fully implemented and another four partially, or implementation had just begun. Similarly, *inter-agency* collaboration (ind. 6.2.) was reported by nine respondents (n=9) as having been implemented to some degree (fully by 4; partially/implementation just begun by 5). Most of the other indicators in the domain had also been partially implemented/implementation just begun in the majority of the submissions. The indicators on multi-disciplinary case conferences/network meetings (ind. 6.5.), service users helped to access other services (ind. 6.7.) and inter-agency/sector referral pathways (ind. 6.4.) had considerable numbers of respondents answering not relevant/unsure (5 in the first case, and 4 in the other two). Areas of improvement and challenges in this domain were also highlighted by one of the respondents:

"[collaboration is] present across the Organisation but requires improvement internally but externally with other agencies and departments to avoid duplication firstly but also to ensure the right support at the right time. This obviously has its pitfalls - as I am sure the protective nature of service delivery is hindering a more robust cross sector / cross service approach."
(Non-Frontline, Education, Statutory)

Perhaps unsurprisingly, the implementation domain on ***Assessment and Intervention***, which primarily related to service delivery and practice change (as written in the survey), was the single domain which had the largest numbers of respondents in this submission category answering not relevant/unsure to each of the indicators (either 7 or 8 in each indicator). Very few respondents (only one or two for each indicator) reported that they had been fully implemented. Despite this, one respondent was able to find relevance for their service and reported that all the indicators had been fully implemented:

"All aspects of service delivery are based on trauma and attachment informed assessments, and interventions provided use a consultative model of practice to build capacity of the core network around the child."
(Non-Frontline, Education, Statutory)

Finally, the composite domain on ***Progress Monitoring, Service Improvement and Evaluation*** painted a mixed picture of implementation. In four of the submissions, it was perceived that all or nearly all of the indicators had been fully or partially implemented. One of these respondents reflected on this progress:

"We are an active Service in terms of evaluation and continual service improvement. We regularly evaluate all aspects of our service provision in our daily practice. We have had an independent evaluation completed in our pilot stage which led to recommendations for the regional service development, along with a Queen's University PhD on one of the interventions provided [The X programme] which recommended the extension of this intervention regionally to all schools. We plan to have another independent evaluation on service delivery after 2 years of service implementation. All training and services provided are regularly adapted in accordance with feedback from our key stakeholders."
(Non-Frontline, Education, Statutory)

One of the indicators least developed in this domain was related to external evaluations (ind. 8.7.). Most respondents (n=7) reported that this had not been considered/progressed, with four saying that it had been either fully (n=2) or partially implemented /implementation just begun (n=2). On the other hand, the indicator which related to identifying measures to monitor service-level change (ind. 8.2.) had more respondents indicating that it had been fully implemented (n=4), with a further one respondent stating it had been partially implemented. The indicator on targeted priorities and practice change goals identified (ind. 8.1.) was considered to have been fully implemented by three respondents (n=3) and partially implemented/implementation just begun by a further four.

Future priorities: Finally, respondents reporting on non-frontline organisations or projects described their short-term and long-term priorities for TIA implementation. For some, short-and long term priorities were to continue doing what they had started in spite of financial constraints:

"Continue to promote and progress TIP throughout our work in any way possible. Continue to work with [Programmes X and Y] to share learning, work collaboratively where possible with the ultimate objective of not retraumatising."
(Non-Frontline, Multiple settings, Statutory)

"Continue to build and drive nurturing approaches and TIP amongst educations sectors (...) against a challenging financial climate."
(Non-Frontline, Education, Statutory)

A few submissions concentrated specifically on workforce development as both short and long term goals:

"Providing TIP training to all new (organisation's) personnel."
(Non-Frontline, Education, Statutory)

"Ongoing signposting to SBNI Level 1 training Facilitation of Level 2 training"
(Non-Frontline, Education, Statutory)

Several others identified the need for further research to evidence impact, with one respondent identifying planning and evaluation as key areas for prioritisation:

"Embed the Evidence Based [...] Service Delivery Model across the School Primary Sector and Social Care Systems. Use OBA [Outcomes Based Accountability] to comprehensively evaluate `is anyone better off` because of the above delivery."
(Non-Frontline, Education, Statutory)

Whereas for another, both short and long-term priorities were about securing commitment and financing:

"Secure agreement for a Programme For Government reference to continue to fund TIP and indeed to make a commitment to a TI Northern Ireland."
(Non-Frontline, Multiple settings, Statutory)

Other long-term priorities mentioned included further work on service user participation (in this case pupil participation), as well as on improvements to the physical environment.

3.4 Implementation outcomes and effectiveness

In this section of the survey, overall, respondents found it difficult to specify measurable outcomes, explaining that often outcomes had not yet been gathered about their organisation/service or project; had not been evaluated; were not known; or indeed had not been established in the first instance. Despite these limitations, respondents went on to articulate a range of anticipated outcomes related to service users, families and caregivers, staff and 'other' outcomes which they believed emanated from TIA implementation (see Table 3.2).

Table 3.2: Outcomes identified (summary of themes)

Service user outcomes	Family/caregiver outcomes	Staff outcomes
Better service user experience (i.e. better-quality service, feeling valued, understood, etc.)	Meaningful engagement and participation in services ('voice') (e.g. home-school links)	Improved understanding of TIP, trauma impact & service users' needs
Access to more appropriate care/intervention/supports	Access to relevant services	Enhanced practice skills & ability/capacity to respond
Improved health/wellbeing, & social, emotional & attainment outcomes	Better understanding of trauma and its impact	Improved health/wellbeing
Meaningful engagement and participation in services ('voice')		Higher job satisfaction

In terms of ***service user outcomes***, most of the outcomes reported were related to enhanced service provision. Many respondents noted improvements in the service user experience such as: receiving a better-quality service, e.g. a more 'empathetic', 'kinder', 'compassionate', 'thoughtful' service; service users feeling valued, supported and/or understood; and better experience of accessing the service. Such changes were primarily thought to occur as a result of improved workforce skills, motivation and empathy, but also improved physical environments:

"[Service users have] A better experience if they are meeting staff who feel motivated and supported to carry out their duties."
(Frontline organisation, HSC, Statutory sector)

"In some areas of CYPS [children and young people's services], e.g. contact services, have been improved significantly through understanding the contact environment and staff responses therein. Some respite residential facilities for children with disabilities likewise have had décor and structure improved."
(Frontline organisation, HSC, Statutory sector)

In addition, many respondents mentioned service users receiving (from staff) a better understanding or awareness of their trauma experience and its effects, thus accessing more appropriate care, interventions or supports and improved service allocation:

"Feel their trauma is considered and understood so services they receive are appropriate."
(Frontline organisation, Multiple settings, V/C sector)

Several respondents identified a range of outcomes related to increased effectiveness such as *improved service user health and wellbeing, and social, emotional and attainment outcomes*. Such outcomes, however, were not always clearly specified in measurable terms and it was not clear whether any current evidence existed to support such aspirations:

"Improved health and wellbeing, understanding of what happened to them"
(Frontline project/service, HSC, Statutory sector)

"Reduced PTSD [Post Traumatic Stress Disorder]"
(Non-Frontline, Multiple settings, Statutory sector)

"Increased effectiveness of services – in engagement, adherence to treatment and clinically reliable improvement outcomes"
(Frontline organisation, Health, Statutory sector)

"Improved Social, Emotional, Attainment and Achievement Outcomes"
(Non-Frontline, Education, Statutory sector)

Another common service user outcome expressed was related to enhancing the service user voice within the provision of services, with more meaningful engagement and participation outcomes expressed, not only in their own care/ intervention/decision-making but also the wider organisation:

"Increased participation of vulnerable young people."
(Frontline organisation, Education, Statutory sector)

"Their voice influencing service delivery through the PO [Participation Officer]."
(Frontline organisation, Justice, Statutory sector)

Respondents specified similar anticipated ***outcomes for families and caregivers*** related to the enhanced *family/caregiver service experience* (e.g. feeling supported and valued); family/caregiver voice (e.g. opportunities to share experiences and feel heard); and their *own health and wellbeing* (e.g. less stress/more hope):

"Families and carers are involved, supported and cared for."
(Frontline organisation, HSC, Statutory sector)

"More empathy and compassion for families."
(Frontline organisation, Education, Statutory sector)

Improvement in *family/caregiver engagement* (e.g. home-school links/ partnerships) and *access to relevant support/services* (in-house or via signposting, referral etc.) to *benefit service user outcomes* were some of the common additional outcomes articulated in this section. Helping families/caregivers have a better understanding of trauma and its impact (particularly in terms of child behaviours) was highlighted by some respondents:

"Improved wellbeing, deeper understanding of attachment and trauma, evidenced attunement to children's needs, greater engagement with community supports, greater engagement with learning, deeper understanding of the impact of trauma, useable regulation strategies, higher capacity to advocate for their own needs and the needs of their children"
(Frontline project/service, Social Care, V/C sector)

Primary ***outcomes for staff members*** identified in survey responses included *improved staff knowledge* of TIP, trauma impact and thus service users' needs; as well as *enhanced practice skills*, ability/ capacity to respond in a more helpful manner:

"Increased awareness of TIP, increased confidence at developing TI formulations."
(Frontline project/service, HSC, Statutory sector)

"Ability to recognise the signs of trauma and ACEs and apply the principles of trauma informed practice through daily practices, policies, language, communication."
(Frontline organisation, Education, Statutory sector)

"Ability to look differently at wicked problems and have a toolkit to do that"
(Non-Frontline, Multiple settings, Statutory sector)

For some, this meant helping staff to understand what they were doing and why, thus enhancing service response:

"Helping staff to name what they are already doing"
(Frontline organisation, HSC, Statutory sector)

"[Facility] is an environment where staff already, to a large extent, used a trauma informed approach. However, the training, language and the tools to structure this approach more formally, have been beneficial to ensure a greater recognition and response to service users."
(Frontline project/service, Justice, V/C sector)

Additional staff outcomes reported were in relation to improvements to *staff health and wellbeing*, as well as *job satisfaction*. Thus, respondents noted staff outcomes of reduced vicarious trauma and staff sickness; and enhanced 'staff morale'; improved self-awareness, self-care and capacity to deal with job demands:

"...staff feeling valued and motivated, focus on health and wellbeing, reduced sickness/vacancies."
(Frontline organisation, HSC, Statutory sector)

"...reduced vicarious trauma and an environment where staff feel cared for and supported."
(Frontline organisation, Health, Statutory sector)

Such changes were thought to be related to improved workforce supports (such as supervision or reflective practice), a shift away from 'blame' toward a culture of learning, and an enhanced focus on staff wellbeing in the workplace, which in turn led to staff feeling valued, heard, and motivated:

"Shift away from blame culture toward learning organisation. Understanding of the impact of work on employees."
(Frontline organisation, Multiple settings, V/C sector)

"More emphasis on health and wellbeing, feeling valued and heard."
(Frontline organisation, Justice, Statutory sector)

Finally, in terms of other ***outcomes*** elaborated, some related to broader organisational benefits such as reduced staff sickness and vacancies; more collaboration within and outside the organisations; and reduced potential for re-traumatisation of all within the system:

"Implementing trauma informed practices within [organisation] has created a proactive approach to safety, with safer physical and emotional environments for service users, families and staff that reduces the potential for re-traumatisation."
(Frontline organisation, Health, Statutory sector)

A few respondents also articulated potential benefits for TIA implementation to better inform wider public sector planning and delivery, including an enhanced focus on the need for a trauma informed response for all, particularly in the context of NI's history of political conflict and trauma prevalence, as well as greater attention to appropriate budgets and planning to achieve meaningful outcomes:

"An emerging recognition of the prevalence of trauma in NI and what that means for public sector delivery and its importance in delivering outcomes."
(Non-Frontline, Multiple settings, Statutory sector)

"Deepening understanding of the essential nurturing approach required by ALL."
(Non-Frontline, Education, Statutory sector)

"Proper awareness of what the system has in capacity to deliver expected demand... [government department and policy makers] need to be trauma informed in response to resource way outstripping demand and staff still expected to meet unrealistic standards and targets. New outcomes framework... should help having a more population-based approach to inform budgets, governance, training skills mix."
(Frontline project/service, Health, Statutory sector)

3.5. Implementation barriers and enablers

The survey questionnaire also asked respondents to specify in text boxes enablers and barriers to TIP implementation progress. Table 3.3 summarises the most common responses.

Table 3.3: Enablers and barriers identified (theme summary)

Enablers	Barriers
Senior leadership buy-in, support & commitment across organisation	Lack of strategic leadership – personnel changes – competing priorities/pressures
Implementation structures, i.e., working groups, champions & dedicated staff etc.	Absence of implementation plan & structures, or dedicated staff
Organisational implementation plan, defined roles & responsibilities, shared vision	Size & complexity of organisation
Adequate & protected TIA resources	Absence of protected or sufficient resources
Staff buy-in, involvement & communication across the system	Over-stretched systems, staff workloads (time) & staff resistance to change
Meaningful staff & service-user involvement	Lack of involvement across the system
Training to promote TIP understanding (training quality, bespoke training & different levels)	Lack of understanding of what TIP entails incl. importance/difference to everyday practice, no training budget/strategy
Centralised resources & tailored support (SBNI TIP Project)	Uncertainty how to take implementation forward; lack of tailored resources
Ongoing staff support & development	Service pressures & lack of protected time
COVID-19 pandemic heightened focus on need to support staff wellbeing	Impact of COVID-19 pandemic on staff fatigue, turnover and service user need complexity
Internal & external collaboration with key stakeholders	Fragmentation of service delivery
Opportunities for shared learning	Lack of development support
Ongoing monitoring, review & evaluations – further evidence of impact	Lack of evidence base of positive impact & cost savings
Alignment with other strategic priorities 'luxury' initiative, not core business	Seen as stand-alone ad-hoc 'low priority' or
Governmental & Departmental support	Lack of functioning Assembly & Executive

One of the ***enablers*** most frequently mentioned in survey responses across all submission categories was in relation to *leadership buy-in, support and commitment to TI approaches*. Effective TI leaders, in senior management positions and across the organisation, were variously described as "committed", "passionate", "empathic", and "active" and central to TIA progression:

"There have been a number of key members of staff who are really committed and passionate about developing trauma informed practice and services. They have taken on a champion role within areas to promote continued progress and development."
(Frontline organisation, HSC, Statutory sector)

"Senior management Director, AD, and HoS have been fully committed to striving to be a Trauma responsive organisation."
(Frontline project/service, HSC, Statutory sector)

Ensuring leadership buy-in from *strategically significant positions* within the organisation was thought by some to be essential in large, multi-faceted organisations such as HSC Trusts or large voluntary sector providers, as a means to bring coherence across departments and progress change as a whole organisation:

"Having a Director [...] and an Assistant Director who are keen to drive this forward is hugely significant. The AD chairs this project and this will enable smaller projects... to become part of a more strategic whole which progresses the goal of becoming a trauma informed organisation..."
(Frontline organisation, HSC, Statutory sector)

"We obtained "buy in" right at the start of this process from the very top of our organisation i.e. Chief Executive, Senior management team and Governing Body."
(Frontline organisation, Education, Statutory sector)

"Having such a supportive Director in Northern Ireland, who really took the time to listen and understand what was truly meant by trauma-informed practice, meant that the [named] service could progress a meaningful and broad process towards becoming more trauma-informed that was not tokenistic."
(Frontline project/service, HSC, V/C Sector)

Connected to this enabler, respondents also stressed *implementation and governance structures*, such as strategic steering groups, dedicated project teams and positions, implementation working groups, TIP champions etc., all of which were noted as essential to progress the desired culture change, action effective implementation, and motivate staff and service user buy-in:

"The commitment of managers and leaders in the organisation to promote the culture of participation as well as to promote processes and structures to enable participation and feedback from children and young people."
(Frontline organisation, Social Care, Statutory sector)

"The Governance structure in place - the Strategic Steering Group / Trust Implementation Team Meeting / Residential Working Group."
(Frontline project/service, Social Care, Statutory sector)

"Having a dedicated project team... led by two senior managers with good understanding and knowledge of trauma informed practice. Cooperation from a wide range of staff, trustees and clients' willingness to ensure the organisation progresses to become a fully trauma informed organisation in all areas."
(Frontline organisation, Health, V/C sector)

For some, this meant making connections with departments and people across the organisation whose responsibilities were aligned with TIA development, although not necessarily 'badged' as such:

"Development of TIP leadership group including senior leaders across Trust from clinical and HR/OD... [there is] significant work within Trust that is trauma informed, even though it is not badged under that term e.g. HSC values/QI agenda."
(Frontline organisation, HSC, Statutory sector)

Alongside implementation structures and leadership support, a number of submissions noted the need for *'adequate' and 'protected' resourcing* for TIA development to take effect:

"Having protected resources - we are in need of more resources but the ones we have, have been protected."
(Frontline project/service, HSC, Statutory sector)

"For there to be authenticity to the TIP movement, there should be adequate resource of social care staff. Workloads should be manageable and support and remuneration must equal demands of the job."
(Frontline project/service, HSC, Statutory sector)

As noted in some of the quotations above, collaboration *within the organisation or service itself*, i.e. good working relationships across teams, disciplines, and all parts of the organisation, was frequently cited as an important enabler, with TIA implementation seen as a 'shared priority':

"Ensure that it's a shared priority across all directorates/parts of the organisation. Some people still need to see the benefits of embedding TIP."
(Frontline organisation, Social Care, V/C sector)

Together these ingredients were thought to enable "everyone working together":

"Staff working to their skill set across different levels, sectors and spheres of influence. Very clear example of top down AND bottom up. Took everyone working together to achieve multi-faceted elements."
(Frontline organisation, Multiple settings, V/C sector)

A meaningful commitment to *staff and service user involvement* was considered by many to be at the heart of TIA implementation and a key enabler, with advice given to leaders to 'listen' and 'live the culture of TIP':

"..listen to staff on the ground and support and try out their ideas for change... listen to service users' views... leadership living the culture of TIP from the top to the bottom"
(Frontline organisation, HSC, Statutory sector)

"...Fantastic home leaders and staff - who do amazing work every day - who desperately want to see and be involved in making better outcomes for their young people and themselves - you cannot buy this type of commitment! it has to be grown and protected."
(Frontline project/service, HSC, Statutory sector)

"... the commitment of young people involved, the commitment of dedicated [staff] and Managers. The tangible benefit... the impact of their contributions including the contribution to policy and practice and provision of a platform to influence."
(Frontline organisation, Social Care, Statutory sector)

"All aspects of implementation are co-designed with leadership, staff, service users, families and caregivers."
(Frontline organisation, Multiple, Statutory sector)

Training for all staff, not only those in front-facing roles, was also repeatedly referred to as essential for progress as a means to continue to improve knowledge, understanding and awareness of the importance of trauma-informed service provision. Respondents mentioned the benefits of "quality training" as well as "bespoke training" tailored to their specific setting. The need for financial resources to invest in such training was also noted as an important factor in this regard:

"Also quality training has been key. Staff who have undertaken the [..] training have described it as the most useful and beneficial training of their career."
(Frontline organisation, Justice, Statutory)

"Having access to a training budget to facilitate bespoke TIP training for staff."
(Frontline project/service, Health, Statutory)

"Access to tailored resources; there is much activity in this area and many generic resources, however organisations need to find time and staff to tailor these to deliver maximum benefit."
(Frontline project/service, Multiple, Statutory)

Many respondents highlighted the *key role of the SBNI TIP project as a central resource*, providing materials, training and ongoing support for TIA advancement in NI:

"As a small country, SBNI push to have Trauma Informed workforces across the country has helped set an expectation..."
(Frontline organisation, Multiple settings, V/C sector)

"SBNI have been a great resource"
(Frontline project/service, Health, statutory)

"Working with and in conjunction with SBNI has enabled further propagation of TIP across the Education sector."
(Non-Frontline, Education, Statutory)

In addition to additional training, ongoing *staff support, including supervision and reflective practice* was noted by many to allow service developments to embed and support staff with the challenges of the practice changes required.

Some responses noted how recent societal developments, such as the Covid-pandemic, have usefully brought greater attention to the importance of *staff wellbeing* as a core component of progressing TIA, particularly in frontline service provision:

"Wellbeing initiatives during COVID 19 highlighting the need for the support of staff ... As a consequence of Covid 19 there is more openness to recognise the impact of trauma."
(Frontline organisation, HSC, Statutory sector)

"...a cultural [...] change to student wellbeing.... Covid enabled conversations and fast- tracked ideas people had, but then they were allowed to deliver as it was seen as a priority."
(Frontline project/service, Education, Statutory sector)

"Trust supporting staff wellbeing and recognition that staff are working with a high level of trauma and the impact of such upon staff wellbeing and consequence delivery of care".
(Frontline organisation, HSC, Statutory sector)

Collaboration with other organisations, stakeholders and disciplines, as well as the approval of governmental departments was also identified as an important enabler in a number of submissions:

"Good working relationships across teams / internal and external partnerships with key stakeholders. Regional collaboration of building [the trauma informed initiative]... connection and 'stamp' of approval from DoH, DoJ and other key agencies..."
(Frontline project/service, HSC, Statutory sector)

"Having MDT [multidisciplinary] MHPs [mental health professionals] in GP Surgeries."
(Frontline project/service, Health, Statutory sector)

For some, this collaboration took the shape of *sharing learning and resources* with other organisations which was identified as a key motivating factor to help envision the next steps:

"Having the links with the Safeguarding Board... and the links with the voluntary and community sector, to be able to share the learning so to speak with grassroots organisations who are dealing with vulnerable people who have suffered multiple traumas in their life, helping organisations to deal with the people they are interfacing with in a trauma informed way. Have only encountered positivity and a real enthusiasm to learn more from and to share the learning from all stakeholders involved."
(Non-Frontline, Other, Statutory)

A number of submissions also mentioned the need for *'research and data'* which were considered to be essential to demonstrate TIA positive impact on outcomes and cost savings:

"[enablers] Research and data that show the difference this can make in terms of positive outcomes and also the cost savings that can accrue as a result."
(Non-Frontline, Multiple Settings, Statutory)

In contrast, *a lack of funding, financial constraints and limited dedicated and specialist resources (including staffing)* were identified as central ***barriers to progress***. Around half of the survey respondents highlighted staff workloads as being "busy", "unmanageable", and "heavy" and noted "staff fatigue". Some respondents described systems of care, including both statutory and voluntary/ community services, as stressed, stretched and under-resourced. In such circumstances, TIP was considered "low on the agenda" or "a luxury":

"... under resourced system will always have people working under stress so in order for there to be authenticity to the TIP movement there should be adequate resource of social care staff. Workloads should be manageable and support and remuneration must equal demands of the job."
(Frontline project/service, HSC, Statutory)

"Busy staff with high caseloads - TIP can sometimes be seen as a luxury."
(Frontline project/service, Health, Statutory)

The *negative impact of the COVID-19 pandemic and other external factors such as the lack of an NI Executive* (at time of fieldwork) on organisational resources and staffing pressures, as well as the complexity of service user need was also mentioned by many respondents as a complicating factor in the current climate:

"There are ongoing staffing and service pressures that continue to place extreme pressure on frontline services. The Covid 19 pandemic has also placed additional challenges to service delivery and the complexity of the difficulties children, young people and their families are experiencing."
(Frontline organisation, Social Care, Statutory)

"The absence of an executive in NI has been stifling in terms of developing the service and accessing necessary funds to develop in the ways we need to as a result of our TIP learning... Crises within statutory social services, particularly around staffing capacity, has made it difficult at times to work in fully nurturing and trauma-informed ways, due to high levels of stress and responsibility for individuals and teams within that context. The Covid pandemic and lockdowns also presented significant challenges for families and staff."
(Frontline organisation, Social Care, V/C sector)

One response to this section, noted the additional complexity of the impact of the political conflict in NI which, combined with COVID, was perceived as providing a further barrier to 'talking about TIP':

"Working within the NI context where avoidance of recognising the impact of trauma is an inherent way of coping with it. Covid 19...reticence about talking about TIP given the understanding that staff were going to experience trauma and distress as a consequence of their work."
(Frontline organisation, HSC, Statutory sector)

Pressures on staff (including a high turnover of staff and in some contexts service users), coupled with increasing levels of service user need due to Covid and other external factors, were noted to make TIA progress more challenging:

"Barriers can include the stressors on staff and the organisation as a result of the impact of covid and other external factors which have increased demand and pressure. Heavy workloads can leave a sense of individuals not being able to contribute to higher level activities which have long term universal benefits when competing with current overwhelming demands."
(Frontline organisation, Social Care, Statutory)

"Coming out of COVID through which our staff worked as essential workers, there has been a fatigue. Staff themselves have been dealing with the impact of the pandemic as well as the cost-of-living crisis and other stressors that have left people flat. You can't pour from an empty cup and staff needing some space themselves has been a barrier as a lot of people left [Organisation] within the past year which has impacted morale and subsequently the ability to rally people and get them to reinvest in their passion around TIP."
(Frontline organisation, Justice, Statutory)

A lack of understanding and knowledge around both trauma and its impact, and indeed TIP itself was also noted by a number of respondents as a key barrier to progress with reference made to definitional confusion; a lack of consistent language; insufficient or inappropriate training; and the relevance for adult services and non-frontline organisations:

"Sounds superficial but the 'branding'. Often our experience is that people assume that 'trauma' refers to a very specific, niche set of roles as opposed to something systemic - this is especially the case when it comes to organisational design. The focus seems to be on frontline delivery."
(Non-Frontline, Multiple settings, Statutory)

"Lack of knowledge in what really is TIP and how this looks for service users and staff. Feels tick box, measuring training at a level that is too low for staff level of work. Feeling that trauma work is onward referral to specialist staff, not upskilling all staff properly as part of mandatory training in skills. How we outreach to [service users]... Main barrier is lack of understanding."
(Frontline project/service, Health, Statutory sector)

"Different understanding across the organisation about what trauma is, how trauma is different from being trauma informed... ACE's [adverse childhood experiences] viewed as being only for CYP [children and young people] service and difficulty recognising the impact that this has across the lifespan exacerbated by traumatic events/distress in adulthood."
(Frontline organisation, HSC, Statutory sector)

In connection to this perceived lack of understanding and confusion, a few respondents identified staff resistance as a potential barrier to TIA implementation. This was thought to emanate from some staff seeing TIP as something they had already been doing, "not core business", or something they had insufficient time for:

"The perception that because we are providing social care intervention, we are already trauma informed (which is not the case). Ensuring the approach to TIO [trauma informed organisation] is not tokenistic."
(Frontline organisation, Multiple settings, V/C sector)

"TIP can sometimes be seen... as something people think they do anyway."
(Frontline project/service, Health, Statutory)

As well as these common challenges, some submissions noted the particular *complexities of implementing TIAs in large, national or multi-faceted organisations* with inevitable delays in decision-making and differing understandings across the organisation noted as problematic:

"Implementing TIP across a large national organisation is challenging - different starting points, different understandings of trauma and different levels of knowledge and expertise."
(Frontline organisation, Multiple, V/C sector)

"Size of the organisation and the layers things need to go through in order to get approved and then for the changes to be rolled out and experienced by all."
(Frontline organisation, Multiple, V/C sector)

"... huge system that is slow and takes time to move / make decisions (although COVID demonstrated that this does not have to be the case!)... a huge amount of making connections and communication and collaboration as everything is being done at Trust / local levels and also regional - this is the nature of the project but it can only go as fast as people have capacity for."
(Frontline project/service, HSC, Statutory sector)

Other barriers to progress commonly reported included the *lack of evidence of effectiveness, lack of committed leadership, implementation structures or adequate resourcing* at a team or organisational level:

"Having insufficient senior staff to champion this approach and time to give greater focused attention to it." (Frontline project/service, HSC, V/C Sector)
"Time, finances, covid impact, resourcing of a full TIP team - there is a dedicated Programme Manager but not a full team."
(Frontline organisation, Multiple, V/C sector)

In light of such combined challenges, a number of submissions noted the potential for TIA implementation becoming seen as 'tokenistic' or 'tick box' and the 'unsatisfactory' nature of inconsistencies in trauma informed ambitions and allocated resource. These multiple barriers to TIA progression were clearly identified in this submission:

"TIP implementation being viewed as we are already doing that. Or TIP is presented in a way that feels too big another task to do in an already stretched service and not knowing where to start. Thinking that TIP is something new and something else to do. Time and permission from management to make changes. Barriers to progress are resources both in terms of staff resource and financial in terms of being able to fund staff time to give this full consideration. Ideally a project implementation strategy would require dedicated support for a specified time. This would allow space to audit what is being done and where identified gaps could be addressed. This would also include a review of current policies and procedures. An ad hoc approach remains unsatisfactory."
(Frontline organisation, HSC, Statutory sector)

3.6 TIA implementation advancement in NI

In addition to many of the enablers and barriers identified about, when asked specifically about what was needed to advance TIA implementation in NI, the following core requirements were identified.

Table 3.4: Core requirements for TIA advancement (theme summary)

Core requirements re. TIA advancement in NI
Support & recognition from Government & Departments
Designated & protected financial & personnel resources
TIA implementation mandated in commissioning procedures
TIA implementation learning events, conferences and networking initiatives
Context-specific training, resources and support
TIA integrated into all professional trainings (e.g. Social Work, Medicine, Nursing, Teaching, Psychology, Youth Work etc.) & CPD frameworks
Universal training & public health campaign

A common response across survey submissions highlighted the critical need for *support and recognition from Government and Departments* as a means to align TIA progression with organisational priorities and achieve sustainable change:

"Political buy-in [is needed] at Ministerial level and, in the absence of that, buy-in from Permanent Secretaries to ensure TIP is within PfG [Programme for Government]."
(Frontline organisation, Justice, Statutory sector)

"A strategic, governmental commitment that reaches down to meet the pockets of brilliant TIP practice already in train. An acknowledgement that much of how we operate in NI, of the levels of trauma that exist, and the impact that they can have if left unaddressed."
(Non-Frontline, Multiple, Statutory sector)

"Greater focus re. a Trauma Informed approach at Government level."
(Non-Frontline, Health, Statutory sector)

"Trauma-informed approaches, learning and implementation will only work in sustainable ways with local communities engaged and leading on these priorities, and with full collaboration and partnerships across communities, voluntary sector, statutory sector, health, education, social care and with governmental commitment and resources. Often this learning is held within the hands of professionals only, but needs to be woven into the whole social fabric."
(Frontline project/service, Social Care, V/C sector)

"Recognition and support at Government level (and thence via Departments)"
(Frontline organisation, HSC, Statutory sector)

"Strategic direction at government level to direct that TIP will be integrated & embedded."
(Non-Frontline, Multiple, Statutory)

With such strategic imprimaturs, submissions noted *the availability of dedicated funding* as a necessary step toward TIA progression:

"I believe that if funding were available via our sponsoring department this would help to embed TIP across the rest of the FE [Further Education] sector in NI."
(Frontline organisation, Education, Statutory sector)

"Commissioned funding to create a multidisciplinary team of staff including admin who can focus purely on embedding TIP across the Trust."
Frontline organisation, HSC, Statutory sector)

Such funding considerations were reflected in a number of voluntary/community sector submissions where respondents noted the need for TIA service delivery to be incorporated into *commissioning processes*:

"Have funders nudge providers to be trauma informed by expecting it as part of service delivery."
(Non-Frontline, HSC, V/C sector)

"Better commissioner understanding."
(Frontline organisation, Multiple, V/C sector)

This additional designated resourcing was thought by many to make possible more dedicated staff and 'protected time' to provide the local leadership and ongoing staff support, supervision and reflective practice to allow service developments to embed:

"Staff whose role is dedicated to leading on TIP within the Trusts in particular - like the Think Family lead roles."
(Frontline project/service, Health, Statutory)

"Added resources - More staff - Protected time to provide reflective practice and reflective supervision."
(Frontline project/service, Health, Statutory)

"A designated resource for ensuring that every school is able to engage with initiatives/programmes which support their ability to be trauma informed... More consideration and promotion of how to allow schools to provide supervision for staff. This would require a resource to support training of key staff to be able to facilitate such conversations in schools."
(Non-Frontline, Education, V/C sector)

A few organisations also noted the resourcing required to fund the additional auditing, research and planning needed to take TIA development further:

"... workloads and time constraints have impacted on our ability to 'take time out' to properly audit what we do and what we need to do."
(Frontline project/service, HSC, Statutory)

In many of the submissions received, a strong desire for and commitment to service improvement was articulated. This involved the recognition of good practice, coupled with enthusiasm for 'doing better' for both servicers and staff. In this section of the survey, many respondents noted the need for *TIA implementation learning events, conferences and networking initiatives* helping organisations share ideas of how they have brought change to their service delivery; the potential for 'buddy systems across agencies'; the need to 'keep up-to-date' with new developments; and the need for a 'central point of support':

"Conferences, opportunities to learn from others, ideas of how to put it all into practice. Have a central point for support. Training initiatives. Buddy system across agencies."
(Frontline organisation, Multiple settings, V/C sector)

"An opportunity to connect, meet and learn from others in a shared environment who are on the journey to becoming a TI service/organisation. Celebrating the successes, case studies of good practice, etc."
(Frontline organisation, HSC, Statutory sector)

"Keeping up to date with emerging trends of those we service and innovative supports."
(Frontline organisation, Multiple settings, V/C sector)

"Development of cross-sectoral TI network, annual conference/event re. local/ national/ international models of best practice."
(Non-Frontline, Health, Statutory sector)

As well as the need for broader networking and learning opportunities, a number of submissions also noted the need for *context-specific support* to take TIA advancement further in particular settings:

"The learning and approaches across Northern Ireland should be brought together within a learning and practice network that is inclusive and accessible. We need to understand the importance of a context-specific approach, and that one size does not fit all in terms of what works well."
(Frontline project/service, Social Care, V/C sector)

"Development of case studies which demonstrate how schools are implementing and embedding these approaches."
(Non-Frontline, Education, V/C sector)

"Sharing examples of good practice, supporting staff to maintain a trauma informed approach when feeling under pressure and under resourced - harder to hold onto this understanding when overwhelmed and attempting to fire fight by focusing on presenting behaviours."
(Frontline project/service, Health, Statutory)

"More publicity and emphasis on TIP in primary care and population health. This should be embedded into the practice of the new MDTs in primary care."
(Frontline project/service, Health, Statutory)

As a means to ensure 'a collaborative, consistent and coordinated approach', a number of respondents recommended the inclusion of *TIP training in all qualifying professional programmes* such as Medicine, Social Work, Nursing, Psychology services, Teaching, Youth Work etc. as well as post-qualifying/CPD programmes:

"A collaborative, consistent and coordinated approach. Opportunities to share knowledge, joint training. TIP to be embedded in professional training of social workers, youth workers, teachers and other professionals."
(Frontline organisation, HSC, V/C sector)

"All organisations that work with people should be trauma informed. I think the biggest thing is that social work and health care professionals have adequate training and knowledge prior to qualification that can be built on throughout career."
(Frontline project/service, HSC, Statutory)

For some this approach to professional development needed to be accompanied by a *broader public health campaign*:

"This should be supported by a public awareness campaign of what is meant by TIP and its universal relevance to understanding the stress response system and how we are all shaped by our experiences - both good and bad - and that resilience is not an internal capability but something that must be supported externally."
(Non-Frontline, Education, V/C sector)

"Better education and understanding of the importance of supporting anyone who has experienced trauma. This will ensure they receive the right support and service. Better awareness to help people change their outlook - not what is wrong with that individual, but instead "what has happened to them", to help explain behaviours and some conditions. People need to understand the full implications of trauma and ACEs, not just on behaviours but on our long term health and how our environments need to ensure our safety, not re-traumatisation. It is at the end of the day, a public health matter!"
(Frontline organisation, Mental Health, V/C sector)

"The nation needs to be trauma aware."
(Frontline project/service, HSC, Statutory)

3.7 Key messages

A bespoke online survey sought to map current TIA implementation developments in NI. Fifty-three submissions were received from senior professionals following targeted invitation coupled with social media promotion. Despite the limitations associated with the self-assessment nature of the survey and time-constrained recruitment strategy, the following key messages emerged from detailed analysis:

- Trauma-informed approaches (TIAs) are currently being implemented across all sectors (statutory and voluntary/community) and diverse service settings (education, health, justice, social care, multiple settings) in NI. Regional, Trust-wide and more local services are represented as well as organisations serving both child and adult populations. However, organisations and agencies serving children appear to have been implementing TIAs for a longer period and to a larger extent than adult only services.

- Trauma-informed implementation initiatives are being undertaken in different types of organisations including frontline whole-organisation implementation, frontline projects or services (within wider organisations), and non-frontline strategic development, support, advisory, governance and commissioning organisations. However, there were differences in implementation between them. For instance, some trauma-informed implementation domains and indicators are more likely to be deemed as not relevant for non-frontline organisations.

- Implementation appears to be taking place across all core domains (i.e. organisational development; workforce development and support; service design and delivery) although progress differs significantly.

- In general, across all implementation contexts, the domains with most progress reported include 'Collaboration', 'Workforce Development and Support', and some elements of 'Leadership and Governance'. In contrast, 'Progress Monitoring, Service Improvement and Evaluation', and 'Resourcing' are those with least reported progress.

- Respondents recognise the benefits of TIA implementation with a wide range of anticipated outcomes reported for service users, families and caregivers, staff and the wider organisation. In general, outcomes appear to have not yet been systematically measured, collected or analysed, despite the perceived need to do so as a means to develop a robust evidence base.

- The most common enablers identified as essential to drive TIA implementation forward include senior leadership buy-in and commitment across the organisation, as well as key planning structures and processes, and staff training and support. In contrast, the most commonly identified barriers noted are financial and staffing resourcing constraints in over-stretched service delivery systems further complicated by the COVID pandemic and the absence of a functioning NI Assembly (at time of fieldwork).

- Further advancement of TIA implementation in NI was thought to depend upon government and departmental support including designated resources and commissioning requirements to create sustainable change; TIA implementation learning and networking initiatives to share transferable best practice and the development of context-specific resources; and the embedding of TIA training in all professional programmes.

Chapter 4: TIA Implementation in Northern Ireland: The Views of Senior Managers & Professionals

4.1 Introduction and Overview

In this section, we present the findings of a series of sector-specific focus groups seeking to establish a strategic overview of senior professionals' assessment of the implementation of Trauma Informed Approaches (TIAs) in their sector or area of expertise in Northern Ireland (NI), identifying implementation progress and limitations; perceived benefits or disadvantages; barriers, challenges and enablers; and exploring a future vision for TIA advancement in NI. Focus groups were conducted online through Microsoft Teams over the summer of 2023. For convenience, they were recorded and initially automatically transcribed through this platform. Automatic transcriptions were subsequently carefully checked, corrected, and analysed using thematic analysis.

In total, eight focus groups were conducted between 9th August and 5th September 2023. Each focus group included senior professionals within a specific sector or field of expertise with some overlap due to participant availability (see Table 1). In total, 52 *professionals* took part in these focus group conversations, reporting positively on their experience.

Table 4.1. Focus groups and participants

Sector	Participants
Cross-sector/Regional (inclusive of some Departmental representatives who could not attend other dates offered)	**6 participants** – including representatives from the Public Health Agency (PHA), District Councils, Children's Court Guardian Agency, Department of Communities, Department of Education, and the Strategic Planning and Performance Group (SPPG)
Community & Voluntary Sector	**7 participants** – representing different community and voluntary organisations
Education	**6 participants** – including representatives from the Education Authority, Youth Services, Further Education, and the Controlled Schools' Support Council (CSSC)
Health & Social Care Trusts	**7 participants** – representing the five Health and Social Care Trusts across child and adult services.
Departments & Regulators	**7 participants** – representing the Executive Office, the Department of Justice, the Department for Communities and Regulation and Quality Improvement (RQIA).
Justice	**8 participants** – including the Youth Justice Agency, Police Service Northern Ireland (PSNI), the Prison Service, Probation and Department of Justice
SBNI	**4 participants** – including representation from the SBNI Board and TIP project
HSC Trusts 2 (for those who could not attend on the other dates offered)	**7 participants** – mostly representing Health and Social Care Trusts, Regional Trauma Network, Office of Social Services

4.2 Understanding and Conceptualisation of TIA: Opportunities and Challenges

'The same language': Many participants across all focus groups acknowledged the increased awareness of the impact of adversity and trauma on service users (and staff) in recent years and referenced the adverse childhood experiences (ACEs) research. Many argued that the introduction of TIAs to NI and associated training had introduced a common language for service providers in different settings which provided a *'more holistic and meaningful understanding' of the impact of adversity on service users' lives*:

"... there's a sense of we're speaking the same language."
(Community & Voluntary Sector)

"The move from labelling to understanding... a much more holistic and meaningful understanding of the person."
(HSC Trusts 2)

'A lot of scope for misunderstanding': However, despite the perceived benefits brought by this shared understanding and common language across services and sectors (in providing consistency and standardisation), concern was also expressed. It was felt by some that the advent of ACEs into professional rhetoric had over-simplified the complex area of psychological trauma. In addition, the language of trauma (and indeed trauma-informed) had become so commonplace and diffusely understood that it had lost some of its usefulness, becoming relegated to a *'buzzword'* or *'the latest thing in fashion'* with limited meaning and the potential for misunderstanding:

"Some people maybe feel that the term is just the latest thing that's in fashion, it's actually maybe lost its meaning, it's been bandied about for a long time, but actually doesn't mean anything."
(Cross-sector/Regional)

"I do wonder that if sometimes... we need to be careful, it doesn't lose its potency, and that we're really clear about what is actually involved. Because I think as it becomes more commonplace in terms of a term that is utilised, I think, you know, lots of people will put their own slant on what that means, and that has to work, I guess, because it has to be appropriate to whatever people are dealing with. But I do worry that there is... potentially quite a lot of scope for misunderstanding here, or people thinking that we're all talking about the same thing, when we're actually talking about subtly or radically quite different things. So how do you balance a flexibility that you need, to make it applicable to your situation without losing the essence of it? And again, I think that's where... I've been kinda struggling with this... in trying to understand what it means and what it means for different people, but I just think that's something that we probably need to be mindful of."
(Justice)

'Different things to different people': Thus, as argued in the quote above, participants in the focus groups acknowledged that the way the terms of trauma and trauma informed care/practice/approaches are understood is not uniform. While some of this disparity was noted as likely inevitable given the need to adapt terminology to fit with practice in different service contexts, concern was also expressed that there exists a certain level of confusion. This concern was echoed in many of the focus groups with the concepts of trauma and trauma-informed thought to mean *'different things to different people'* with the need for greater clarity articulated:

"People are using the same words and... [it] can mean so many different things to different people."
(HSC Trusts 2)

"... language is always an issue... the medics and maybe nursing, what they were talking about was trauma in the medical sense, and then..., well, psychological trauma has nothing to do with us..."
(SBNI)

"I think you need to be very clear about defining what your terms are... because people will misinterpret it to how they want to see [it], and we - we, as the clinicians, sometimes need to be clear about what we're talking about."
(HSC Trusts 2)

Similarly, a tendency to refer to a hierarchy of trauma, elevating the validity of some experiences over others, was noted as a source of concern:

"You need to have a particular type of trauma, otherwise your trauma doesn't count."
(Cross-sector/Regional).

'The social determinants of health': Adding to the discussion about psychological trauma, some participants were keen to reference how social, economic and structural issues compound the impact of adversity or produce adversity for some children and families. Attention was also drawn to 'intergenerational trauma' and the need for action across all governmental departments:

"you look at...how our childcare services, you know the... lack of affordable childcare and how we're treating families, and that parent-child dyad in the years and months that are most important in terms of brain development, you know, it's just goes against everything that we're talking about... we really need to get this across all government departments, and all of the really important social structures."
(HSC Trusts 2)

"...remembering that children we're working with today are becoming the parents of tomorrow, and trying to ensure that we do get things right for them now."
(HSC Trusts 2)

'There's so much more to it than that': In relation specifically to the term trauma informed practice, participants noted the complexity of the multiple TIA implementation domains. There was a perception amongst some participants that TIP is often misunderstood to refer solely to training:

"... the awareness of trauma informed practice is, you know, it differs, it means different things to different people... there'll be some groups or organisations will say they're trauma-informed maybe because they've done some training and don't understand actually there's so much more to it than that."
(Cross-sector/Regional)

"So you would have trauma informed practice that applies to your workforce. You have trauma informed practice that applies to the services you provide. You have trauma informed practice in the context of what that means to citizens that you're engaging with. And actually... it will mean something different in the context of all of those different areas."
(Cross-sector/Regional)

'It's not totally new': Others argued that practice in their own settings and services had already been trauma-informed before the language was introduced. In these cases, a trauma informed approach was often equated with compassionate, nurturing or relationship-based practice or community engagement:

"TIP may appear to be the buzzword of the moment, you know... It's not totally new. Schools have been doing it, nurturing relationships all along."
(Education)

"...I suppose trauma informed practice is just, well, I suppose it's a given to say that it's, it's something that's just core to everything that we do in terms of the social work world."
(HSC Trusts)

"And even from a Council point of view, like for me, everything we do is trauma-informed, even before trauma-informed... was a buzzword because if you look at community plans, if you look at our corporate plans, everything around that is trying to improve everything around our communities."
(Cross-sector/Regional)

'In the same vein': There was also recognition expressed that some current initiatives (such as restorative practice), while not specifically named as trauma-informed, were underpinned by similar principles:

"There's excellent practice, which isn't named trauma informed practice, but essentially is that, and I think it's really important that we capture some of that. Some of the work, for instance, that we would support around with restorative practice or problem solving, is very much in the same vein in terms of TIP."
(Justice)

"So a lot of what we already do across all councils in Northern Ireland is that trauma informed better feeds into that trauma informed practice stuff, particularly around community plans and what the communities are telling us are important to them to make their lives better. So we are already doing that. So it's about how do you actually capture that and then, within an organisation, make sure that everybody is aware that that is a trauma informed element to what we are delivering as an organisation. Because when it's what you just do, because you do it, because that's what you've always done, it's almost like re-labelling it almost."
(Cross-sector/Regional)

'Nothing to do with us': In addition, a number of participants noted a tendency to underplay the relevance of TIAs in adult settings:

"Whereas in adult, I think..., probably because of the terminology, in terms of ACEs, in the adult world, it tends to be lost – 'nothing to do with us'. Um and actually trying to break that barrier down, it's something that we really need to focus on... actually that's all about us..., you know, it's from birth to grave in essence and the impact that [childhood adversity] has, but also the impact that trauma in adulthood has, in terms of working with people and service users."
(HSC Trusts)

'There's not so much guidance': This perceived lack of relevance was echoed by some representatives from arm's length bodies who argued that TIAs often tended to be understood solely in terms of frontline service provision. Thus, one participant articulated the challenge of developing a conceptualisation of TIAs that was relevant for other types of organisations, such as commissioners or Councils:

"There's so much focus around trauma informed practice, particularly in terms of service delivery... and a lot of people maybe look at that within the Health and Social Care world, but what does it mean for a trauma informed commissioner? So I'm thinking [name of organisation] as commissioner... there's not so much advice or guidance as to what does that mean in terms of a trauma informed commissioner. So I think that's another challenge, and I'm sure it's the same for... you know, for the Councils - what does it mean to be a trauma informed Council? ... trying to apply it across different sectors and... different areas."
(Cross-sector/Regional)

'Naming it': Thus, for many there remained the need to keep clarifying what a TIA or a trauma informed organisation is, moving beyond the confines of frontline practice or specific settings or services, toward an understanding of TIAs as a framework to embed a culture or way of working across the whole organisation that recognises the impact of trauma and adversity, and seeks to do no further harm:

'I think the issue we're struggling with is about naming it in terms of a corporate badge.'
(Department & Regulators)

"...but also just... that grounding of what a trauma informed approach is. [...] there is a danger and we need to keep constantly clarifying, you know, what is a trauma informed organisation? What are we talking about when we mean a trauma informed approach?"
(SBNI)

"I think people get what this is about when they're working with the service user, but I'm not sure they get what this is about culturally, what it means for the culture of an organisation."
(Justice)

"A lot of my work and the work of my team is... driven by recognising the impact of trauma on victims and also that the justice system itself can be traumatic to victims and witnesses. So it's about actually... trying to take the trauma out of the system and out of the system structures."
(Department & Regulators)

4.3 TIA Implementation to date: Progress and Limitations

'We're on a journey': In this section, we focus on how TIAs were perceived to have been implemented by focus group participants in their various services or fields of expertise. The analogy of a journey was repeated across all focus groups when referring to TIA implementation progress in different sectors and settings. While some stressed their organisation was at the beginning of this journey, others appeared to be further along but noted there remained a lot still to be achieved:

"So I guess there's definitely a lot we can still develop. We very much recognise that we're on a journey."
(Justice)

"We're very early on the journey but... so we're working to try and gain wider buy-in across the organisation"
(Cross-sector/Regional)

"We have come on a journey, but we're absolutely no way there yet."
(Cross-sector/Regional)

"We're not anywhere near the point of saying 'right, we have this right.'"
(Departments & Regulators).

In the following subsections, we explore the perceived progress and limitations explored by focus group participants in each of the three overarching TIA implementation domains (organisational development; workforce development and support; and service delivery and practice change).

4.3.1. Organisational Development

'Resources and priority': Participants across focus groups noted the relatively common embracing of trauma-informed principles, with different levels of ***governance and leadership*** buy-in noted and the development of some form of implementation teams and structures described by many. However, progress within this implementation domain was noted to have been constrained by a range of barriers explored in detail below. Central amongst these was the availability of ***funding*** and the prioritisation that was given to TIA implementation within both statutory and voluntary and community sector organisations. It was noted that the responsibility for progression of trauma-informed policy development, training, supervision and support often rested on a relatively small number of individuals:

"But we've a really small central team that is responsible for... implementing the trauma work and the training... that probably has kind of flowed and ebbed at times, in terms of resources and priority"
(Community & Voluntary Sector)

'Overall strategic commitment':
While progress was noted by some in providing more trauma-informed service delivery across different sectors, with some 'excellent pockets of practice' acknowledged, the development of a more strategic commitment by way of whole-system trauma-informed ***policy development*** was seen as the next priority:

"There are some really excellent pockets of practice that we can see across different departments and agencies. But that hasn't necessarily translated into some sort of overall strategic commitment."
(Justice)

"There's quite a lot of development around policy and practice... everybody always says 'Oh, we're trauma informed, we are sorted', but ... or me, it's not about implementation plans anymore, it's about the culture of the organisation."
(Justice)

"There's been a lot of work has gone on at an operational level within the Education Authority and other organisations in terms of trauma informed practice and making sure our services are trauma-informed... but how do we make sure our policies are trauma-informed as well".
(Cross-sector/Regional)

Given the wide-ranging nature of the task in hand to achieve regional consistency, it was acknowledged that there was a need for systematic and gradual incremental implementation:

"...screening (regional policies) through a trauma lens... it's not been done very consistently, and people can't really embrace it all at once, but you can do it in in kind of gradual steps."
(SBNI)

Where more strategic leadership had been achieved, participants noted the clear benefits in terms of wide-ranging implementation and strategy development:

"Where we have seen true leadership, we have seen the results of that... that's a really good example... At the time, we had a Minister for Education who mandated that training would go out to all schools.... when we had a Justice minister... the Minister was asking for reports as to how things were working. So you were getting that top down, bottom up, you know, reporting."
(SBNI)

"...the development of the Executive Strategy on Violence Against Women and Girls, another really good example of, you know, it does name it [trauma informed] in the draft strategy."
(SBNI)

"Explicit leadership commitment... I've come from the Protect Life world, Northern Ireland Suicide Prevention strategy. That was endorsed at governmental level because it was an issue at a political level, suicide deaths. It was there in the media. We have a Protect Life strategy.... cascaded to the localities. Everybody is feeding into that."
(SBNI)

'Trying to not work in silos': While there was clear aspiration toward working more collaboratively across agency and operational boundaries, many focus group participants lamented that in practice this was difficult to achieve for a range of reasons including a sense that everyone was 'looking after their bit'. In some instances, this was known to have left services unaware of developments in other areas:

"We have this vision of trying to not work in silos, but on the ground, it's really difficult to not do it. It's really... you're aware of it. You're trying not to do it, but everyone is sort of working in their own operational area and... I wasn't even aware of those things and didn't have knowledge of them and how they interface. So that's been a bit of a frustration."
(HSC Trusts 2)

"We're so... involved in looking after own areas, or even like the voluntary and community sector are looking after their bit... and the health and social care looking after their bit, and people becoming almost divisive, because it's like 'well no, this is what we do.'
(HSC Trusts 2)

'Not fit for purpose': The physical environment was one element of TIA implementation that some participants felt had been largely overlooked to date, but which could potentially enhance engagement. Some acknowledged that the buildings where staff work and individuals receive a service are *'absolutely not trauma informed'* (Cross-sector) and *'far from therapeutic'* (HSC Trusts). Some environments were variously described as 'horrendous', 'dire', 'not pleasant' or 'not fit for purpose' with acknowledgement that the environment can be traumatising in and of itself:

"The other areas we should be paying attention to in terms of trauma... it's just the environment, the environment we're doing our work, especially if we work with a traumatised population. Some of the environments are absolutely horrendous, and they would be traumatising, and you're expecting to do work, you know, trauma-type work."
(HSC Trusts 2)

"The physical environment. It's ... a massive, massive problem that we have in Trust land... the environments that we're bringing people into are just not fit for purpose. It is far from therapeutic. The environment itself can almost be traumatising in itself."
(HSC Trusts 2)

"Some of the offices that social workers and health visitors and health professionals work in are dire. Some of the facilities that contact takes place in for families are dire. And some of the offices where parents have to have very difficult conversations with social workers are atrocious. They're absolutely not trauma informed physical environment'."
(Cross-sector/Regional)

"Our jobs and benefits offices are not pleasant place places to be and yet we expect people to come in and talk about, you know, you know, very personal issues there as well."
(Cross-sector/Regional)

Although some good development was noted in this regard, attention to estates and facilities was considered a priority for development, while recognising the financial implications of doing so:

"I think [the physical environment] is something that's difficult and financially challenging. Our interview rooms, they're not brilliant when you're thinking about you do not want to retraumatise people or trigger service users, and some of our spaces could be a lot friendlier. We've got to strike a balance between keeping everybody safe, but also the trauma piece. So I guess there's definitely a lot we can still develop"
(Justice)

'What difference has it made': While acknowledging a wide range of perceived benefits across the organisation and beyond (see section below), participants identified important limitations to the ***progress monitoring and evaluation*** of trauma informed initiatives achieved to date in their service or sector. A fundamental question posed by several participants noted the evidence gap with regard to the added value of the training investment, particularly in relation to the service user experience:

"We've trained X amount of people and all of that but what difference has it made to the families, children, young people or whoever are our client group that we're working with?"
(Community & Voluntary Sector)

"What difference do the people who receive those services think it made?"
(HSC Trusts 2)

Relatedly, robust evaluation appeared to be lacking and noted as an area of priority to explore moving forward. Aligned with this aspiration was an acknowledgement of the need to re-think the concept of outcomes with regard to relevance and feasibility. For example, several participants noted that evidence of 'less trauma' was neither feasible nor the most appropriate. Indeed, as more focus is placed on an issue, quite often the more that is observed:

"Well, I was going to start off with there'd be a lot less trauma because we've addressed it all. Then I thought, well, no, realistically, whenever you bring things into sharp focus, what we would actually probably be seeing is more trauma being identified. Because whenever you start making something more mainstream, then there's more identified."
(HSC Trusts)

Others noted the usefulness of the Outcomes Based Accountability (OBA) framework but pointed to the need for further critical engagement with service users as an important element of this debate. Greater attention to service user personal outcomes was also recommended:

"Question three - what difference did it make? needs to be broken down into 3a - What difference do we think [emphasis] it made?... And question 3b - What difference do the people who receive those services [emphasis] think it made? How are they going to co-design and co-produce and co-evaluate with us in the future? and those are real, real challenges, because if we don't begin to open up that issue, the danger is that we further traumatise people by deluding them into thinking that we are going to produce better outcomes for them by engaging them and then let them down. There's nothing worse than a breach of trust to bring further trauma."
(HSC Trusts 2)

4.3.2 Workforce Development and Support

'The big one': Workforce development was central to most focus group discussions and appears to have been an area which has seen significant progress in NI. Training, and in particular universal training, was generally perceived by participants as key to TIA implementation, with most commenting that the training had been particularly useful in providing a greater awareness and sharper focus on childhood adversity and trauma-related issues among all levels of employees:

"...our focus has been on the workforce development. So that's sort of...that's the big one really, in terms of the direction of travel, largely because of the size of the organisation, it's where... you need to build capacity in order to be able to infiltrate some of those other domains."
(HSC Trusts)

"The workforce development for me is the one area that we have really delivered on and are seeing those positive outcomes."
(Justice)

"People are aware of childhood adversity, they are aware of the impact of adversity in either the area they work in or in terms of children and adults in terms of the life course".
(SBNI)

This was perhaps unsurprising as many reported training as most often the first step to introducing a trauma-informed frame of reference to their workforce. It was also noted as the central objective of the first phase of the SBNI TIP project:

"The workforce development... tends to be where organisations say, 'well, we need to train everybody', and that's where we started off in our EITP [Early Intervention Transformation Project]... we were Workstream 4, which was workforce development, recognising... that there are skills and knowledge already, but also there were plenty of gaps. So we focused on that, ourselves."
(SBNI)

An important strength of the training to date appears to have been the multiplier effect. While some noted an ongoing need for widespread training for all levels of employees, several sectors had invested in cascading training through the organisation by adopting approaches such as train-the-trainer, which extended the reach of initial awareness-raising efforts:

"We've developed further training across our school... where we have ten staff now able to deliver the basic awareness training in TIP across the organisation. We obviously also have worked very closely to establish an accredited programme in TIP, which is available on OCN or will be available later this year, and we will deliver it to community and to the school sector."
(Education)

Others noted how initial TIP training had been supplemented to good effect by other trauma-focused specialist teams, such as the Regional Trauma Network:

"Having our local Regional Trauma Network team has really made a difference in terms of helping staff and other services start to think a little bit more from a trauma perspective. And we're already starting to see the benefits of that across our other mental health services."
(HSC Trusts 2)

'Tiering and tailoring': A minority of participants reported that some training was more useful than others, with the suggestion that there is a need to have greater flexibility to choose from a suite of universal and more ***specialist training programmes*** which are culturally appropriate to NI, but also more tailored to skill-level, experience and context of staff taking part:

"[External trainer] came in and did a load of training with everyone and, you know, it was a really big investment but... It was a bit how do you train lots of people at different levels with different knowledge, with different experience across the organisation? and there was a feeling, I think with a lot of practitioners... it was maybe a bit basic compared to what we had been doing in our practice, and because of the Northern Ireland context, I think we were a bit ahead of that."
(Community & Voluntary Sector)

"People get frustrated because they feel that's too basic for me or people say, do I really need to know... all of this in my job as a shop manager or, you know, a business services person. So I think that tiering and that tailoring to need and expertise and knowledge is really important."
(Community & Voluntary Sector)

This recognition led some participants to suggest the need for more specialist training, beyond awareness raising, tailored to the challenging contexts that they work in, and the complexities that they regularly encounter:

"So there's the universal kind of training that everyone has access to... such as the level one and Circle of Courage training and so on. But then we have youth workers that are working in quite complex environments with young people who are very much disengaged and at risk."
(Education)

Staff 'worries and challenges': Increased attention to workforce wellbeing, in part influenced by the COVID pandemic, was an area where many focus group participants thought progress had been made across settings in NI but there remained significant work to be achieved. Many participants highlighted the critical importance of addressing not only the needs of service users, but also understanding the concerns of staff:

"We need to really understand how our workforce feel. We need to really understand what their worries and challenges are. We need to understand what they're going through."
(Education)

Staff were appreciated as a critical resource for TIA implementation with investment in staff wellbeing and involvement thought to reap rewards in service user outcomes:

"If we're going to influence the ethos and the environment and the culture within the school, we need to look at it... for everybody within the school. And starting off with staff emotional health and wellbeing... you know, because if we don't have staff who are emotionally intelligent... who feel valued and feel part of the ethos and whatever, we're not going to get anywhere with our children and young people."
(Education)

There was acute recognition across the focus groups that many frontline staff delivering services to individuals and families with complex needs could equally have experienced significant, and potentially traumatic events themselves with particular resonance given to the troubled history of Northern Ireland:

"I suppose one of the things for me that I think has been important that's been recognised in the organisation is that... we all as individuals come with our life experiences and given what we know about trauma and I suppose particularly relevant in Northern Ireland..."
(Community & Voluntary Sector)

"As an organisation, we see the impact of historical trauma right across our organisation."
(HSC Trusts 2)

Such acknowledgement of personal adversity in their staff teams led organisations to consider the critical importance of supports for their workforce when embedding a trauma-informed culture across the organisation:

"... we were very conscious that, in undertaking that awareness training, it probably was going to impact individually on certain staff as well... because equally they may have had adverse childhood experiences and this might surface again for them...you probably need to ensure you have those wrap-around supports for your staff as well."
(Education)

In this regard, a number of participants noted significant development in the increased organisational offering of *workforce wellbeing initiatives*, e.g., external short-term counselling or mindfulness/yoga classes. Another example was given by a participant who noted the success of getting a staff wellbeing enquiry formally integrated into their annual appraisal processes:

"One of the things that we tried to do across the Councils I work with is within our yearly appraisal systems... only recently introduced, we have a specific section on that health and wellbeing piece, where... the onus is on [the organisation], but we're encouraging the staff to tell us what's happening in your lives and is there anything we can do as an organisation to support you."
(Cross-sector/Regional)

While such developments were acknowledged to be perceived by some staff as a 'bit of a tick box', others argued that it remained an important area of progress with organisations now accepting some sort of responsibility for staff support.

"In some ways it doesn't... really matter to a massive degree that staff see it as a bit of a tick box because the offer is there, the [EAP Employment Assistance Programme] is there, the [wellbeing] class is there for people to go to... and all those different sort of things that lots of people avail of. And I think that's a really positive step. I think it's been a long term thing to get people to see it as a natural responsibility of an organisation to support staff and that will come in the long term. But by continuing to offer it, by continuing to push forward with it, to support staff, building it into everyday discussions, building it into appraisal systems... I think it's a really positive way of organisations demonstrating their trauma informed approach to supporting staff and helping them to continue to work, not be off on the sick and actually provide a better service to the customers that they're working with."
(Cross-sector/Regional)

'Listening to very difficult stories every day': While some progress was therefore perceived to have been made in the more general staff wellbeing domain, more limited progress was reported in the development of consistent workforce support mechanisms, such as supervision, reflective practice or de-briefing:

"Some organisations have always... [been] offering their staff supportive, reflective spaces, but it wouldn't be consistent... obviously, in certain professions, there would be... opportunities, there should be structured supervision, reflective supervision... but that wasn't consistent."
(SBNI)

"...the focus of my work so far has been looking at providing better debriefing for frontline staff...we're sort of providing some preventative and buffering support, but ... how do we develop that further, because they don't have the same... supervision arrangements."
(HSC Trusts)

Overall, there was acknowledgment across the focus groups that there was still 'a lot to do' to address the impact of the work on the worker, and the potential for vicarious trauma, in many sectors and settings:

"Vicarious trauma for the professionals that are involved in this work...There is very little to support those professionals, like I think back to Muckamore and all the trauma, all the patients, the families and the staff, and there's been very little focus there... So I think yeah, we've got, we need to do a lot."
(HSC Trusts 2)

Participants were also keen to note the need for such regular support mechanisms to extend beyond professional staff working directly with children or adults to administration, corporate and council workers:

"That isn't just about the professional social work staff, and I feel very strongly about this. This is also about our admin and corporate staff because a lot of our staff will type reports, and actually what they're typing or what they're listening to in an audio recording to type up can be very traumatic. And we have to really appreciate some of those triggers, and make sure that that support goes across the staff who are doing that, as well as the staff that are professionally practicing face to face."
(Cross-sector/Regional)

"... actually, you know, when you're looking at admin staff or in councils, bin men or refuge, you know, people doing street cleaning, all those different sort of things... Actually the significance of what they see or what they experience in the workplace can be as massive to them as it would be for people in another area of business that are dealing with the pointy end of children... or adults with difficult problems."
(Cross-sector/Regional)

A noted tension in this domain was to maintain the primary focus on service user wellbeing with concern expressed that *"the pendulum had swung too far"*, with greater emphasis sometimes placed on workforce needs at the expense of those whom the service was designed to serve.

4.3.3 Service Delivery and Practice Change

'There's a lot of work to be done': As noted above, the relevance of TIAs for adult services was perceived to not have been fully grasped. Consistent messages were articulated across focus groups that more TIA implementation progress had been made in child settings as compared to adult services:

"...within adult protection, trauma informed practice hasn't...um...it hasn't been introduced."
(HSC Trusts)

"For our children's staff in both children's safeguarding, children with disability and CAMHS. It would be very much a core component of what they do and a very integral part of how they work. It's perhaps not to the same extent when we move out into even mental health commissioning or commissioning for older people services or... learning disability. So... I wouldn't say we have a consistent picture within our organisation, definitely better informed across children and understanding how trauma impacts on children, not to the same extent across the other programmes of care."
(Cross-sector/Regional)

"I think in adult safeguarding, there's a lot of work to be done."
(HSC Trusts 2)

In addition, some concern was expressed that the incoming Adult Protection Bill for Northern Ireland might inadvertently lead to greater service fragmentation and less focus on service user needs:

"The adult safeguarding world... we are so much further behind the children's safeguarding and child protection... we have this new bill coming... and in fact... we're probably becoming... we're going to become more siloed with the Bill, because there's a strong emphasis on single adult protection teams within every Trust. But that's purely about looking at what happened within what the allegation is.... working with the police to try to achieve justice and protecting that person. There's nothing in there about responding to the person's needs as a result of what they've experienced."
(HSC Trusts 2)

'Back to basics': Many focus group participants noted how TIA implementation in their organisation had brought renewed energy to frontline practice development, seen as the 'bread and butter' of everyday engagement. A general shift towards 'more holistic and meaningful understanding' of service users' lives and behaviours was also observed:

"We're going to have [external trainer] come in and do two days with us, which is about practice. And yet that's our bread and butter, because I felt that we needed to go back to basics and refresh people about their current practice and about up to date practice and about what that means when they're working individually with children and young people and with families."
(Cross-sector/Regional)

"The move from labelling to understanding... a much more holistic and meaningful understanding of the person."
(HSC Trusts 2)

"... 'oh, that's what that is that I'm observing'. There was a name for it. They were able to put a name to it. They were able to understand. Oh that links."
(SBNI)

'More difficult conversations': Some also mentioned that trauma-informed 'language' had enhanced opportunity for 'more difficult conversations' at all levels within the organisation, as well as supporting children's understanding of the impact of adversity in their lives:

"Outside of social work, it has given people a language that has allowed some of those perhaps more difficult conversations to take place, whether that's employee to employee, member of staff to member of the public or, you know, manager to employee. I think it has opened the door... and given people I suppose a framework and a language to have some of those conversations. And I think that has only been a positive."
(Cross-sector/Regional)

"And that's a bit about children understanding that language, you know, and accepting that things happen to them and it has a name or a label or an understanding that will help them with their own psychological wellbeing."
(Cross-sector/Regional)

Other examples of enhanced service delivery reported included visiting arrangements for children to see their parents in prison:

"a trauma informed prison service... some of the programmes that they had, like their children coming in to visit their parents, they're really good examples of... trying to resist retraumatisation for children... in those circumstances."
(SBNI)

'What do we do': However, there were perceived challenges to these practice advancements, including the acknowledgement of the further thought required regarding *practices that may retraumatise*:

"We have a policy or procedure for unacceptable customer behaviour. but we never say how do we actually contribute to that unacceptable customer behaviour... but we don't actually have a question about what do we do, you know, that traumatises people."
Cross-sector/Regional)

The need to redraft recording guidance was one such example of thoughtful engagement with the service user experience, acknowledging the potential for retraumatisation when viewing court or care reports and the evident need to bring a trauma informed perspective to this core task:

"We need some guidance and assistance on trauma informed recording because we're very mindful of the fact that children will come back and read their files, they'll read their court reports, they'll read the recordings of the Guardian make on our files even though they're electronic... On the one hand, we talk about practicing in a trauma informed way. Yet on the other hand, when they're reading the court report or case conference report, they're rereading again and again and again and again negative information about themselves.... (...) that is just a piece of work that we've been doing internally."
(Cross-sector/Regional)

'Identification without support': A few participants also stated the limited access to specialist trauma-focused services for those that required further therapeutic support following screening identification:

"The only disadvantage, I think, is identification without any support. If there's high levels of people going you're all really traumatised. Everybody's got the language but no one's got the... there's nothing done about it, you know...."
(HSC Trusts 2)

Also noted were challenges to acknowledging people's lived experience of abuse related to concern about legal implications:

"We even struggle at the minute to use language that would validate people's experience, because we are shying away from saying things like abuse has been... you know, [until] the allegation has been substantiated. We are avoiding that, because of a fear of the legal ramifications and that came out of JRs [judicial reviews] in the past."
(HSC Trusts 2)

4.4 Perceived benefits or disadvantages

'No downsides': Although discussions about the benefits of TIAs encompassed a relatively small proportion of focus group conversation due to the constraints of the limited time available, it was notable that the question about whether there were any disadvantages to trauma-informed service delivery was frequently met with a thoughtful silence. One participant articulated the multifaceted benefits of TIAs at all levels within the system, noting that such working had the opportunity to make the organisation 'a better place for everyone':

"There are no downsides to this at all. And actually sometimes that can be overlooked as well. You just go, yeah, here's the benefit, but actually there's no downside. If people implement that, whether that be from a workforce point of views, organisational responsibilities, services to customers, the experience of customers. If you're doing all this stuff, it's just a better place for everybody. Simple as that."
(Cross-sector/Regional)

'Positive impacts': Over the course of the focus groups, participants articulated a wide range of 'positive impacts' which were perceived to emerge with TIA implementation, particularly when 'the longer term' was taken into account. In relation to service user outcomes, participants noted the need to extend consideration beyond traditional outcomes (such as academic achievement) to more fundamental health and wellbeing outcomes and the follow-on benefits of these over time:

"The outcomes for children and young people are really evident and really obvious. So... in terms of their achievement, in terms of their not only academic achievement but their ability to engage with others, their ability to actually progress in school etcetera... in the longer term, there's positive impacts in terms of behaviour, there's positive impacts in terms of emotional health and well-being, which also leads you know to positive impacts in terms of health... justice etcetera, etcetera. So there is some evidence of that. I think it's probably really important to reflect that."
(Cross-sector/Regional)

Other related positive impacts for service users and their networks, included the benefits of enhanced practice such as holistic assessment, and improved and meaningful service engagement. Additional organisational benefits expressed across focus groups included improved staff wellbeing and retention, and reduced litigation.

'Spend to save': Such longer-term impacts were also noted as important when considering potential public sector cost savings associated with early (or earlier) and more targeted intervention. Thus, the need for having supporting evidence in this regard was a noted priority.

"The long-term economic cost to... the country in the context of the services that would have to come later. If you're fixing things earlier, your intervention is earlier then, it's going to make a difference in that."
(Cross-sector/Regional)

"There's always an issue over money, what will this cost? so there is something about... getting work that can show, you know, spend to save... we have to talk as to what will this save."
(SBNI)

'Northern Ireland is different': A common theme amongst focus groups was the particular relevance of trauma informed approaches to the NI context given our particular history of political conflict:

"We have the Troubles in our past, there's an extra cognitive load that brings, and we need to be honest about that, and we need to really reflect on what we're doing."
(HSC Trusts 2)

As a result of this unique context, the implementation of TIAs was referenced by some to elicit an opportunity to leverage political and societal momentum toward sustainable peace building:

"Northern Ireland is different to our neighbouring jurisdictions and the sorts of trauma it faces and is experiencing or has experienced, so is there a way of turning that into something that's a bit more positive and actually is seen as something more like... reconciliation and broadening this out into something that is fundamentally about a part of peace building?"
(Justice)

It was thus acknowledged across a number of focus groups that TIA implementation, and the associated greater awareness of trauma impact, had provided a new opportunity to explicitly consider the impact of political conflict on service users (and staff), an area often reported previously as unvoiced:

"Just remembering, I suppose, ourselves as a traumatised society and that's not often spoke about, that's something we found in the Regional Trauma Network. Often just the language itself, not even being used or people not even asking about exposure to the Troubles of the conflict, and how that should inform the work that we do."
(HSC Trusts 2)

4.5 Implementation barriers and enablers

A wide range of factors that either facilitated or hindered TIA implementation were explored in focus group discussions. As in previous sections of this report, we have separated these barriers and enablers into three categories i.e. individual, organisational and external factors which interface with one another. In this section, we have also included some of the inevitable challenges to TIA implementation progress identified by focus groups participants. A summary of the enablers, barriers and challenges expressed is provided in Table 4.2. below, drawn from all elements of focus group discussion.

Table 4.2. Implementation enablers, barriers and challenges (summary)

Individual factors	
Enablers	**Barriers and Challenges**
Staff understanding of TIAs as relevant to them across departments – increased buy-in	Lack of 'time & space' e.g. reflective practice opportunities in over-stretched systems
Psychological safety for frontline staff - 'a just culture'	Staff reticence, fear & lack of confidence
Enhanced workforce support to understand & address the impact of the work on the worker	'Traumatised' workforce – staff with personal traumatic experience as well as vicarious trauma
Embedding changes into policy to make meaningful difference	TIA implementation perceived as 'tick box' & not bringing meaningful change
TIA Implementation to 'start small' & expand 'overwhelming'	TIA implementation perceived by leaders as
Understanding of TIA as culture change - relevance for all organisations	Perceived lack of relevance for non-frontline organisations (& adult services)
Organisational factors	
Enablers	**Barriers and Challenges**
Senior leadership buy-in/commitment	Lack of leadership buy-in/commitment
Individual TIA champions	Staff turnover & burn out
Connecting TIA with other current priorities	TIA not seen as 'core business' - procedural processes take priority
Adequately resourced systems	Systems under financial & workload pressure
Smaller size of organisation	Large size & complexity of organisation
Cross-sector and intra-agency collaboration – a joined-up approach	Tendency for organisations to work in silos
External/wider context factors	
Enablers	**Barriers and Challenges**
Prioritisation of what can be achieved in economic climate – potential for cost savings	Limited resources in current economic climate
Trauma informed commissioning	Short-term funding limitations in V/C sector
TIA Governmental mandate	Lack of political impetus, no Assembly, policy-making 'paused'
Covid pandemic highlighted importance of staff wellbeing	Covid pandemic interrupted TIA implementation & led to staff changes
	Regional challenges in staff recruitment & retention - public sector reorganisation
Trauma-informed development knowledge exchange opportunities & training framework	Fragmented & siloed development
Clear evidence of benefits & cost savings	Lack of robust evidence base & need to review outcomes framework to ensure fit with TIA agenda

4.5.1 Individual factors

'Fear and confidence': At an individual level, frontline staff fear and lack of confidence was identified across focus groups as a primary barrier to TIA implementation. It was argued that staff were concerned about inviting service users to 'open up' and consider previous untold, potentially traumatic, aspects of their lives:

"...one of our main barriers will be, is, fear and confidence. So fear of what you're opening up, our colleagues regularly talk about opening lids. They regularly talk about putting the things to bed and leaving it there."
(HSC Trusts 2)

In addition, there was a recognition across focus group participants that staff members may be 'traumatised themselves' with a combination of their own personal experiences of trauma (sometimes related to the NI conflict) as well as trauma related to their frontline service role. The need for enhanced workforce support to understand the impact of the work on the worker was frequently expressed:

"Our colleagues are often traumatised themselves. So they're trying to deliver trauma interventions to our client group and our patients but... that's still a work in progress and I think that's a lot of where we're going to have to start looking at for the future."
(HSC Trusts 2)

"We have potentially a traumatised workforce, so we have some of them who have been traumatised by their work, by the system they work in, or indeed because of their own personal histories or our societal history as well, and the Troubles, the conflict as well."
(SBNI)

"[It's about] how staff feel they're treated as well. And this is a recurrent theme, but it's just so important, because you can't have... good outcomes, if you have staff who are dysregulated, who are under stress and pressure. They're not going to be in a position to treat people they engage with, with any sort of compassion or even identify what their needs are, and get those relational connections right, the which is the basis, the foundation of healthcare, you know, it is about caring and compassion."
(HSC Trusts 2)

'A very safe environment': In order to counter staff fear, build staff confidence and address the potential for vicarious trauma, there was a noted need to establish a 'psychologically safe' working environment for staff themselves, while recognising that frontline staff in high impact environments regularly faced challenging presentations:

"If we are asking someone to be self-aware, that needs to be a very safe environment for them to be able to do that, in particular in organisations like [the X service] where there is historical trauma, trauma every day."
(HSC Trusts 2)

In this regard, some focus group participants referred to the need to create an organisational 'just culture'. This in itself was noted to require strong leadership:

"We're having conversations at the moment around duty of candour, 'being open' framework, you know, to create the psychological safety for staff, you do need that just culture. And of course, that's characterised by strong leadership as well. So I think that's one of the things... we need to measure psychological safety."
(HSC Trusts 2)

'Tailor your pitch': The need for staff to have a clear understanding of the rationale and relevance of trauma-informed practice for their respective roles, as opposed to simply 'another thing to do', was expressed across the focus groups:

"...making sure that it is framed in a way that is beneficial, and is not threatening...It can't be seen as another thing to do. It must be framed as an enabler."
(SBNI)

To help staff understand this, it was thought essential that TIAs were introduced to staff across different organisational departments (including non-frontline positions) in ways that 'made sense to them'. When this occurred, it was reported to greatly enhance motivation:

"The rationale for trauma informed practice itself is one of the key enablers is... actually when you put across the rationale, well we face some very hard and tough questions... when you put across the rationale, sort of the consensus was, well, it's a no brainer then really, isn't it? So... if you're fit to put across the rationale in the right way to the right people, because people obviously you need to sort of... tailor your pitch in a way to people. But once you do that in the way, then people like, well, it makes sense."
(Cross-sector/Regional)

'Why do I need to bother': While progress was reported in some organisations in achieving staff buy-in, some identified the challenge of extending the understanding of TIA relevance beyond frontline service provision and in terms of promoting a different 'organisational culture and approach':

"The big issue that we continue to face with many who are not involved in frontline service delivery... there's still this perception that why do I need to bother with this? This isn't for me. and I think the challenge is a cultural one in terms of being able to see that this is very much about resilience, organisational resilience and culture, and not just the preserve of people or organisations who are dealing with trauma in that very frontline sense."
(Justice)

"Some of the conversations we have been having internally... actually it sparked a bit of curiosity... made people take a step back to think 'Oh well how does this apply to HR?' And you know people are actually very keen... we need to take a step back and think about this differently... and see how this fits. And, you know, at one of the meetings, it was almost like a light bulb that went off with the colleagues and a colleague's mind is oh, this makes perfect sense and I can see how this might fit."
(Cross-sector/Regional)

'Space and time': According to some focus group participants, to achieve these goals of psychological safety for staff and enhanced buy-in/understanding required staff to have reflective practice opportunities ('time and space to think about it'). Thus, over-stretched services were named as a 'massive challenge':

"...to implement this and make it meaningful... you need time and space to think about it, to understand it, to integrate it, to apply it, you have to, you know, you need a bit of space and time in order to be able to do that. And actually, when services are just running from pillar to post, that that that's a massive, massive challenge."
(HSC Trusts 2)

"People having the time to actually understand what trauma informed practice is and how it can impact children and young people and how, you know, how it's relevant to them."
(Cross-sector/Regional)

'A tick-box thing': Some participants identified perceptions that TIA implementation was simply a 'tick-box' exercise or simply a way for organisations to 'score points' as a current risk, rather than engaging in meaningful transformation in the best interests of service users:

"But there is a danger that this could become a tick box thing, and people go 'well, what do we do now? what do we need to do to get our Gold Star for being trauma informed? and then we can move on'"
(HSC Trusts 2)

"People want to be able to see that they're doing it and to score points and to get lots of, you know, validation for being trauma informed. But at the heart of it, you know, the mindset shift hasn't happened around how people are treated as individuals.... and there is a lot of kickback I'm seeing, especially on social media, especially in the education system."
(HSC Trusts 2)

'Start small': However, the need for support extended beyond frontline staff to those in leadership positions, with TIA implementation perceived as potentially 'overwhelming'. Focus group participants shared learning about 'starting small' and building incrementally on these foundations:

"One of the things that they learned was that you maybe need to start small and look at a particular area because I would agree [...] It is a wee bit overwhelming for people."
(Cross-sector/Regional)

"It's so big, you know, you could get a bit lost in it. So it was a wee bit about... 'okay, what can we do and how can we build it incrementally?'"
(Cross-sector/Regional)

"Having the foundations correct before you build and spread."
(HSC Trusts 2)

It was acknowledged by many that they were not, however, 'starting from nothing', with good alignment with other participatory and relationship-based service development initiatives in recent years, despite being at different stages in the implementation process:

"We're not all starting from nothing. This has been known about and going on for years. Everybody's at different stages."
(SBNI)

4.5.2 Organisational factors

'Right from the top': As found in the rapid review and the survey, senior leadership buy-in was one of the key enablers identified across focus groups. Thus, participants talked about different organisations' leaders (e.g. Directors, Chief Executives, Trustees, etc.) being instrumental and vital in driving TIA implementation and organisational change:

"... part of that process naturally was for us to get buy in from our senior management colleagues right from the top of the organisation...so we gained the commitment from the Chief Executive."
(Education)

"... one of the really important things that has been very evident is that the Executive Board and Trustees of the organisation have very much driven this"
(Community & Voluntary Sector)

In contrast, lack of senior leadership buy-in or commitment was seen as a central barrier to implementation which could lead to staff 'burn out' and 'cynicism':

"Trying to do this in the absence of leadership will lead to burnout in individuals... that's kind of what I'm seeing. If the leaders in the organisation aren't committed to this... then people doing it on their own end up getting burnt out, and that's so harmful because it leads to some cynicism".
(HSC Trusts 2)

'Passionate people': Aligned with this was the critical issue of leadership across the organisation. Individual champions were noted as essential for TIA implementation progress assisting 'everyone to join the dots' and develop buy-in. These champions were frequently described in positive terms such as 'passionate', 'committed' or 'visionaries':

"I keep talking about those champions... it's having those champions sort of scattered in all around [the organisation], who are helping everyone to sort of join the dots and connect up, to help get that buy-in."
(Cross-sector/Regional)

"I do think there's a lot of passionate people involved in the area, a lot of people that really want to make sure that the work is trauma informed."
(HSC Trusts 2)

While a good deal of momentum was thought to have been generated by individual TIA champions, there were noted limitations when knowledge is located in individuals who inevitably at some point 'move on'. Thus, participants argued that commitment was needed to continually refresh the knowledge to counter the natural turnover of staff, and as a means to get newer members of the workforce 'up to speed':

"A lot of those visionaries and a lot of the people that were engaged at that time have moved on. So you've people like me, who's been there from the start and understands the journey, and then you have other people that were trying to kind of get them up to speed. And I don't know if... there's the same momentum, if I'm being really, really honest."
(Justice)

'Not core business': The fact that TIA implementation is not considered 'core business' to many organisations, in particular non-frontline providers, was articulated as a key barrier, with the expressed need to connect TIA implementation to existing priorities and developments:

"Trauma stuff is not core business to the Council. It's absolutely not, nor is safeguarding in its widest sense, even within my role. So actually it's getting buy-in... those linkages... to get people to see where that fits."
(Cross-sector/Regional)

"[Organisations] understand trauma and adversity. But actually what does that mean to become a trauma informed organisation? What does that mean for me? How can I realise that this links to my staff wellbeing, that links to the quality of care patients receive, that links to reduce litigation, that links to improved retention... So I think that's the piece of connecting trauma informed practice to existing priorities and developments, that I think is under way."
(SBNI)

'Busy putting fires out': A number of participants, in both child and adult safeguarding contexts, spoke about their perception of how organisational procedures and priorities could augur against TIA implementation. As one participant frustratingly commented, 'we're busy putting the fires out', the implication being that there is often little room to take preventative action, or to proactively build capacity for trauma informed practices to become mainstreamed:

"People are... so busy focused on the sharp end of the functions of statute... those are very, very heavily regulated in terms of child protection, children in need, what's required in the lives of looked after children... and those things, just keeping the show on the road or putting the fires out."
(HSC Trusts 2)

"I think we've got a lot of work to do in the adult safeguarding world. Our role at the minute seems to be very policy-driven... very process-driven. So we're very paperwork-driven and data-driven. There isn't a lot of time to think about trauma... we're just trying to protect, and there is no time and no room and the resource to look at everything else that needs to be done, especially supporting people."
(HSC Trusts 2)

'Running to standstill': Aligned with this, was a general sense across the focus groups of the pressures organisations were currently under, which left little time for anything perceived as additional to the core tasks:

"Just the services and the system has never been under such pressure and as a result, we're just..., you know, services are really running to standstill just to try and get their basic level of work done... I think time is probably the most precious commodity that we have now, and it's actually the very thing we have the least of."
(HSC Trusts 2)

'Proportionate resource': Adequate resourcing was identified as a significant enabler across all focus groups. Some participants also commented on the size and complexity of an organisation as a significant barrier to TIA implementation:

"I think we also have to reflect on the size of the [organisation]... So it's easier, you know, if you look at 250 staff.... [or] 400 ... versus... kind of 20,000 almost in the [name] Trust...etcetera, etcetera. So I think... the challenges in large scale organisations... one of the barriers is proportionate resource associated with the size of the organisation."
(SBNI)

'Right across the system': As noted above, participants spoke frequently of the challenges of working in a more integrated manner across organisational and sector boundaries despite the noted desire to do so. There was a recognition that much knowledge was lost with siloed-working:

"It's just in talking the talk, then making that into action... implementing it right across the systems seems to be difficult. There's a lot of... silos, really, in terms of the work."
(HSC Trusts 2)

"How do we integrate more and keep everyone understanding what's going on? Because I know from... sometimes, from my own colleagues... they're in the trauma field, but there's so much stuff going on that we don't know about."
(HSC Trusts 2)

Going forward, participants clearly expressed their view of the great need to work better together in order to effect the desired change:

"There's different levels in terms of what we're doing here. There's... school level. There's... the operational level... and the delivery organisation and there's the policy level. I think the challenge for us is also going to be joining all of that together... because it's vast you know education's massive. So it's how do we join all of that together."
(Cross-sector/Regional)

"...moving forward... the important thing is just to keep it all joined together."
(HSC Trusts 2)

4.5.3 External and wider context factors

Integral to an implementation perspective is understanding the wider context within which any trauma informed approach is embedded. As many participants noted, the current economic and political context has been, and continues to be 'tough'. Thus, this broader context was often identified as a key barrier to TIA implementation.

'A massive challenge': Limited resources in the current economic climate were repeatedly identified as a significant challenge. This was the case across the organisations represented in the focus groups but appeared to be felt more acutely by representatives of the community and voluntary sector, given the reliance on short-term funding. The absence of trauma informed commissioning was a noted additional barrier in this regard:

"So I think one of the major issues that we have in this system is... in our commissioning and I think that is really not trauma informed at all"
(Community & Voluntary Sector)

With a fairly pragmatic approach, several participants noted that resources were unlikely to become available. Thus, the challenge for leaders within organisations was to understand what could be achieved with the resources currently available, and where possible, what could be mainstreamed into routine service delivery:

"We just can't ignore that resourcing is going to be a massive challenge, so some of this is going to be about how we prioritise to make best use of the resources that we've got. We cannot do everything. So where do we make the most positive benefit?"
(Departments & Regulators)

"[given the] effectively the limited resources we have, and certainly, for us, there has been no additionality and it's been looking at how does this fit within the resources we have available?"
(Education)

'The political vacuum': Across the focus groups, the absence of a functioning Assembly (at time of fieldwork) was a noted barrier to progress. In this 'political vacuum', it was considered difficult to gain any momentum with policy-making 'paused':

"When you look at central government, particularly no minister, no Executive, no funding, you know a lot of our policy development has paused. We do say we'll keep it warm, but actually it's paused because we don't have, we've been without a minister for nearly a year, without an Executive for longer. So it is really difficult."
(Cross-sector/Regional)

In contrast, an explicit governmental mandate was considered essential to ensure the cross-departmental collaboration needed for progressing TIA implementation across NI:

"...that political element... you know trauma informed practice came out as a cross-departmental piece of work. Yet on a local level, politically, there was no vocal support for it, that wasn't driven forward at that level. And I certainly think for Councils and I think across the whole of Northern Ireland, across everybody, actually having that vocal political element sort of voice to it would make such a difference in moving a lot of things forwards for all organisations, not just Councils... without having that central voice coming down to say actually we need to do this together at the same time, that's a real challenge."
(Cross-sector/Regional)

'We hit the wall': The Covid pandemic was perceived to have significantly stalled implementation progress across NI, when services had to shelve other strategic initiatives (including TIP) to deal with the evolving emergency and there were 'a number of other significant moves of people in the system':

"Prior to COVID, there was a lot of momentum in quite a lot of those areas. There was a strategic steering group that was really leading trauma informed practice development, both at a strategic and operational level across various agencies. Once Covid hit, that all disbanded and I don't feel we've really ever got the momentum back."
(Justice)

"There was good will, and as we were going [well]... we hit the wall. It was Covid, and then we realised that Covid thing itself was trauma-inflicting."
(HSC Trusts 2)

"COVID did not help embedding [TIP] because there was, you know, [everyone] was in crisis management."
(SBNI)

'The knock-on effect': While the negative ramifications of the pandemic were many, participants also highlighted the positive focus on staff wellbeing, which emerged at that time and was perceived to have positively influenced further development in this domain since:

"One of the positives to come out of Covid, that actually... supported the whole trauma informed practice is that piece around the health and wellbeing... a lot of organisations now offered to support staff that came out of Covid because of the difficulties with Covid and all those different issues.... But actually the knock-on effect to that is it feeds right into organising organisational support for staff across the board, whether that is our Pilates class that... we would run for example in a council in different locations at lunchtime..."
(Cross-sector/Regional)

"...because of the likes of Covid and, you know, crisis within the organisation and recurrent trauma on the workforce, we've really seen it developing in terms of safeguarding our own teams and key strategies being developed that are really coming to fruition now."
(Justice)

"The wellbeing aspect... I think that has become much more of a focus since... Covid really highlighted that... the focus on that, we suddenly thought 'oh, my goodness, we got to look after these staff'."
(SBNI)

'Very challenging external environment': Additional inhibiting features in the external environment noted by focus group participants included the challenges of recruitment and retention across health and social care, as well as significant public sector reorganisation in recent years:

"The recent Independent Review of Children's Social Care Services, which has pointed at the very, very challenging external environment of recruitment, retention and... allied to that, then, is the training and the investment of staff and the duration of which they are remaining in post. So whilst I think the will is there on the part of professions and agencies, I think the challenges that are there in the wider environment have led to

associated challenges for governance and leadership."
(HSC Trusts 2)

"There's been quite a bit of internal reorganisation here, you know, with the Board closing and SPPG starting."
(Cross-sector/Regional)

'I can copy that': As already noted, the pitfalls of silos and the benefits of joined-up working was a strong theme throughout the focus groups. Connectivity was seen as synonymous with better partnership and ultimately better outcomes. Participants commented on the benefit of multiple agencies all working toward a trauma informed agenda. Opportunities for knowledge exchange were considered important to facilitate peer learning and promote collaboration:

"...where collaborative effort is seen to be an enabler... people going 'oh, I can pick that person's brains, or I can look at that strategy and I can copy that, or I can tweak it'."
(SBNI)

4.6 Future Vision

In terms of *immediate priorities*, focus group participants pointed towards the areas of implementation that appeared to have been more neglected up to this point in the different sectors and settings, including policy development, and especially the monitoring of outcomes and evaluation. *Longer-term* TIA advancement, however, was thought to rest on a number of strategic imperatives.

'A trauma informed strategy for NI': The primary vision articulated across focus groups was to have a strong mandate across all policy-making and commissioning of services, led by government ministers via government departments and cascaded through all levels of organisations:

"What I would love..., is there's actually a trauma informed strategy for Northern Ireland... because there's lots of small... people are doing lots of lovely things. But for the movement to gather momentum, there needs to be policy in place at the government level."
(HSC Trusts)

While the issue of leadership was common across focus groups, it was the perceived absence of political leadership that appeared to be impeding future development. For several participants, the political vacuum had prevented a whole-of-government approach, which in turn could provide the implementation framework within which a trauma informed strategy could be embedded:

"I think if we really want to reach the vision, for me, the disconnect is with our political leadership and with our systems... I think that impacts us and impacts our ability to do the best that we can do."
(HSC Trusts 2)

The clear message from focus groups is that while organisational leaders and individual champions have been influential, they can only do so much. Whole-system change requires a whole government approach and political leadership, with cross-party commitment to provide *'central voice coming down to say actually we need to do this together at the same time'* (Cross-sector/Regional). To move from TIP being *"something that is good to do..* into a 'have to do"' (SBNI) is likely to require a clear statutory mandate and explicit commitment from government. With this comes vision as well as accountability. Without such a strategic imprimatur, it was feared that TIA development would remain piecemeal and ultimately ineffectual and 'destructive':

"One of the goals ... was about getting commitments from our political leaders, from the ministers across the government department... that they're going to do this... because... in the absence of that, what you get is... people who've been hurt themselves, and they end up getting burnt out, and they do a lot of good work. But... it's ultimately so destructive."
(HSC Trusts 2)

However, there was recognition that policy in many areas had stalled. This was thought to mean that when the Assembly does return, there will be competition for ministerial attention:

"There will be a log jam, you know, when, if, if and when, hopefully we have a new Executive, there is going to be a log jam of issues."
(SBNI)

Given NI's unique history, it was envisaged by some that TIA advancement as a strategic imperative could also contribute to the development of a trauma informed society as part of a foundation for sustainable 'peace building':

"...that's a cultural piece, given our history in Northern Ireland, I think a longer-term future [vision], is a society that appreciates and understands the impact of trauma, whether that's small or large."
(Cross-sector/Regional)

'Where's our evidence': However, to achieve buy-in from political leaders for such a strategy, it was thought that ministers would need to know that investment in TIAs is cost-efficient and supported with evidence:

"[the] thing for me is evidence, that's the vision, you know, as we go forward is about where's our evidence... of our outcomes."
(Community & Voluntary Sector)

Outcome measurement, therefore, appeared to be an important element of any future strategy, and one that would require moving beyond a focus on outputs and careful re-consideration of the most relevant metrics, including taking closer account of service user experience:

"We've got the Regional Outcomes Framework, which is actually really strong and asks service users about their experience, and what I would like to see is a shift towards that compassion and kindness. Did you experience compassion within services? because that's a very basic thing, but a lot of service users don't get that, and that's one of the things I hear all the time, it's the way they were treated, when they're accessing services. So there's the thing of... did it improve things for you? were your needs met? Absolutely. But were you treated with compassion and kindness?"
(HSC Trusts 2)

Several participants suggested that forging stronger links with academics and researchers could help address this knowledge gap, provide new and novel insights, and facilitate the refinement of the trauma informed organisational process:

"They help us to understand because we're 'do-ers'. We're not understanders. We need to lean on academics."
(Education)

'Compassionate leadership': For some, a long-term vision of TIA advancement in NI involved 'a culture change' in leadership style from one of 'command-and-control' to one of 'compassionate leadership' that was thought to bring benefits for all:

"Our vision is to move from command-and-control culture, to keep command and control to the places where it's most useful, for example, a major incident... and then to have a compassionate leadership model and a culture change. So that is our vision for the next five years. If that is successful, then we will... the outcome of that for patients will be more of the compassionate care that they expect, our staff won't be as burnt out. They won't be carrying as much. They will not feel the need one to one with other colleagues to release all of the tensions and concerns and worries that they have... they'll be able to experience a compassionate approach in the workplace, enabling them to keep providing that to patients."
(HSC Trusts 2)

'A shared understanding': Bringing such a vision to fruition was thought to require 'a shared language and understanding' of what it means to be a trauma informed organisation across different types of organisation:

"the long term vision would be we have a shared understanding and a shared language in terms of being trauma informed and ultimately then that we're a confident organisation both in terms of being a trauma informed commissioner but a trauma informed employer as well. So, looking at both internally and externally, so that we're an organisation that that's not just talking the talk but walking the walk."
(Cross-sector/Regional)

'Make sure that staff are well': This leadership vision also included an enhanced focus on staff wellbeing as an imperative in order to create a 'just, learning and restorative culture' across the organisation:

"In 5-10 years, we need to make sure that staff are well because, at the minute, none of the staff, anywhere that I know, are doing great, and in order to deliver services for traumatised people, we need to make sure that staff are looked after too."
(HSC Trusts 2)

"We need a survey across our staff so that we can establish where we are, and how staff really feel within the system, and then we need to work to make that better, to improve that, and to create that just and learning and restorative culture."
(HSC Trusts 2)

'Trauma informed leadership': To achieve this culture change was thought to require additional trauma-informed leadership support:

"We need to be helping [leaders] get this across. Most of them want to do it, but it's the how. It's the how to, you know."
(HSC Trusts 2)

"[Be the Change leadership programme] if that were available on a rolling basis, or there was a trauma informed leadership module, either embedded within the existing leadership training course. But, actually, I think there needs to be something bespoke for leaders and policymakers working within... various domains."
(SBNI)

In addition to leadership training, participants also mentioned the potential development of a regional trauma training framework, akin to the national trauma training programme in Scotland, which could differentiate and coordinate between universal and more specialist trauma-informed leadership development and trauma-focused training:

"The national trauma training programme in Scotland is so impressive."
(HSC Trusts 2)

As a means to ensure 'consistency and standardisation' and promote collaboration and knowledge exchange in relation to trauma informed developments across services and sectors, the creation of a regional TIA Centre was also proposed:

"Having some form of, say, potentially, a Northern Ireland Centre for Trauma Informed Practice that would sit... independent, I just mean not owned by a department that could make it feel that it was somehow not relevant to the other departments. So if you had that... philanthropic funding coupled with some form of government funding... that Centre being the area that provides the consistency and standardisation in terms of innovation... having this Centre to support and enable and benefit from the expertise of all those other groups. But what you don't have is somehow somebody owning a trauma informed approach."
(SBNI)

4.7 Key messages

Eight focus groups comprising 52 senior professionals across sectors and settings were conducted during the summer of 2023 to ascertain their views of the implementation of TIAs to date in NI and their vision for the next steps. The following key messages emerged:

1. *TIA conceptualisation* remained an area of some confusion with the need for further clarity articulated by many in order to work toward a shared understanding of TIA implementation as meaningful whole system transformation. Key areas in need of clarification included: the distinction between trauma, trauma-informed and trauma-focused services; an understanding of how TIA implementation takes account of structural issues; the relevance of TIAs for all organisations engaged in service design, delivery and policy development across child and adult settings, and frontline and non-frontline services; and how TIAs differ from or align to other strategic initiatives e.g. restorative practice, service user involvement, early intervention, Protect Life strategy, and Outcomes Based Accountability.

2. Progress was reported in the implementation of certain elements of TIA *organisational development* including senior leadership engagement and implementation structures. The need for more attention to policy development as a means to embed a strategic TIA commitment, the physical environment, inter-agency collaboration, and progress monitoring and evaluation were reported across focus groups.

3. *Workforce development* was identified as the primary area of TIA implementation progress in NI. This was particularly apparent in the high levels of universal training reported, with greater attention now required to ensuring access to different levels of TIA training and context-specific support. In contrast, *workforce support* was identified as an area with more limited progress with inconsistent provision of supervision, reflective practice and incident de-briefing articulated. Overall, focus groups reported greater attention to *staff wellbeing* since the COVID pandemic, but this remained an area of need in light of recruitment and retention challenges.

4. Overall TIA implementation was reported as more progressed in child and young person services, with the implementation and relevance for TIA advancement in adult services identified as an area of significant need. Noted *practice changes* included enhanced focus on positive, holistic engagement with service users with further work needed to consider the potential for service user retraumatisation and ensure access to specialist trauma-focused services.

5. Wide-ranging *positive benefits* of TIA implementation were reported for service users, staff and organisatons, with no disadvantages identified across the focus groups. TIAs were thought particularly suited to the NI context given the history of political conflict, creating an opportunity to address some of the legacy of the conflict.

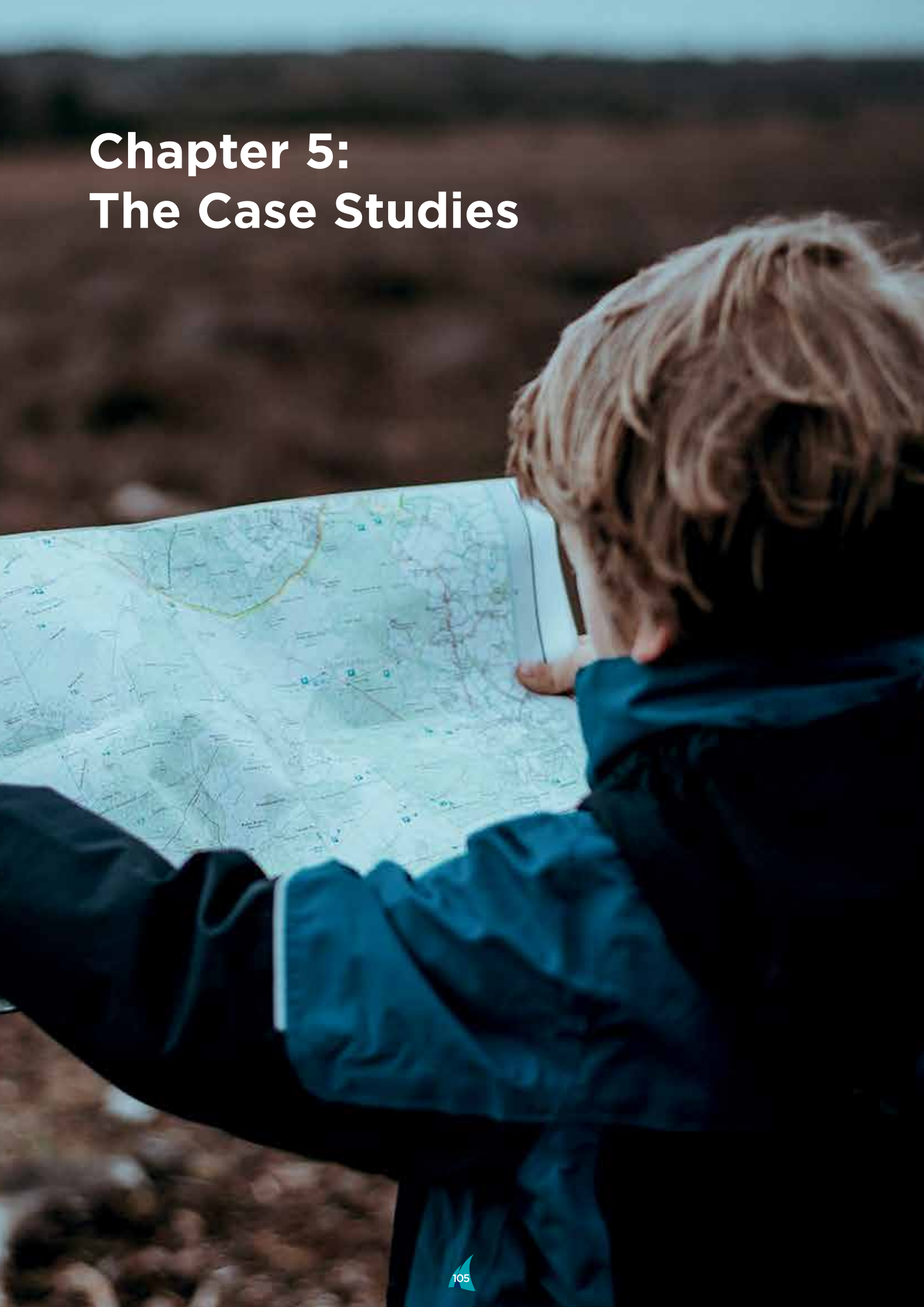
6. Common *individual enablers/barriers* reported included the need to address staff fear, reticence and burnout by enhancing tailored workforce development and support opportunities to build staff confidence, understanding, skills and wellbeing; embed meaningful policy change to mitigate perceptions of some elements of TIA as 'tick box'; and address the perceived lack of relevance for adult and non-frontline services.

7. *Organisational enablers, barriers and challenges* commonly noted across focus groups included the need to embed TIA advancement as 'core business', connecting with other aligned strategic initiatives; the need for senior leadership and TIA champions across the system while addressing staff turnover and burnout; adequate resourcing and capacity to support TIA developments; and the perennial problem of working in silos.

8. *Enablers, barriers and challenges related to the external or wider context* centred on the need to achieve a governmental TIA mandate and the current political hiatus in NI without a functioning Assembly (at time of fieldwork); prioritisation challenges in a stringent economic climate; the absence of trauma-informed commissioning; dealing with the aftermath of the Covid pandemic; the development of a research strategy to evidence TIA benefits; addressing regional workforce recruitment and retention challenges; and the need for knowledge exchange opportunities to advance cross-sector TIA standardisation and collaboration.

9. The clear message for future TIA advancement across focus groups is that whole-system change requires a whole government approach and political leadership to provide a cross-departmental mandate and commitment to create a trauma informed strategy for NI to provide vision and accountability. To achieve such buy-in from political leaders, it was considered important for a research strategy to enable the development of a robust evidence base. Additional support is also thought to be needed for organisational leaders with the proposal for a national trauma training framework and trauma-informed development Centre to enhance standardisation and promote collaboration.

Chapter 5:
The Case Studies



5.1 Introduction and Overview

In this section, we present the findings of four qualitative case studies of organisations or services implementing trauma informed approaches (TIAs) in NI. Case study organisations or services were selected by the QUB Research Team from the survey submissions where they had indicated an interest in case study participation. All the case studies selected had implemented TIAs across the three primary implementation domains adopted by this study i.e. (i) organisational development, (ii) workforce development and support, and (iii) service design and delivery. In total, four case studies were identified using critical case sampling, taking account of: organisation/service size; target population (adult/child); service setting; geographical remit; and service sector.

Case study methodology adopted an integrated process and outcomes evaluation approach to comprehend the implementation of selected TIA initiatives, specifically enquiring about: 1) what was implemented; 2) how it was implemented; 3) what difference it made and to whom; as well as 4) perceived enablers and barriers within the service context and 5) transferable implementation learning.

Case study methods encompassed three core activities: 1) analysis of relevant documentation or information related to the TI initiative provided by the case study service; 2) a focus group with key people associated with the development or leadership of the initiative; and 3) a focus group of staff drawn from different positions across the organisation who had differential experience of the TIA initiative. All focus groups were recorded and transcribed.

5.2 General description of the case studies

The four case studies selected were drawn from different types of service settings, including Education, Justice, and Health and Social Care. They also involved both statutory and voluntary/community organisations of different sizes, serving different populations (see Table 5.1). Each case study organisation presented unique implementation strategies and a range of trauma-informed initiatives that permeated through the whole organisation. Each had begun their journey with TIAs some years previously. Although service leaders recognised they had not arrived to a perfect destination, we believe there is plenty of learning to be gleaned from their different journeys.

Table 5.1: Case study description

	Type	Setting	Size	Service users	Area
Youth Justice Agency	Statutory	Justice	100-500 employees	Children/ young people	Regional
Fane Street Primary School	Statutory	Education	Less than 100	Children/ young people	Belfast
Salvation Army UK/ Thorndale Family Service	Voluntary	Multiple settings/ Social Care	500 plus employees	Children, young people & adults	UK/ Regional
Belfast Inclusion Health Service	Statutory	Health	500 plus employees	Adults	Belfast HSC Trust

Youth Justice Agency

An Ghníomhaireacht um Cheartas i leith an Aosa Óig

Agentrie fur Young-Yins Fang'It wi tha Laa

Case Study: Youth Justice Agency

5.3. The Youth Justice Agency

5.3.1 Context

The Youth Justice Agency (YJA) is part of the Department of Justice. This regional service was formed in 2003 and aims to make communities safer by helping children to stop offending. The Agency works with children, aged 10-17 years, who have offended or who are at serious risk of offending. The YJA provides a range of services, often delivered in partnership with other agencies, to help children to address their offending behaviour, divert them from crime, assist their integration into the community, and to meet the needs of victims of crime. YJA has a staff team of just over 200 people who deliver a range of community-based services through five Area Teams located across NI, in addition to the sole regional custodial facility for children and young people in NI, Woodlands Juvenile Justice Centre (JJC). For further information about the work of the YJA, please see https://www.justice-ni.gov.uk/topics/youth-justice.

Two focus groups were conducted as part of this case study. One with senior managers who had been involved in designing and leading TIA implementation in the YJA, and another with staff in different roles across YJA community services and the regional custodial facility.

5.3.2. TIA Implementation

The implementation 'journey'

Senior managers spoke of how their 'journey' with TIAs began, noting how in 2016, the YJA Assistant Director had been approached to represent youth justice on the ACE Regional Reference Steering Group. This group, made up of public, voluntary sector and Departmental representatives, convened by the SBNI, had been commissioned at that time to look at how to 'use this new research around ACEs to inform practice'. Following an initial conference, the YJA 'signed up' to becoming a trauma informed organisation.

When considering their experience of leading TIA implementation over the intervening years, focus group participants were clear that they perceived their trajectory as a 'journey' rather than a 'destination'. They noted how continuous (sometimes unanticipated) changes (in staff, management, priorities etc.) demanded that they constantly review progress, revise initial plans, and build in mechanisms to evaluate what change had occurred in order to 'go back at it again':

"... our strap line is we're on the journey to becoming a trauma informed organisation. And I do think it's a journey. I don't think it's a destination. I think staff, your staff teams change, your management changes, other priorities come in and you're constantly having to revisit what we've learned... You know, you've implemented something. You think that's grand. Then you realise actually... is anybody actually doing what we're supposed to have implemented? You're going back. You're reminding people, you're building in mechanisms to evaluate and review, and then... You're going back again, so it's a constant journey."
(Senior Manager Focus Group)

Following what was experienced as a somewhat lonesome start, the YJA TIA leadership team described just how far they felt they had come, with trauma informed practice now seen as 'normal practice' across the Agency, embedded within central policies and procedures:

"...in the early days, I know [the TIA leadership team] felt like we were a bit like beating a drum... was anybody else hearing it? I think we've really come a long way, that the whole management team now gets it. This is now normal practice... I'm seeing the words trauma informed practice being rolled into, you know, policies, practice guidance and whatever, you know, using a trauma lens.... the language is really becoming embedded in how we work, and in our core documents, but that has been a journey."
(Senior Manager Focus Group)

Participants in the staff focus group also expressed their sense that TIA implementation across the Agency had been sustained over a longer period, with the potential for longer term impact:

"... there's been various times over the years, I can't think of exact examples, but there's been various times that the Agency has took on some notion of training, and it's been sort of thrown towards everybody, and it's flavour of the month for a wee while and then it just disappears into the ether somewhere. Um... (...) but you know, I think... the whole trauma informed thing has had a bigger impact and probably will have a longer impact. I don't think this is something that, you know, next year people are going to say 'oh trauma informed was the last couple of years. We're moving on to something else now'. Do you know?"
(Staff Focus Group)

TIA conceptualisation and the fit with the YJA

Participants in both the staff and senior managers' focus groups noted how there was a good fit between the rationale and principles underpinning TIAs, and the work being undertaken by Agency staff with children and their families. Senior managers remarked that while TIP may have been 'the new lingo', they felt the Agency had been working in this way for some time, albeit not so coherently or with the embedded level of impact:

"Now, over the years, trauma informed practice, while it might be the new lingo, I would argue we've always been working in a trauma informed way. Maybe a bit more, I suppose sporadic, not as cohesively and it wasn't permeated through our policies and practice in such an obvious way."
(Senior Manager Focus Group)

There was also recognition that many of the children involved with the YJA, and their families, had experienced significant adversity and traumatic life events. The advent of TIAs was thought to provide a new and 'different language' to talk about the impact of such experiences and the aim of practitioners to 'get alongside':

"...at the very start, while we didn't have a title of being trauma informed... this is what we did. We work every day with troubled people that have lots of conflict, lots of issues. (...) As in, people dealing with really traumatic things that have happened in their life, so we've always had to deal with that (...) And I suppose we always sort of thought when we started doing this, we thought oh flip... well, we sort of do that already, but that's just different language, and it's then just trying to get that language right and embed it in the staff."
(Senior Manager Focus Group)

Senior managers, however, also noted some of their struggles with the language of trauma and trauma informed care which was perceived as referring to a medical model of understanding presenting issues, more suited to health contexts. For the YJA TIP leadership team, trauma informed practice was considered a more appropriate term which was thought to be well understood by partner agencies as 'understanding that child and that family's journey and what has impacted them':

"...when we met with [name], initially around the [TIC] questionnaire that we're doing with SBNI, you know, we had a very frank conversation with her to say we don't use trauma informed care, that's a medical model. That's not our model. It's practice, but I think we've got there, and the organisations that we mostly interface with understand the language that we're using because they use the same language, because unless you're going into Trusts where you're working with psychology or working with psychiatry, and it's very much a defined medical term, everybody else is using it in the same context, really, understands it. In my view, the simplest explanation of it is understanding that that child and that family's journey and what has impacted them."
(Senior Managers Focus Group)

Staff focus group participants also noted how the language and conceptualisation of TIAs made 'sense to our staff and how we work'. TIA principles were reported to fit well with current interventions, offering a new framework to help staff return to what they were trying to achieve:

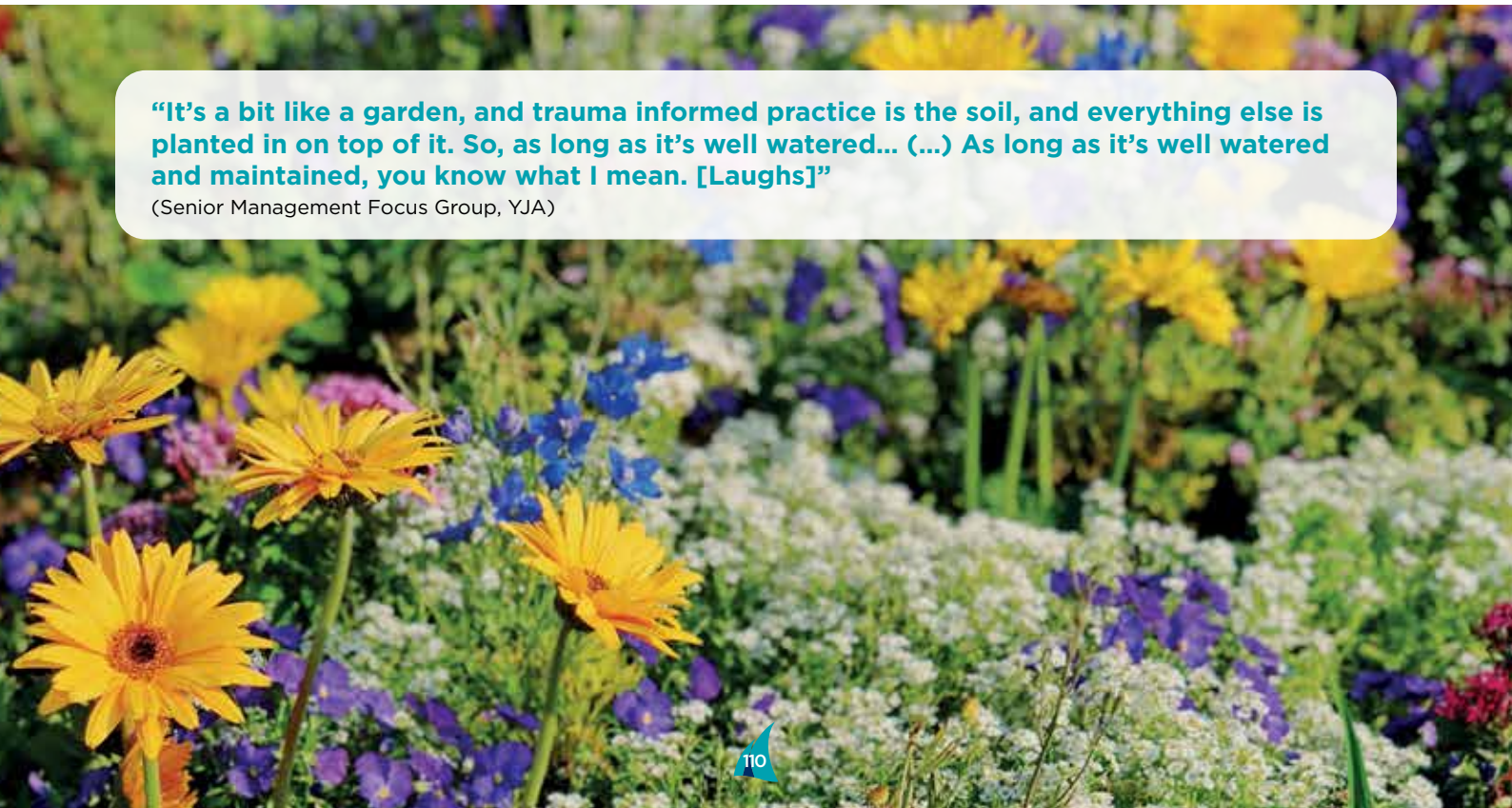
"... when we were doing the initial ACEs training (...) [we] were saying, this is work we were doing anyway and I was able to put a label on it, (...) these are actually all the cornerstones of a good youth conference plan, and it's what we were doing anyway, is trying to connect young people into training or employment or their community, in terms of pro-social activities, doing one-to-one work for themselves or others to look at, you know, emotional regulation, etcetera. So we were doing it anyway and it was nice for us to say, well, there's a framework we're already using."
(Staff Focus Group)

The senior managers' focus group spoke of how they used the analogy of a garden to describe how trauma informed principles acted as an underpinning framework for the many ways TIAs were actualised in different service settings. Such analogies were thought to help managers and practitioners understand the rationale behind aligned change initiatives across an organisation, from human resources to estate management, to policy development and frontline practice:

Collaboration across the system and policy developments

While designated as leading on TIA implementation across the Agency, senior manager participants noted the vital importance of making connections with senior colleagues and aligned initiatives underway across the organisation as a means to ensure trauma informed principles were embedded across the system:

"While we [the TIP leadership team] have led on a lot of the stuff, it's dove-tailed into other AD's portfolios, for example, my colleague [name] has led on review in the Youth Justice Agency assessments, moving it from being risk-focused to needs-focused. That was a trauma informed intervention... The development of family work that [colleague] has been working on. Again, it's like the trauma informed practice... Our development of early stage diversion initiatives, exiting young people from the justice system as quickly as possible, again this is another trauma informed initiative. I mean, you could nearly argue all the work of the agency is [trauma informed]"
(Senior Leaders Focus group)



"It's a bit like a garden, and trauma informed practice is the soil, and everything else is planted in on top of it. So, as long as it's well watered... (...) As long as it's well watered and maintained, you know what I mean. [Laughs]"
(Senior Management Focus Group, YJA)

A number of aligned YJA strategic initiatives were noted as central to the embedding of trauma informed principles and practice across the organisation. These included the development of the YJA Model of Practice; a new 'children's first' needs assessment; enhanced multi-disciplinary involvement, in particular with CAMHS; the Participation Project; enhanced family engagement; and early intervention/ diversion initiatives.

The **YJA Model of Practice** was developed as a means to bring together the different practice principles which the leadership wished to embed in all YJA service provision (children first; trauma-informed; systemic; relationship-based; restorative; strengths-based and future-focused; participation and engagement; evidence and outcomes-based), and articulate these as a single coherent model for purposeful engagement with children and their families (see Figure 5.1 and Box 1).

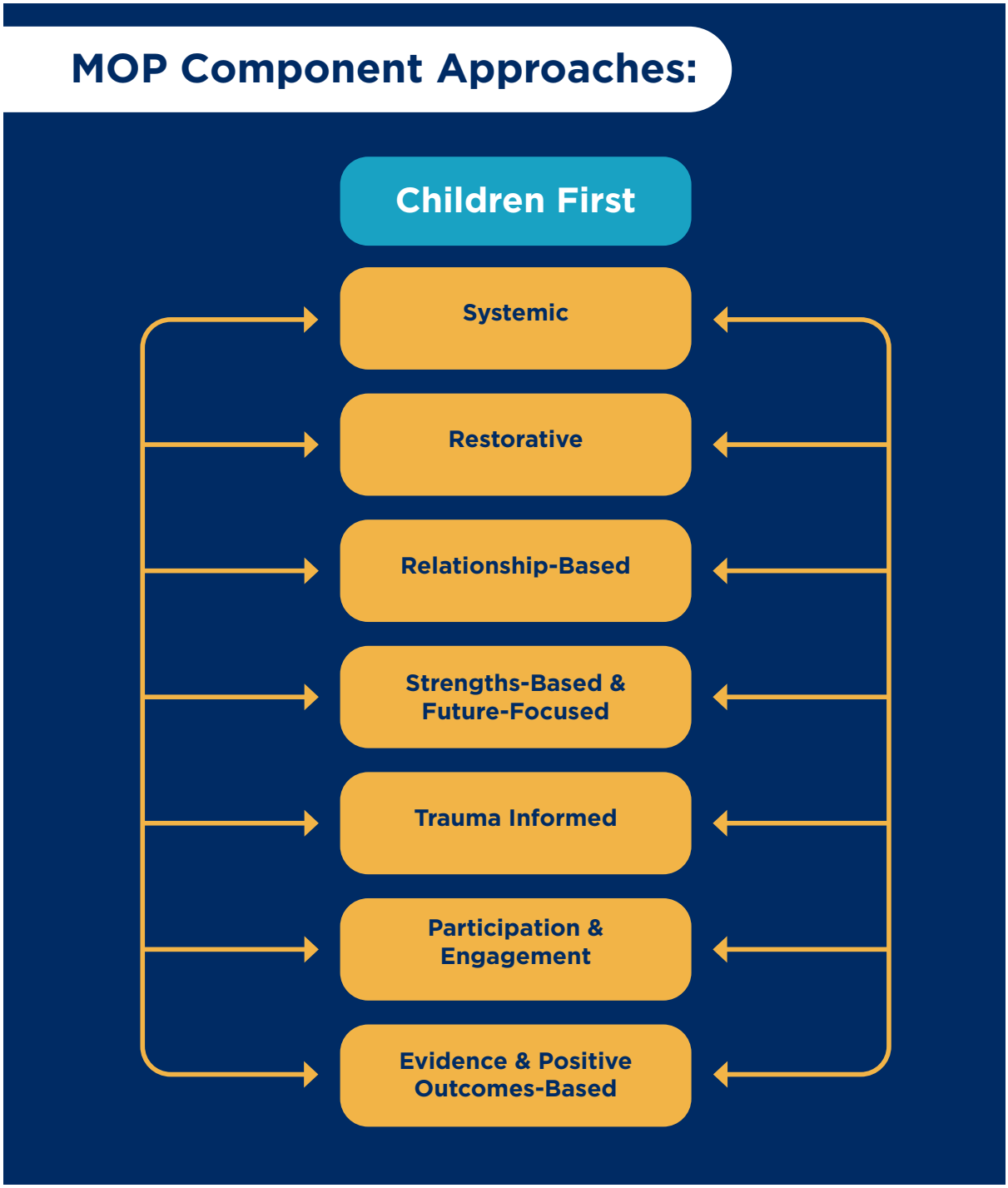
'Children First' Needs Assessment:
Another key policy initiative which offered opportunities to further embed trauma-informed principles included the development of a new 'children first' needs assessment which seeks to explicitly consider children's wider needs, life experiences and life stage, as well as their offending behaviour and other attendant risks. This enhanced consideration of children's needs was expressed by staff as a 'fundamental shift in thinking' inviting them to understand the child's 'back story' as a context for their behaviors:

"with, you know, the ACEs Level 1 and 2 [training], there's been like a collective consciousness of, you know, looking more at young people's... the back story, and I think there's been like a change around the... what has happened to you? rather than what have you done? And you know what. That's a sizeable shift in thinking about young people, and we're not just addressing the [offending] behaviours, it's what's led to the behaviours. You know the back story. So that's been a fundamental [shift]... you know, it puts a context [around the behaviour], it doesn't take away any responsibility from young people, but it does put a context on it."
(Staff Focus Group)

This new assessment process was thought to be more supportive of the child and family, bringing benefits for their relationships with staff:

"The assessment for the agency, it has been developed and changed and... rather than more based on the risks, it's more on the needs, and it's very, very much supportive and very much in line with the mitigating factors and how we support that, and that's throughout the agency now... most of the staff have bought into it, and can see the benefits, not only for our young people, but for their relationships with the young people, as well, and also with the families."
(Staff Focus Group)

Figure 5.1: YJA Model



Box 1: YJA Model of Practice

YJA Children First Practice Principles:

- We ensure that the rights of children are respected and that children are treated as children
- We deliver services in a child-friendly and child-appropriate manner
- We recognise, build on and celebrate children's positive behaviours, strengths, resilience and their positive contribution to society
- We consider the needs and developmental stage of children
- We consider, assess and address the broader context and underlying causes of offending by children
- We recognise the responsibility of society and adults to help children to avoid conflict with the law
- We promote Earlier Stage Intervention in maximising opportunities for prevention and diversion ensuring the minimal necessary intervention.

Model of Practice Component Approaches:

1. **Systemic:** This means Children's offending behaviour is understood from within its broader social context; work is undertaken by YJA and its partners to address both offending behaviour and its underlying causes.
2. **Restorative:** Children are encouraged to make amends for the harm caused by their offending behaviour. Restorative processes are used to "restore" children, families and victims and to promote the inclusive reintegration of children within their communities and wider society.
3. **Relationship-based:** YJA interventions are delivered within the context of positive working relationships. These relationships are based on meaningful engagement, empowerment, respect, honesty, trust and optimism.
4. **Strengths-based & future-focused:** YJA focus is on recognising and celebrating the existing strengths and resilience of children and their families/carers. We aim to nurture and sustain hope, personal agency and to strengthen social networks. Our interventions promote and support positive change.
5. **Trauma-informed:** Multiple Adverse Childhood Experiences (ACEs) and trauma may contribute to offending behaviour by children and/or make it more difficult for them to address it. All YJA staff are ACE-aware and practice in a trauma-informed way.
6. **Participation & engagement:** YJA is committed to continuing to develop and deliver services in partnership with service users. Children and family engagement in service design is crucial.
7. **Evidence & positive outcomes-based:** YJA practice is informed by holistic research and is evidence based. YJA measures the impact of its services both on a population and individual basis.

This shift from a predominant focus on risk was also articulated in the custodial context on an ongoing basis, rather than simply at point of assessment, with staff invited to 'think outside the box' in relation to support for the child as opposed to applying a security-focused lens alone:

"So... an awful lot of our policies and procedures or the operational policies were very much based on risk, were very much based on this must happen and you do this, this and this, ... (...) we're very lucky in the [Juvenile Justice] Centre where we have... an OT, we have a psychologist and... the psychiatrist there. So we kind of... we meet with them on a daily basis at our morning meetings, we would be discussing the young people and discussing things that have went on, where that wouldn't have happened before, say a young person had lashed out or he had smashed the window or he had smashed a phone line... it would have been about, first of all, keeping him safe and keeping him safe from everybody else, where now it's kind of... we're kind of thinking outside the box and looking at what, what can we do to support this young person rather than just maintaining the security?"
(Staff Focus Group)

CAMHS collaboration: As noted in the quotation above, actioning this practice change, in the context of challenging behaviours, involved multi-disciplinary collaboration with CAMHS colleagues on the secure campus with daily meetings held to share ideas and ensure coherent, tailored, supportive relational practices with individual young people across the unit. This enhanced collaboration with CAMHS was also mirrored in community settings with the development of an ongoing programme with the HSCTs, which to date has seen the co-location of CAMHS practitioners in two of the area teams, and the use of the Strength and Difficulties Questionnaire as a screening tool to identify additional need. This co-location was thought by both staff and senior managers to have made a significant positive difference to young people, ensuring that they had direct access to relevant support rather than having to go through their GP for referral and be placed on a lengthy waiting list. Participants noted that this helped the young person 'feel listened to' with a sense of 'instant hope' apparent:

"In terms of CAMHS, we [have] the initial pilot of having a CAMHS senior practitioner co-located between the community CAMHS team and Youth Justice Agency... and then, what we started implementing was the Strengths and Difficulties screening tool for every young person... and that was two-fold. Part of that was to see what extra services the young people needed and was to get a direct access point to CAMHS, rather than having to go through the GP in a waiting list. So that gave us immediate access to [CAMHS practitioner]... (...) also to collate all that information and build up a profile of need in our area, and I think it was coming out of 60% plus of the young people involved in offending behaviour had other needs that weren't being met, you know, and we were able to get the referral process in place for that, and that's also been now expanded out into the other sort of community teams and obviously... ACORNS in the JJC."
(Staff Focus Group)

"And that's made a real difference in people, because I suppose when kids get a referral, they'll have to wait weeks and weeks and weeks before something happens. And when they actually get to be involved with YJS and the community and they meet that CAMHS worker, see even just that initial 'I can see your face... I've had a conversation with you', that gives that child a certain amount of hope... Something's going to be done about this...You can see the difference from the kids meeting the CAMHS worker in the community. They've got that instant thing. They're not waiting 12 weeks to get an appointment. They're not having that... 'Oh, nobody's actually listening'. It's instant and it gives them that instant hope."
(Senior Manager Focus Group)

Participation Project: Central to the over-arching TIA initiative was the promotion of participative practices across the Agency. This included the development of the Youth Forum, a Participation Officer and the Expert by Experience pilot with young adults with CJS experience as means to promote the 'voice of the service user' and work toward 'meaningful engagement and consultation' with young people in the design and delivery of YJA services:

"But [the Participation Project] was very much linked back into the trauma informed practice piece around understanding the voice of the service user and how we get to that point of co-production. So that actually came out of the trauma informed practice, a pilot, the need for a Participation Officer... I mean we do have satisfaction surveys... we survey our young people, you know, [they are] surveyed up when they complete their plans and orders and any intervention, we've lots of data around that, but we needed to go beyond that in terms of meaningful engagement and consultation, have an Experts by Experience and at some points how they inform service, like co-production in terms of developing future services. So that's where that bit came in."
(Senior Leaders Focus group)

The development of the Participation Project formed the focus of the YJA's response to this study's online survey (Chapter 3). Please see Box 2 (YJA survey submission excerpt) for further information about this particular element of service provision.

Enhanced family engagement was noted as another important strategic initiative across the organisation where trauma-informed principles were embedded. Both practitioners and senior managers spoke of family engagement, including with parents and siblings, as a key part of the needs assessment process and essential to understanding the 'child as a whole':

"When I think of working in a trauma informed way, I suppose, I think very much of like you know working with the child as a whole, ... you know working with the family, the families as a really important, you know, way of me working in a trauma informed way."
(Staff Focus Group)

"It's a core component of our model of practice... children aren't taken in isolation. So there's a lot of systemic practice work undertaken, and a lot of kind of pathways identified for parents and for siblings as well, because obviously young people within the environment um..., everybody's kind of assessed, you know, what are the needs?"
(Senior Manager Focus Group)

Such engagement was considered essential to achieving better outcomes for the children, with the direct provision of YJA services to family members (e.g. supportive family conversations with therapeutic intent; parent group work; acupuncture for parents) as well as referral and liaison with other specialist services when needed (e.g. mental health, trauma and domestic violence services). Such enhanced engagement was undertaken in recognition that many families involved with the YJA, have had personal experience of a range of adversities and traumas:

"So we do have parents getting regular acupuncture. We do have a lot of support, one to one support with families, with parents, with everybody around the table, or with who we can get as well, you know, because sometimes it's, you know, we work with who we have... But yeah, there's a lot of family support and family work happening, you know, within cases, and then connecting with other services, if, you know, childhood trauma sometimes can be disclosed... or mental health or domestic abuse. And it is about having those conversations, and staff recognising the trauma of family members and parents, and the importance of the support, and when people are well, then, then things work better within the homes and we see that a lot with our cases."
(Senior Manager Focus Group)

Box 2: Development of Participation Across YJA Service Delivery

Project Aim: As part of the YJA trauma informed practice implementation, it was agreed by YJA Senior Management that YJA would develop a Participation model. This would ensure the involvement of service users in the design and delivery of our services. We hoped to build on existing participation forums and set up a formal Youth Participation Forum (YPF). We also ensured YJA had a dedicated Participation Officer to develop, co-ordinate and take forward participatory practice. The term participation means the involvement of children and young people in decision making on issues that effects their Lives. It is enshrined in Article 12 (1) of the UN convention of the Child and is ratified in NI since 1991. Embedding effective participatory practices and involving young people in multiple levels of decision making, presents a number of unique opportunities in a justice context.

In line with the YJA commitment to 'deliver services in partnership with service users' as outlined in the YJA Model of Practice, a participation pilot was launched in January 2022 wherein a YJA staff member was seconded into the participation officer post to:

1) develop the YJA position around participation;
2) Allow for a scoping exercise with staff to assess current YJA participatory practices and what may need developed or improved;
3) the Development of YJA guidance on consultative participation framework both for internal and external requests;
4) Begin the process of developing a Terms of Reference and scoping exercise for what a Youth Participation Forum may look like.

Brief description of project: The YJA focus on the participation of young people in 3 key areas:

i) **Direct Practice** - 'Young people are given the opportunity to discuss areas of their work or plans, appointment times and areas of support' (YJA Staff Input- Scoping Exercise Feb 22). Young people's contribution to areas of individual work can be seen in: Youth Conferences and other disposals, plans of work and reviews, weekly appointments – choice of date, time, location, area of work etc.; Provision and activities

ii) **Service Development** - 'Young people should be more involved in conversations regarding their needs and safety planning. Gaining feedback from young people about approaches and interventions' (YJA Staff Input- Scoping Exercise Feb 22). Young people's contribution to processes in which decisions are made about them, such as: Contribution to YJA assessments and screening tools; attendance or contribution to priority case discussions and safety planning; pathway planning

iii) **Strategy & Policy** - 'Young people's views should be sought before the implementation of new policies or procedures which will impact them' (YJA Staff Input- Scoping Exercise Feb 22). Young people's contribution to organisational direction and governance, such as: Consultation on corporate and business planning; Consultation on policy introduction or change; Contribution to publications, PR, social media presence etc.

As the pilot has progressed the buy-in from YJA staff from CEO level to operational frontline has been significant. This has allowed for meaningful engagement with staff and young people on the value of proceeding with the project.

Young People through our consultation on the Corporate Plan have told us what we are good at 'building, relationships, offering help and support' - but also highlighted what we need to improve – 'more work with families'; 'more support around education, training and employment'.

Staff have told us that this is a new area of work for YJA which needs time and commitment to build and grow into an authentic organisation which looks to its service users as co-designers of services which fit their needs. However, we need to be aware that there will be conflicting and contrasting views as there are inherent tensions across all key stakeholders in the area of youth justice."

Such family-focused interventions are mirrored in the custodial setting with efforts made to ensure children continue to have 'family experiences' while in the JJC, such as having a meal together or going swimming. This was noted as a key change in how custody was organised over the years, with family visits now recognised as important interventions in their own right to help children and families remain 'connected' in the knowledge that (most) children would eventually return to the family home. Family accommodation had been upgraded to ensure that this welcoming ethos was apparent:

"I think that's probably one of the big changes... custody has changed greatly in the last 30 years to what you can achieve and what you can do. And certainly, we have looked at visits. We've got lovely family accommodation here, but it's about bringing kids and siblings up and allowing those young people that are here to still have family experiences... have a meal together, to cook together, to make buns, to go to the swimming pool together, you know, all those activities... maybe go to the gym, and keep that connection, because we're very conscious that once a child leaves us in custody, they're going back out to the same environment, and the same issues, and all the other things that are going on. So if we can make that connection with their carers or parents better..."
(Senior Manager Focus Group)

In addition, parents are provided with a wide range of group work activities based in the JJC as a means to offer relevant support:

"So ... [parents] meet every Tuesday night and they would do a table for the year about different supports that they'll do. So they'll talk about conflict. They'll talk about, you know, ... mental health and have CAMHS... they'll come down for a visit to the Centre. We'll do first aid with them, with their young person then, so if you were, you know... if you were overdosed on drugs, what would you do? All those sorts of things. We've also modified... and delivered a bit of [trauma] training as well to them, to just let the parent realise the supports are there, and then... we've produced a toolkit to give the parents... even over COVID, we gave newsletters out, to how you're coping with your own mental health, how to deal with your young people... and signposting them to different services."
(Senior Manager Focus Group)

One initiative, initially developed over the COVID period when visits and group work were restricted, was 'wellbeing boxes' for families. These were created with the children and tailored for their particular family, as a means of supporting families but also affirming for children that staff understand that 'family is important', and that children are still 'part of a family' while in custody:

"And then we also did..., which I would like to see more of probably, is those wellbeing boxes that we created and we got the young people in the Centre to design what would go into a wellbeing box if your Mummy or Daddy or whatever, you know, suddenly lost you and you came into custody, what would reassure them? If they got a box, what would be in that box to help them cope with you not being about... So they designed a box and we were able to produce some of those and get them out to the community in custody, so that we were able to maintain that connection, that we actually... we knew that your child has come into the services of youth justice, but we also recognise you, as a parent, or a carer, that it's a difficult time for you as well. So within that box, we were able to give instructions about looking after yourself, looking after your mental health... little things in it that the kids had made like, you know, there was like a wee lavender pillow the girls had made in custody, and they put that under to help them sleep better, you know, there was fidget toys. There were like motivational magnets that were done... little things like that, that just made... 'Well, no, we recognise that, you know, your son or your daughter are with us, but we realise they're part of a family and that family is important'."
(Senior Manager Focus Group)

Early intervention/diversion: Focus group participants also highlighted the positive impact of early intervention strategies, as an important strand of the YJA's implementation of TIA to divert children away from the CJS where possible. Staff were at pains to note that dealing with offences at a 'lower level' in the CJS did not, however, mean that offences were not appropriately acknowledged or that the intervention received differed. Rather, it changed how offences were recorded, thus avoiding children being unnecessarily criminalised early in their CYJ pathway, and improving longer term outcomes:

"There's young people coming through now for community resolution notices, where, you know, ten years ago, for exactly the same offences... they would have been dealt with a couple of levels higher. They would have had a diversionary youth conference and then they would have been in the court... now, that's not to say that youngsters are being let off for what they're doing, do you know what I mean? It's just that they're being... with at that lower level, [it] means essentially they get the same type of intervention that they would have got before, but as far as how it's recorded on their criminal records concerned, it's recorded at a lower level, which... gives better longer-term outcomes for young people."
(Staff Focus Group)

Focus group participants also described initiatives to try and keep young people out of the JJC when on remand, if considered safe and appropriate to do so. This was done in the knowledge that the experience of entering the Centre can be 'traumatic' for some young people:

"We would interface with the police custody suites every morning and... have a discussion with the bail sergeants who have the power to oppose bail, which in turn means young persons, you know, get remanded to the JJC in the first place, and say, 'well, listen, we can offer a package of support to the family'... and then work with the young person in the community to sort of offset them going to JJC in the first place... and that's all based on trauma informed practice as well, providing that family support work... and the young people, because we are aware of how traumatic, you know, going into the Centre can be for some young people, and again particularly young people, say like ASD [autistic spectrum disorder]or whatever, you know, that... could be very detrimental to their wellbeing."
(Staff Focus Group)

Other aligned initiatives in the early stages of development involved the use of foster care for young people on bail who could not return to their family home through no fault of their own:

"We are also piloting bail fostering... so we have our first... up and running... so we have a young person using that bed at the minute who would have been remanded to the Centre... (...) But rather than him being in the Juvenile Justice Centre... he's with a foster family in the community."
(Staff Focus Group)

The physical environment

While many of these aligned policy initiatives have developed and grown over time, senior managers reflected on the challenge of getting TIA implementation started in the early days of development. They noted how they sought to start with the 'very obvious stuff' such as their 'physical spaces', as a means to achieve some 'quick wins', while getting staff on board and making the change visible:

"I mean, you could nearly argue all the work of the agency is [trauma informed], so... we tried to start with very obvious stuff. So how we started in the early days was looking first of all, one of the quick wins we thought, was looking at our physical spaces. So [name] led on that for the Centre and we looked at that in the community because that was something very obvious that staff could grasp."
(Senior Manager Focus Group)

"...if you'd come into our office five years ago, before trauma informed was being talked about, and if you came into our office now, I do think that you would genuinely physically see... a difference."
(Staff Focus Group)

"The ambiance and the way the place feels and looks when you come into it, it is a nice place to come into."
(Staff Focus Group)

As well as the upgrading of family accommodation and visitors' rooms in the JJC to make them more family and young person-friendly, staff participants also noted the development of 'softer' rooms in some community settings, where children could receive alternative therapies:

"I do agree in terms of the, you know, the physicality of the offices.... [they] have definitely changed and it does feel warmer... I suppose when we were trained in the acupuncture, we got the go ahead to create, you know, a room to carry it out in, which was great. So it is a room that the young people actually... like, even if they're not getting acupuncture on that [day]..., that's where we would see the young people, they like that room. It's just softer. There's pictures. There's, you know, fidget toys. There's...food as well in the room, and it's just a nicer environment.
(Staff Focus Group)

Participants also spoke positively of other practical changes to the physical environment. These included the provision of food and drink or 'grab bags', and hygiene toiletries in many community settings. Such seemingly small, 'simple' trauma-informed changes were viewed as important by all participants across the focus groups in the context of the cost-of-living crisis and in the knowledge that children cannot concentrate if they are hungry:

"Another thing we did was ensuring we had... the language is not great... we changed the language, like poverty boxes, but food basically in all our offices so that children were getting fed when they came in because we realised no, a child who's hungry isn't going to concentrate on what they're doing. So... ensuring that those very simple basic, back to basic stuff was happening."
(Senior Manager Focus Group)

"We've got a couple of practical sort of changes... we would have a big box at the door filled with what we call grab bags. So they're like wee snack packs of, you know, a bottle of water, a couple of wee snacks, different things. And any young people who are... coming into the premises or more importantly, when they're leaving, you know, just hand them a wee grab bag and say you should take that with you, um... just with the whole cost of living thing, you know, you don't know whether people are eating or drinking or whatever... in our toilets, we would have free period products, you know, available for people to lift. Um... you know, none of these things are mind-blowing, but we weren't doing them before, and we are doing them now."
(Staff Focus Group)

Such changes to the physical environment were noted as particularly important in the context of the work undertaken by the YJA, with participants noting that both children and families are often 'very nervous' when first engaging with the YJA:

"... it definitely helps... when you've got the CRN's [community resolution notices] coming in, maybe with their parents, and they're nervous... So it's like a one-off and you would meet them for, you know, one session, but these are very, very young kids coming in like, 12,13, 14, and they're very nervous. They're coming into our system for the first time, so having them come into, you know, a room, an environment like that, just eases them straight away, you know?"
(Staff Focus Group)

The availability of fidgets was also noted as important for young people with complex needs. In the custodial setting, a focus group participant spoke of how these were used to assist young people to regulate their emotions in challenging circumstances, such as case review meetings. This had evolved into the creation of 'self-care boxes' with young people to help them find alternative ways to manage stressful experiences:

"I suppose the benefits for... the young people is that... because of their complex needs ... within custody, what we have noticed is they're able to manage their emotions and regulate their behaviours more. It's a silly thing. I'll give you a practice example of... bringing... like fidgets, having fidgets sitting on the desk while we're trying to engage on a one-to-one or even while a meeting's going on, like a LAC review or a case review, you know, actually having those things in the meeting, a young person maybe sitting fidgeting with that, is being able to regulate themselves and their emotions more, and participate in the meetings. Now that's just a wee silly example, but that for us, has been really beneficial and we have been able to build upon that.... We have, what's called self-care boxes for those young people that have, you know, who are struggling. So, we... alongside them and our ACORN, our CAMHS people, we kind of look at, well, what can we have in the physical environment? What can you have here? To maybe support you and help you... if you have come off a bad phone call or... your bail's been turned down, you know, rather than go to emotion or lashing out, we were able to build upon that."
(Staff Focus Group)

This range of visible physical environment changes were thought to act as a reminder for new staff that the Agency was trauma-informed:

"I've definitely kind of noticed that change in the environment... I suppose for new staff coming in, it's good to be reminded, you know, and it's good that trauma informed has become a focus [in the physical environment], and it is, you know, constantly reminding new staff."
(Staff Focus Group)

Everyday practice changes

Participants also mentioned a range of seemingly 'small' changes to their everyday practice which had developed as a result of TIA implementation. These included an enhanced focus on child advocacy with external partners; renewed attention to recording and information-sharing practice; enhanced child support including connecting young people with external support agencies; and outreach efforts made to promote engagement and avoid traumatisation.

Collaboration with external partners: Both senior managers and staff noted significant changes in their work with external agencies, with an *enhanced focus on child advocacy* as a result of TIA implementation. One senior manager noted that once you start to take account of the child and family's life history, it shapes 'how you intervene' but also 'how you advocate for that child' with the other services involved in their lives (e.g., the police, education, Trusts):

"That was the other bit that, I suppose, attracted me was in terms of understanding that child's trauma, that child's journey, even that parent, or that family's trauma and journey gives a different focus to how you intervene and also shapes how you advocate for that child. So it wasn't just about youth justice. Looking at our practice and our service delivery, it was about how we communicate with the police, for example, around what they're doing might not be the best approach...How we hold the Trusts to account to say actually you need to provide a service and here's why... how you go back to education around reduced timetables and all the rest. So that was that collaboration piece and that working in partnership and, as a result, we also were able to develop new partnerships."
(Senior Manager Focus Group)

The shift to integrate a 'children first' philosophy was noted to have brought greater attention to the child's 'backstory' and wider needs (as well as risks), and led to focused consideration of *recording and information-sharing practices* with regard to what information should be shared with other involved agencies as well as the language used:

"We also looked at our court reports and our reports to the Public Prosecution Service to change the focus and language within those reports, to make them more needs-focused, to... bring the language of trauma and adversity."
(Senior Manager Focus Group)

"It's getting it out to the PPS [Public Prosecution Service], the district judges, etcetera. You know, high court applications, getting it across there as well."
(Staff Focus Group)

"Through court reports and PPS [Public Prosecution Service] reports and assessments... we probably have more of a focus on at least mentioning or referring to, you know, young people's adverse childhood experiences."
(Staff Focus Group)

In these ways, collaboration with external agencies were considered to have been enhanced and new partnerships developed in the best interests of the child.

Enhanced child support: Staff focus group participants reported how YJA practice had changed over the years of TIA implementation, with perceptions of enhanced child support rather than mandated courses. One relevant example was the shift away from 'anger management classes' to working to support young people to 'manage their emotions' and make 'different choices':

"Managing emotions is obviously the big one for our young people... people have mentioned youngsters with neurodiversity, you know, back in the day... the number of young people who came through for fighting or punching somebody and they had to do anger management classes or something like, do you know what I mean? It's not that they need anger management. It's that they need to learn and understand what their emotions are and how to, you know, make different choices... It's about managing emotions, rather than about anger management."
(Staff Focus Group)

Staff also noted the vital importance of *linking young people in with other services* and the provision of *short-term training,* e.g., forklift driving licenses. It was emphasised that 'small things' can be 'transformative' for young people's lives, providing new opportunities and changing how they are perceived in their families and wider communities:

"Being connected is trying to link people, young people, into other services or other resources... a lot of the fund, small grants that we would have, you know, goes to pay for forklift driving licenses... and people are thinking, you know, we're sort of... providing for all of the warehouses of Ireland. But you know what I mean? A youngster who is 17 with no qualifications, no GCSEs, no experience, they go and do that 3-day forklift license and the next day they can go on and be working that night in a warehouse. Do you know what I mean? Those small things are actually transformative... And then the young person within their family changes from being that no-hoper who's always in bother with the police, to the person who's working in the warehouse tonight.... that can be life changing for some young people."
(Staff Focus Group)

Staff also noted additional *outreach efforts* made by themselves and partner agencies, to help young people with complex needs engage in a positive manner by, for example, going out to meet them at home rather than bringing them to the office or allowing them to attend court via video-link:

"I've seen a really big shift with regards to the police... we will work very closely with the YDOs [Youth Diversion Officers]... I've had a few cases lately where we've had difficult young people, I'm thinking of one case in particular, the guy is quite autistic. And you know, the way the YDO came out with myself and we did a home visit, rather than bringing him out of his environment.... you know, rather than bringing him in... he doesn't like to leave the house, so rather than bringing him somewhere, and that's going to make him uncomfortable, she came out to the house with me. You know, so wee things like that, that wouldn't have happened, you know, a few years ago... they're definitely... the message is getting across to different agencies as well, which is great."
(Staff Focus Group)

"In a similar vein, we would have some of our young people with neurodivergent sort of issues... attending court by site link rather than in person, and the court environment and all the stress that goes with that too... But explaining to the district judges why we're looking to do this, so it's not a case of young people, you know, not attending or adhering to court.... It's, you know, it's the issues they're facing, the stress of... So that wouldn't have happened years ago either, you know?"
(Staff Focus Group)

Workforce development and support

'Loads of support and loads of training' was seen by focus group participants as essential to the YJA TIA implementation journey, with staff recognised as the essential 'tools' which make any initiative 'work'. Efforts were therefore needed to create environments that were 'just as supportive to the staff' as the young people:

"One of the big things that we maybe haven't talked about is the wellbeing of staff, and about the fact that... that's a major thing for us at the end of the day, is to try and create an environment that is just as supportive to the staff as it is to the young people, because they are the tools that make it work and that's a massive thing."
(Senior Manager Focus Group)

Workforce development: In the early days of implementation, senior managers spoke about developing an initial training plan to 'skill people up about trauma informed practice' with universal training (such as Levels 1 and 2 of the SBNI TIP training) 'rolled out' across the organisation. There was a recognition, however, that this in itself would not be enough with the ongoing development of a 'bespoke' training agenda to meet staff needs:

"We also developed then a training plan around what we need to do about skilling people up around trauma informed practice. So our staff, all would attend the trauma conference, but we also identified different bits of bespoke training. That's an ongoing thing."
(Senior Manager Focus Group)

A range of specialist training programmes were sourced, responsive to service development requirements, and provided to designated staff with the need for a 'good budget' noted. More specialist training offered included: SBNI Training for Trainers for the TI champions; SBNI 'Be the Change' leadership programme; Systemic Practice and Family Therapy training; Compassionate Inquiry Training; Alternative Therapies training; and externally commissioned TI supervision training. Training opportunities were described by staff and managers alike as 'not tokenistic' and often of excellent quality:

"For staff training, we have a very good budget for staff. So some of our staff are actually in the second cohort doing the compassionate inquiry training, which is amazing, you know, staff have reported this is the best training that I've ever done."
(Senior Manager Focus Group)

Staff support and wellbeing: Both staff and senior managers noted a transition in the more recent years of TIA implementation toward an enhanced focus on staff wellbeing and support:

"In the sort of the first few years of the whole trauma informed, the focus has really been towards the young people and families who we were working with, but I think, you know... there's now maybe a sort of looking at policies and procedures through a trauma informed lens. But I think the agency are possibly now... taking a bit more of an interest in, you know, thinking about staff welfare and staff wellbeing, you know, potentially with the trauma informed kind of link."
(Staff Focus Group)

Senior managers spoke of their aspiration to *create a 'compassionate and caring' trauma-informed work culture* for staff. While recognising the ongoing challenges and pressures to do so, efforts had been made over the course of TIA implementation to 'listen to staff' and be 'responsive' to their needs. This included the provision of staff wellbeing events; staff autonomy to manage their own diaries; and time off in challenging personal circumstances. Together, these were thought to have helped retain staff in spite of the challenging work:

"We try to be responsive and not reactive, and we do try to listen to staff and develop things, you know, that they find useful and beneficial. Pre-COVID, we would have had a health and wellbeing day where all staff came to the JJC and they got slots to get things like reflexology, massage... and I mean we have staff who came across from the Trust who were going 'we would never get this in the Trust'. So sometimes I think we've a way to go in terms of how we work with staff when they're being difficult or challenging and how we remember to keep that trauma lens and all the rest. But I think, in terms of other practices, we're light years ahead in terms of, you know, having budgets for staff wellbeing events, looking, understanding... giving people the afternoon off... staff members being particularly challenged, having a difficult time at home, [name] will go, 'you know what? just go home early or do what you need to do, sort it out'. We use that kind of approach, our staff have a lot of autonomy and they manage their own diaries. ... staff have stayed with us because of that. So there's something there in terms of we are trauma informed, well to me it's compassionate and caring, which is part of trauma informed practice and we try to do that. I just think at times, know, managers have different competing priorities."
(Senior Manager Focus Group)

This focus on workforce wellbeing was appreciated by staff participants with increased attention to the impact of the work on their own wellbeing, and agency efforts made to improve *line management and supervision practice* across the organisation:

"It definitely has brought focus to managers as well in terms of staff and management of staff. So definitely there, you know, over the years I have seen... a shift in terms of how we're managed and supported, and you know, and we also have to... think of our own trauma, and how we manage that and how we manage with regards to young people. So that definitely has been a benefit for me because there's more focus, you know, on young people and staff, you know, rather than just the young people."
(Staff Focus Group)

This focus on management practice had prompted the TIA leadership team to externally source trauma-informed supervision training for their middle managers, which was currently underway and reported upon very positively. It had prompted the initial draft of a supervision policy. It was envisaged that the current trauma-informed supervision participants would be involved in further developing as a means to 'harness that motivation' and build on the learning. A bespoke 'slot in supervision' to discuss trauma-related issues was envisaged as a future development:

"It gives us really good direction... we did a draft policy about what supervision should be. But the people that are actually doing it are now going to be involved... the feedback on the sheets is great and really good indicators of... right, this is a really good positive way to go forward, and that's the main thing. We want to do now is try and just harness that motivation now that people have"
(Senior Manager Focus Group)

"Understanding of vicarious trauma for staff, working with young people over periods of time too... whilst I would like to see a slot in supervision, specifically to discuss trauma-related issues and on how that may be affecting yourself as a staff member, I know the training's ongoing and that's hopefully a future development."
(Senior Manager Focus Group)

Another noteworthy example of policy development in the area of staff wellbeing, commented upon in both focus groups, was the development of *practice guidance following the death of a child* – unfortunately, a not uncommon event when working with this highly vulnerable population of children. In such circumstances, the impact on staff was noted as significant:

"... our cohort of young people who we work with are extremely vulnerable. And I think most staff members, both in custody and in the community, have experienced the death of a young person that they were working with and you know, we work with some young people for years and years and years and have, you know, very deep relationships with some young people and it can be very traumatic to ourselves."
(Staff Focus Group)

Staff participants noted how previous practice in these circumstances would have been to simply 'close the file' and ensure staff had completed all the necessary tasks:

"I know they've reviewed a couple of different policies, especially things that are quite serious, like, you know, the death of a child who staff are working with and, you know, how staff might be better supported in that scenario, rather than the olden days, when simply the file was closed and somebody was asked to make sure that they'd done all that they were supposed to have done."
(Staff Focus Group)

Senior managers reported that when developing this policy document, they had contacted other agencies to see if any similar practice guidance existed but discovered, to their surprise, that none had. This was a policy that managers were reportedly proud of with the primary emphasis on how the agency management would support the staff member in such circumstances:

"One of the things we did develop for staff was we have a practice guidance around what happens if a child dies, and when we were developing that, we went and spoke to CAMHS. They don't have anything. We went and spoke to Child Paediatrics. They didn't have anything. We went and spoke to Social Services. They didn't have anything, and then we realised... Yeah. So what we're... really proud of that document. It's a brilliant document... It talks about what management will do to support a staff member ... And then the second bit of it, is about how that staff member will be supported to manage their own grief, because we've all worked with staff members and have known children who have died in traumatic circumstances. So that piece of work was really interesting for me, particularly when we realised none of the organisations or departments that you would expect to have some sort of policy guidance... for their own staff, didn't have it."
(Senior Manager Focus Group)

Examples were provided when this had been implemented with good effect following a child's death by suicide:

"There was really positive feedback in relation to that from one of the teams who recently lost a young person through suicide, where the Chief Executive had phoned the staff and it was very positive feedback."
(Senior Manager Focus Group)

5.3.3 Outcomes and Perceived Benefits

Focus groups spoke of a wide range of outcomes and perceived benefits that were thought to have emerged from the implementation of TIAs across the YJA, both in community services and the custodial facility. These included child (including family) outcomes/ perceived benefits, as well as those for the staff and the organisation (Please see Table 2.2 for summary).

Table 5.2: YJA Outcomes and Perceived Benefits

TYPE	SPECIFIC OUTCOMES AND PERCEIVED BENEFITS
Organisational	Relevance of TIA for children with complex needs and repeat offenders – leading to better outcomes – potential for cost/resource savings
	Common language of adversity and trauma across agencies – enhanced collaborative working and 'collective responsibility' – more effective intervention
	Fewer restraints and separations in custody
	Improved de-escalation and recovery practices, including the creation individualised support plans
	Reduced staff sickness
	Improved staff retention
	Lower numbers of children going to court
	Fewer convictions
	Lower number of children entering custody
Staff	Staff motivation to make a positive difference in children's lives
	Staff feeling valued and included
	Staff (including unqualified staff) feeling more confident that their contribution and opinion matters
	Purposeful and focused practice/intervention
	Enhanced attention to staff wellbeing and vicarious trauma within organisation (e.g. trauma informed supervision; support following death of child)
	Enhanced staff self-awareness (re. triggers/stress) and confidence to reach for support
Child and family	Enhanced family/network engagement and relationships
	Child connected back into education, training, employment and wider community
	Better relationships between staff and young people (and their families)
	Child feeling heard and valued
	Improved child mental health and wellbeing (short term)
	More positive long term life chance due to (earlier) CJS diversion

Organisational Outcomes and Perceived Benefits

While resulting in improved service provision for all, senior managers believed that a TIA was particularly useful with *children who presented with greater complexity of need* or who engaged in more persistent offending behavior. For such children, a TIA was thought to offer more 'meaningful' intervention and better outcomes. It was also noted that working with complex cases was expensive in terms of resource and long-term involvement:

"I mean it's relevant to a large percentage of our population. I wouldn't say it's relevant to all... we do get some kids that [offending behaviour] is just experimental, or they've made a silly mistake or whatever. But the chaotic and complex kids, the prolific and persistent offenders. Yeah, that's really relevant to them. And I suppose they're the population that we spend the biggest resource on and work with the longest. So in terms of really ensuring our interventions are appropriate, we're making a meaningful difference, to have better outcomes for those children then, yes, definitely."
(Staff Management Focus Group)

Focus group participants frequently mentioned how the knowledge of ACEs and trauma had provided a common 'language' between services. For the YJA, this had led to more child advocacy with interfacing services in order to consider different ways of understanding child presentations and how to intervene (please see above for further detail). This common language was believed to have resulted in *improved interagency collaboration, instilling a 'collective responsibility'* for ensuring services worked together in the best interest of the child:

"So... all this has started to kind of dovetail at the same time because people were making the connections, because the good bit for me around the language of ACE and the language of trauma, is it creates commonality. So when you're going into meetings, and Trust staff or Education Welfare Officers or whoever... are now understanding the language, then it's easier then to kind of funnel in resources and have, I suppose, the conversations that you need to have rather than us all using different terms. It created a collective responsibility in my view, which made our job a lot easier in terms of not just how we develop trauma informed practice internally, but how we promote [it]... how we push that externally... our staff are brilliant at. They really are. It's part of their core work."
(Senior Management Focus Group)

In custody, focus group participants spoke of *decreased use of physical restraint and separations,* with noted improvements in *staff ability to de-escalate situations* before crisis-point and promote re-integration. Improvements in helping children 'process' a crisis, either before or after an event, were reported as preventative measures, with efforts made to tailor support plans to the individual child:

"... in custody, (...) we also obviously have to deal with conflict and behaviour, (...) there are times where we have to put hands on young people as a last resort for physical restraint (...) and certainly staff have got better understanding and diffusion, before it gets to that element of absolute crisis. So I would say for us, the benefits that we can see is... the relationship between staff and young people is better in regards to helping them process that crisis, and not flip over into violence or aggression. So our numbers in physical restraints and single separations have greatly reduced. Also, (...) once a child goes into the room, we're always trying to say how quickly can we get you out of your room. (...) So it's about being able to write a support plan that understands you as an individual and what you actually need, where beforehand, we probably would have just been very generic."
(Senior Manager Focus Group)

In community settings, senior staff spoke of reduced staff illness and improved retention (as key organisational outcomes being targeted):

"In the community, the focus is slightly different... so one of the easier outcomes in terms of staffing is reduced staff sickness, and people are feeling valued..., so that is something... we are looking at and monitoring. And retention, ... that we're retaining staff."
(Staff Management Focus Group)

As noted above, participants spoke of enhanced efforts toward early intervention with children and families as a means to divert away from the CJS where possible (please see section above). Organisational outcomes mentioned by focus group participants aligned with this practice included *lower numbers of children going to court, fewer convictions and lower numbers entering custody.* All of these reductions were thought to have a beneficial impact on children's longer-term outcomes across the life course.

Staff Outcomes and Perceived Benefits

The embedding of trauma informed principles and practice in the work of the YJA was thought to have a range of benefits for staff practice, and indeed for staff themselves. As previously outlined, trauma informed principles were reported to 'make sense' to frontline staff (across the organisational hierarchy). Thus, the TIA training and language provided a framework that helped affirm the purpose and importance of their everyday practice, including that 'small things matter'. In this way, it was thought that TIA implementation efforts had the impact of keeping *practice purposeful and focused.*

Improved staff motivation was thought of as a corollary of TIA training and implementation, helping affirm the importance of the staff member in the child's life and the opportunity to make a positive difference over the life course:

"...the first mitigating factor about, you know, young people benefiting from a stable, caring adult relationship, I think that in itself... really kind of helped to remind and reinvigorate people that, you know, you can actually make a difference with these young people, whether you're with them for one session, (...) or whether you're with them for six sessions, (...) whether you're working with them for three months, six months or 12 months, you know, whatever the time frame, you do have an opportunity, you know, to be a positive influence, to give them a sense of hope and destiny, to point them the right direction, to connect them with other things in the community.... [it's]... an easy win for us."
(Staff Focus Group)

Staff confidence, inclusion and feelings of being valued were also perceived benefits reported by focus group participants. This was particularly stressed given the range of staff working in community and custodial settings, with unqualified staff sometimes having the most direct everyday contact with a child and their family:

"Yeah, I find... it nearly generates... and gives a voice to people (...) qualified workers and unqualified workers. So everybody's opinion and voice and experience of working with that child... you know, their story was heard, or their evidence of, you know, their interaction with that child or what they thought ... accepted. So I personally feel that a lot of the unqualified staff in custody have now started to realize 'Oh, right. Well, my professional opinion about how that child should be supported, is now being taken fully into account.' (...) it's encouraged staff to become more... maybe confident in actually expressing, you know, their experience and their knowledge, do you know?"
(Senior Management Focus Group)

Enhanced attention to staff wellbeing, including the impact of the work on the worker and knowledge of vicarious trauma, was a perceived benefit across focus groups. As described above, a range of initiatives had been developed to take this area forward within the Agency including trauma-informed supervision training and the development of practice guidance and support for staff in the aftermath of the death of a child. These important developments were noted as still in progress with more work required:

"And when [death of a child] has happened, and I suppose it also raised the whole understanding of vicarious trauma for staff, working with young people over periods of time too, and whilst I would like to see a slot in supervision, specifically to discuss trauma-related issues and on how that may affect yourself as a staff member, I know the training's ongoing and that's hopefully a future development."
(Staff Focus Group)

As part of this focus on staff wellbeing, some participants reported an enhanced self-awareness of their own triggers and stress, and confidence in reaching out for support from management:

"Even as a practitioner, and on a personal level, I have been through the training and through even delivering the training… I've been able to even identify my own triggers and identify when I am stressed, and see that in myself…. And also being confident enough to have that conversation with my manager. Say I'm struggling a bit here, I just need to do this or I need a bit of support here and on a personal level, I definitely have seen the benefit to it."
(Staff Focus Group)

Child Outcomes and Perceived Benefits

A range of child and family outcomes and perceived/anticipated benefits, associated with TIA implementation, were mentioned during focus group discussions. These encompassed different aspects of *child and family wellbeing in the short and longer-term.* Senior management participants noted the four domains that were considered important in assisting children recover from childhood adversity, i.e., stable relationships; feeling connected; feeling heard; and mental health/resilience. Participants reported that the YJA regularly carry out service user surveys, which provide insight into child and family experiences and perspectives, and what was important for them. It was argued, however, that outcome measurement is an area of ongoing work in order to evidence change in addressing assessed child need across different domains, with some benefits noted as 'hard to capture':

"…if [the children] feel their needs have been met. So we haven't perfected this yet, this is a work in progress, because we've rolled out our new needs assessment. It's about how we measure what impact that has had. (…) there's like 6 different domains, … we're working with our statistician (…), so that we can use that as a measurement tool to show that when a child's discharged, there's been a change in, you know, their socio-economic needs or whatever it is, their mental health, or their family or whatever. So… we're just developing it. As you know, (…) that kind of work is really hard to kind of capture. So… it's a work in progress, but… it's not to say we haven't thought about it."
(Senior Management Focus Group)

Staff participants reported how their practice had always been focused around *building relationships with the children and their families.* This was seen as a way to offer 'help and support' for the rest of their lives, rather than simply concentrating on the crime itself:

"Young people and families have always given a very positive view of the experience of how we work with them, because it's always been about relationship (…) it's not just been about the crime they've committed, it's been about trying to help and support them in the rest of their lives."
(Staff Focus Group)

However, in spite of this focus on relationship-building existing before TIA implementation, *improved family and network engagement,* enhanced staff-family relationships and increased family support were identified as benefits across focus groups, thought to be evidenced in survey responses. Staff participants reported the increased importance given to engagement with family members and significant others, in the knowledge that YJA involvement in the child's life would end at some point:

"Our outcomes in terms of family work and the surveys that we do… people give feedback in terms of the contribution they think Youth Justice staff have made in relation to their families, so we have that."
(Senior Management Focus Group)

"[discussing one available adult]... Is that their aunt? Is it a sports coach? Is it a teacher in school? (...) who is that person, who they can go to and be encouraged to get help and support from, you know, when we are finished."
(Staff Focus Group)

Alongside this resourcing of children's relational network, participants across staff and senior management focus groups reported enhanced efforts in helping children and young people to 'feel connected' by *building their community connections* and helping them engage or re-engage with education, training and employment:

"... feeling connected, so linking [young people] back into education, training and employment, linking them back into their community, and again... we're in the process of measuring our outcomes around that."
(Senior Management Focus Group)

Other child-centred benefits and outcomes reported, included *children 'feeling heard' and 'valued'* and improved relationships between staff, children and families, picked up in service-user surveys:

"Most of the staff have bought into [TIA], and can see the benefits, not only for our young people, but for their relationships with the young people, as well, and also with the families"
(Staff Focus Group)

Improvement in *child mental health and wellbeing* was an important child outcome area. Senior management noted how the co-location of CAMHS workers within the Agency was assisting in bringing greater attention to evidencing short term outcomes in this regard:

"...[child] mental health, building resilience, key outcome, ... we're doing that through the rolling out of the CAMHS partnership, but we do have data from our CAMHS co-located worker that has shown that kids who were referred into our service really have a positive experience, ... they're able to be discharged and not... re-referred back into the service, so there's positives around that."
(Senior Management Focus Group)

Longer-term child wellbeing outcomes were thought to be evidenced by the lower numbers of children going to court and custodial sentences. This was associated with the early intervention and CJS diversion work undertaken, which were understood to enhance children's life chances.

It is of note that participants reported *no disadvantages* to trauma-informed working in their agency context. The only noted tensions were working with staff challenges and ensuring victims also received a trauma-informed service.

5.3.4 Enablers, Barriers and Challenges

Across the YJA focus groups, participants discussed a range of factors that were identified as having facilitated or impeded TIA implementation. While some of these have already been mentioned in previous sections, others are expanded here. Please see Table 2.3 for a summary.

Enablers

Key external factors which assisted progress included the *strategic driver* provided by the SBNI imprimatur to progress TIA implementation:

"One of the real enablers was SBNI… taking it forward as one of their key areas, cause then that also gave us license to say 'we're a member of SBNI, this is a key theme, we're involved in the reference group. We need to look at this.'… with [SBNI] pushing for it to go on the Programme for Government, conversations were happening at a strategic level."
(Senior Management Focus Group)

Staff noted *whole-organisation implementation* as an important factor in successful TIA implementation in the Agency itself. However, they were also critically conscious of the strategic nature of development across interfacing services, such as policing and the Public Prosecution Service, without which diversionary efforts could not have progressed:

"It seems to have been a project that has been whole agency. It's been custody. It's been community. It's been staff on the ground, but it's also been from a senior management level as well, from the very outset… and that's why some of those bigger pieces (…) why early stage diversion has been pushed forward. (…) discussions have been had with the police and the PPS [Public Prosecution Service] to allow early stage diversion to push forward. It's because it's been pushed forward at a strategic level and from the ground… the whole, the whole place, it's like a whole agency thing."
(Staff Focus Group)

Table 5.3: YJA Enablers, Barriers and Challenges

Enablers	Barriers & Challenges
Strategic imprimatur with set up of regional ACE Reference Group & SBNI TIP project	Not having senior leadership support
Common language and goals across YJA (community & custody) & partner agencies	External agencies being at 'different places' on TIA journey
Senior leadership – support from the very top	Senior leaders (in own & interfacing organisations) 'move on' or retire
Forums that allow senior managers to reflect together & facilitate whole-system planning	Individual nature of the judiciary – retribution/ punishment model still apparent
Implementation plan – also allowing things to develop	COVID pandemic – 'everything stopped' – loss of momentum
Implementation planning support from SBNI TIP project & other organisations	Staff in 'different places' with TIP
Developing a whole system vision – enthusiasm & 'thinking big'	Some staff resistance to reflective practice
TIA leadership & modelling across the system (incl. champions in each area) – drive and enthusiasm	Applying TIA principles to challenging staff situations
Workforce training (external and quality) and follow up (not one off)	Organisational 'red tape' – slowness of response to staff challenges & accessing staff support
Workforce development budget	Attending to the victim needs though trauma-informed lens (as well as offender)
Joint custody & community training coming together) – learning with and from each other	
Follow up initiatives to cascade, affirm & promote further development	
Staff involvement from outset – all levels of staff – staff buy-in & practice relevance	
Investment in promoting staff wellbeing and motivation – feeling valued & included	
Workforce support & wellbeing initiatives – e.g. developing TI supervision	

This whole-system implementation, aligned with parallel developments in other agencies, was identified as a critical factor toward successful staff engagement with a *'common language, goal and intent'* expressed across community and custody services. The fact that TIA principles aligned well with previous practice and 'made sense' to staff was also thought to 'breathe life' into the implementation process:

"A common language and a common theme across the agency has been useful. You know, going back 20 years, custody was a separate thing. Community was a separate thing and youth conferencing was a separate thing. And at times, one of the three strands might have been promoting something or two of them might have been promoting something or, you know, three of them might have been promoting something in a slightly different way. (...) but I certainly feel that the whole trauma informed piece, there has been a commonality of language, goal, and intent, ... across all of the agency, and that is, you know, probably what has kind of helped breathe life into it as well, as well as the fact that it makes sense to everybody. You know, there are very few people would kind of fight against it because, you know, it does make sense to us."
(Staff Focus Group)

As a result of these coordinated efforts and parallel changes in other agencies, focus group participants believed that the implementation of TIAs within the YJA appeared to offer the *potential for longer-term impact,* as it was no longer considered just a 'flavour of the month' agenda, but rather a long-term Agency commitment:

"I think it's something that will continue to build and, you know, as it rolls out into the other agencies, like I have noticed the difference with regards to the police. So as it rolls out, you know with other agencies becoming more aware... (...) definitely I can see that's growing, it's not something that's just going to go away."
(Staff Focus Group)

Senior leadership support for TIA implementation was identified as a key enabler or barrier, dependent upon its availability. The senior manager group noted the critical importance of the support from the Chief Executive as the 'biggest enabler'. Without this most senior level of support, even TIA leaders, often very senior managers themselves, noted the limitations to what could be achieved and feelings of isolation:

"... [the Chief Executive] really got it and really has enabled us to just flourish. (...) in my view that is the biggest enabler. You need support from your most senior level. If you don't have that... (...) it would be very difficult for anybody in an organisation to roll out a trauma informed agenda, if they didn't have that."
(Senior Management Focus Group)

With support from 'the top', TIA leaders reported how time was made in senior manager team meetings to think about TIA implementation across core service areas, with developments 'mushrooming' as a result:

"We have a senior management meeting, it's called Thinking Time, which is all the senior managers from custody and community, and [the CEO] would table trauma informed practice. We have conversations about it... That was just like fresh air and as a result of that, the development of the project just mushroomed across all our kind of core areas and model our practice."
(Senior Management Focus Group)

The TIA leadership team were acknowledged by staff as needing to display great 'passion' and 'drive' which acted as a source of motivation for everyone:

"Well, the reason the whole project was driven forward, it's because there was somebody who had a keen passion and interest to drive it forward. (...) if you don't have somebody at senior level driving the thing forward, then, you know, nothing would happen."
(Staff Focus Group)

The leadership team themselves highlighted the importance of the collegiate support from each other in helping them to keep 'pushing' forward despite hurdles. They also spoke of the need to 'model' the approach with staff, even in challenging circumstances.

In addition to leadership, *implementation planning* was needed to progress TIA and create 'the nuts and bolts of a five-year plan and a strategy', while enabling developments to organically grow as progression evolved. Developing a *whole-system vision* and 'thinking big' was noted as critical by the YJA TIA leadership team who used the analogy of steering a 'big boat' when speaking of their TIA implementation trajectory:

"When we started the journey back in 2018 (...) our vision was a big boat. I can still see it... we probably had stickies everywhere and we thought really big because we're enthusiastic... we're doers and we get stuff done and we've loads of ideas."
(Senior Management Focus Group)

Some of the *practical support and training,* provided by connections with the SBNI TIP project and other organisations, was credited as providing an important resource in developing the TIA initiative. The TIA leadership team described the need to *'start somewhere'*, and how universal training such as the Resilience video (which emerged from the original US ACE study) and SBNI ACEs training had been 'rolled out' across the whole agency, from Board members to domestics:

"The [Resilience video] really sets the scene... so that was rolled out to everybody from domestic, staff drivers, right through to the chief executive and the board members at that time. Jumping forward, and how we started really was rolling out the SBNI training, we needed to start somewhere. So that was the starting point."
(Senior Leaders Focus Group)

This was followed by using the SAMHSA TIC domains as key principles and discussions at a leadership level to *determine the change agenda:*

"And then from that [starting point], we had separate conversations around what we needed to look at. We used the SAMHSA domains, as you'll see through our implementation plan. We took them as the kind of key principles, and then [the TIP leadership group] would have had conversations around what we feel needed to be developed... or change."
(Senior Leaders Focus Group)

As well as the use of the SAMHSA domains as part of the initial planning process, the TIP leadership group spoke of using the pathway mapping activity articulated in the Sequential-Intercept Model (SIM) (see Mooney et al., 2019 & 2024). This activity invites service providers to consider the child's pathway through the criminal justice system (CJS), noting important transition points, where there might exist opportunities for enhanced engagement and diversion out of the CJS where possible. Such pivotal transition points noted by the YJA TIP leadership team included children's entry into the CJS in NI, bringing a renewed focus to early intervention and diversion. Children leaving custody was also noted as a critical transition point for the YJA, affirmed by the international justice literature which refers to 're-entry' as a known time of heightened risk. 'Horizon scanning' was also reported by senior managers as essential to the TIA planning process ensuring that the leadership was continuously alert to new developments that required further attention. In the YJA's case, these areas for development included the needs of asylum seekers and unaccompanied children, as well as neurodiverse children and young people.

Implementation structures were also spoken of in the senior managers focus group as essential to consider in the early days of TIA implementation with the recognised need for different 'types of groups' with a focus on strategic planning and implementation respectively:

"If you go back to the outworkings of that [initial SBNI ACE] conference. I then was designated the lead around how we implement trauma informed practice in the agency by the Chief Executive at that time. So we decided that we needed two types of groups. We needed a strategic steering group and an implementation group."
(Senior Managers Focus Group)

Thus, a number of groups were established as part of the YJA TIA initiative, which were viewed as key enablers of the whole-system implementation process. These included the formation of a TIA Strategic Steering Group and a separate Implementation Group. Other structures and positions that emerged, as the TIA implementation journey progressed, included the establishment of designated trauma-informed champions and working groups in each area team, as well as the JJC.

As already noted, *workforce development and enhanced staff support* featured as key enablers of the implementation process with a wide range of universal and specialist trainings provided (see above for further information). *Joint training* was identified as a key factor in maximising the potential of such training, allowing staff to come together from different parts of the organisation to learn with and from each other:

"I think that's what you enjoyed the most probably, ... the fact that you were able to come together as a group from custody and from community, and actually really share a lot of shared experiences, and learn from each other ... you know, ... we look after the same kids but in a different type of context, in a different type of environment. (...) the feedback I got was very positive about that."
(Senior Management Focus Group)

Managers spoke, however, of the challenges of 'harnessing' staff motivation and maintaining 'momentum' following initial trainings, conscious that, despite training quality, staff response will inevitably be variable:

"The issue is keeping the staff momentum. ... as with every organisation with some staff who grasp this and are brilliant, and this is just innate to who they are. And then we've other staff members that we have to work with and support and develop, and that's what the challenge is."
(Senior Management Focus Group)

As a result, in addition to the various trainings themselves, a range of *follow-up support and communication strategies* were utilised to help embed and make relevant the main messages from group trainings. These included enhanced trauma-informed supervision and reflective practice, and monthly follow-up with external trainers:

"I'm part of that training...it's solely trauma informed supervision. It's very, very good and we're really enjoying it, and it's the agency's commitment ... there's going to be monthly updates around with [the trainer] as well. And if there's any issues and how we can support the staff team."
(Staff Focus Group)

Participants also spoke of the development of an online magazine to share good practice and celebrate staff achievements across community and custody settings, which practitioners from diverse contexts contributed to through case studies and small practice examples:

"So all staff have done the ACEs 1 and 2, but then through that working group, maybe once every six months, a sort of a magazine or an E-zine would have gone out... maybe promoting a certain type of trauma informed theme, or simply reminding people what the four key mitigating factors are for ACEs and how that links with people's day-to-day work... may be putting together case studies or examples of their everyday work... different people from different teams would have contributed towards it."
(Staff Focus Group)

Key themes would then be discussed at team meetings as a means to help people 'join the dots', thus keeping the main ideas alive in people's thinking and promoting the relevance of the learning for staff's everyday practice in different contexts:

"And then once the material was put together, it would have been well... in our area, promoted through team meetings, you know, so everybody would have been emailed it, but then at a team meeting, I would have maybe done a small input, just so that everybody's reminded, refreshed and encouraged... You're not trying to encourage people to do something that they weren't ever doing before. People have always been working in this way. It's maybe really just a slight reframing or encouraging people to sort of join the dots. Um... you know, say, look, you have been doing this... and encouraging them maybe to be a little bit more focused on it, through court reports and more focused on needs rather than risk of offending. I mean, that's just a kind of a general spin."
(Staff Focus Group)

Given that staff were recognised as the essential 'tools' for TIA progression, *staff involvement* in planning from the outset was also noted as an important enabler, helping promote *staff buy-in* and ensuring that the *relevance for frontline practitioners* was maintained:

"The whole agency or the whole team will be on a journey together from top to bottom, bottom to top, and it's not a something that's being done on to you."
(Staff Focus Group)

"From the initial onset, practitioners were involved, ground level workers were involved, and I think that was very important because it wasn't just sitting at a policy. (...) it was real and it was live for the people actually delivering the work."
(Staff Focus Group)

As part of this involvement, staff spoke of feeling 'trusted' and enabled by managers in their work with young people, and supported to pursue their training interests when relevant to the Agency goals:

"I suppose, it's management as well, (...) allowing and trusting that, you know, in how you work and the way you work. So if I went to a manager and say 'look, I need to work at the weekend because this young person needs... I get permission to do that, because she knows that I'm not going to suggest something like that, if it's not needed (...) So (...) my manager, you know, trusts me enough to make that decision and let me go ahead..., and I think for me that has made all the difference."
(Staff Focus Group)

Barriers and Challenges

However, a range of challenges to implementing a TIA approach to promoting staff wellbeing were also noted by senior managers. In the first instance, it was recognised that not all staff were ready or willing to engage in self-reflective practice:

"There's a culture of trying to get staff to be involved in that [reflective practice]. That's quite hard, do you know what I mean? Sometimes people don't necessarily, you know, want help, seek help, see that they need to reflect on that. So that's a whole big, you know, onward journey that we still have to try and embed and we need to get better at doing that as an Agency, I think, you know in regards to looking after staff's wellbeing."
(Senior Manager Focus Group)

Senior staff members also reflected upon the challenges of achieving consistency across the organisation when working with a 'difficult staff member'. In such circumstances, additional efforts were thought to be required to *apply trauma-informed principles to staff as well as service users.* This was reported as an area of ongoing development:

"I think the issue is... I suppose... staff wellbeing, some of our colleagues might see as an extra. They don't see it as lengthy trauma informed practice and a fundamental pillar. If we don't have staff who feel valued and respected and whatever, then they're not going to deliver the job that we need them to deliver. Now we are, I think, much better than other organisations in terms of offering health and wellbeing events and support and all the rest. But it's how that language is consistently applied, so that is more of a challenge, believe it or not, than some of the other stuff... applying trauma informed principles to staff. So if you have a difficult staff member, the language that the manager is using, or the senior managers are using about that staff member, instead of using the language of trauma. If you have a difficult staff member, I will be asking 'what is that about? Is there something they're dealing with? Did they need support?' But that's me. That might not necessarily follow through the whole of the agency... that's partly the reason we rolled out the trauma informed supervision, that's middle management, but that needs to go up to senior management as well. So we're very aware... of that, in terms of how we ensure, you know, that's 'Oh, that's something operational staff do'. No, it applies to everybody. So that would be an area that we would need to develop and look at."
(Senior Manager Focus Group)

Senior managers also spoke of their frustration with the *perceived 'red tape' and delays when dealing with challenging staffing issues or accessing timely staff support:*

"It gives [the children] that instant hope, and I think that's something that we have to do as... an agency, not just with our kids, but also with the staff... is that whenever something arises whether it's conflict or whatever the processes of dealing with stuff has to be acknowledged, accepted and dealt with quickly. And I think there's too much of all the red tape that goes on... some of the things, I suppose that really frustrate me about it is, that although we're here, staff support and wellbeing is all connected to HR [Human Resources]and welfare and all the rest of it. And if they're slow and I know the resource challenges that they have are immense, I appreciate that, but also... on down the line, that affects that member of staff or kid or whatever, because ... it's not good for me to say 'oh I hear what you're saying, um... come back to me in 4 weeks and sure we'll have a better conversation about it."
(Senior Manager Focus Group)

Other barriers or challenges to TIA implementation progress reported in focus group discussions related to *key partner agencies sometimes being at a 'different place'* on their TIA 'journey'. Influencing the judiciary was seen as another challenge, as individual judges can have very different approaches, with some still working from a traditional retributive, punishment model of justice. *Key personnel changes in partner agencies* could also present challenges with senior people 'moving on' or retiring, and progress becoming 'a bit higgledy piggledy' as a result. However, in spite of these challenges, senior leaders asserted that they do not 'give up', with problem solving a key element of their leadership work:

"And so that's a challenge… but that doesn't mean we stop. We still try to negotiate and influence and all the rest, so no, we don't give up. We realise that, we're a public sector organisation and we're always going to have to work within parameters, and it's (…) how we problem solve to overcome the obstacles."
(Senior Manager Focus Group)

One obstacle already navigated had been the *COVID pandemic* when 'everything in the whole world stopped', and implementation momentum had been lost.

An additional area of challenge (rather than barrier) commonly reported across focus groups was bringing a *trauma-informed focus on victim experience and public protection* in the context of serious offences, while simultaneously embracing a 'children first' philosophy when working with young people involved with the justice system:

"We have to keep asking where is the victims in all this process? (…) the tensions are between the 'child first' approach… the victim's needs, but also public protection…. (…) obviously there's going to be a push, pull in connection to that."
(Staff Focus Group)

Senior managers spoke of applying a trauma informed approach to address victims' needs, on occasion sourcing external therapeutic supports, arguing that victims were treated in the same way as other children and families. They noted the similarities in many of the victims who access the YJA restorative justice process, with many victims also young themselves:

"…in terms of our restorative justice practice, that is a core component, because it's the same staff who are working with the young people that are working with the victims and… quite a high percentage of our victims are young people themselves. So, we're working with some very similar young people. So there is a trauma focus in terms of how we work with victims. I mean, we do use our budgets at times to buy in bespoke, maybe counselling or art therapy or some service that's needed for a victim. So I wouldn't say victims are treated any differently. In fact, victims are treated the way that we would treat the young people and the families that we work with, they just, they just have a different label. The approach isn't any different in terms of how we support, engage and inform them of what we're doing."
(Senior Managers Focus Group)

5.3.5 Future Vision and Priorities

Staff wellbeing was reported as a key area for further development during focus group discussions. Both staff and managers spoke of their hopes for the development of **trauma informed supervision** across the organisation to further enhance the support available to the workforce. An additional area of immediate priority was to continue efforts to find ways to **understand, measure and evidence child outcomes,** following the introduction of the new assessment of need.

Senior managers also spoke of their interest in **increased staff involvement and feedback** as they move forward. They noted that, as an Agency, they were currently undertaking the detailed Trauma Informed Oregon staff survey. Their participation was seen as a means of ascertaining staff perspectives of TIA implementation to date, with consideration of areas where progress had been made, and areas that required further attention. Senior managers reported that they were approaching this with some trepidation. However, they were keen to involve staff in future planning discussions, and they wanted to understand what difference staff believed TIA implementation was making to take them to 'the next level' of development:

"We are nervous about that... because (...) staff feedback in surveys, I don't know, people use it as an opportunity to moan. We are bravely participating... we were really keen to push that, because we feel we need something now to kind of take us to the next level... we can map all this stuff, but let's sit now and look and say, well, 'we've done all this, what difference does it make?' and know where do we want to go next? driven by the staff who respond... I think it is a very powerful statement because staff are driving that, not us sitting in a room coming up with our great ideas on the flip chart, so... we'll see where that goes."

This focus on increased **staff involvement and future leadership** was evident in senior leaders' hopes that 'someone else would pick up mantle', as they moved forward into a different era of their TIA implementation 'journey'. They noted the need to ensure that the principles and practices were embedded throughout the organisation, and 'not reliant' on a small number of people:

"I would hope we've instilled the same passion for trauma informed practice and approach in staff, that if we leave tomorrow, there's somebody else to pick up the mantle... it doesn't stop with us. So it's about staff really getting a grip on that they're saying 'no, this can't be dropped and we want to continue this journey because we see value in it for ourselves and for young people'."
(Senior Managers Focus Group)

"I think that you always want to leave it in a better place than you found it. And you know, that's what you really hope... we want to get it to the stage where it's embedded enough (...) it's not reliant on... a handful of people to make it work or to drive it home."
(Senior Managers Focus Group)

5.3.6 Lessons learned

When asked what advice they had for other organisations wanting to progress TIA development in their agency setting, both staff and managers identified important factors associated with effective implementation.

One of the key messages from YJA senior managers was about **being 'tenacious' and 'not giving up'** on the vision, in the face of indifference or barriers. They noted that people, both senior management and frontline staff, can be at 'different places' in terms of TIAs, and they encouraged an acceptance of this. They argued that the strategic and staffing landscape can change as an initiative evolves, presenting new opportunities as well as challenges:

"So part of the journey, in terms of influencing others, is not having an expectation around that, and just continuing on with your vision, and we were lucky enough that we were able to continue on, and then the landscape changed ... So I think the learning was that you just don't give up. You just go on ahead. It would have been very easy for us at one point to go 'we'll just pack this in because nobody gives a frick about what we're doing'... but we've really come through the other side of that. So being tenacious."
(Senior Manager Focus Group)

Involving staff from the outset 'from top to bottom, bottom to top' was noted as an area of priority to ensure staff do not feel TIAs are not being imposed or 'done to them'. This was thought to engender an enhanced sense of 'team' with everyone 'working together' to make the changes, thus addressing any underlying staff 'reticence'. Such involvement would assist staff understanding that TIAs improve 'everybody's working practice', with the ultimate aim of improving children's life chances, and indeed the wider community:

"I think the notion that... the whole agency or the whole team will be on a journey together from top to bottom, bottom to top, and it's not a something that's being done on to you... (...) you know, [staff] reticence, you know, 'oh, your working practice is going to change'... it enhances everybody's working practice, but that has to be like 'we're all doing this together for better outcomes, for the people we work with, and the community... in general'."
(Staff Focus Group)

Aligned with this, TIA leaders were implored to **'listen to staff'**, as there are often 'reasons behind' staff resistance to particular initiatives. For instance, staff talked about a planned development that had been abandoned following staff feedback:

"... listen to the staff. If there's something that... you're trying to introduce that [staff] really don't want, understand, you know, why they don't want [it] (...) if staff are, you know, objecting to certain things, I suppose listen as to why that would be. It's not just because they don't want to do it. There's reasons behind it."
(Staff Focus Group)

While 'making a start' and 'taking the easy wins' were asserted as important mantras, **the pacing and evolving nature of development** was presented as a key area of transferable learning, expressed by the leadership team. Managers acknowledged that there was a need to make changes gradually, taking 'small bites', 'taking stock' and 'constantly revisiting' what has been learned, as implementation progressed. However, taking it 'slow and steady' was noted as easier said than done in a pressurised work environment, with leaders reporting how initially they had put themselves 'under pressure' to 'get it all done'. As previously stated, their collective leadership learning has been one of seeing TIA implementation in a whole organisation as a 'constant journey', which will continuously evolve. Invitations were given to build in mechanisms for review, build the leadership team, 'not to give yourself a hard time', 'trust the process', and 'enjoy' the challenge:

"I think... one of the things that we learned very quickly was... not to give yourself such a hard time and (...) realise, you know, small bites, you know what I mean? (...) there's not an end date, that's what I'm saying... I suppose we've been fortunate, we've had a good laugh, (...) Just enjoy it."
(Senior Management Focus Group)

"I think at the start we really put ourselves under pressure around, we have to do this and it has to be done .... And then we've realised that we're never going to get it all done. It's just going to continue to evolve and that's OK. And we're now comfortable with that, because we've realised the things that we have targeted have been the right things."
(Senior Management Focus Group)

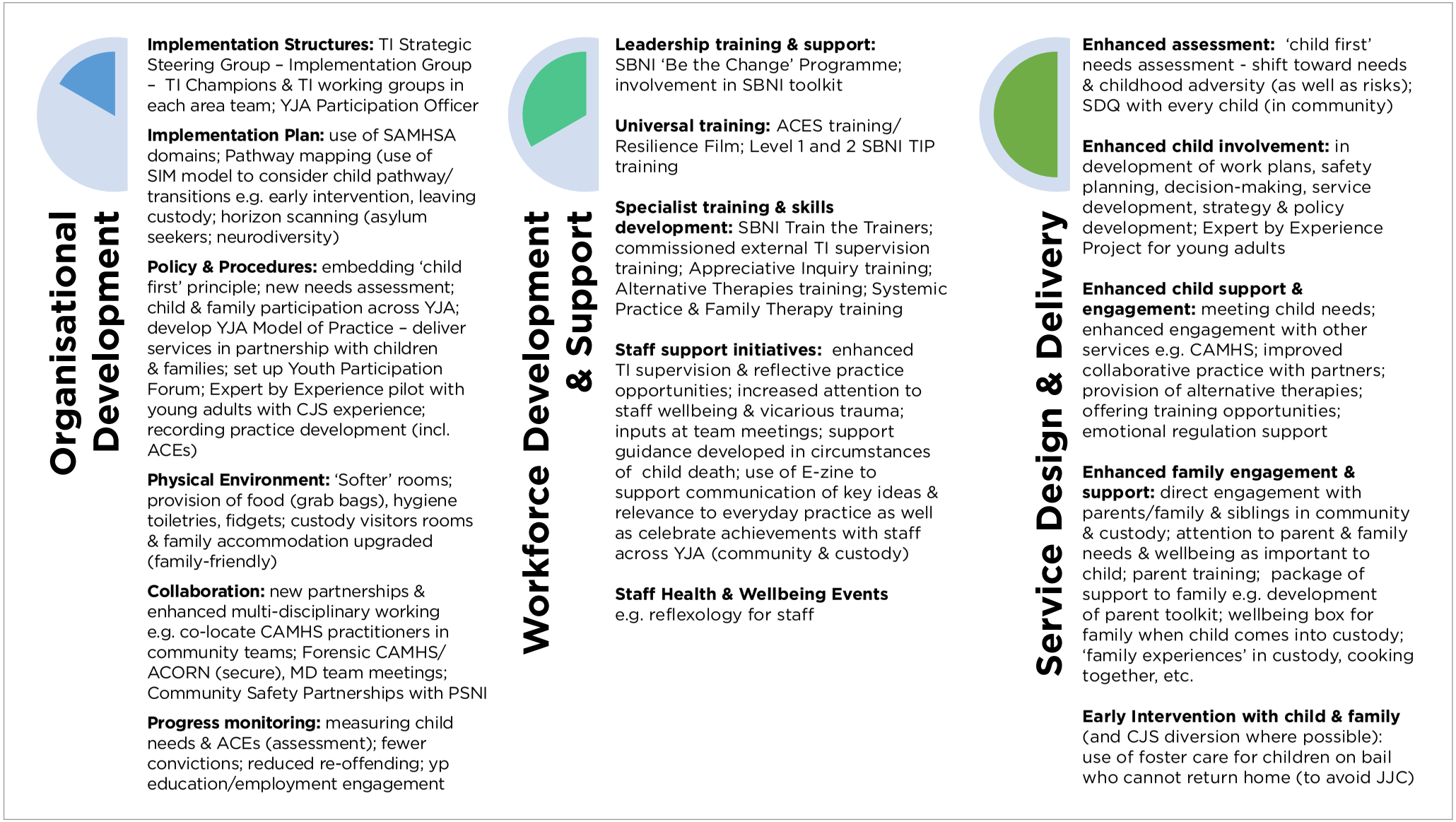
"...just slow and steady, (...) I suppose, at times (...) I was like, I don't know whether I've the energy to do this. So it is about slowing it right down and trusting the process and, you know, taking stock and just being calm about it."
(Senior Management Focus Group)

Finally, leaders highlighted the need to be open to their own **personal learning associated with trauma-informed leadership,** whereby they were required to 'model' the principles in their interactions with colleagues and staff, often in the context of challenging situations or discussions. Doing so was thought to promote the embedding of TIA underpinning principles in the organisation's culture:

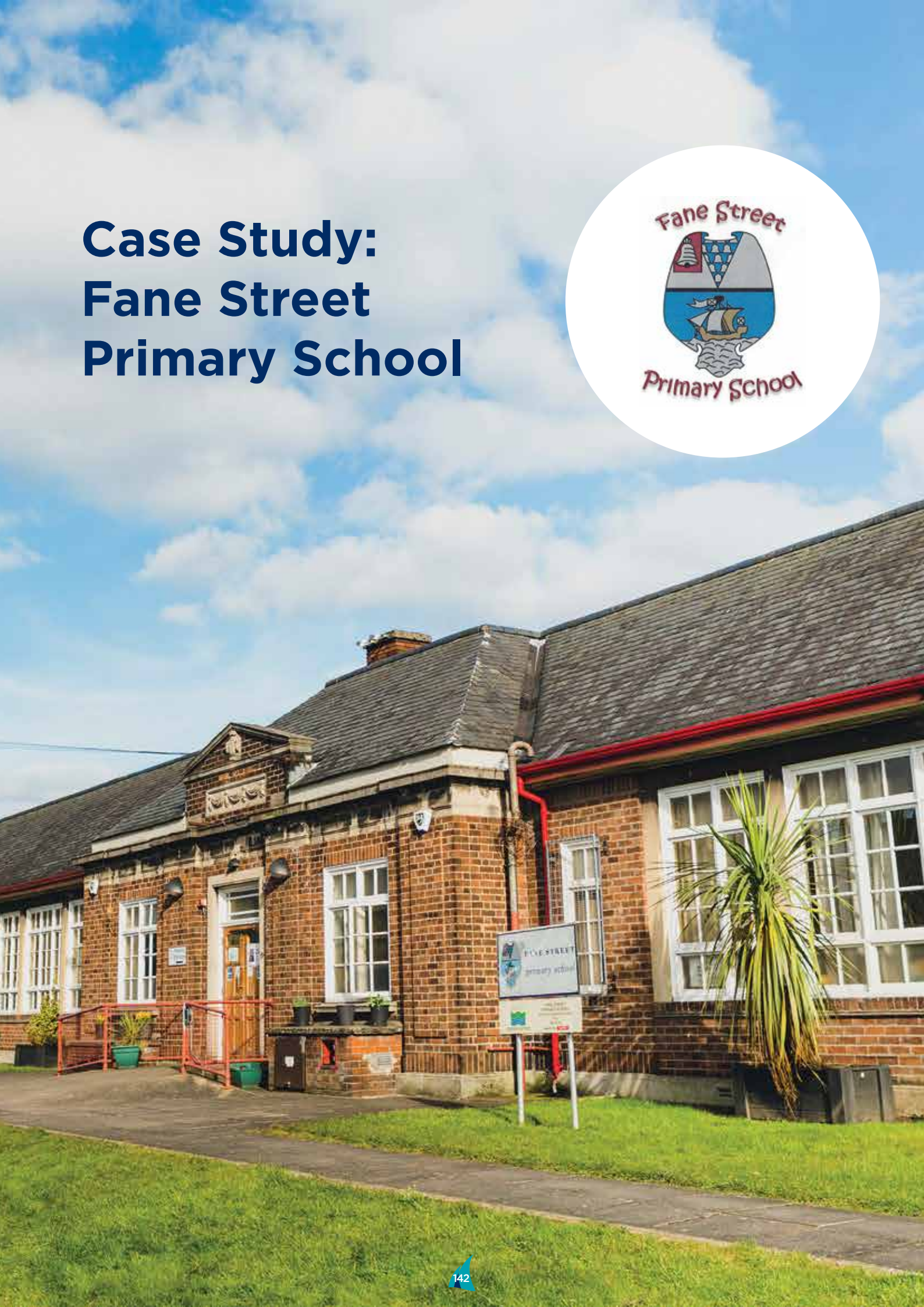
"One of the key things, which I always think stuck with me (...) and I've really tried to apply, has been us modelling the model and us being the change, even when it's been really hard to do so, and realising that every interaction is an intervention (...) But I think we have done that. And because we've done that, people have gone 'Oh, there's something in this' (...) so that has been a massive learning for me."

(Senior Management Focus Group)

Figure 5.2: Youth Justice Agency Trauma Informed Implementation



Case Study: Fane Street Primary School



5.4 Fane Street Primary School

5.4.1 The Context

Fane Street Primary School is a Controlled co-educational Primary School located between Donegal Avenue and the Lisburn Road in Belfast. The school originally opened in 1929 as a public elementary school, although it was a secondary school for a brief period in the 1960s and 1970s.

The pupil population has grown and changed over the years. In the early 2000s, pupils were primarily from a white working-class Protestant background (mainly from the Village area and also the Lisburn Road) with a small minority of Chinese children. Since 2008, however, the diversity of backgrounds has increased exponentially with children from a Muslim background now the main religion represented in the pupil population (see Table 2.1). At the same time, pupil turnover has gone from less than one per cent in 2008 to over 30 per cent in 2023 with families regularly arriving and leaving, sometimes at short notice, primarily due to their accommodation needs. These changes have brought both challenges and opportunities, as explained in the other sections.

Table 5.4: Fane Street Primary School Pupil Population 2008 and 2023 (as provided by Fane Street)

September 2008	September 2023
145 pupils	327 pupils
76% indigenous 14% EAL	10% indigenous 90% EAL
6 languages (including English)	42+ languages (including English)
Main religion: Protestant 55.1% Others: Roman Catholic 16.6% Muslim 7.6% No religion 1.3% Other Christian 0.7% Hindu 0.7%	Main religion: Muslim 31.5% Others: Protestant: 21.7% Roman Catholic 15.6% Other Christian 13.15% No religion 11.31% Hindu 5.5% Buddhist 0.92% Unclassified 0.31%
Refugee/ Asylum Seeker Population: 0%	Refugee/Asylum Seeker Population: 15%
Pupil Turnover: 0.8% in year (excluding Intake and Transition)	Pupil Turnover: 31% in year (excluding Intake and Transition)

5.4.2 Trauma-informed Initiatives

Figure 2.1 summarises the initiatives developed in Fane Street within the key three TIA implementation domains, i.e., organisational development, workforce development and support, and service delivery and practice change. Some initiatives are represented within more than one domain. For instance, a focus on restorative practices encompasses all three areas i.e. while seeking to respond differently to behavioural challenges in the classroom (practice change), a new policy was developed to move from a punishment-based to a restorative relationship-based approach (organisational development) with staff across the school provided with training and ongoing support to develop and implement these changes in their everyday work with children (workforce development and support). In this case study, we found three key trauma-informed approaches that permeated throughout the school: a restorative justice approach, a whole-family approach and a nurturing approach.

Nurturing approach

Fane Street Primary School clearly adopts a nurturing approach, which is embedded throughout the whole school and the way it works. This nurturing approach was noted as being rooted in the Principal's own personal ethos, summed up with this phrase:

"We're here to teach. And to me, you teach with care. You're caring for the children." (Principal)

The Principal explained how her own teaching experience and educational vision had aligned well with her introduction to TIP. This vision was represented by building what she called 'social credit' with the children, ensuring that they knew they were cared for:

"I suppose it came really from my own ethos over the years as a teacher. (...) I also taught in North Belfast for 13 years... (...) So I was aware of all those generational issues that are still there. So it was... always to me, it's always the social credit with the children that they actually know they're cared for. (...) it just came from my own personal beliefs that, you know, shouting at a child doesn't work (...) And the more I heard about the trauma informed practice, that's what we were kind of trying to implement anyway.."

This nurturing approach permeates all policies, practices and procedures in Fane Street PS, and is considered vital to the school's functioning. It involves adopting a caring mindset for all pupils and knowing each individual child. Although a key pillar of this approach is the fully functioning and staffed Nurture Room, called the 'Sunshine Room', the nurturing approach can be seen within the entire school, and is closely integrated with the restorative justice approach (explained in the next sub-section).

This nurturing approach starts at the beginning of each school day with **'check-ins' and 'meet and greet'**, when a small team of staff members is at the front door every morning to welcome all the pupils (and their families/caregivers). This 'meet and greet' team includes the nurture teacher, nurture assistant, the Principal and the SENCO teacher. This is considered 'a vital part' of the school day to help relieve children's worries, settling them in for the day. It gives staff the opportunity to detect any difficulties or issues, which can be subsequently passed on to the class teacher. Class teachers reported that they valued this daily information-sharing, which facilitates them to be more attentive to the children that need it on a particular day and are better equipped to understand their behaviours. It was noted that this daily practice is especially important for particular children who are thought to need this additional re-assurance at the start of the school day:

"We meet and greet in the mornings to make sure that the children know that they've been noticed on the way in, and they can actually just do a quick check in with [the nurture staff] first thing in the morning. And if you don't speak to those children, they're looking at you, why have you not spoken to me, you know? And even if they don't answer you, they're still looking for that little check-in in the morning."
(Principal)

"I would be part of the meet and greet in the mornings and I find that it's a vital part of starting our day with the children, you get to see the children as they come in and you know the different wee moods, and maybe if something's not right at home (...) especially children, who would be known to say the nurture room or known just to the teacher, that they maybe have different backgrounds, different home lives, and we can get a chat with them, you know, just good morning or if they give you a hug, they approach us, and sometimes they just need a hug in the morning to start their day. But it's very much that starts them off for the day and we can then go and speak to the teacher and say, 'X has come into school today. They're not feeling... Mum has spoken to me or dad or whoever the carer is at home...' And you know, the day starts and we're always on the lookout for them, you know, from the get-go, from the minute they walk in the doors of school."
(Nurture Assistant)

'Check-ins' for particular children are also conducted after lunch, as this might be particularly important when medications wear off, and children become tired, etc.:

"We've got check-ins for children straight after lunchtime because that can be a flashpoint for children."
(Nurture Teacher)

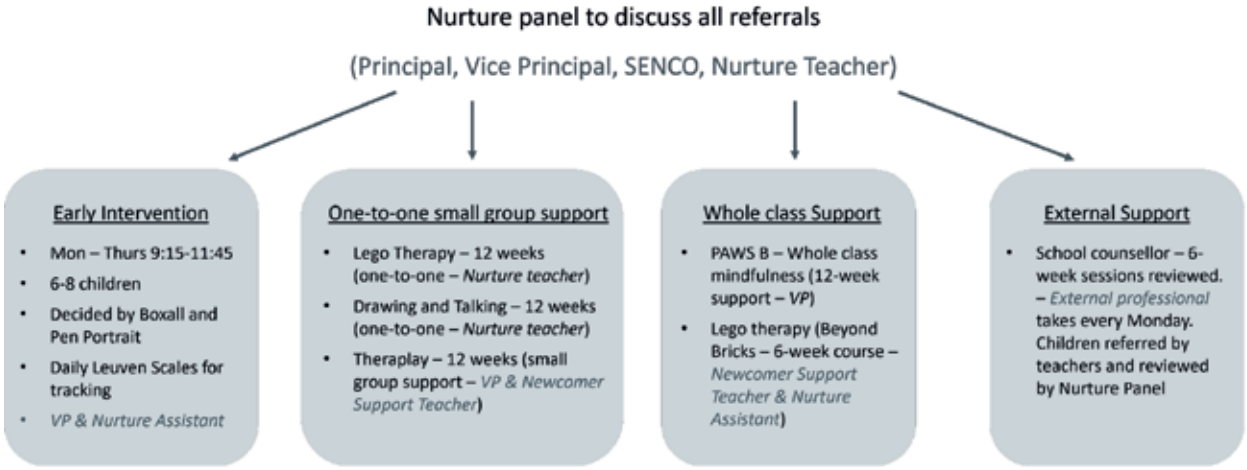
As already mentioned, one of the key elements of this approach is **the Nurture Unit itself**, which is staffed by a dedicated nurture teacher and assistant, who work closely together to provide care for children who need it. This unit was self-funded by the school, as they did not automatically qualify for one, supplemented by the use of the extra funds they get for newcomer children, as explained below:

"Over the years, as we got more newcomer children, more traumatised children, I suppose we started to look and say, well look, other schools are getting nurture. Why are we not getting nurture? And we sat down Monday and thought and chatted about it, and just went through it all. (...) because we were getting the newcomer support money, I wanted to put it into teaching English to the children, because that's what it's for. But I also wanted to address the issues that they had as well. So that was where the nurture teacher came from, and I didn't want to do it half-heartedly. I wanted to do it properly. I wanted to do it the way that it's meant to be done."
(Principal)

In the nurture room or 'Sunshine room', there is a full timetable for a specific group of children in the morning and one-to-one therapeutic work in the afternoons, with inputs tailored to meet the needs of individual children:

"We've got early intervention, which is run like a full timetable nurture environment for... we've seven children at the moment (...). That's from Monday to Thursday, up to lunchtime (...) And then in the afternoon, I do one-to-one work as well with selected children. They may be children that have been with myself in the early intervention. We then do theraplay, drawing and talking, Lego therapy. So selected children that are struggling for whatever reason really get a lot of care and support. You know, and we don't take them out of the nurture sphere or nurture umbrella until we're really, really happy that the child is settled and can cope. And that could be going from early intervention, full timetable to one-on-one support or even just to check in on a daily or weekly basis."
(Nurture Teacher)

Figure 2.1: Fane Street Nurture Support Provision Map (provided by the Principal)



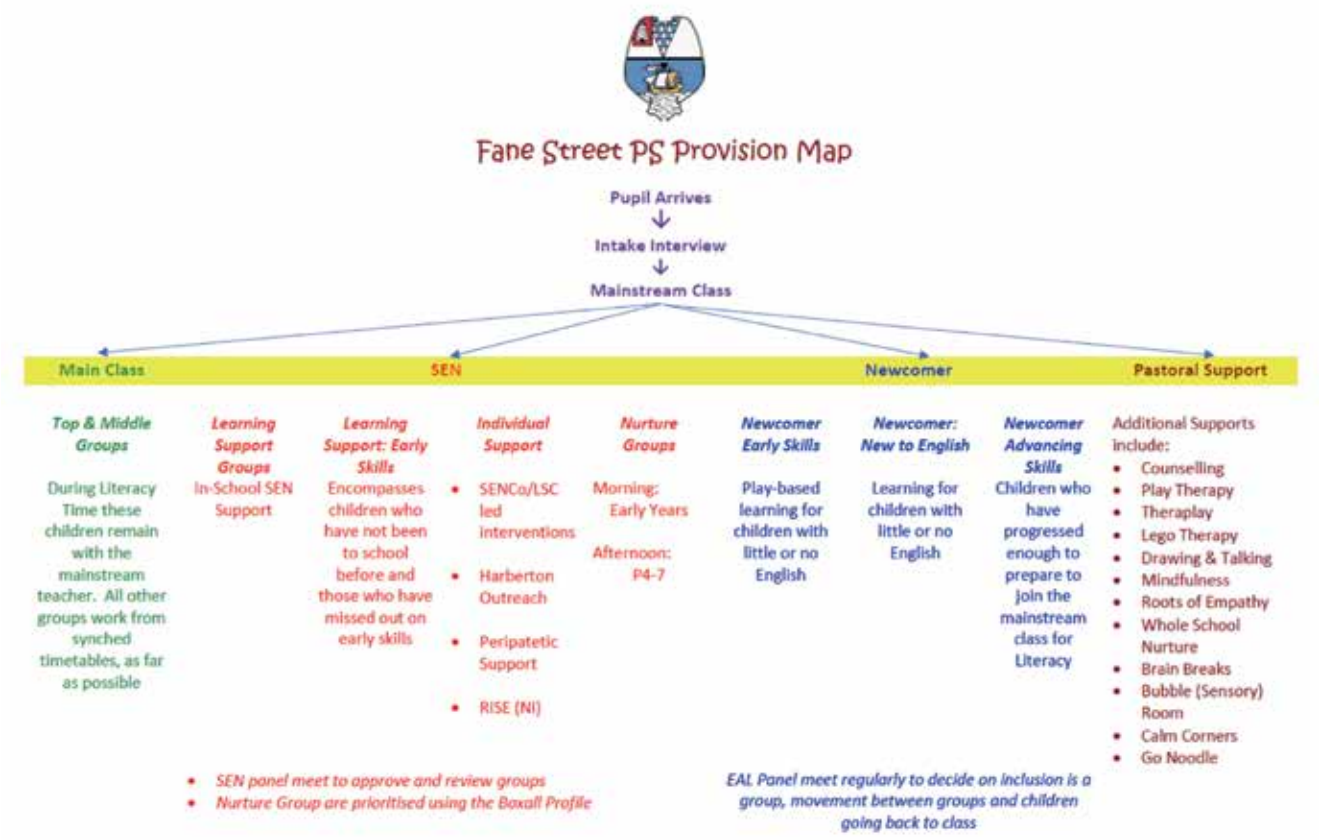
Staff, however, recognise that children's needs and situations change, thus, the children who have check-ins or who are in the Nurture Unit for the morning timetable also come and go. In other words, the school uses a flexible approach based on need, adapting to those constant changes (see Figure 2.1). This approach is thought to work well, in part, because of the effective communication and collaboration between staff in the school. Nurture panel meetings are regularly set up by the nurture teacher with the Principal to discuss the needs of individual children. Teachers are also encouraged to talk with the nurture teacher if they have concerns about any particular child to see if they require individual support. In this way, the **nurturing approach is extended to all children in the school**, with additional supports put in place or eased out when no longer required:

"So it's selected children there, (...) I think what's so important is clarity and communication with the teachers and your team and your staff, because we have an open door in the Sunshine Room, so that after school, any teacher can come and talk to me about any child. So (...) we may have children whose situation changes, whose life changes (...) we've got to be really open to those changes. And it comes from great communication because teachers will come to me about children and say, 'they're really struggling because of XYZ.' So the first thing we look at is, When are they struggling? Why are they struggling? What are the issues? If it's a child that's struggling in the afternoons, and I can think of one child we have, that's on medication that runs out in his system around lunchtime. (...) he comes to me de-stress, we'll play a game (...) or something calming, and that sets him up for the remaining 45 minutes. So no, it's not just a specific list of children, it's on a need-by-need basis. And those needs can change, check-ins can change, because (...) if children are coping really, really well, then we'll start taking really slowly provision away, because the children need independence as well. So there's one lad I think I've had that has been with me from P1 and he's now P5, and(...) he's gone full early intervention. Then he's gone check-in morning and afternoon, then he's gone check-in just afternoon, and now he's on a check-in only on a Monday. But he's still there. I'm still checking on him, making sure he's alright."
(Nurture Teacher)

This tailored approach, which originally came about due to the increasing enrolment of newcomer children, has been extended this year with three specialist non-classroom-based teachers to support children with a range of additional needs (see Figure 2.2 below):

"We get extra money for the newcomer children that we have (...) and because we've such a high number, we thought, right, how are we going to use this money best for the children that it's aimed at? So initially we started off by having extra support where the children were out of class. So we have a really comprehensive system now. This year is our first year of having three teachers who work outside the class to work with the children. So we've children who need a play-based approach. We have children who are new to English but don't need as much play. And then we have children who are preparing to go back to the mainstream class. So that covers their education."
(Principal)

Figure 5.4: Fane Street PS Provision Map (Provided by the Principal)



This tailored approach is important because, as well as recognising the fluid nature of children's needs and situations, the leadership in the school also recognises the diversity of the pupil population the school provides for. Thus, although many of their pupils are generally identified as 'newcomers', the term 'newcomer' can be problematic, as it masks the great diversity of this group of children:

"We have newcomer families that are coming in that are professionals, we've newcomers coming in (...) that are living in hotels, you know, the term newcomer does not do it to justice. There are newcomer children who come in that we can tell straight away... they've got zero English, but we know the place for this child, if they choose to do so, you know, they can push on, they can go to [names of grammar schools] and whatever they want to do. We know that they're coming, and they've got real potential there, or whatever else it might be. We know others are going to have to be um... (...) it's meeting where they're at, giving them what they need in order to then help them make the next step. But it's being ready to make that difference from the word go."
(Vice-Principal)

Another key element of the nurturing approach is that **children's achievements, both big and small, are celebrated** and rewarded. For instance, children 'graduate' from the Nurture Unit with a graduation ceremony, and a reward system has been developed around five key basic principles (listening, looking, speaking, thinking and concentrating), which allows for constant encouragement of small achievements tailored to build children's independence and self-confidence/self-worth/self-belief:

"We would celebrate the children that have been through the nurture room. You know, we would call them graduates of the nurture room. We celebrate their actual graduation ceremony. (...) That sort of sticks with them if you like. Everybody knows, you know, they've been through there. They've done that, you know, they're blossoming back in class. They're really giving it their best shot. It doesn't mean it's always a smooth road when they leave. Of course, it isn't. But (...) they've really shown that they're able to cope back in a full class environment, and maybe do just need that check-in once a week with [the nurture teacher] (...) they're very much looked up to by the other children. (...) what they've done is celebrated."
(Vice-Principal)

"We try and do something in the Sunshine Room called the 'Upward cycle of success'. So ... it's very different, you know, you can run your nurture room in any way that you want really. But the way I run it is based on five key principles of listening, looking, speaking, thinking and concentrating. And we have a reward system on a board. So as soon as they show me any one of those skills, I can put on a star on the board and make a big show of it. Now, we do have individual targets as well, but cause we've stripped it back to those five really, really basic skills is that a child who may have not been doing very well in class and really struggling to achieve what's been asked from them, or maybe from a home background where reading books and working together and praise is not forthcoming or has been around the world, have been in a refugee camp, and had to survive and not necessarily had lots of... you know, praise and enjoyment and experiences. We can really, really quickly build this child's confidence by saying, 'You looked at me. Well done. That's great looking. There's a star'. 'You spoke. You shared something, there is a star'. So from the moment that they come into the room, to the moment that they leave the room, they're being rewarded continuously."
(Nurture Teacher)

Recording and evaluating progress was also reported as important. An example of that was given by the nurture teacher, who explained how he records comments about positive changes from family at home, peers at school, etc. within a 'Statement of Impact' document for each child in the Nurture Unit as another means to celebrate a child's progress:

"Now, it's a bit difficult and it would be unrealistic for the whole school to do this, but I have a document I created called the 'Statements of Impact' because, as well as your Boxall profile* and your daily observations and daily movement scale, I wanted little statements. You hear these little titbits and little snippets from home, from in class, from outside in the playground. So each child in the nurture room with me has this document. And anytime I hear a positive comment from the time they've been with me, I just date it and put it in. It could be a link to an observation. It could be a phone call with the parent at home who's saying he now uses a knife and fork at home and never used to, now can go to bed at time, and that might seem insignificant on its own, but when I put it in the statements of impacts, we can see this lad in school is now playing with children outside, this lad in class is now doing his homework, this lad outside or at home (...) He's now using a knife and fork."
(Nurture Teacher)
* The Boxall Profile provides a framework for the assessment of children and young people's social, emotional and mental health development.

However, as previously said, this **nurturing environment is felt around the whole school** (not just within the Nurture Unit) Examples of how this approach is embedded in the school physical environment include:

- *Bells are turned off:*

"The child gets what the child needs, and you know, they see that. They hear that. They also won't hear certain things. They won't hear the bell going off. We've turned our bells off, you know."
(Vice-Principal)

- *Calm corners in every classroom:*

"In P1, even like my calm corner, I have sort of like pillows and blankets and stuff, and they just go and take themselves off, you know, they know that that's there for them. So actually, in P1, some of them will get quite tired, you know, they would take themselves off and get a pillow and the blanket around them and say '... night night' and, you know, 'read me a bedtime story' or, you know, things like that there. And they need that because for us, ... their needs need to be met first before they can even start doing any sort of learning"
(Teacher)

"(...) in the classroom, you can distinctively see where the Calm corner is and what way it's branded for each particular child, and you know, they just know. Like even if children do come into the Sunshine Room, which is our nurture room, when they've been sent down... and we just go, 'just go into our calm corner', and there's just (...) there's lots of pillows, we've a bubble tube. And it's just time for them just to get what... just rebalance, you know, their emotions."
(Nurture Assistant)

- *Images displayed* (to go with words) everywhere to enhance understanding (having in mind that a lot of the children do not speak English as their first language) (e.g. the Feelings thermometer displayed in every classroom):

"I think having really a language rich environment as well as, you know, the likes of images and things is very important for us too, because obviously we are 90% newcomer.
There's a vast range of languages and language abilities and things like that as well, so making sure that (...) giving them the language, teaching them the language, but also having pictures that go along with that. So they really know when they start to develop their emotional literacy um... can help as well."
(Teacher)

"We have the feelings thermometer, which is displayed in every classroom and you know, we can say to a child, 'where are you? how are you feeling?' And they can say 5 to 1 to 0, whatever feelings they have. And again, it's right throughout the school, so any teacher can pick up on it straight away, you know it's a language thing as well. Where are you on the thermometer? 1, 2, 3, 4, 5? Once you know they're getting to like 3-4, we need to then kick in with our 'how can we help you?"
(Nurture Assistant)

- *The 'Calm Corridor',* which was recently renamed with pupil participation during whole school assemblies:

"There's a particular corridor in school, this year we decided, right, what are we gonna do about this and, you know, it would have been one [corridor] that they would have ran down all the time. And, you know, you can only tell them so many times. Stop running. Please stop running. You can do the proximal praise. Well done. I love how you're walking, but the best thing we've done is actually just rename the corridor. This the Calm Corridor, and it's simply that's the expectation and it's working."
(Vice-Principal)

[talking about the calm corridor] "And with the trauma that these kids have, they don't like the loud noises. They really, really struggle with that. So... if that's what, I don't know, what a third of them need, then that's what we have to give them to make them feel safe in school. So it has to work. (...) I think with that particular idea, it came from the kids and ... well, initially from the teachers. But again... the pupil voice ... the whole school, we had a chat about it at assembly, whole school assembly. Then they went off and did little posters, you know, to really try to... [Nurture Assistant: empower] I was going to say advertise [Laughing] But that wasn't the word I was looking for. Advertise the calm corridor, and then again it's ownership from them. You know, and it's really giving them that power that allows them to kind of carry it out. And again, as [Teacher] says, then start to correct each other with that as well. And then, it just becomes the norm."
(Teacher)

The example of the calm corridor shows how children are also involved and given ownership of the practices and spaces in the school. Other examples of *pupil engagement* were also given by staff, including 'talk boxes' in every classroom and circle time:

"Well, the Student Council this year introduced 'talk boxes' and the talk boxes have been put in each classroom and the children can go and put in there a wee idea, anonymous or whatever way they choose (...) the teacher can read them and see what the children feel. And again, there's sometimes you might pick up on something in those boxes, unexpected, that a child is struggling, that you maybe don't see, but it's their way of letting us know they have the voice to tell their teacher."
(Nurture Assistant)

"I was going to mention circle time. I think given the kids, just a time in the week or in the day to be listened to and to put their opinions across is really important as well. And I know that we've had lots of ideas that have come out of our circle time in P7, which has been great because I think, just building that 10-15 minutes into the week even, even that short amount of time really has helped with pupil voice, and giving them just again the ownership over, you know, their experience in school."
(Teacher)

Finally, this caring, nurturing environment is not exclusively for pupils, but is also **evident in the way the School seeks to look after the staff.** Examples reported in focus groups included: staff team meetings; informal support; members of staff feeling listened to and supported by the Principal and Vice-Principal, who have a commitment to an 'open door' policy. This element is further discussed as a key TIA implementation enabler in the Barriers and Enablers section below.

Restorative practice

The nurturing approach is complemented by a restorative practice approach in relation to behaviour management. The combination of these two core approaches was described by the school leadership with the phrase **'high care, high boundaries'**. In the same way that achievements are acknowledged and rewarded, mistakes/negative behaviours are also acknowledged (rather than ignored), as a means to promote learning and have ambition for the children:

"Yes, we want to provide nurture for these children, but we also want the very, very best for these children. So if these children make a mistake, which I'm sure they will, you know, a social mistake, let's say, we give them a consequence. We give them a consequence with learning to say what could be done better next time. But we don't just gloss over and say, never mind, don't worry about it. We have a high boundary, and we say this is how you do better next time. (...) if they're particularly traumatised or they've had attachment issues at home, they need to know where they stand. So we have to set the high boundaries, and so many parents will say, 'oh, well, they've been through a lot of trauma' or 'yes, they've got some special needs' or 'he's autistic, he doesn't understand'. But if you don't set the high boundaries, how are the children ever going to learn?"
(Principal)

"That's the one, high care, high boundaries. It has to be high care, high boundaries and, you know, and there are high expectations with that as well. (...) We've done our job when they're able to tell us what choices they could make the next time. That's when we've done our job, well actually when they've actioned that, when they've been in a similar situation and made a good choice, and again we'll celebrate that, 'oh, you've made a great choice there', and it just happens naturally."
(Vice-Principal)

This approach, which was mentioned in both focus groups, is characterised by a key change of policy - from a behaviour management policy (punitive approach) to a **positive relationship-based policy**. According to one of the staff focus group participants, this change of policy has made a significant positive difference to the pupils in the school:

"Rather than the punitive approach that schools tend to take and still tend to take, which is unfortunate, we would actually do a review of what the children have done and chat through them and ask what has happened and say, you know what, what post-incident learning can we get from this? So... I use the PIL app, which is a post-incident learning app. Most of the other staff use paper copies."
(Principal)

"There's a very clear difference whenever we switched that policy from punishment-based to positive behaviour, there is no doubt that there was a huge, huge difference, in terms of the child's um... confidence, their self-esteem, you know, their learning process of all of that, emotional literacy and building upon that, giving them a voice, you know, all of that has been really, really beneficial."
(Teacher)

A key element of this approach is the lunch time practice led by the Vice Principal and the nurture teacher.

"We've got a restorative justice approach that myself and [name of Vice Principal] do during lunchtime, for if there's any problems outside, any arguments or conflicts, rather than a stand at the wall approach or a punitive approach, we bring the children in, and we we go through our restorative scripts to talk about what happened, how behaviours can change and look for ... each individual case as learning, you know, as someone, how they can learn. They can learn from the things that's happened."
(Nurture Teacher)

However, the lunchtime practices are just one element of this relationship-based approach. All staff are expected to adopt the approach, with training and additional support provided to see beyond children's behaviours and find ways to support them to heal relationship fractures:

"We've done quite a bit of training over the years. ... particularly with [name of trainer], who's really kind of big on trauma informed practice (...) ... one of the things that did come out of that was the restorative practice (...), if you know which child does display kind of negative behaviours, it's looking at where is that coming from and what's that telling us, but also not punishing the child for that, you know, really having natural consequences and really discussing and going deeper. Yeah, really trying to enrich the child to say, you know, 'OK, this has happened. What can we do now? what can we do to help you? What can we do to help restore the relationship between you and this other child, or whatever? you know, not just leaving them there or taking something off them, you know, really building that positive relationship, meeting them where they're at and helping them, you know, really modelling and helping them through what's going on. So I think that [training] has been has been great for us."
(Teacher)

Thus, negative or 'challenging' behaviours in the classroom are dealt with in a consistent manner throughout the school, albeit with the age and stage of each child taken into account. While older children were reported to be given time and space to calm down with a series of steps in place if the behaviours continued, for younger children, the teacher spent some of her time teaching about feelings and giving children options to deal with them (e.g. calm corner, puppets, talking with someone, using the feelings thermometer to communicate their feelings, etc.):

"if a child does this in class, then they go to a certain area within the class to calm down or you know, they're given options at that point, and then further on, if it keeps happening, then they get, they go out for a little chat to one of the senior members of staff, so (...) the vice principal. Um... then after that kind of timeout period where they've calmed down where, they've been, you know, chatted to, they'll come back into class. And if that re-occurs, then the same steps are taken, you know, and then after so many steps, obviously, if that's not working, then there would be maybe a call home or a parent brought in to really discuss what's going on, to see if there is something else, you know, that's

really annoying the child that's making them, you know, do the, I don't know, low level stuff, I guess, is what we're dealing with (...) It's different further down the school, but yeah, ours would be low level things that would happen, and usually a call home is all it takes to say, 'look, such and such have done this today, it was three times and we've, you know, chatted to them', and usually the parent will say 'well, do you know what? actually this has happened at home, this could be, you know, annoying them, or you know things are not going well', or else it could just be 'OK, I'll chat to them' and then usually (...) it's done and dusted."
(Teacher)

"in P1, you definitely would get some children who would definitely need to go and speak to, you know, the [vice-Principal or Nurture teacher] and it would be quite negative behaviours you would see, but I think also for young children, they don't have the language or they don't have the like emotional literacy to comprehend what's going on. So they can't tell you in words, so they're then lashing out in their behaviour. So a lot of P1, we spend a lot of time like learning about what your feelings actually are, and what that looks like, and what you can do if you're feeling like this, you know, you can go to the calm corner, there's puppets, you can speak to someone, you know, go through all the options that they have for each of their feelings. And it is beneficial for them because by the end of the year, you know, you will find that they are starting to identify 'I am feeling like this'. (...) 'This is probably what I need to do to, you know, help me here or if I go and speak to this person, you know, they're going to help me get through what I'm feeling'. Because for them all, they have feelings are so big and scary. You know, they don't know what all that is going on and to not have the vocabulary or the language, to voice that, you know, it's a lot."
(Teacher)

Whole-family approach

The final key trauma-informed approach embedded within Fane Street is based on the premise that the whole family needs to be supported, rather than simply focusing on the child alone. This has been a key concern in the school, and both the school leadership and staff we interviewed see their family support structure as one of the main strengths of the school, with the school perceived as playing a pivotal community resource role:

"Another key element of which is where [Newcomer Support Coordinator] comes in... we actually believe in working with the whole family rather than the child. If the child is not being supported at home, isn't getting their basic needs met, they're never going to succeed in their education."
(Principal)

"From my point of view, we've always over the last number of years very much been of the opinion that you can't support the child without supporting the whole family. We're very much about community in the school and school in the community. We are the sort of trusted partner for our families in terms of being their place of refuge, their safe place... (...) we understand that if the parents aren't happy and, you know, they're not happy with where their child is and what they're currently going through, then the child's not in a position to learn, physically or mentally. So we want to do it... A, because it's the right thing to do but B, because it's the only way we're actually going to be able to make the children be in a position to be able to learn."
(Vice-Principal)

"So we're always looking at... not just the child, but the child through a lens. You know, in terms of the whole family, what's going on there, are they struggling? And I think that's something that we do really well here, not just focused on the child, but bringing in all aspects of the child's life."
(Teacher)

This whole-family approach **starts from enrolment** when parents and children come through the doors of the school for the first time. Enrolments occur most days of the school year due to the transient nature of the pupil population as many families are asylum seekers or are required to move accommodation due to their volatile situations. During the enrolment meeting, parents are encouraged to bring their children with them, so staff can informally get a sense of the child's needs and characteristics (e.g., how they interact with others, etc.), and they can also meet their class teacher on the same day. However, children only start their first formal day of school on a Tuesday, so the class teacher has had time (on Mondays) to prepare for the new arrival. From the moment the child is enrolled, families are welcomed into the school community, treated with care and understanding, and provided with practical and emotional support (e.g., children are given a school uniform on enrolment day). Given the traumatised backgrounds and precarious situation of many of these children and families, efforts are made to ensure school is experienced as a 'safe place' for both child and family where relational trust can be built:

"I would say a couple of years ago, really, we started to get the families from the asylum system coming in. So families who were living in hotel situations where, you know, you might have four or five people to a room and just really cramped, inappropriate living conditions, they might be there for months, months and end, you know, 6-9 months a year even in some cases. And yeah, I would do the enrolments with them, and you can see them like visibly distressed, you know. Some of them are in tears, um... they're confused, disorientated. They've just had, you know, you may be talking about several sort of processing meetings with the Home Office. They've got to meet this person, that person, they're getting asked all these questions. They're getting asked for their ID constantly. You know, if you think about it from their point of view, it's so stressful, you know, and nobody's really... nobody's listening to them. Nobody's actually really showing them any kind of human empathy or concern that, you know, that they might be in a really difficult place. So I guess you can either, you've got a choice really there, you can just go 'Right. Well, I just need to get this paperwork done and get this child enrolled', or you can go, 'Right. Let's try and meet this person where they are and think about... right, how can we build trust with you and show you this is a safe place for you actually, and that we're not going to treat you the way that the Home Office is treating you and that other agencies might be sort of treating you', and just build it from there"
(Newcomer Support Coordinator, currently on temporary secondment)

"...quite often...we're maybe the first people that have actually given them a bit of time, offered them a tea or coffee and sort of... maybe they've come in thinking it's going to be more formal process than what it is. You know, we like to remove the airs and graces and, you know, give them a cup of tea or coffee, help them get enrolled, and they very quickly see that we are very much set up to support them, not just their child."
(Vice-Principal)

This **relationship-building process with child and parent** is thought to 'start at the front door' with the school 'ready' to make a positive 'difference from the word go':

"It starts at the front door. You know, it really does... from the minute they come in. Increasingly now ... (...) It would be an e-mail that would come first of all, sometimes... from outside agencies that know about the work that goes on in the school. So they would set up an appointment... a lot of information is captured at that stage in terms of the journey, yeah. (...) And it's the journey they've been through... the child is with [the adult] that's going to enrol, because you learn a lot from watching, from observing them, you know, how are they playing, how are they interacting with others, how are they interacting with their parents, how are they interacting with me, somebody they don't know. So you learn an awful lot and, you know, it's time well spent. It's a lot of work, you know, we would have enrolments on most days... There's... usually one every day throughout the year... the turnover of pupils is huge. (...) it's being ready to make that difference from the word go..."
(Vice-Principal)

"And it's even a couple of things like whenever they come in for the interview, we will give them a new uniform, so they don't have to worry about getting the school uniform or anything like that. We have been funded, we've been very, very fortunate that we've received funding from external agencies."
(Principal)

This **practical support** comes in a wide range of forms, including providing clothes and heat, a school food bank, referrals to other support agencies and signposting. For example, a dedicated Family Support Officer helps families fill out forms on Tuesdays and organises classes for parents in the afternoons. In addition, the Newcomer Support Coordinator (and the Vice-Principal) performs a key advocacy role, making phone calls and writing emails on families' behalf (e.g., registering families with a GP). First time appointments are sometimes arranged in the dedicated family room in the school at school pick-up time in order to facilitate parent attendance. Indeed, having a room dedicated to family support, with 'an open-door policy on a Tuesday', has enabled the flourishing of a family support 'hub', as expressed by one of the staff in the quote below:

"... prior to the parents' room, there was hardly any parents came over the door. Since we launched that parents' room, um really, there's a whole hub that goes on, on a Tuesday (...) So there's like Barnardos have held like English classes for the parents. (...) they help them with forms like transfer forms (...) they help them fill those out, free school meals, uniform grants and things like that. (...) before that, it was hardly anything. Now, I mean, because it's kind of an open-door policy on a Tuesday. I mean, there's, there's all sorts goes on in there"
(Teacher)

"In terms of working with the families then I suppose list a few other things (...) there's a food bank, there's referrals to other agencies and signposting. Um... there is almost a kind of casework approach as well. I would take certain things on, and [the Family Support Worker] would do as well, or we're making phone calls, emails on people's behalf. We had a good referral relationship with [name of organisation], they have an advocacy service and we know about 'Advocacy for all'."
(Newcomer Support Coordinator)

The family service also provides an essential support to teachers, so they can seek support for families when they notice children are 'struggling' in some way:

"We would just look for, I guess, trends. Um... you know, if a child hasn't got a snack or you know was really struggling with maybe hygiene or something like that, we would approach the family. (...) we do, you know on a weekly basis give out bags of food to families as well.... We've got a whole room dedicated to, you know, uniforms and clothing and shoes and coats and things like that."
(Teacher)

Indeed, a whole family support structure has been built to support families, in **collaboration with partner agencies**. This includes:

- Newcomer Support Coordinator (full time)
- Dedicated Family Support Officer (30 hpw)
- Intercultural Education Service (IES) Roma and Asylum Seeker and Refugee (ASR) Support Officer
- Incredible Years (on a Thursday)
- Acacia[1] Path English Classes for Parents
- CASA and LORAG[2] Family Support Hub
- Trussell Trust Foodbank
- Storehouse[3]
- The Windsor Fund[4]
- Family referrals to outside agencies

[1] Acacia Path is a Christian-based organisation that runs English language projects in a number of locations across the Belfast area for newcomers living in the community.
[2] CASA and LORAG are names for different Family Support Hubs: CASA covers Windsor, Blackstaff, Finaghy, Malone, Musgrave and Upper Malone Wards, and LORAG manages the South Belfast, a family support hub which covers the Ormeau Road area from city centre to Belvoir.
[3] Storehouse was formed by Belfast City Vineyard Church. They provide food, clothes and furniture for those in need
[4] When external agencies donate money to the school to help families, it is placed into a ringfenced fund named The Windsor Fund by the Board of Governors. The name comes from the local area and from the Church who made the first donation: Windsor Baptist Church.

This family support structure has benefitted from partnership building with other agencies, e.g. Inspire, Barnardo's, South Belfast Food Bank, etc. Thus, the school works closely with a lot of charities, who provide support for the families in the school. For example, Acacia Path holds English classes for parents, the Incredible Years programme on a Thursday, as well as events for families in the school, that include cookery demonstrations, when parents are given recipe books and other free products. While some events may be targeted at newcomer families, others are open to all the families in the school. Inter-agency collaboration, therefore, is considered a key enabler, as further explained in the Enablers and Barriers section:

"I think a successful approach for me is about bringing in as many partner agencies and things as you can as well, and using the school as that base, because... so, so many times I've made referrals and nothing happens with them because (...) the agency might phone the person back in about three days. By that point, best will in the world, the parents have got a lot of going on. (...) they've forgotten basically, or they're getting a phone call, they don't know what it's about, or they don't want to answer the phone because they don't know who it is. Do you know what I mean? Whereas a very simple thing, like just going right, we'll arrange... I'll arrange the meeting. I'll not refer them. I'll arrange for them to come here, and they'll meet them in the family room at 3:00 o'clock, when they're picking the child."
(Newcomer Support Coordinator)

"That event that Barnardos had was very good, where they had all the families in, and they showed them how to cook healthy meals and it actually gave every family who took part a £20 Sainsburys' voucher, so they could go and get some shopping, and they did draws for air fryers, and it was a real success because the families loved it. ... there was a real buzz about the environment. (...) It was a really successful event and you know, there was... a lot of our families came. It wasn't just even the newcomer families, the asylum seekers, the local families came too and took part in it and enjoyed it."
(Nurture Assistant)

Many of these families require not only practical but also emotional support due to the extreme adversities they have experienced. As a result, therapeutic work (based in the school) with families has commenced this year. In addition, 'calm plans' are provided not just for children but for whole families. Some teaching staff also mentioned how teachers would check in with siblings whenever there is a particular issue with a child to try and understand the whole family situation, and be able to provide more effective support:

"Apart from having a school counsellor who we bring in as well, we have this year, (...) [name of therapist] is coming in to do therapeutic work with families. So she's actually working with parents and children to work through their trauma."
(Principal)

"I think our main strength is in the fact that we support the whole family. [The Nurture teacher] has been known to actually write calm plans for parents as well as children. I think it's... because we're supporting the whole family, then it's filtering from the parent to the child as well. And because they feel cared for and they feel that we're listening to them, then they're more likely to encourage the child to behave better in school."
(Principal)

"If there's something wrong with one particular child, I think we're very good then searching like the siblings, if there's siblings, and going and checking up on the siblings as well as the child who's maybe in crisis, just to see if there's a bigger picture than just this one particular child. And I think we're quite good at dealing with that and we all know such and such has a brother here or sister there, and we would go and search out the whole picture."
(Nurture Assistant)

Finally, it is worth mentioning how **cultural, religious and ethnic diversity is celebrated** in the school environment, with the celebration of festivals, etc. Focus group participants spoke of how beneficial this is for the whole pupil population and the staff. Despite the many cultural and other differences represented in the student population, the staff talked about the 'Fane Street family', with the family support services and celebratory events helping to engender a strong sense of community

within the whole school, using phrases such as “we’re all together and we’re all in this together”:

“I think it just creates a sense of community for them. Umm, you know, it is like a community, you know and everybody knows each other’s faces. And then we have all these things that then helps, you know, integrate our parents into our community and our family as well. (...) I think that’s something we’re really good at, is building positive relationships with both the kids and with their family, so that they know, you know, that we are here to help, and even if we are going with something negative, you know, it is because we want to help them and yeah, we want the best for them and their children.”
(Teacher)

“We really celebrate ... all different types of kind of festivals and religions and everything. I think when you do that, it just is a natural, a natural kind of occurrence. We celebrate Christmas. Last week we were celebrating Diwali, and things like that, and I think when you have that, the kids are just interested, you know, and that’s a norm around here, you know, celebrating each other’s cultures and talking about religions and different festivals.”
(Teacher)

5.4.3 Enablers, Barriers and Challenges

Participants in the focus groups identified a range of enablers, barriers and challenges to the implementation of the various trauma-informed initiatives throughout the school, a summary of which is provided in the table below.

Table 5.5: Enablers and Barriers/Challenges

Enablers	Barriers/Challenges
Leadership drive and vision	High turnover of pupils/transient pupil intake
Key agents of change / champions / role models	Emotional toll to staff – risk of burnout
Collective vision	Large class sizes
Supportive staff culture – close team with a whole team approach	Lack of external recognition of the importance of the non-academic work the school does
Supportive management	Limited resources and time
Management having realistic expectations of staff and trusting staff to do the right thing	Lack of understanding from other services (e.g. health service hard to engage with; as well as institutional racism)
Staff buy-in (motivation, commitment, involvement and investment)	Difficulties to engage families with little English
Staff training	
Collaboration – building partnerships with external organisations	
Using school environment as central base/resource	
Adequate Resources	
A common trauma-informed language to support understanding of relevance and inter-agency working	

Enablers

Leadership drive was seen as a key enabler of any initiative. As the Newcomer Support Coordinator explained, you need 'key people to lead' in order for people to really understand and think about the difference they can make in their everyday work:

"... you need key people to lead that forward, and that's how you'll have successful system change. What won't work is that if you go out to every school and say you've now got to be trauma informed and there's no champion for that, because people just go 'well, what does that mean?' ... people have to understand, you have to really get to them. You know, you have to get right into their heart, really, and get them to think about how they carry out their day-to-day work because that that's what makes the system kind of roll forward."
(Newcomer Support Coordinator)

Connected to that, some participants noted that as well as the Principal and Vice-Principal, there were **other key agents of change or champions**, such as the nurture teacher, who acted as role models for all the staff. Through this whole school approach, it was thought that everyone's 'mindset' changed in ways that influenced all the interactions with the children and their parents:

"if we zoom out slightly, think about the systems aspect of it that you're talking about. So (...) what is the system? The system is people really. And so to kind of influence and change any system, you've got to change the way people are thinking about the jobs and how they're carrying out their jobs. And to me that... (...) it's about ethos and values really. And what I suppose what we've done is we've noted really that maybe the old operating model, the traditional operating model wasn't really working for this cohort, wasn't working for our community anymore. So, so we had to change the way we were doing things and you've got to... to really do that, you need people like [the nurture teach] who's been like a role model basically for other staff members in the way he interacts with children, the way he carries out his day-to-day work... I would say like the leadership we've all provided has kind of had that knock-on-effect on other staff and (...) not just on the teaching staff, all the staff in the school, and I think it gradually over time that mindset sort of seeps into everywhere, into everybody. And so everybody's then changing how they're interacting with the kids and with the parents that come into the building."
(Newcomer Support Coordinator)

Through the focus groups, it became apparent that the ethos of trauma-informed approaches had 'seeped' into the **school culture**. As staff bought into the leadership vision and contributed or became involved in the different initiatives, a collective vision was engendered, with staff feeling that they were 'all on board':

"But in terms of the ethos of the school, to have the staff sit down and to think, you know, to say, 'here's where we're at and this is where we want to be and we're all on board, we're all on the same train, going the same direction'."
(Teacher)

This was also reinforced by a sense of community and a supportive staff culture, where all staff members supported each other, 'checked in' with each other, 'looked out for each other', with staff encouraged to seek support rather than 'sink or struggle' alone. There was a strong sense of a whole team approach, and as expressed by the previous quote, all staff worked together towards the same aims, i.e., to support and serve the pupils and their families. This was further encouraged through good team communication with staff perceived to have 'grown together':

"We're actually quite a tight team in that we do rely quite a lot on each other, because we get quite traumatised with some of the things that we hear as well, and we were offered support last year, and we said, 'No, we'd rather that went to the children because we support each other'. So the staff have grown together"
(Principal)

"That sense of community that if a child does come and is really challenging, that is going to challenge the member of staff, the member of staff is going to find teaching really tricky because of what they're bringing in their history, the member of staff knows that it's not for them in their class just to sink and struggle with this child's behaviour. They know that there's a team, so they know that they can go to myself, the nurture teacher or their 'English as an additional language' teachers or to [the Principal]."
(Nurture Teacher)

"And we're quite good, if we know someone is going through a tough day, we would always check in, you know, if you've been involved in that, can you come and help me? Like is everything OK? Are you OK? You know, we're quite good at talking with each other and supporting each other. (...) this is my (...) third year, there's never been a day when something hasn't happened, you know, it could be very minor, or unfortunately it can be very major, but we all know, and we've just, we talk, we have good communication and we all just sort of look out for each other. It just sort of happens."
(Nurture Assistant)

In addition, as explained by the Principal, staff were committed and invested, as they could see how this way of working was making a difference, thus igniting **staff motivation**:

"So the staff have grown together (...) even just by going into the nurture room, you know, simple things like that, they would go in and say have breakfast with the children, seeing that and seeing the difference in the children has made a huge difference to our staff and it's just the whole ethos of the school."
(Principal)

Other key enablers had to do with the **characteristics of the leadership**, in particular, the Principal and Vice-Principal, who were reported as being accommodating and supportive to staff (having an open-door policy, etc.), with staff feeling listened to, their ideas valued, and concerns taken seriously and addressed. In addition, senior staff were reported as having realistic expectations of staff with 'trust' featuring as an important element of staff relationships. Staff reported that they felt trusted to make the right decisions and do the right thing, as well as feeling supported in their efforts. Thus, a **mutuality of respect**, contribution and purpose was created where difficult issues could be aired in a 'safe space':

"I think what's not been mentioned is trust as well. Because [the Principal and Vice-Principal] as well, whenever we set up the Sunshine Room, they gave me the room, [the Principal] sent me on the training, and I said, '[name of Principal], if you want me to do this properly, want me to set up the room properly, I'm going to need a month out of class to get this room sorted, to get the systems in place so that when the children come to me, we're 100% ready, the children are coming walking into a place that's 100% ready to cater for them'. [They] said, 'Take as long as you need. I trust you, I sent you on the training and I know it'll be good'. And we've always had that. You know she's not over my shoulder. We have meetings about um..., nurture panel meetings, where we discuss certain children. It's on me to set that up. [The Principal] is not saying 'come and tell me how it's going and I need a deadline'. I say, '[name of Principal] can we meet? I'd like to share'. She says, 'perfect'. She has great trust in her professionals to do what you know what is expected. Now, that's not you're left on your own to do it. You're supported if needs be but you're trusted to do."
(Nurture Teacher)

"I honestly think we're very good informally, just going and having a chat. I mean, and the principal's doors always open. And..., the vice principal as well, you know, anybody that has a problem or a moan, we go and we do that, and I certainly feel that I'm listened to, when I have a problem, when I pass it on, or if I have a... um an idea about something, I certainly feel that it's... and it's not just, you know, listened to, it's implemented, it's talked about, and it's kind of... you bounce back and forth between the couple of members of staff and then the next thing it happens, you know, it's really, it's... You feel, you feel like you are listened to..."
(Teacher)

"[Senior staff] definitely give you opportunities as well to come forward and say, 'look, you know, this maybe isn't working as well or maybe... could we try this?', and have ideas like that, and having a space, safe space to talk as a staff team, you know, about things. Because it is hard, you know, you know it's hard going sometimes, so you do need to have a good relationship with each other to get each other through it, you know."
(Teacher)

As previously mentioned, collaboration and building **partnerships with external organisations** was deemed as a crucial enabler, particularly in terms of supporting the families. Central to this was using the school environment as a 'base', a central resource, with support coming into the school to attend to staff wellbeing as well as the needs of the children and families:

"So I think it's about bringing support into the school as a base and making use of the resources, other resources that are in your community, other assets that you've got to kind of draw from. That is what successful model will look like because... while it's great that we did all this stuff, it's very hard on our resources and our time and, you know, you've got to think about sort of staff wellbeing and all the rest of it as well. So I think a successful approach for me is about bringing in as many partner agencies and things as you can as well, and using the school as that base."
(Newcomer Support Coordinator)

Training was also considered very useful so staff could feel better equipped and confident in their practice and have a better understanding of the issues. In other words, as expressed by a staff member, it reassured them that they were 'on the right track':

"Something else that helps is definitely the training that that the school, that [the Principal and VP] have organized. It's definitely good to have that behind you. I mean, we could sit and chat here all we want about our experiences, but actually having that behind us, and the theory behind everything, really helps to kind of match everything up, to make sure, 'oh, this, I am doing this right.' You know, it gives you a bit of... you're on the right track, sort of."
(Teacher)

There was a recognition in the focus groups that **adequate resources**, although not deemed essential to start implementation, were nonetheless important and helped trauma-informed initiatives develop. In this case, the extra funding the school received for the newcomer children was used thoughtfully, creatively and efficiently by school management to bring about their vision:

"We get extra money for the newcomer children that we have. (...) because we've such a high number, we thought, right, how are we going to use this money best for the children that it's aimed at? So initially we started off by having extra support where the children were out of class. So we have a really comprehensive system now. (...) So we then thought, well, so what else can we do because we have so much trauma coming in? And then we thought, well, nurture was something that we'd always sort of fancied and toyed about with because of the indigenous children that we had. And I looked at the budget and said, right, OK, let's do this."
(Principal)

"Resourcing is huge for this as well. I mean, it's money in terms of all the equipment for calm corners and bubble rooms and sensory, you know, even the nurture unit like, you know, all the training, it's all money at the end of the day."
(Teacher)

Finally, the last enabler noted by participants was the use of the **trauma-informed language**, which, although considered 'still in its infancy', was found useful in two respects: 1) 'to get it across to' governors or 'the slightly more resistant' staff; and 2) to bring different settings/ sectors 'out of their silos':

"I think to get to get it across to the likes of our governors or to maybe the slightly more resistant staff (...) it's actually given them a raison d'etre, because you're actually saying 'well look, this is brain development, this, these are basic things that happen'. So they can see a reason for it (...) with some staff, they needed a little (...) more persuasion... So I think actually seeing that there was reasoning behind it made it more to our staff."
(Principal)

"From my point of view, it's helped us sort of from a networking point of view (...) in the vast majority of cases, we know who to pick the phone up and speak to now, because we've worked hard to develop those relationships, you know, we know there's a problem in this area or that area. We know who to pick the phone up to. (...) I think it's helping bring trauma informed practices used in all those areas... health, justice, education. It's helping, it's bringing them closer together. ... It's bringing us out of our silos and that's what we need to do so."
(Vice-Principal)

Barriers and Challenges

Participants in both focus groups identified a range of challenges and barriers to trauma-informed implementation in their particular school environment. Firstly, the **high turnover of pupils** (or transient pupil intake) was seen as a challenge for two key reasons: 1) in terms of limitations on what can be achieved for individual children who are only in the school for a few weeks or months; and 2) difficulties for staff teaching in their classroom, as it takes time to work out how to help each individual child and meet their needs. This was thought to take its toll on teachers who needed support to manage their energy. In addition, participants argued that a re-conceptualisation of child outcomes beyond traditional academic achievement was needed to understand how the important preliminary work achieved by the school was enabling children to be in a position to engage with learning:

"... the turnover of our pupils is huge (...) we would have over 50% of our children, you know, the cohort would change by that amount every year, you know, from September to June, but some of them might only be with us for three or four months, and it can be very, very difficult if we're pushed, you know, on paper, how do you sell that you've actually made an impact on that child, and it can be something as simple as, you know, their head was on the floor. They were really, really not in a good position. But they're now, they're happier, they're confident, and they maybe leave school, but what we've done is actually prepare them to learn, you know, ..., they may not be reading yet or they may not be doing this or that, or they may not have moved from a level 2 to a Level 3 in literacy, but what we have done is fill their cup, if you like, or fill their jug, you know, or fill their bucket, whatever analogy you want to use, to enable them to learn."
(Vice-Principal)

"... intake at school is very..., you know, very transient. I think last year it was nearly 50%. So that's very very tricky, because whenever you get a child and, you know, you're waiting to have them assessed um... in the class, um... you know you're trying, you don't know what the trauma is necessarily. So you're trying out different things, and if that's not working, I mean you do kind of start to tear your hair out, like how can I help this child? What is going on? Um... you're trying the best as you can. And then the next thing you know, maybe you do get somewhere, and then they leave, and then you get two more kids like that. So it's kind of like... you're flogging a dead horse sometimes, but you just keep going because that child in front of you, at that moment, needs your help, you know."
(Teacher)

"And then you also have the issue where they go back to their own countries for a long period of time, so the work that you have done in class, you've built up this lovely level of getting them to where they need to be, and then they maybe disappear for 2-3 months and then all that work goes, and they come back with having no schooling and maybe in their country, maybe experiencing more trauma, then they come back to us, and it's like starting again, and you just have to pick up and you know that that's also, you know, difficult too."
(Nurture Assistant)

Thus, considering the situations and characteristics of a large majority of the pupil population, one of the challenges flagged by the Vice-Principal is to encourage education bodies (e.g., ETI and EA) to recognise and **value the important preparatory work** that the school undertakes with such pupils and families. While this work many not be focused purely on academic development, it is nonetheless considered critical for children's engagement with learning:

"I would put that down as one of the challenges (...) ETI will come back. (...) But again, you're banking on people on the outside, again, realising that excellence and outstanding teachers look different in different places because, you know, if they come in here and they're looking for, 'OK, give me top, middle and bottom literacy books and numeracy books from every class', they will see good work, don't get me wrong, but we would rather be showcasing the outstanding work that we're doing that's just sits in a different department, and that has to be, that has to be held up and valued as much as the academic side, because our children aren't there yet to do that, academically, it doesn't mean they won't be in two years or four years. But we're playing a really important part in their journey, and it needs to be recognised."
(Vice-Principal)

Limited resources and time was also identified as a central barrier or challenge to TIA implementation:

"We can't do everything, because we've got limited resource and we've got a particular remit as well."
(Newcomer Support Coordinator)

An additional challenge mentioned by various focus group participants was regarding **the impact of the work on the emotional wellbeing of staff**. Everyone recognised that although the work the school did was very 'rewarding', it was also 'emotionally draining', in particular due to the traumatic experiences the pupils and their families had endured and the challenging nature of some behavioural presentations. Staff noted how they worried about their pupils and their families and how this, in turn, often affected their own emotional wellbeing. School management recognised that staff burnout was a risk, but countered this by being mindful of the importance of staff wellbeing in the support processes offered. While staff noted these inevitable challenges, as previously mentioned, they also reported feeling supported by the senior management team in providing this high level of care:

"... when you're working with children who have experienced trauma, you know, it can be hard going for you knowing, you know, sometimes what that child or that family is going through or has went through, you know, it could be quite emotionally draining sometimes. I think when you really look at it and understand wow, you know, that's unbelievable that that's actually real life and happened to somebody and they're standing there in front of you. And also you know when a school environment, you know the behaviours and stuff as well, you know, sometimes can be very challenging and it could be hard, you know, when you're trying to ... meet somebody's needs and find out what that behaviour's about, but also teach the rest of your class."
(Teacher)

"You can sometimes take on some of the trauma and think about it a lot, you know, it can affect mental health at times, like I've had times last year, especially, where I've gone home and maybe have a sleepless night, you know, a lot of sleepless nights, thinking is that child going to be OK? And it costs you a lot of money because some of the kids don't have the basic things and you say, 'ohh, such and such would like that. I'm gonna buy that for the room'. And you know, you invest so much of you in the children, it can drain also."
(Nurture Assistant)

Large class sizes were also identified by the staff group as a key challenge to provide this level of nurturing care, especially when many children in one class have complex needs:

"... the class sizes, just whenever you have so many kids needing so many different things from you, you are only one person. Um... class sizes have to be kept to a certain, certain level. I mean, we are pushed, you know, to our limits. We really, really are. (...) like I have 24 in my room, which is so lovely. I'm almost afraid to say it because, but then it would be like ohh, you've got room, right? but actually last year I had 32, you know, which was very, very challenging and a real strain on mental health, you know, it really, really is."
(Teacher)

When asked about implementation barriers and challenges, the Principal also mentioned the difficulties in engaging particularly with the health service, with experiences of institutional racism noted as common among the families in the school:

"One of the barriers for me is that the families are still encountering racism within other services in Northern Ireland, which will remain nameless. So that's a huge barrier for us. We have been fighting for years. We want to get health on board. I am more than happy to facilitate health appointments and things like that here, but people just don't seem to. I don't know whether they're just not interested or whether there's not the manpower or whether there's not the money or, you know. So that's a big barrier for us, I think. (...) Yes, yes, but we have experience of that and we find that, say [Vice-Principal] rings up and says we need to register this person with a GP, they get registered, whereas when they rang themselves, they didn't... (...) So unfortunately, there's, there's still a lot of racism out there that we're really suffering from."
(Principal)

Staff also mentioned difficulties in engaging with families when parents' understanding of the English language is poor with challenges reported when using translators:

"But it is difficult to connect with the parents because a lot of these parents don't have English, a good understanding of English. So during our parent meeting week, we make sure they have translators and things like that. (...) sometimes we use those phone translators if we need to talk to parents, but they're not always great. (...) sometimes the kids have to then translate (...), which is not ideal either."
(Teacher)

5.4.4 Outcomes and Perceived Benefits

According to focus groups participants, Fane Street's trauma informed approaches did work, and there were numerous indicators that testified to that. The school management and staff mentioned a range of **benefits and positive outcomes for the children and their families**. However, they recognised it was challenging to evidence the myriad of small but critically important outcomes that assist children move toward a place where they can start to engage with learning. Examples of benefits and positive outcomes included children settling in school and being 'prepared to learn'; changing their behaviours to those that are helpful to them; increasing their confidence and self-esteem; and feeling heard and understood:

"But the most important thing to know is that it works. You know, our children are from very difficult backgrounds, and we have children that can come in and display behaviours of trauma, of aggression, of violence of... real nervous responses and we work with them, and they slot in and they manage to get an education. Now that education might not be (...) they're doing straight A's and going off to [grammar school]. For them, it might be that they've learnt to read and write, but they've been in the school, they've managed to change their behaviour to a behaviour that will serve them better in the community leaving our school. So it works. That's the real important point, it does help children change their lives. It does get them settled."
(Nurture Teacher)

"There's a very clear difference whenever we switched that policy from punishment-based to positive behaviour, there is no doubt that there was a huge, huge difference, in terms of the child's ... confidence, their self-esteem, you know, their learning process of all of that emotional literacy and building upon that, giving them a voice, you know, all of that has been really, really beneficial. And I think the kids in here, I personally think they feel heard, and they feel listened to, and they feel like if there is a problem, the teacher will listen and do something about it."
(Teacher)

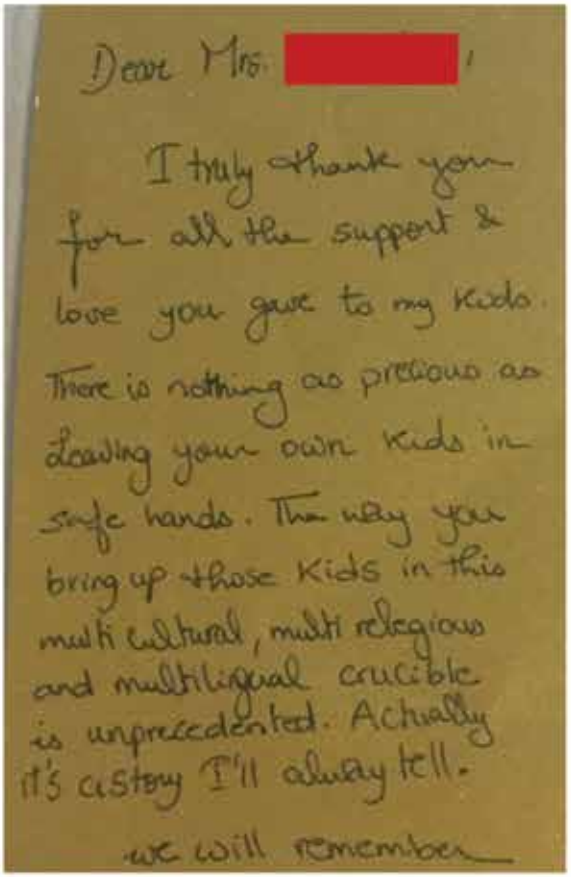
Many examples of positive indicators were expressed by focus group participants and also provided in school documents (see Figure 2.3), as families expressed their gratitude to the school. However, as previously mentioned, it was difficult to evidence the progress the school had made in traditional measurable terms, and difficult to record the numerous 'small wins' that their involvement had made to pupils and their families:

"We've actually got a child who's rejoined us this morning... a child from the local area that was at [another] school, [...] and couldn't settle, left in September, and has come back to us today. And I spoke to the mother this morning and we're giving the lad a check in... and she says, [...] 'in the other school, he was treated as...' he has problems, he said this morning'. You see the lad, he worries. You check him in and you're making sure he's alright and that. That really is us in a nutshell. We know this boy so well, we know his background. (...) And he had to leave and move for, you know, family circumstances. But it speaks volumes that although they still live in [another area of Belfast], they're driving all the way to come back here to us because they know that the lad will settle, they know we'll look after him and they know we care."
(Nurture Teacher)

"I have a parent at the moment, (...) the family are the most traumatised family (...) and she was really distressed. (...) She was really distressed one morning a couple of weeks ago, and I sat down and I didn't even know if I was doing the right thing, and I just rubbed her back, and (...) well you offered her a cup of tea, and we got her a glass of water and everything, and she would never have met my eye before. And I think that was cultural. She didn't want to meet the eye of somebody who was older than her. And since I did that, she has checked in with me. She smiles at me every morning. She makes sure she speaks to me. She now sees me as a trusted person, and that's what it's all about, that you have won the trust of somebody (...) they know that you're there to help them, and that for me, that's the job satisfaction. It's not the awards, which we have won (...) That's absolutely lovely. But it's little things like that, or an e-mail last week to say that this girl's child who was screaming and just absolutely horrendous six months ago is now wanting to stay in school and now wanting to play with other children."
(Principal)

"It's a... a wee boy (...) who is now in P5, he was rolling about the corridors in P1. There was just nothing we could do with them and now, with the feelings thermometer that we have rolled out throughout the school, he can now come and say to me, '[name of Principal] I'm a three', and I know exactly where he's at. He doesn't have to say I'm feeling really bad. My sister annoyed me this morning. We know straight away and he is, he's just such a different wee boy. But that's not something we can tangibly record. We just see that."
(Principal)

Figure 5.5: Letter from former pupil's family to Principal (provided by Principal)



Dear Mrs [redacted]

I truly thank you for all the support & love you gave to my kids. There is nothing as precious as leaving your own kids in safe hands. The way you bring up these kids in this multicultural, multi-religious and multilingual crucible is unprecedented. Actually, it's a story I'll always tell.

We will remember

It was also argued that the benefits of TIAs were not just for pupils and their families, but they were also felt for staff, in terms of **job satisfaction** which in turn led to staff retention. Some staff that participated in the focus groups talked about feeling 'privileged'.

"It is a tough station because you could go in and sit in any middle-class school, get your outcomes, earn your money, and go home and forget about it in the evening. But that's not what we're about... and it's the job satisfaction. I don't want to be anywhere else." (Principal)

"Staff are now tending to stay because they love it. Now I think, [name of staff member] was starting to burn out. So I would say burnout is a risk with us. But at the same time, the satisfaction that we are getting from what we are doing, and it's the small wins."
(Principal)

"And it is tough, but I feel like we learn from our children every day. They teach us so many things and I feel privileged to work... with them and help them, because we do learn so much from them"
(Nurture Assistant)

5.4.5 School vision and priorities

Participants in the school management focus group were asked about their future vision for the school. Their wishes were varied, and included a social worker; a better relationship with responsive health services; to become a 'community hub' for their families, i.e. a 'one-stop-shop' for some vulnerable parents (e.g., refugee families) where services could come to them; and to expand the family work they are already doing:

"I want a social worker. I wanted one for ages. I want a social worker."
(Vice-Principal)

"We want to be a community hub for our families. We would really love to expand what we're doing. I don't know how realistic it is with funding, but we would like to be... and we would like to be involved with health. We would like to be a one-stop-shop for some of our parents. You know, rather than the refugee families who can't afford to get a bus up to the Royal or whatever, that they can come in here where they know us, where they trust us. They can get their physio appointments, they can get their, you know, their speech and language appointments, all that sort of thing. You know, just a community hub. I suppose [this] is what the school would have been in the country many years ago. So it's kind of going back to old-fashioned."
(Principal)

5.4.6 Lessons learned

Focus group participants were also asked what advice they would have for other schools embarking on implementing trauma informed approaches in their school environment. Responses were varied. The importance of **building relationships with the pupils and the families** was highlighted across both focus groups:

"My one word, my one word, would just be relationships, because everything we've said is all people-based. It's all relationships, but it has to be. You have to mean it. You know it's about relationships."
(Vice-Principal)

"I would say building relationships with the kids is number 1. And yes, listening to them, yeah, listen to their needs,... build relationships with them."
(Teacher)

"I was just going to say what [other teacher] was saying. Definitely, just really getting to know them kids that are coming through your door. Like I said once you know them, you know, it is so helpful for me as a teacher, because I know then what, you know, I need to do or I can be prepared for that for myself. Do you know what I mean?"
(Teacher)

Staff also had more specific advice, in relation to **giving children the tools to be able to learn** and understand their emotions, etc.; the importance of **consistency and a whole school approach**; and (if possible) **reducing class sizes**:

"Put the tools in place. Put them on the walls for them to see, you know, build that emotional and expressive language, so that they do understand..."
(Teacher)

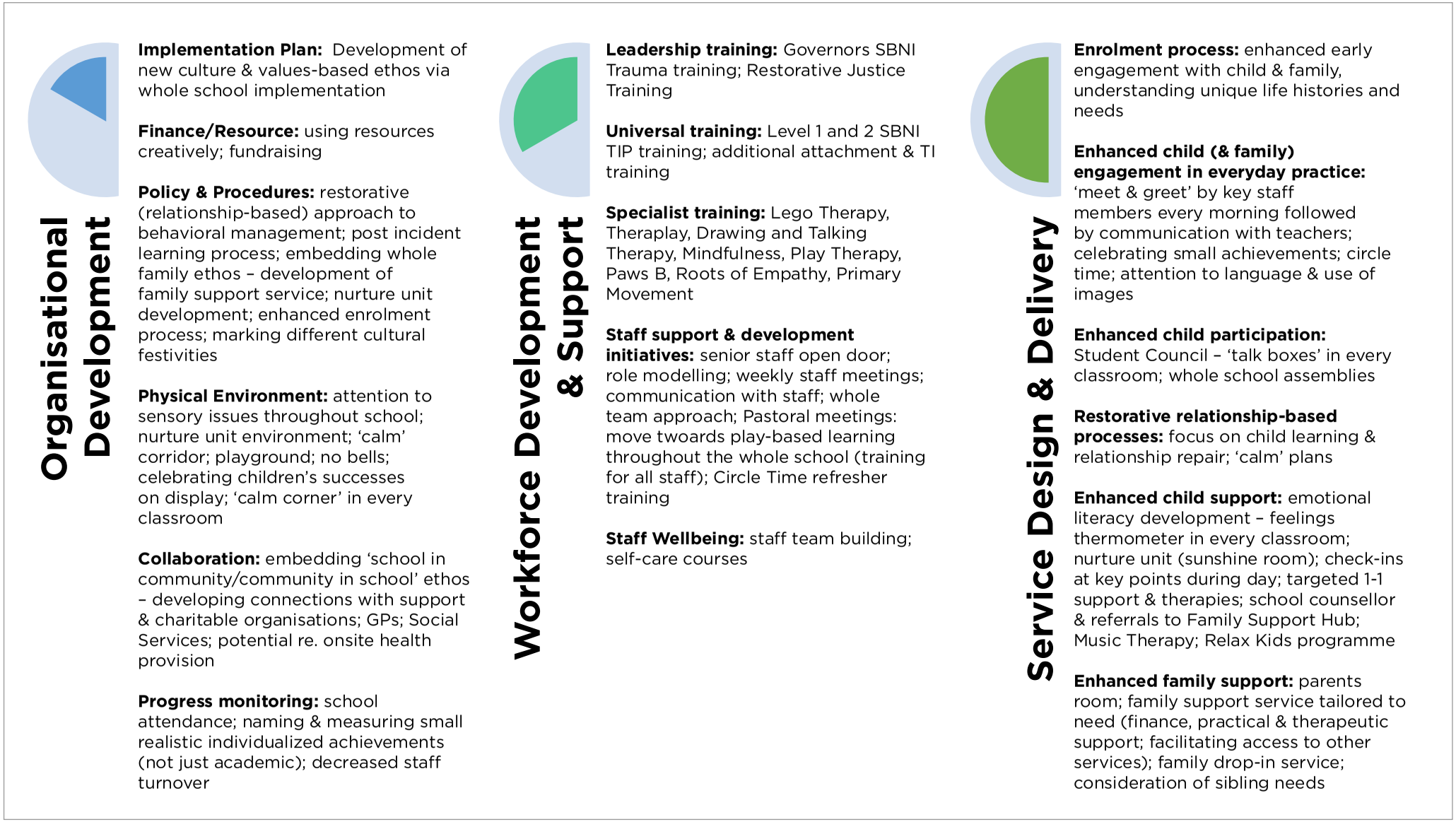
"And again, like just what we were saying about giving the tools ... for them to learn what all them big feelings are, and the language and all that their stuff."
(Teacher)

"And a whole school approach. Everyone has to know what's happening... you can go... in this school, we can go into any classroom and it's the same thing. You know it's the same... feelings thermometer, calm corner. Everybody talks and we're all using the same language all the time (...) And it's different in every class actually, you know. Consistency does not mean exactly the same throughout the school. It's actually different, but it's the values and the morals in behind it, the message in behind it, is the same."
(Teacher)

"if I was saying to another school, the class sizes, the class sizes, just whenever you have so many kids needing so many different things from you, you are only one person. (...) class sizes have to be kept to a certain, certain level. I mean, we are pushed, you know, to our limits. We really, really are."
(Teacher)

Some participants in the school management focus group were more personal in their advice. This included **being open and willing to adapt and change their practice** (from what they may have been originally taught in their teacher training); and to use their own negative education experiences as motivation to make a positive difference to children's lives, so their pupils do not have negative experiences of education.

Figure 5.6: Fane Street Primary School Trauma Informed Implementation



Case Study: The Salvation Army UK and Ireland

5.5. Salvation Army UK and Ireland

5.5.1 The context

The Salvation Army (SA) is a church and charity which operates across the UK and Ireland, including N. Ireland. The SA aims to help people by providing immediate, practical support to overcome issues such as addiction, homelessness, social isolation or poverty and recovery from slavery. It also strives to address the reasons that cause these situations, with a view to effecting sustainable change in individuals and society at large. The Salvation Army combines centrally co-ordinated services and locally co-ordinated churches and community services, which are perceived as all playing a part to bring about positive change. The SA call this its 'integrated mission'.

As well as 89 services in the UK, the SA provide 11 services on the island of Ireland, five of which are located in NI. These include three family homeless services, one homeless service for men only, and the specialist Thorndale Parenting Service (PS). All services are based in Belfast. Thorndale Parenting Service has three strands to its work. These incorporate a residential Parenting Assessment and a bespoke Day Intervention and Assessment service based at its North Belfast facility. Parents and children are referred to the residential facility by Social Services where there exist child protection concerns. During a minimum three-month residential stay, specialist staff assess capacity to parent safely, providing recommendations to the courts in relation to children's safety and their potential rehabilitation to parental care, or possibly removal into state care. This is the only service of its kind in NI. Having left the residential service, parents and children can continue to avail of ongoing support from the Day Service. Families referred to the Day Service attend for targeted intervention and focused areas for assessment. On conclusion of this, some families may progress into the residential service if necessary. The final strand of Thorndale's service offer is 'The Bridge', a new early intervention and family support service, developed in partnership with Belfast HSC Trust based at the newly refurbished building 'The Orchard' in North Belfast. The Day Service and the Bridge are non-residential, while all other SA NI services are residential. They are part of the SA strategy to branch out of traditional residential services.

5.5.2 Trauma-informed implementation

In this case study, the senior management focus group was made up of three representatives from different parts of the Salvation Army UK & Ireland. These included the Director of Addiction Services who advises all SA projects/ services across the UK and Ireland; the Head of Mission Data from the Research and Development (R&D) Department, of which both departments are based at Head Office London; and the Social Work Service Manager at Thorndale Parenting Service. The staff focus group included staff from the different services provided by Thorndale as well as one regional trainer who provided training to staff teams and projects across the UK and Ireland. These combinations provided an opportunity to consider TIA implementation from a local service perspective (Thorndale PS) as well as the broader SA UK and Ireland context.

The Salvation Army's TIA Implementation 'Journey'

Each of the senior management focus group participants described their respective relationship with TIA implementation to date, and how these different roles, positions and experiences had come together to bring the organisation as a whole and the local Thorndale PS to where they had arrived at today. TIA implementation in the SA, at both a local and national level, was described as a 'journey' and 'learning process', with assessments shared that they still had a long way to go' from an organisational perspective.

The national context: The Director of Addiction described a long professional history with TIAs, arguing that while the language around ACEs, attachment and trauma had not been there in the early 2000s, addiction and homeless services (which encompass a significant proportion of national SA's services) had been already working in ways that were trauma-informed at some level. He described how he had been involved in the roll-out of 'psychologically-informed

environment' principles across Welsh Governmental Departments, i.e. Housing, Police, Education, Health Care, etc., when working with the Welsh ACEs Hub, so was aware of the challenges of supporting widespread TIA implementation first-hand. The Head of Mission Data described her involvement with TIAs, dating back to 2007-9, when SA carried out 'The Seeds of Exclusion' research. This involved conducting mental health assessments with over 1000 individuals receiving SA services. At that time, SA Head Office had committed to using the research recommendations to change its practice and a 'Wellbeing Framework' had been developed in conjunction with SA's homelessness services. This Framework aimed to create an 'enabled environment' in which trauma-informed and psychologically-informed models of engagement were embedded. In tandem with these developments, a 'Valuing People Strategy' had also been developed which included an ambition to provide 'a healthy and flourishing environment'. It was here that trauma-informed practice was explicitly noted. Such high-level national strategies, in which the language of TIAs was embedded, were reported to have led to inter-departmental national-level conversations on how to create this envisaged 'healthy and flourishing environment'. These policy developments coincided with the introduction of a Harm Reduction Strategy to SA UK & Ireland in 2013, which was felt to have strongly resonated with trauma informed principles. As a result of these combined initiatives, TIA implementation was reported by senior manager focus group participants as already progressed to some degree across SA nationally.

However, TIA implementation progress at the national level was reported to stall at the time of the COVID pandemic, when strategic developmental work went 'on hold' and the 'workforce fundamentally shifted'. During this time, according to participants, a lot of experienced staff left, new inexperienced staff arrived, while those who remained were 'jaded' by their pandemic experience. As a result, senior leaders were concerned not to 'push' TIAs on a tired and depleted workforce, noting that some of the previous foundational work needed 're-done':

"A lot of people who had no experience came in, so it almost felt like you were re-doing a lot of work, laying the foundation again.... what you also had was the ones who did stay were very jaded by the whole experience of COVID. So I think we were very... not apprehensive, but very patient in pushing again because it felt like people were literally just start to draw a breath in."
(Senior Management Focus Group)

Bridging the local and the national:
However, into this challenging national environment, new opportunities for TIA implementation emerged from the local NI service context. The Thorndale service manager spoke of how she had embarked on implementing TIAs in the Parenting Service as one of the SBNI TIP project's trauma-informed pilots (starting in 2020), following her participation in the SBNI 'Be the Change' leadership programme. The NI Service Manager described how the 'local level' pilot project at Thorndale had enabled a 'bottom up approach' for TIA progression, where learning from a frontline service could be used to reinvigorate TIA implementation at the national level. However, it was noted that the wide-ranging development achieved, could not have been managed alone. Senior colleague support from the national organisation was seen as essential to leverage support for the local initiative, as well as cascade the learning throughout the wider organisation. Participants noted that the harnessing of this 'bottom up' and 'top down' approach was essential for wider progress with 'organisational growth' dependent upon 'everybody being involved.'

This strategic alignment of different senior staff members, each with their different local and national remits, were considered essential to achieving whole organisational 'buy-in', where 'together', they could 'make quite a lot of things happen':

"We were at different levels within the organisation and had different levels of influence. So [NI Service Manager] was very much able to obviously influence what was happening locally. (...) So it meant that at the different levels (...) people were able to have those conversations and we were able to kind of get ... some of that traction, to get the buy-in."
(Senior Management Focus Group)

TIA Conceptualisation

As noted above, senior management participants indicated how elements of TIAs had already been operating (to some extent) in homelessness and addiction services prior to the introduction of ACEs, trauma and attachment to the UK policy landscape in the early 2000s. Participants reported *TIA alignment with other organisational strategies*, such as the introduction of a Harm Reduction Strategy to SA UK in 2010s, as the organisation moved away from its 'strong abstinence focus'. Harm reduction principles of 'choice, control, empowerment, and strong relationships' were noted to resonate well with TIA principles. As a result, TIA implementation was thought to have found 'fertile ground' in many frontline service contexts.

However, despite this alignment, senior participants noted the challenge of introducing staff to 'something new', particularly in the aftermath of COVID. To overcome staff fatigue, staff were invited to think of TIA principles as a 'coat rack', somewhere where they could 'hang their coat'. Using this analogy was thought to gives practitioners 'a sense of relief', avoiding potential 'overwhelm' while helping practice become 'more intentional', where the underpinning purpose or 'meaning' behind the practice was better understood:

"So you see a look on people's face just like, please not something else. I can't deal with something else now. So the way that I've always... described [TIP] (to staff), is almost like the principles are like a coat rack. This is the thing that you've already done and you've already been wearing. This is just something to hang your coat on now. So you've got names and phrases and understanding for that thing that you've already done. So this is not a question of something new, it's a question of, I can take it off and feel a relief I'm actually doing that thing. So it gives people a sense for... trauma informed practice... this is not something that's overwhelming and overloading you... this is something that gives you a sense of relief. That's the thing that I'm doing. And when I do that now, I am much more mindful of it because I can give it a name... [it's] meaningful... when you know you're doing that thing that you know is a good thing to do... [practice] becomes much more intentional."
(Senior Management Focus Group)

Focus group participants described TIA implementation progress, at both the local and national level, across the key areas associated with: organisational development; workforce development and support; and service design and delivery.

Organisational development

Bridging the disconnect between different parts of the organisation: In the TIA organisational development implementation domain, some of the challenges spoken of in the senior management focus group focused on *leadership and policy development* in a large and complex organisation like the SA UK & Ireland, where there was a perceived need to bridge the 'disconnect' between senior SA Head Office staff and frontline practitioners in local services. Senior practice staff noted the challenge of helping senior SA Head Office staff get an understanding of TIAs in order to progress national-level development. It was thought that often frontline practice was more advanced in their understanding of TIAs as they were 'actually living it', more so than for Head Office staff for whom at this time, trauma-informed was 'just a word'.

Similar challenges were noted in terms of bridging the gap between the policy world and frontline service provision, with the local NI TIA pilot project considered an opportunity to 'join the dots', helping bring meaning to various strategies and policy terminology:

"Whilst I was aware of some of those [policy developments] happening, I probably wasn't as connected to them... But I knew that there were conversations (...) and all of this terminology being floated around 'enabling environments', 'psychologically informed environments', 'flourishing environments', you know, 'wellbeing' and things. But the pilot project that we undertook... and it was a small pilot project with two groups of staff in Northern Ireland and we get that... it has limitations and things. (...) but that pilot project just kind of highlighted for us, that there was a massive disconnect between what was happening higher in the organisation and... you know, (...) the practice and services and all the different kind of supports and expressions of Salvation Army work that was happening. There was a disconnect between what anybody knew anybody else was doing (...) So this experience and project I think really helped everybody to join those dots."
(Senior Management Focus Group)

This work was reported to have helped emphasise the interconnected nature of organisational development at local service provider and national levels. This was described as an ongoing 'learning process', with close collaboration with Human Resources elicited to advise in relation to policy development. Such high-level strategy development was noted as important in large, multi-faceted organisations, with concerns that without policy/practice alignment, the central organisation could inadvertently 'stifle' local TIA development:

"It's very much a learning [process] at the minute. We're nowhere near 'there' from an organisational perspective, in a place where it's working well, but I guess my role in this (...) has been to try and help educate and support those individuals who have the responsibilities to make these changes, so that they understand the importance of it and start enacting some of ... those changes that need to happen organisationally, so that anything that's happening locally isn't being stifled because our policies and processes are counter to the way that we're trying to work."
(Senior Management Focus Group)

Consultation with staff and service users, referred to by senior participants as a *'trauma informed inquiry approach'*, was understood by all focus group participants to be at the heart of all TIA implementation. In addition to the practical changes that emanate from such involvement, senior SA managers noted how such an approach also meant that staff were being given more time and space to reflect and 'properly process' proposed changes, rather than have change foisted upon them. According to participants, this trauma informed inquiry approach had been taken on board by the organisation as a whole, with staff and service user involvement now embedded as a core feature in many policy documents:

"I think the reason that the [NI TIA] pilot was so successful was because of the trauma informed inquiry approach. The fact that people were given the space to reflect and understand and embed [the changes]... it was a very different approach that we took to the way that we sometimes do training, and ... it's definitely something that as an organisation, that we recognise and are trying to take forward in other areas. This way of giving staff the time to properly process and then be supported in the embedding of [the initiative]."
(Senior Management Focus Group)

Such consultation was reported to be influencing the type of services SA wished to deliver at a national level. For example, in the development the Homeless Services Strategy, meaningful involvement with service users and staff was claimed to have brought a notable shift away from larger scale residential provision to the proposed development of smaller services and facilities.

At the local level, the Thorndale PS manager spoke of how TIA implementation had essentially started with consultation with staff and service users. She described how they had used the 'transformation model' (introduced at the SBNI 'Be the Change' Leadership Programme) to *map the service user pathway through the service ('from entry to exit')* as a means to explicitly consider and understand their experiences while receiving support from the service. However, in addition to the service user experience, it was considered essential to understand the experiences of staff during their time of working for the organisation:

"We looked at the... transformation model, looking at the [service user/staff pathway]... from entry to exit,... to get a deep dive with staff and service users, really looking at from when people enter our services or our supports or start their engagement or... their employment with us, what is that process like for them?... How do they experience that? And we reflected on that entire journey and... (...) we mapped the staff reflections against the [TIA] domains."
(Senior Management Focus Group)

In addition to paying attention to the 'welcome' offered to service users, the central Human Resources (HR) Department was also reported to be undertaking work in relation to *staff experience of recruitment, induction and support* at SA. This work was aimed at understanding how staff could be better supported to feel 'safe and secure and valued and connected' to the organisation, thus reducing staff turnover:

Figure 5.7: Graphic developed by Thorndale Parenting Service to depict the core components of their TIA implementation process (Artist Beth McComish)

"And we looked at that in so many different… not just the welcome to service users when they first arrive (…) But when staff first apply for a position, what is that recruitment process like? (…) and HR have really stepped up about that… they're doing a big piece of work at the minute around… really looking at the turnover of staff in the first year, and… why is that happening? What? What do we need to do about it? What could be better? You know, how do we keep people? (…) This is… our welcome. You know, so not just literally that first day, but that first week, that first month, those first six months, that first year, you know, what is it that we can do to make people feel safe and secure and valued and connected within our services? And so, it needs to be looking at recruitment. It needs to look at support. It needs to look at induction (…) how do we make people feel more welcomed and valued and intrinsically a part of what we do, whether that is the people that live or work in our services."
(Senior Management Focus Group)

The importance of the **physical environment** was discussed in both staff and senior manager focus groups as an area that had received significant attention and where the benefits had been much larger than originally anticipated. The Thorndale TIA pilot had proved the catalyst for these developments across the wider SA organisation. The NI senior manager described the process of refurbishing one of their buildings on the site in North Belfast. While acknowledging that it was still 'just a building', her experience of the 'intentional' efforts taken to involve service users and staff in the design process had brought many unanticipated benefits:

"I get that it's just a building and I get that…a building and a place isn't everything. But I think what this has really taught us is that actually with intentionality, if you really seriously focus on the physical environment or the environment… that people either work in or come to live or receive their support, the benefits of that, I think, are even bigger than we had anticipated."
(Senior Management Focus Group)

It was emphasised that these changes had been achieved with a small, limited budget in a non-purpose-built environment:

"This is just a small building, it's not purpose-built. We just did a little bit of refurbishment too, but we did it with a lot of careful consideration and consulting with people… and we looked at trauma informed design and trauma informed architecture and things. And obviously, if we had had millions and millions of pounds, it would have been done very, very differently, and we've done it on a shoestring, but it really shows that actually with a little money, but with the right intention that actually a place and a space, the physical environment can make a massive difference."
(Senior Management Focus Group)

Part of the learning from facilitating this process, initially in Thorndale PS, and then in other projects across the UK, included the organisation, as a whole, developing a more fulsome appreciation of how the physical environment in which people work or receive a service has an impact on the individual (through their senses) and shapes what happens within that space. Given SA's many residential services for homeless people, it was noted that for many service users, these buildings become their 'home', at least for a period of time:

"So I think that the learning… what is the environment like where people live, where they receive their support, where they either come to on a daily basis or where… you know, that's their home for a period of time, and… what impact does that have on them… everything that they see here, smell, experience… all the signage, the noticeboards… all of that. I think that's been a massive learning curve for the organisation."
(Senior Management Focus Group)

However, to achieve such benefits from the redesign of the physical environment, the *process of involvement* (i.e. trauma informed inquiry approach) was clearly emphasised, as opposed to the end product itself or differences in colours/ décor, etc. This was noted as frequently misunderstood by organisations who wished to come and visit the refurbished building. The involvement process started with facilitating staff to 'walk through' their own work environments, or indeed other SA projects, using a trauma-lens to consider what service users would see, hear, or smell to help orientate to their experience:

"I've been to [different regions and services]... they're starting to do these walkthroughs of their services, you know, with photographs and swapping staff teams, and getting staff from one service to go into another service and really look at it and think about how that looks and smells, and what they hear and the buzzers... just everything."
(Senior Management Focus Group)

"You know, when we look at the building like, you wouldn't have the big strobe lights in your house, but we expect them in every service we've got."
(Staff Focus Group)

It was argued that, with time, the environment in which we work frequently becomes a taken-for-granted backdrop that we stop noticing. Making time to purposefully consider service users' experiences of the physical space was perceived to have brought 'massive learning' for all involved, with the benefits of walkthroughs cascaded throughout the SA. While appreciating that a building will 'never be enough on its own', the reflective discussions elicited by such walkthroughs was reported to have led to renewed appreciation of how seemingly 'small and insignificant' aspects of the environment 'really matter', with an enhanced appreciation of service user experience described:

"There's been lots and lots of learning from that and lots of development, and although it might seem as if that's small and insignificant to some people, I don't think it is. I think it's massive.... We knew that the physical environment was important. The pilot study showed us that we needed to pay a lot more attention to that... small things, you know, but small things really matter... And it's never going to be enough on its own, don't get me wrong, I get that all of this other stuff has to go around it, but even with that,... involving [staff] in these reflective spaces and reflective discussions to say 'let's look at how this might be from the minute that somebody has referred to your service, you know, how does that happen? what happens? how might that feel for somebody? how might that feel for somebody who has just fled, you know, had to flee their home country or... you know whatever their kind of trauma sort of history is or how they've arrived at that service and things. So staff are having the opportunity and the space and the support to consider those things a little bit more than they had done previously, and I think that's having a massive impact."
(Senior Management Focus Group)

These sentiments were echoed by the staff of Thorndale PS. They described the new trauma-informed building as 'a paradise', where *thoughtful attention to 'tiny things'* helped to engender 'a positive environment' for both staff and service users:

"The new building as well... It is like a paradise, and everything about it is perfect. It smells good. There's always like fresh flowers... there's colour everywhere. Everyone's always smiling. It just... you don't like realise how much the small things, like the little tiny things, the thoughtful details, mean to not only staff, but to service users as well. So I think this, like our surroundings, have a lot to do with like the positive environment."
(Staff Focus Group)

Staff emphasised the process of meaningful involvement in the design of the building, which had been central to its success. They spoke of how, as a team, they had felt 'so included and consulted and involved at every step of the way', from choosing colours, purchasing furnishings to naming rooms:

"We felt so included and consulted and involved at every step of the way... right from the very beginning.... it was things like choosing the colour of paint. Yeah, you know, we love shades. We went shopping together... We just imagined what our rooms are going to be like... (...) yeah, for me, that definitely was a real biggie."
(Staff Focus Group)

Stories were also shared of how the children had been involved creating mosaics in the play area:

"I also love the story about the kids doing the mosaics, breaking the plates and stuff. I don't know why it always makes me smile.... So there's wee like stations outside in the [play area], the kids got their wee goggles and stuff and they broke these plates to make the mosaics for like wee seats and stuff. It's absolutely gorgeous. (...) it makes me so proud of the service."
(Staff Focus Group)

Echoing the NI Service manager's concern, participants in the staff focus group expressed caution that the refurbished building itself could be put forward as an end in itself, 'the crowning glory', without understanding the 'long journey', team involvement and relationships that made it happen and make it work:

"Specifically looking at Thorndale… they're amazing at relationships. So, of course the building looks outstanding… it's absolutely terrific. But see if we don't get the relationships right, that doesn't make any odds. I've been in some lovely buildings where people are being treated really, really badly, so although the physical environment is amazing, which it is, and it's probably the crowning glory for the Salvation Army, that would all be lost if you didn't have that staff team and the relationships."
(Staff Focus Group)

"I think the building can be misconceived. So what I mean by that, is people think… this has been in the process here a few weeks, and then they'll get this all whistles and bells building, and it's so not been the case. It's been such a long journey, you know, and it's been really, really difficult for the team. It's been really, really hard, but so, in a sense, the building can be misconceived because people think, oh, that's absolutely brilliant. But there's been, … even internally within the organisation… a lack of understanding of the journey."
(Staff Focus Group)

However, these reservations aside, the process of involving staff and service users in purposefully reviewing the physical environment from a trauma-informed perspective was described as an 'an easy starting point' for projects embarking on their TIA implementation journey. With Thorndale seen as a 'blueprint', it was reported that the walkthrough and reflection process was being used across projects and regions with favorable effect. Thus, these local developments were reported to have an impact at the national level, eliciting Head Office consideration of all their buildings, including how to embed trauma-informed principles as an essential design concept in all new builds. This was reported as an ongoing development:

"So within research and development… the team that go in and support the local expressions of the Salvation Army to think about their buildings… they've been doing work in the last year looking at what does it mean to have a trauma informed environment, and they're trying to build that into their design principles… So the person that's been given the responsibility to understand what this means has been in contact with [Thorndale]. They've had some conversations with architects … when we're building, starting to think about this. What does it look like? So are our buildings like this across the board? Absolutely not. Are we trying to start to consider how when we create new buildings, we need to have this as a design concept? Yes. And that's for our churches as well as our centres where we provide social services effectively."
(Senior Management Focus Group)

Collaboration with external organisations was also an area positively impacted by TIA implementation. The NI Service Manager spoke of how the relationships had been developed with different agencies over many years. These were described as having been significantly enhanced since they started their trauma informed journey, with their service and 'expertise' now being explicitly requested by the courts. This was, in turn, thought to bring benefits for families:

"Locally here… in the parenting service, we always have had quite positive… connections with… external agencies, statutory providers and…, the judiciary and things like that. That has grown over the years, and it grows through relationships and… involvement and professionalism and reputation…. But… the trauma informed journey and development has clearly further massively enhanced those connections and relationships, and it's being recognised more and more… and, that in turn then, is having a much better impact on families because, you know, maybe, where it's not the Trust Care Plan to return children or something, Independent Advocates, Barristers, you know, the Children's Court Guardians… are now all going to the court to say, hold on a minute here, this family, I think, would benefit from the trauma informed approach that the Salvation Army are taking. (…) and the direction of the court is that… a holistic trauma informed

approach, is required with this family and they are asking for the Salvation Army to undertake that service rather than the statutory family centre, because of our development and our expertise."
(Senior Management Focus Group)

Implementing a trauma informed approach was therefore seen to have a 'ripple effect', as more people became aware of what it looked like and what it could offer. For organisations, such as Thorndale PS in the voluntary sector, commissioned by statutory services, this acknowledgement of their expertise was seen to alter the power dynamics with the local HSC Trust strengthening cross-sectoral relationships:

"It definitely is that ripple effect, (...) the more that people hear [about a trauma informed approach] and see it and learn about it... and have experience of it (...) Not only is it improving the quality of care and outcomes for the service users, but it is improving those relationships and connections as well. We're now probably able to be stronger with the statutory referring teams than we were previously. They used to just think 'we're paying your contract, we're the ones commissioning you' (...), whereas they are now coming seeking our advice, because we're seen to be the people with more knowledge about the benefits of this approach. So I do think it is influencing, relationships and ... cross-sector collaboration as well."
(Senior Management Focus Group)

Progress monitoring and evaluation was identified as an area where significant progress had been made at both local and wider national levels. The local TIA pilot at Thorndale was reported to have engendered a revitalised focus on bringing the abstract terminology used in over-arching policies and strategies to life in more concrete ways. From there, it became possible to explicitly consider what difference TIA implementation was aiming to make for service users as well as staff, and how any impact might be measured. From these beginnings in the local project, it was anticipated that these processes could then be implemented in other SA contexts:

"So, I think that the pilot project and then all of the work that we've really done from that has helped us ... just not to use the terminology and put concepts into strategies... but really do a deep dive around what does that actually mean? How are we going to know whether that's happening? Who's going be any better off? How are we going to know that? How are we going to measure it? And you know, what are some of the intended kind of outcomes?... And that's what we did at a very small local level. And then looking at how can we transfer that bigger and better, and higher and stuff."
(Senior Management Focus Group)

Assessing TIA intended outcomes and the specific benefits for the people using the service and the workforce was understood as being important in moving beyond 'good intentions' and 'niceties' toward a stance that fully understands the principled rationale behind the change initiative and its implications:

"The Salvation Army has... always been well intended and they always try to do well... but... sometimes it's just not enough... this process I think has started a momentum of... is what we're talking about enough. What impact is it having? Why do we need to do that? You know, even all of this stuff around, wellbeing for staff, you know, looking at staff wellbeing, creating an enabling and flourishing environments and stuff. That's all very well and good, but actually, what difference is that going to make? And why do we need to do that?... Not just that we want to provide nice environments for staff to work in..., but that deeper sort of approach around, what happens if we don't? and what impact does that have on the workforce? and on the people that we're... supporting and things? And for me, that's the difference that we have now, moving forward, that it's not just all these well-intended, you know, ideas and concepts and things around creating niceties for people, but actually really... understanding the why."
(Senior Management Focus Group)

However, a range of difficulties in designing and implementing TIA progress monitoring strategies were expressed in the senior management focus group. For example, the pandemic was thought to have limited opportunities for assessing impact on service users, with under-staffed services attempting to 'simply get by' and 'keep people safe':

"I think measuring the impact on people in receipt of services over the last couple of years, it's just been difficult... coming out of the pandemic, you were on a bit of a kind of skeleton staff situation... Sometimes you were simply getting by, you know you were trying to keep people safe and keep people in work."
(Senior Management Focus Group)

The relational nature of some TIA outcomes was also reported as potentially difficult to measure by standard output metrics, prompting people to think differently about outcomes and outcomes measurement:

"... the more abstract outcomes... people are starting to think about outcomes differently and starting to really question 'hang on a minute, when we do this work, what would actually be the outcomes that we would want to see? or that we would expect to see?'. Whereas before, it was, how many people have moved in? How many people have moved out? How long did they stay? You know what I mean, the very outputty kind of metrics, whereas now, we're thinking about outcomes in a really, really different way and not... understanding the difference, that's an output. We're not an industry... this is a relational dynamic that's going on here, so how do you measure the impact of that?"
(Senior Management Focus Group)

However, in spite of these challenges, work appeared to be underway at the organisational level to find ways to evaluate the impact of the 'Valuing People Strategy' by reviewing staff metrics such as grievances, attrition, and retention and undertaking staff surveys in relation to wellbeing, organisational engagement and job satisfaction:

"From an organisational perspective... the evaluation of this has been wrapped around the work that's happening within the 'valuing people' [policy] work... of which trauma informed practice is obviously a central thing... So we're obviously looking at the standard type metrics that you'd look at in terms of... attrition, trying to understand why that's so high, you know, the grievances, the retention and all those kind of standard things."
(Senior Management Focus Group)

Satisfaction surveys had also been conducted with service users. While results tended to be positive, concern was expressed at how trustworthy such surveys can be, given inevitable power differentials, prompting efforts to consider alternative approaches:

"There have been, over the last couple of years, a lot of satisfaction surveys and stuff like that done with frontline service users, which come back very positively. It's really hard to tell how genuine that is because when you ask somebody who... to a degree, you're in control of whether they stay in a service or not, are they going to say bad things necessarily? I don't know, but I think we're starting to understand, hang on a minute, we probably need to do this in a different way as well, and actually understand the experience of people."
(Senior Management Focus Group)

While evaluation work was underway, with some baselines established, it was acknowledged that, as yet, there was no 'clear framework' to adequately capture or measure the organisational cultural change elicited via the 'upwards and downwards and across-ways approach' of TIA implementation:

"So we have some sort of baselining markers, but I would say that we don't have a... to date, a clear framework for how we're going to do this. It's very much being considered, but it will be considered as part of the broader work that's happening... from a cultural change perspective... that's so significant to our organisation that's allowing this... kind of to happen more successfully, and that's very difficult to measure."
(Senior Management Focus Group)

However, work was reported to be currently happening at the local project level to advance development of such a framework. At the new early intervention project 'the Bridge', staff have been working with the central SA R&D team and an impact measurement specialist to develop a set of impact measurement tools to capture parental wellbeing, strengths and struggles at the point of service entry and exit. These would be combined with practitioners' views of change and importantly the 'family voice' to consider people's personal assessment of what difference/if any has been made and their experience of the service:

"... in the new strand of the service here, the Bridge, which is the early intervention service... for families in partnership with the [HSC] Trust, we have been really looking at outcomes and impact measurement. So we've been working with [the SA R&D] team and the impact measurement specialist (...) So we're looking at parental wellbeing whenever they first come in, we're looking at what are the issues that they're struggling with... you know, parental strengths and struggles. (...) So we're taking a measurement of that when they first start with us, and then again when they leave. Now, the overall outcome of that is a three pronged thing. It's based on [the impact measurement tools], but it's also based on the on the practitioner's ... analysis of... how things were with this family when they first arrived with us? how are they now? What has been done? What was the impact of that? You know what's different? And..., where are we sitting at now? and what has made that difference? So the professional or the practitioners' view, the impact measurement tools, and then the family voice. So for them, what's different (if it is different), what was different? What was it about here? What was it about the service that meant that things were different for you? or that you were able to access the support or, you know, receive it in a different way, or benefit from it and whatever."

(Senior Management Focus Group)

Staff also spoke of the importance of service user feedback collected through satisfaction surveys and regular interviews with service users by a representative of the RQIA. Staff also described a box and 'comment tree' at the service entrance with messages from service users. Reading some 'lovely messages there' were reported to help staff when they had a 'bad day':

"We also have a box out the front as well and we have a little tree... a wee comment tree with little hearts on it and the people can write messages. There's some lovely messages. We read them. Sometimes you have a bad day as well, it's nice just to refresh your memory and remember why you're doing it, but yeah, there's some lovely messages on there."

(Staff Focus Group)

Workforce development and support

In relation to **workforce development**, senior managers reported a number of significant changes to routine SA training delivery modes across the UK and Ireland which had emerged through TIA implementation efforts. These included the incorporation of the trauma-informed inquiry approach into all training delivery. This meant that training was no longer considered a one-off, primarily didactic event with large amounts of information delivered to the audience:

"So I think a lot of the work around harm reduction, where it was going around and doing a lot of training around trauma. In hindsight, it was done in a really, really bad way, because you would just be going into services, training the whole load of people really passionately - going over there, doing over there, going over there, doing over there, and you were just hoping your cheering enthusiasm would make it stick. And I think in some places it kind of did, but now... they're training in a really different way."

(Senior Management Focus Group)

Instead, *training delivery was reconceptualised as a form of 'facilitation'*, where participants were invited to actively engage with the material, with opportunities for follow-up built in to progress discussion and understanding:

"I'd say it's more kind of that facilitation... So, rather than going in and throwing a load of information about trauma or ACEs or attachment, it's going in and talking about it, and then going back and having another space to talk about, and going back again to happen. So they've really taken on that kind of trauma informed inquiry approach to... this is an ongoing conversation and this may never end."
(Senior Management Focus Group)

In these ways, it was thought that practitioners were better able to voice their concerns over some TIA core messages regarding sharing power with service-users. Staff perceptions about a lack of attention to their safety and wellbeing could also be discussed and addressed in the reflective conversations. As a result, senior leaders got to understand staff fears and were able to engage practitioners with the proposed changes at a 'very deep level', thus overcoming any latent hostility and providing a real opportunity to embed practice change:

"And as a result, we're seeing, certainly within services, a lot of people... connecting with it at a very, very deep level, where you used to get the hostility or 'we're not doing this because all of the service users will have complete control over us', we're able to sit there and say 'why does that frighten you?... why is that so scary? and why is this a conversation about control? Like should we be having a different conversation?' And because you're able to work with people very slowly, there's a real organisational understanding that if you don't feel safe, you're not going to move anywhere, and that safety applies to staff just as much as it applies to the service user. So that's really good. So I think we do [training] in a different way."
(Senior Management Focus Group)

In addition to embedding this more reflective and facilitative form of routine training delivery at a national level, the move toward using online platforms, elicited during the COVID pandemic, to facilitate *'online communities of practice'* was perceived to promote shared learning across sites and regions:

"We're bringing these communities of practice together online, in terms of Family Services and training people up in child sexual exploitation and, you know, and then they're providing the lead and the guidance for other people in different countries."
(Senior Management Focus Group)

Together, these changes were thought to have engendered a significant 'cultural shift' in how training is delivered across the national organisation. Training was described as more 'agile', in terms of the use of online platforms to facilitate greater participation, maximise cross-site engagement and learning, and also speed up training delivery. However, the type of trauma-informed inquiry facilitation with the emphasis on participant response and reflection was also noted as slowing the process, with better tailoring to the specific context and opportunities to address staff perspectives. In these ways, it was considered more likely that the key messages would be fully grasped and learning embedded:

"One of the other things that we've got, which has come again out of the kind of the shift into more digital ways of working, there's far more communities online than they ever used to be. So in the organisation, historically, there was always this we had to work face-to-face, and therefore everything slowed down, and conversation slowed down, and you would have somebody working in Skegness who wouldn't even know about [Thorndale] service. Now we can have communities of practice online, where loads of people coming in are having conversations about the work, how it makes them feel. That's echoed in the wellbeing spaces. That's echoed in the way that we train, so this kind of cultural shift around let's do this slowly. Let's think about how this feels as we go along. I think that's probably one of the biggest shifts that I've seen. We work in a different way than we used to, and that's at all different levels."
(Senior Management Focus Group)

At the local level, another change of note in the delivery of training was the *inclusion of personal testimonies from service users* who had been through the service at Thorndale. This was reported to be 'so powerful', enhancing training provision:

"One of the things that's really enhanced... our training programme... (...) people who have been in the parent assessment team coming back and giving personal testimonies, which is just so powerful. Sometimes there's not like a dry eye in the house. (...) you know, when all the odds were stacked against them and they come through it. So the personal testimonies have absolutely been fantastic also. Well, actually it wasn't part of the training. But it's become part of the training (...) we'll reach out to some of the people that have been through this service and that more than happy to come back and share those personal statements."
(Staff Focus Group)

In terms of *training curriculum content,* staff and service managers spoke of delivering training on harm reduction, ACEs, attachment, trauma, suicide and self-harm, amongst other topics, tailored to particular services. Coaching for managers during the COVID pandemic was also noted as a training priority. The NI Thorndale staff reported that they had recently received the 'Think Family Model' delivered by the service manager. In terms of leadership training, SBNI 'Be the Change' Leadership training programme was noted to have been influential in helping the NI Service Manager plan for TIA implementation.

Senior management focus group participants highlighted the very significant organisational shift toward recognising and addressing **workforce support and wellbeing**. This shift emerged through the impact of the COVID pandemic and lockdown, and happened to align with the local TIA implementation pilot in NI, to bring new organisational learning both locally and nationally. Over the pandemic, participants noted how the organisation as a whole became more acutely aware of its staff and their wellbeing as critical factors, with refreshed efforts to look at workforce support:

"I think some of this as well is about timing,.. sometimes things kind of just align. (...) we were doing this pilot study and the report, and we had COVID, and as part of the process through COVID, the organisation became a bit more aware of its staff... and staff wellbeing and what did that look like and how could we support our staff better."
(Senior Management Focus Group)

At a national level, the COVID pandemic was thought to have brought greater recognition to staff as the organisation's 'magic wand' or 'most valuable resource', without whom the work with service users could not occur. Given the many challenges associated with the pandemic for everyone, it became appreciated that staff were 'fragile' also and could not be taken for granted, thus bringing attention to how the organisation could offer support:

"... maybe that space in time where people start to ask during COVID... The people started to reflect on how staff were feeling and the wellbeing of staff. Maybe it became really, really blatantly obvious that your resource... (...) it's your staff is your magic wand, it's the conversations they have, and if you're not looking after them, they're not going to be able do that work that we sometimes take for granted, so maybe that space all of a sudden was a 'hang on a minute, the thing that we've just relied on that we thought was always going to be there, is suddenly a little bit more fragile than it used to be'."
(Senior Management Focus Group)

Over this period, an additional organisational change was observed in how the organisation responds to crisis. While previously, crisis response (to both service users and staff) may have been limited to short-term practical support such as 'bacon sandwiches and a cup of tea', this was recognised as no longer fit for purpose in situations where a longer-term focus on emotional wellbeing was required:

"... the organisation is very paternalistic (...) we can practically help, but it wasn't just about making a cup of tea out of a van anymore for people, [it was] who was actually looking after the wellbeing of them emotionally. So there was a change in what a crisis organisation can do. Crisis is not just giving bacon sandwiches and a cup of tea. Crisis is actually looking out for the wellbeing of people."
(Senior Management Focus Group)

This was reinforced through the local staff consultations in NI as part of the TIA pilot. The local senior manager noted, from a staff perspective, how the organisation tended to respond to crises in one of two ways – either to 'rush in' and offer 'rescue', or to 'blame' and seek punitive redress perhaps too quickly via disciplinary or capability procedures:

"Yeah. And that's what the staff were feeding back... in the focus groups in the pilot study to say 'we don't need the organisation to race in on a white stallion, you know, whenever things go wrong or crisis kind of happens and rescue us'... either that rescue being done in a very compassionate way or in a very blaming way, in terms of something has gone wrong, you haven't managed that very well. You're clearly not managing your role very well. Therefore, you need additional organisational supports. So you need to be referred to wherever (...) or you know, ... in a more punitive level, you know, then disciplinary procedures start or capability or something like that."
(Senior Management Focus Group)

Rather than short-term 'pastoral' support at times of crisis, in the TIA pilot staff consultations, it was found that staff expressed their *need for ongoing support* for the complex and stressful work they were undertaking on a daily basis. Given the heightened vulnerability of many client groups in local SA services, there were frequent incidents involving serious harm and fatalities. In such circumstances, staff reported their need for 'skills', 'resources' and 'strategies' to help them 'manage this complexity of work' and stay well themselves, in order to be able to offer that support to service users:

"What staff were saying was... because we were working with staff from [another local SA project] and obviously there were lots of... really, really serious incidents and fatalities and things... they were saying 'we don't need people to just come in at those times and provide tea or hugs or, you know, pastoral support or whatever, we need this all the time. We need this support... We need to be provided with the skills and the resources and... the strategies and... in order to enable us and help us manage this complexity of work that we're doing every day, and actually to keep us well and to keep the service well and to keep the... the families or the service users well, we need that support on an ongoing basis, really, really seriously looking at our wellbeing, not just looking at staff wellbeing whenever your wellbeing's compromised or whenever you're struggling, you know it should actually be a much more sort of holistic thing.' And that's what I suppose we've done here on the more local level.
(Senior Management Focus Group)

From these beginnings, the local NI senior manager spoke of her desire to create a *more 'compassionate, enabling and supportive' work culture* where staff could be resourced with the skills, training and 'spaces for reflection' to enable them to be in a position to offer such support to the people using the service:

"We've looked at how do we create a place and space which hopefully enables people to feel like that all of the time. I know that's a bit idealistic. There's obviously going to be, you know, bumps in the road and good days and bad days and stuff. But (...) how do we support our greatest resource within the organisation? Because if we don't have the staff team, we don't have anything. And if we don't have them well, and if we don't have them resourced and trained and skilled and, you know, spaces for reflection and not just here's your job, get on with that and if you don't do it well, we're going to come and speak to you about it... how do we do that in a much more trauma informed, you know, compassionate, enabling, supportive way. And then if we do that, what might happen? You know what might happen for that staff team? and what might happen for the people that we're serving and supporting? And so how does everybody experience that in a slightly different way?"
(Senior Management Focus Group)

The setting up of an *online interdisciplinary wellbeing group* made up of senior participants across the national organisation toward the start of the COVID pandemic was noted by the senior managers focus group as an important initiative. This spontaneous online response became an important vehicle that helped consolidate organisational commitment to staff wellbeing and also TIA implementation, as it helped move TIA beyond 'just words' to how it could be 'lived out' at a time of crisis:

"And so we set up a Wellbeing for All steering group, … it was an interdisciplinary group which kind of just randomly came together with no constitution… with no terms of reference. But it was because, at the very start [of the pandemic]… people were concerned about what was happening to frontline staff and how they were coping through COVID, and on the back of that, having then the [TIA] report and the pilot [in NI] around the trauma informed work and some of that learning and the links to Enabled Environments (…) the report resonated with what was kind of going on here. So these individuals suddenly became more focused… more aware of what it meant to be trauma informed and why it was so important to the organisation, that we kind of started to really think about how can we make this not just words but actually live this out…. I don't know, if all these things hadn't happened, we would… we're not anywhere near, but… this kind of gave us this momentum that has enabled us to take this on more intentionally."
(Senior Management Focus Group)

One national initiative which emerged from this was the creation of *virtual wellbeing spaces.* These were initiated during the COVID pandemic as a means to offer all SA staff support with the enormous challenges occurring over this period, such as lockdowns, furlough and working from home. These virtual spaces or meetings were described as offering 'facilitated safe' spaces for staff to have conversations with each other – at a time of disconnect. Importantly, they were not intended as spaces to find 'solutions' to problems, but rather as an opportunity for staff to reflect upon any challenges they were facing with their peers and colleagues. While each group created an initial contract with each other, these groups were described as having 'no fixed agenda' and no feedback mechanism to the wider organisation. Initial themes which emerged were directly related to staff members' COVID experiences, such as returning from furlough or working from home. Importantly, there was an understanding that, while there would be commonality represented amongst participants, there would also be difference with, for example, some people welcoming working from home, while others finding it very challenging (e.g., due to living in small bedsits, or with partners and caring responsibilities).

The groups were small, consisting of no more than five or six people, from across the whole of the UK and Ireland organisation, who self-selected to 'drop in'. They were facilitated by staff members who had received bespoke training to do so, with the organisation having taken external advice at set up. Staff could take part in six sessions, increasing to up to 12 sessions. It was noted that these groups were very well received by staff, building up 'internal support systems across the organisation'. On occasion, the external facilitator was reported to 'step back' with participants self-selecting to continue to meet independently. While these virtual wellbeing spaces had continued beyond the COVID era, they were reported to have become organised around specific themes in more recent times, e.g., menopause.

Building on this development, senior management focus group participants spoke of the more recent establishment of *racial inclusion spaces* with the longer-term aim to expand and create other 'safe spaces' for staff members with different protected characteristics. These spaces were reported to be managed slightly differently from the original wellbeing spaces. While a clear contract would still be established, there was an expressed purpose for these group conversations to provide some feedback to the wider organisation, with the noted intention that 'there are things that the organisation needs to hear' in order to improve the experience of both staff and service users from different minority groups. The development of these more targeted virtual spaces was reported by senior manager participants as an important ongoing development, which had helped open up new, and sometimes uncomfortable, conversations with the leadership of the SA UK and Ireland about gender, sexuality and race:

"The other thing... that we're doing, which is... in parallel to that, is we've created ... racial inclusion spaces, and we're trying to look at how we can develop other ones around for different protected characteristics. You can imagine that for us as an organisation, it's a bit complicated as well, as we navigate that. But the idea is that these places can be for people to come. They're managed slightly differently because sometimes in those spaces, there are things the organisation needs to hear, and so the way that we contract with those individuals is slightly differently. But again, it's an intention, and it isn't always comfortable for anyone and for the organisation to hear some of these things that come out of these spaces as well. But we are trying, we're trying to grow into that, and develop that work a bit more."
(Senior Management Focus Group)

The focus group with Thorndale staff members helped elucidate how these national developments came together in a local context and what a 'compassionate, enabling and supportive' work culture looked like in practice. It was of note that two of the participants in the focus group were relatively new to the project and the SA, while two others had been there for many years and had worked through the COVID pandemic and at the initiation of the TIA pilot.

As well as the meaningful involvement of staff in TIA developments (e.g., the building refurbishment), *good communication between staff was seen as central to developing a supportive work culture* at Thorndale. In addition to handovers, supervision and regular team meetings, participants spoke positively about the 'open door' policy to the team manager and colleagues, where they could discuss anything within outside of the more formal structures:

"We operate an open-door policy, you know, we're not afraid to sort of approach each other and offload or ask opinion or whatever, you know what I mean, outside of the handovers, more formal meetings, you know, so we're pretty much always kept up to date. And the other thing is we all know each other intimately, for want of a better word. We know how each other thinks and yeah, and stuff like that, which again works well."
(Staff Focus Group)

Reflective practice was reported as an important aspect to Thorndale's workforce development and support processes. While the structured reflective practice with an external facilitator was not reported as particularly useful by one participant, it was noted that it had generated discussion, and staff reported that they were continuously reflecting on their cases on an informal basis with colleagues:

"We had very structured reflective practice. We had an external facilitator for that. It worked OK... I don't know.... we felt that we weren't getting a whole lot of that, but... it did generate discussion after the reflective practice session... so we did get a benefit out of it, but we talk about our cases hourly, you know, it's constant state of reflection... You know, like... 'oh this just happened. So what do you think about that? Well, let's think about it this way. Maybe it could be that'. And it's just having that collective discussion with each other."
(Staff Focus Group)

Participants stressed the importance of *team relationships*, describing how they knew each other 'intimately', crying together, and laughing together to get them through difficult times. To emphasise this closeness, the team was variously described as 'close-knit' and 'my work family':

"We read body language easily. If I walk into a room, if I know [name] has had a difficult day, I'll know,... just by looking at [name]... I'll know by how they maybe talk, their tone of voice changes because this is a residential setting, we are with each other 8 hours a day. So... this is my work family, you know what I mean, (...) like we are a very close-knit team and we know when we're having those bad days, you know, we look after each other. So it's extra cups of tea, an extra hug and cried together, if we need to cry,... laugh if we need to laugh."
(Staff Focus Group)

Reflecting on before and after TIA implementation, staff members described a *flattening of organisational hierarchies* between support workers and social workers with the creation of one team as opposed to two, with everyone's opinion and experience valued:

"I actually think now, from we've become more trauma informed, that we are seen as one team, and not two separate things. Whereas before, it would been support staff and social work, and it might have been support staff versus social worker almost, whereas it's not like that now, do you know what I mean."
(Staff Focus Group)

A strength of the Thorndale team, noted by the regional trainer, was the 'different backgrounds and experiences' that staff members brought to their work with vulnerable service users, enhancing the service:

"You've also got a brilliant balance in your team. You know really, like, people with very different backgrounds and experiences and stuff, which really enhances the service."
(Staff Focus Group)

Participants also noted their willingness to draw on *their own lived experience* of challenging issues to help orientate to their service users' struggles:

"... the obstacles that [our service users] overcome as well are like really common things that happen in life, like domestic violence um, you know, drug use, alcohol use. I would say probably everyone [in team] has some kind of first-hand experience with stuff like that in their everyday lives, whether it's parents, partners, children, friends, extended family. So yeah, I think like sometimes you'd be supporting someone, and kind of be able to draw from your own experience."
(Staff Focus Group)

The focus group participant who delivers training to SA services across the UK and Ireland noted how 'unique' the *staff induction process* was at Thorndale. While the induction included the usual three-day staff training on harm reduction, ACEs, attachment, trauma, suicide and self-harm, it was the focus on investing in staff that was reported to set it apart:

"[In Thorndale] how they induct people into the service is totally unique to any other service... So that's right, across the UK and Ireland and it's a very unique service. (...) the staff have got very comprehensive induction process and (...) policies are really really good. But you know it's about that relationship. So when everybody comes in, that's the first thing that is fostered is a relationship. They are primarily invested in staff. (...)"
(Staff Focus Group)

Service Design and Delivery

Changes to service design and delivery were reported as a result of TIA implementation at both local and national levels. These included: 1) enhanced service user engagement (e.g., adaptation of admission and assessment processes); 2) greater attention to service users' trauma history and intentional efforts not to retraumatise; and 3) improved quality of service delivered, with value given to connecting with service users in meaningful ways, tailoring and adapting service provision to better meet their needs. In addition, at the national level, senior managers reported a shift toward smaller residential facilities as a result of service user and staff consultation.

Enhanced engagement with service users (and indeed with staff) was a key target of TIA implementation, highlighted by both staff and senior managers across the local and national organisation. It was thought if this 'welcome' was enhanced, many other aspects of service provision would also 'blossom':

"Our welcome needs work...[a key finding from the TIP pilot] and that's something that I think could be applicable across service delivery and the wider organisation... if we got that right, you know, so much of what we do would just blossom."
(Senior Management Focus Group)

Staff at both Thorndale PS and the Bridge early intervention service identified a wide range of ways in which they had sought to enhance their 'welcome'. They emphasised that many parents referred to the residential parenting service by Social Services often came with great mistrust of services. To address this, practitioners were encouraged to explicitly seek to understand parents' prior service experiences, so they could adapt their practice accordingly and better meet the client's needs. This was reported as making a 'massive difference' to families, who had indicated that this was their first experience of a service seeking to adapt to them, rather than expecting them to adjust to the service:

"So we're... just helping families look at... 'if you've been hurt or harmed previously by the system, then we need to understand that a little bit and then we're going to start at a different place... so that's a different experience for you... (...) Let's talk about that first, so that we've got a better understanding... so then we can, you know, make sure that our... response... is very different' and that is having a massive difference on the families, because they are saying for the very, very first time people are asking them, 'why is this not working for you? or how is this experienced by you? And in order for this to be different for you, what do we need to do differently?' Not what you need to do differently."
(Senior Management Focus Group)

Staff were acutely aware that there was a lot at stake for parents when they entered Thorndale PS, with the possibility that their children may be removed from their care. Focus group participants noted how they sought to attend to how parents 'feel' when they enter the building. Efforts were extended to ensure service users could see that they were 'genuine' and transparent' by their actions, moving beyond more obscure words such as 'person-centred' or 'trauma-informed':

"I think for me it's always 'how does it make a person feel?' So you can have as many posters up on the wall saying that... we're inclusive in this area, in that area, but see for the people, if they don't feel it coming into our service, it's meaningless, you know, and you can say we're person-centred and stuff like that, but see unless you are doing that, for me, it's meaningless, (...) like being genuine with people,... you know being transparent when they come into the service, telling them, you know, that it's a service where..., people are at risk of losing their kids. But if you're genuine and you're transparent, you know, it adds weight to all those conversations. (...) So if we are saying we're person centred, if we're saying, ... we're trauma informed, how does that translate to that person walking into our building?"
(Staff Focus Group)

Focus group participants spoke about how they adjusted the admission process to the residential service to take account of parental fears, even when not explicitly stated. They were cognisant of service users' trauma histories, even when details might not have been fully known, and that they had been mandated by the court to attend the service. Efforts were taken to avoid retraumatisation by taking time to complete the full admission process:

"There are policies and procedures with the Salvation Army, technically we should have certain things done within a 24-hour period... but we will do the very important documentation within that time, so like... they have to sign a license agreement (...) So things around sort of health and safety and the legality of things, we would do that first and then we would leave it over... we would maybe carry it out over a week and take like a full week to do an intake, rather than it needs to be done in an hour and get it all done in one go. It's just too much.... There's a lot at stake for [service users] while they're here, and it's just about recognising that and understanding that.... So the majority of families have not chosen to be here. They've been directed by a judge or by Social Services. They're already... they're already losing that agency, that power, and you know that control over their own lives. So we don't want to do that."
(Staff Focus Group)

Understanding of service users' trauma history was reported as important while recognising that such histories had not always been responded to sensitively by other services:

"There was no consideration, given the trauma that went on in [the parent's] life, you know (...) it was a baby died in here... and the mother was told two weeks later to pull her socks up... To pull her socks up and take care, which I remember thinking as a mother, horrendous, horrendous. But I had no power, you know, at the end to stand up."
(Staff Focus Group)

Staff members spoke of taking a 'gentle approach', offering parents 'lots of reassurance' at the outset. They described seeking to get to know parents first by 'just chatting', building some trust and relational safety, before seeking to talk about more difficult matters:

"And I suppose people that's coming in through these doors are already very, very traumatised for whatever reasons or whatever's going on in their life. They're more traumatised by coming here. So it's about trying to take a bit of a gentle approach, and get them to settle down. (...) Yeah, cup of tea, just sit and chat. Maybe just chat, trying to capture what they're interested in and chat about that (...), instead of getting into the nitty gritty straight away, offering them lots and lots of reassurance is what I would do. Tell them that I'm here to work for them... I'll go into the whole evidence gathering thing that you know... the more evidence that we see, the more we can pass on, you know, our job is to get them home, but they need to work with us."
(Staff Focus Group)

By altering the pace of admission and building relationships, staff members sought to avoid creating a 'cold clinical environment', where parents would not be able to demonstrate their parenting ability:

"Yeah, because we want to replicate home in this residential unit, you know, we want to replicate how life would be like for them at home in the community, ... so that we can get an understanding of their parenting ability within that environment. So if it's, if we create a false environment... then they're not going to be as relaxed, and we're not going to see their true capability."
(Staff Focus Group)

Such engagement efforts were echoed by the day services offered by Thorndale and the Bridge. Staff described working to attune to the service user experience and possible fears, sending a text message to referred families as a means of introduction before calling to explain the service offer:

"Every time before the first session with a client,... I'm sitting with myself and I'm thinking like how I would like to be treated, how I would like to be seen, and how I would like to be listened to, so that's helped me to have a conversation with them and also understanding that... they will have to talk to ... someone who never was in their life never before, you know. So what we try to do in the Bridge,... before that phone call and to say, oh, 'hello, we are calling from the Bridge, the family centre, and you've been referred by Social Services', so we create like a wee small text message. So we would send that small text message before our phone call to be more familiar for families (...) alright, this is [name of worker], from the family centre, what is she able to offer me? You know what I mean? So I think that helps."
(Staff Focus Group)

Service managers described how **enhanced support offered to service users** involved a move away from a 'pity-focused' model of practice toward an empowerment approach. This was understood as an approach that took into account the long-term impact of trauma on people's difficulties and presentations, seeking to 'listen to people' more, rather than only offering short-term solutions:

"It's a bit of a shift away from pity, 'cause the organisation I think... felt that it was very empathic and is now starting to come to terms with it was very much a pity-focused kind of model that we've historically used, and therefore those expressions of our work like the Food Bank... some of them are starting to work in a much better way with people, where it's about sitting and understanding the person."
(Senior Manager Focus Group)

This enabling approach was also reported by staff members who noted the skills required to facilitate useful conversations:

"Yeah, in terms of ... like our skills, I think it's around our... questioning and interviewing skills, ... maybe framing a question to try and get the best response,... making sure it's open-ended and allowing people... enabling someone to be able just to let it all out and to offload."
(Staff Focus Group)

Staff focus group participants spoke of how they had begun to think differently about service user presenting behaviours, particularly when problematic, seeking to take a 'step back' and helping service users talk about what was happening for them. They noted how training with the SBNI had encouraged them to consider the service users' presentation through a 'trauma lens' and seek to understand what additional needs may be being communicated:

"I think it was through that training. Remember, we looked through the trauma lens. (...) right, hold on, whenever we see someone who is maybe dysregulated, had a difficult day, we were maybe just seeing the behaviour for what it was, you know, as it stayed in front of us, without really thinking, what's the presenting need, what are they trying to communicate to us that maybe they just can't at the minute? And I think for us, it was around taking a step back and then actually giving them the time to talk about what's going on there."
(Staff Focus Group)

Being 'attuned' and 'available to listen' to service users and having the time to respond 'in the moment' was seen as key to building trust with service users, helping them 'process' challenging life experiences and engage with other services:

"I know that with a lot of services that they're really busy, you know, people wouldn't have time to say I'm really struggling right now. Can you speak to me for half an hour? You know, it would have to be. It would be like 'I'm busy. I have a meeting' or whatever... and I think just like having the availability to be able to listen to someone and be there for someone in the moment, rather than being like 'I can come back tomorrow at half two' or whenever I've got the time, you know, I think like that kind of style of dynamic working (...) we're also able to be there and say, you know, 'I've noticed you're not at your usual form today. Is there anything you would like to talk about?' or you know, someone is kind of a bit quiet... it's the ability to kind of be able to listen to someone non-judgmentally, but also have the same, you know, professional support... we can listen to them, but we also have to like help them to get through that and process that, and you know, push them in the right direction towards signposting or services."
(Staff Focus Group)

Staff reported how they sought to 'meet people where they were at', sometimes giving 'extra chances' rather than swiftly discharging following non-attendance. In these ways, staff sought to try and understand that service users may not always be 'strong enough' to engage, thus making intentional effort to adapt their practice in the best interests of the service user:

"I know from experience as well, whenever you get referred to counselling services via the GP or whatever, if you miss a session, you know you'll get a letter or text saying please be aware that if you miss another session, you will be discharged, you know, so I think... it's the fact that we have the ability to kind of give people extra chances because a lot of the time, you know, people have a bad day, you know, don't sleep well. They wake up in the morning. They have an appointment and they want to cancel it because they're not feeling super receptive to receive the information that day, you know, they're having, like, a bad day. And they're like 'I don't want someone to talk to me about this and I'm feeling this way'. So I think... the way that we're able to, you know, be willing to meet people where they're at, and make the extra bit of effort if they're not strong enough to make the effort themselves, you know."
(Staff Focus Group)

"We don't expect a person to change for us. We need to change ourselves to that person. We need to adapt to each individual person, because they are unique, and not expect them to conform to us."
(Staff Focus Group)

'Small' details were perceived as important to service users. For example, staff noted how they 'don't give up' if people fail to attend, instead they sent appointment reminders, and did check-in calls if they were aware someone had a 'difficult week':

"And we keep going. We keep going even after six, seven, eight times of not turning up. We will continue to offer (...) We don't give up. We're very stubborn...And then even during the week, sometimes if we learn that maybe someone struggles with remembering appointments, we would put a wee reminder in our diary to be, right. You need to text so and so the night before. Or did you just remind them that we are meeting them at 11:00 o'clock tomorrow or something like that. If we know that they had a difficult week, we would maybe give them a wee call halfway through the week to check with them over the phone... those are just small kind of details, but they do make a difference."
(Staff Focus Group)

Speaking about the early intervention project and efforts to measure monitor progress, staff spoke of how the 'protected time' offered enhanced the quality of support available, allowing them to 'dig deep' with service users when needed:

"... I don't think anybody has went backwards. It's all moving forwards (...) thanks to [HSC] Trust and being able to give us that sum of money to be able to do that work, we've been able to have really meaningful protected time with people, so we are allocated two hours per session... with that one parent. (...) we understand that you know the Health Trust does not have that luxury of time, so having that two-hour session just really allows people to dig deep, whenever they need to, whenever they can."
(Staff Focus Group)

Being 'transparent' and 'honest' with service users about any parenting concerns was considered by staff as central to building useful relationships. This was noted as particularly important in the context of potential child removal, given some parents' previous experiences with Social Services where they felt the 'goal posts' had been changed:

"I'm just reassuring them that, you know, we're here to do a job, but I will be honest, you know, if things are going to worry me, I'm going to talk to you about it. I'm going to be transparent about it (...) transparency, for us, that is one of the biggest things in Thorndale because families have not felt that Social Services have been transparent with them and that they would move the goal posts quite a bit. So if things are working quite well, maybe Social services didn't expect it to go well, to them, maybe they would, all of a sudden, 'oh, we're concerned about this', you know, and then the parents are like, 'woah, this wasn't the concern before', and they would maybe begin to nitpick a bit,... I suppose we kind of then wrap-around the families and go 'it's okay, we can see what you're doing, we can see, you know, we have the evidence around this, we could stand over that, and just kind of reassure them."
(Staff Focus Group)

Staff described how they ensured they informed parents immediately if they had any concerns about their parenting, rather than wait until the weekly review or the end of the assessment. This was reported to be preferred and appreciated by parents:

"... but also letting them know that if it wasn't good enough, if things were not OK, we will tell them there and then, we're not going to wait till the weekly review. We're not going to wait till the end of the assessment. We're going to tell them in that moment, and they really, really, really respond to that. They prefer it, you know, they prefer it, even if it isn't going OK, parents want to know."
(Staff Focus Group)

This transparency, 'open and honest way of working' also extended to note taking and recording practice, as staff were supported to be 'accurate', 'clear' and concise', but also 'compassionate'. Staff members appeared to be acutely aware of the impact of their reports, and that service users may ask to see their records, sometimes many years after their time at Thorndale:

"On the... note taking and the recording also, look at me saying in the training... 'always act as if the service user is looking over your shoulder', you know, so of course it has to be detailed, it has to be accurate, but it has to be done through a compassionate lens, because at the end of the day that is someone's son and someone's daughter, somebody's granddaughter [All say – yeah] So we have to be accurate. It has to be clear and concise, but it can always be done through our compassionate lens, because that person can ask for that. And how would that person feel when they read that material?"
(Staff Focus Group)

"It's that open and honest way of working,.. I think there is an element of it that we are somewhat protected because we're not statutory services, but [the parents] are very aware of the impact of our final reports and our recommendations. They're aware of what could happen if we say no or yes. (...) it's about transparency and about opening up and about, you know, they've known at every step of the way what we're recording,... what we're thinking and stuff like that."
(Staff Focus Group)

Staff participants perceived their 'values' to be important in bringing empathy to their everyday contact with parents. Indeed, considered efforts were believed to be made not to judge people because of their past, but rather seek to evidence current capacity:

"I think for us we have never lost our values and I think that's why we work...I suppose empathy would be the biggest thing. Yeah, you know, and while we're talking about it, ... having a non-judgmental attitude, and we do, and we don't judge their history in the past, but we're judging people from the minute to walk through the doors, and we need to be concerned about that."
(Staff Focus Group)

A notable shift away from larger-scale residential provision to the proposed development of **smaller services and facilities** was reported by senior managers as a result of staff and service user consultation. They explained that national SA were considering their 'minimum quality footprint', i.e. the minimum standards for becoming a SA project. This was considered a 'bold move' by senior manager participants, as it involved a 'big financial investment' in both buildings and teams, with SA potentially stepping away from large-scale residential facilities, recognised as their largest income-generating activity:

"It wasn't just that they clutched... a model out of the air, or a building should look like, the whole of their strategy was based on an awful lot of conversation with service users and with staff... They've been led by feedback, so people are saying we need much smaller services, we need them to be far less intense, less warehousy with their needs. They're having a real... a genuine conversation around what does their footprint look like, so when they step into a service, if we can't do A, B and C, we don't do it. So there's almost a minimum quality footprint that we need to have this in place, otherwise this service will not have integrity and we're not doing it. Now that's a fairly bold move for an organisation that one of its biggest income areas, our local authority contracts through the homelessness services, and they're prepared now to turn around and say we're not doing that anymore... that may fundamentally overhaul all of the services they've got but they're prepared to do it.... this is going to be a big financial investment and people are not put off by it."
(Senior Management Focus Group)

5.5.3 Outcomes and Perceived Benefits

Participants across both focus groups identified a wide range of perceived **benefits for service users**, staff and the organisation as a whole. In relation to benefits for service users, Thorndale staff reported perceived *positive relationships with service users.* Even in the circumstances when they did not recommend a return to parental care, parents retained good relations with the staff and service. This was thought to be evidence of how they worked compassionately and openly with service users, in ways that maintained their dignity. This, in turn, was thought to lead to better outcomes for children:

"And also the other way too, you know, even if it wasn't a good outcome for the parent, it's still the best outcome for the child, you know that (...) they are safe, following our intervention. What's really... blows my mind still is, even whenever we're telling parents, you know, I'm sorry, you know, we are not recommending a return to the community, they still have a really good relationship with us. Yeah."
(Staff Focus Group)

Staff also mentioned the wider benefits to society of the preventative and supportive nature of Thorndale's range of services. Indeed, these were perceived as contributing to *interrupting the intergenerational cycle of children in state care and homelessness* by addressing 'root causes':

"I think it's wider than individual referrals... this approach, as we sit here today, has stopped children falling into that cycle of homelessness. So this has stopped generations of future children... like instead of... pulling people out of the river, we should go upstream to see why they fall in. And I believe that's what our service does. (...) You know, it looks at the root cause, [it has] literally stopped generations of kids who their mum's been in the care system, their dad's been in the care system... through that approach (...) That, you know, has totally changed life for kids in the future."
(Staff Focus Group)

While service user satisfaction surveys were conducted with services at the local level and across the national organisation, senior managers were aware of the inherent power differentials which could make service users reluctant to give negative feedback. At Thorndale, however, staff described the many 'lovely messages' from service users on the comment tree and via RQIA service user interviews, which attested to how positively parents had experienced the service.

In relation to **staff outcomes or perceived benefits**, TIA implementation and particularly the commitment to staff consultation and involvement was thought by both service managers and staff to have led to *staff feeling valued* by the organisation:

"... what staff were asking for was what we've needed for years, and this is what we need constantly, not just in the middle of a pandemic, you know, (...) being seen and heard and valued and recognised, and the connection and the relationships and things, all of the things that staff needed and all of the things that the service users needed from staff... and those are the things that then we've really tried to really build in with greater intentionality."
(Senior Management Focus Group)

Staff reported on the *positive impact on their own wellbeing and mental health*, as they argued that the local service felt like a much "more pleasant" place to work, which was thought to have a positive ripple-effect on service users also:

"I think in terms of mental health. I think it's much more pleasant. It's much more relaxed way of working."
(Staff Focus Group)

"Yeah, for both. Because certainly I mean our demeanour sort of... the residents can pick up on it."
(Staff Focus Group)

A wide range of outcomes and perceived benefits were identified at the **wider organisational level, both locally and nationally**. The TIA pilot at Thorndale was reported to have contributed to a 'very different feel' in the local service, which had in turn translated into positive outcomes for both staff and the service. *Improvements in staff morale, team relationships and communication* were perceived benefits, with reports of people 'going the extra mile' to support colleagues. The Service Manager also noted that it had become easier to get night shift covered, as staff members 'upped their game' and felt more connected to the service:

"There is just a very, very different feel... all over, you know. It has improved staff morale and the team relationships (...) The building has done a lot, but... it's the investment that went into the building and the space that I think has had the big impact on the team, you know. We were worthy enough and the service was worthy enough for people to put the time and energy and effort into actually making this a better place and space for us all to do the work that we do... So, certainly, it has had a massive impact on team and relationships and communication, and how people are willing to go that extra mile to support each other. Previously, you know, it would have been difficult to get staff to cover extra shifts and all of that. People are literally have upped their game and they're pulling people out, and they're... covering each other. And you know there is just a very, very different feel, locally."
(Senior Management Focus Group)

At both local and national levels, *enhanced engagement with staff* involved recognising and valuing staff members' contribution to the organisation and specialist knowledge and skills. The NI TIA pilot and wider TIA implementation across the organisation was considered to have enhanced relationships across projects and regional areas, with greater 'openness' and inclusion across hierarchical structures contributing to a wider sense of *enhanced collaboration:*

"I think it feels different within the organisation, even from my position... I am being included in conversations now that I wouldn't have been previously... I'm being asked to share things with people. People are coming in asking for advice and guidance... Those conversations didn't happen before because of the hierarchy and because of the structure. That person didn't speak to that person, and you didn't have permission to do it. Whereas, now, there's a sense of 'oh my goodness, let's all do this together. And who do we need to talk to? And who's going be able to help us? and how can we support each other a bit better?... That feels very, very different (...) I think there's more openness around it. And I suppose that then feeds into people being recognised for their strengths and contribution to the organisation, and you know who (...) is particularly skilled at this, let's go to that person, you know, rather than just, well, they don't work at that level."
(Senior Manager Focus Group)

The *enhanced attention to staff wellbeing* was a noted change associated with TIA implementation and the COVID pandemic. This had contributed to a range of policy and wellbeing initiatives across the organisations (see workforce support section above) including an initiative by Human Resources to look specifically at staff retention. It is of note that a significant number of the staff at Thorndale had been there for considerable time periods. This focus on staff wellbeing was noted as a perceived benefit with people given the time and space to reflect more in recent years. This was reported as an area for ongoing development:

"I think as an organisation, we've also started to reflect more (...) we created wellbeing spaces, which were just spaces that people could just drop into and just reflect on how they were. (...) suddenly, it feels like as an organisation, we are trying to reflect more, and trying to kind of give ourselves this space. And I think that's so important to how we will continue to embed the trauma informed work, it's a fundamental principle, you know, a fundamental thing that we need to be able to do better."
(Senior Manager Focus Group)

Aligned with this, senior managers reported that conversations at a senior leadership level within the national organisation had changed due to TIA implementation. These were reported to be more 'reflective' with an openness to 'vulnerability' and 'emotional resonance', which had not been apparent previously:

"I'm having conversations with people at a fairly senior level, and the conversations are fundamentally different to how they used to be,... you're able to have more vulnerability, I think, within work, you're able to talk about how the work makes you feel. People are having different types of conversations... (...) There's a definite emotional resonance within those conversations (...) So all of those conversations are really different."
(Senior Manager Focus Group)

As a result, it was thought that there was *enhanced capacity to engage with some of the more challenging areas of development* for the national organisation such as race, gender, sexual orientation considerations, which might have been previously avoided. This perceived willingness to engage with these more 'uncomfortable conversations', in spite of different 'starting points' was described by senior managers as 'really refreshing':

"I've also seen a big movement towards... beginning to call out our own principles a lot more, a kind of stance on certain issues, such as same-sex relationships, issues around race, issues around gender. So we're starting to have a lot of uncomfortable conversations. (...) Like we started at different points here. So this is really progressive for an awful lot of people to be having these conversations. And you can see a lot of people experiencing huge discomfort but being prepared to. And that's really, really nice. That's really refreshing."
(Senior Manager Focus Group)

However, challenges were also noted here with some people perceived to be resistant to such changes and have 'dug in double hard' as a result:

"... the people who maybe don't want to or [development] is in conflict with their own principles, or maybe they're just frightened, have dug in double hard, if that makes sense. So there's almost like a hard core of people who are just like, I'm not doing that. I'm not... and they become very almost fundamentalist, whereas everybody else is moving."
(Senior Manager Focus Group)

5.5.4 Enablers, Barriers and Challenges

Both staff and senior managers spoke throughout the focus groups of a range of factors that had assisted TIA implementation at the local project level, and more widely across the large national organisation. Barriers and challenges to progress were also reported. These are summarised in Table 2.1, with some key issues examined in further depth below.

Table 5.6: Enablers, Barrier & Challenges (Salvation Army UK & Ireland)

Enablers	Barriers & Challenges
A whole organisational effort - 'bottom-up and top-down' approach	Budget restraints, local authority commissioning
TIA pilot projects at the local level that enabled learning to be cascaded across the wider organisation	Loss of implementation momentum & experienced staff during COVID pandemic
Strategic inter-departmental connections across the organisation	Size & complexity of organisation leading to areas being 'disconnected'
'Buy-in' from those in key decision-making positions	History & structure of organisation not being well aligned with TIA principles
TIA leadership vision and drive	Potential organisational discomfort & resistance to change
Meaningful staff involvement and consultation (trauma informed inquiry approach) in all TIA development to promote staff engagement	Misunderstanding of the term 'trauma-informed'
Team relationship-building in the service/project/organisation	TIA implementation considered 'just another fad'
Adequate financing & resourcing (people & buildings)	
Greater use of digital technologies to enhance workforce development, support, relationship-building, connections & shared learning across projects, regions & department.	
Commitment to TIAs embedded in organisational policy	

Senior managers spoke consistently of how a **'bottom-up approach, but also top-down approach'** had been pivotal to successful TIA implementation across a large organisation like the Salvation Army UK and Ireland. To effect whole organisation change, it was thus proposed that *'everyone had to be involved':*

"That [TIA development] was at a local level. I couldn't have done anything else with that... without the involvement of [names], and their positions within the organisation. (...) but what really worked for us was a kind of bottom up approach, but also top down as well. (...) Probably none of us could have done that without the other, (...) real top leadership within the organisation probably didn't have an understanding of what it is like at the frontline (...) frontline couldn't have fed that up any further if we hadn't had the connections and the collaborative relationships with [names] (...) in order to enable organisational growth, everybody had to be involved."
(Senior Management Focus Group)

Collaborative relationships and strategic connections across different departments within the wider organisation were reported by senior managers as pivotal in driving the change process. These key people were then able to use their influence in different parts and levels of the organisation to educate, engage and get whole system 'buy-in'. The three senior managers who took part in this study (a local service manager; senior national operations manager; senior R&D and policy manager) spoke of how their 'good working relationship' had been essential to achieve that 'traction' across the organisation as a whole. It was only 'together', that they had been able to 'make quite a lot of things happen':

"We were quite lucky. A lot of this is about relationships, isn't it? And so... the three of us have a good working relationship and so... and we were at different levels within the organisation and had different levels of influence. (...) So it meant that at the different levels (...) people were able to have those conversations and we were able to kind of get ... some of that traction, to get the buy-in."
(Senior Manager Focus Group)

The importance of relationship-building across the large organisation was therefore emphasised as a means of ensuring **support from key 'top' positions** such as the Director of Human Resources who could 'make decisions and influence policies' that could drive implementation forward:

"I think that comes back to a central point... about the importance of relationships in this. Having... good organisational relationships in key positions is central to... any success... because you do need to have the Director of Human Resources on board, otherwise things aren't going to move forward. (...) You need to have people that can make decisions and influence policies and stuff like that."
(Senior Manager Focus Group)

However, while senior decision-maker support was regarded as pivotal for the overall success of the initiative at an organisational level, it was reported that there needed to be key people at different levels who had vision and energy to 'drive' the initiative forward. These **TIA leaders** were described as 'real conduits in the workforce':

"So we couldn't push with [TIA implementation] too far after COVID, but then we got involved with [Thorndale service manager] on the Safeguarding Board in Northern Ireland work... (...) [name] drove a lot of this work. If it wasn't for [name], it wouldn't have happened... what I was able to do is to make sure the conversations were happening in a number of places and the people were on board."
(Senior Management Focus Group)

"There were people who were real conduits in the workforce who made it happen and made sure people sat and had conversations around - do you know how this is affecting people?"
(Senior Manager Focus Group)

Such TIA leaders were noted to have a strong sense of social justice which instilled a drive to 'make things happen' rather than 'wait around':

"There is something particular... about the people who choose to do this type of work in the third sector. And therefore, I think it might be easier to do it in places like this, than it would be in statutory services, because you have a particular type of person who is driven by things other than money, clearly, is driven by a sense of social justice and probably politics to a degree (...) they won't sit around waiting for things to change, they'll go out and make them happen (...) where people are not prepared for things to ... wait to change, they'll just go and do it."
(Senior Manager Focus Group)

This 'energy' for change was thought to 'attract' others with similar vision and 'driving force', snowballing to build 'key relationships in the right places':

"Yeah, I'm not going to sit around waiting for you to come to terms with this because we might be waiting for ages. We're just going make this happen and we'll make it happen in a way that you will notice this and you will come and look at this, and that experience will be something that maybe will help change practice. (...) So there's something that's attracting people. There's an energy that people want to be a part of, and I think that that... is really, really powerful. So I think... it's relationships, it's key relationships in the right places."
(Senior Manager Focus Group)

The importance of TIA leaders in **gaining staff buy-in** was reported by frontline staff. They noted how 'people buy into people' with staff noting how they 'go the extra mile' when they feel valued, supported, included and treated well by their service managers:

"People buy into people. I'm a great believer in that, that people buy into people, you know, and [senior manager] is amazing."
(Staff Focus Group)

"The thing for me is if you have a decent boss and a boss that works with you, I go the extra mile too. And I think we all have went that extra mile to make things happen."
(Staff Focus Group)

As well as relationships and connections across the wider organisational, intentional efforts to build **team relationships in each service/project** were thought to be a key enabler of TIA implementation. In the local TIA pilot of Thorndale which coincided with the COVID pandemic, staff noted how they had 'come together' with their manager with a strong sense of team support and comradery apparent:

"I suppose it was a bit of a reliance on each other, that we were all sort of come together and pull together and bail each other out."
(Staff Focus Group)

"It happened in the middle of COVID. I think that probably was a factor in all of this as well, that we felt we needed to be together and there was a sense of comradery and looking after one another in the face of adversity that everybody was experiencing at that time. We lost quite a bit of staff as well. Staff just left,... you know, they hadn't been replaced. So we were quite short of staff for a long time. So I think we were just wrapping around each other... it just naturally kind of flowed in. I think [senior manager] realised as well that we all need to be together here."
Staff Focus Group)

As discussed in the consultation section above, **involving staff in the TIA transformation process** was considered a core feature of all TIA implementation in the Salvation Army, strongly connected with achieving staff buy-in, promoting positive team relationships and enhancing meaningful and relevant practice and service change. SA as a whole were reported to have committed to embedding a 'trauma informed inquiry approach' into all workforce development and support initiatives (see workforce development section above), thus promoting staff buy-in and addressing staff fears at all stages as implementation progresses. Senior managers reported that they were starting to see this 'ripple effect' change across the organisation:

"...because of simply this [trauma informed inquiry] process, and [the worker] was like it's literally like somebody has lifted a veil on the way that I work (...) when you see that happening... you can see that everybody's getting buy-in into this now and that's, I suppose what feels different (...) we're really tying into what the organisation's principles were around social justice, everybody started to get it and that's been nice, that ripple effect you can feel now."
(Senior Manager Focus Group)

Adequate financing and resourcing were identified as important enablers of TIA implementation. Such 'investment' in people and buildings was noted as essential to promote meaningful change, enabling staff to offer a quality service, as well as protected time and a welcoming environment:

"It is that meaningful investment. We've invested or we're starting to invest not just in buildings, but in teams."
(Senior Manager Focus Group)

In the case of the development of the main building at Thorndale, it was noted that this was achieved 'on a shoe string'. However, larger financial investment was recognised as likely to be needed, presenting inevitable challenges going forward, dependent upon the organisations' priorities and local authority commissioning (see physical environment section).

The **impact of the COVID pandemic** was reported as both a challenge and an opportunity in relation to TIA implementation progress. One challenge involved a great change in the workforce with many experienced staff leaving, and new less experienced arriving. As a result, it was perceived that a lot of the TIA groundwork had to be 're-done'. TIA implementation progress at the national level was reported as 'stalled' during COVID, with the focus inevitably redirected toward simply 'getting by' and 'trying to keep people safe and keep people in work'.

However, the pandemic was also noted by both staff and senior managers as an 'important opportunity', inadvertently **'creating a space' for 'reflection'** about the organisation's focus and priorities. However, that momentum for change was argued to be potentially lost again as the draw to revert to 'business as usual' increases in this post-pandemic era:

"I think what COVID did was almost create a space for us to really, really, truly reflect on... 'hang on a minute what actually is going on here?' I would like to say that that's fundamentally changed our practice going forward, but we seem to be losing that sense of connection again fairly quickly as well because now we just get on with the job. Well, hang on a minute. There was something really important happened here. There was a point in time... there was something significant went on there, (...) not randomly because there were people who were real conduits in the workforce who made it happen... So it wasn't completely random, but there was something spontaneous about all of those conversations that happened as a result of COVID, where everybody was, like, hang on a minute.... So there was a real sense of alignment, horribly, like I would rather have not gone through that, but there are benefits that have come out of time."
(Senior Manager Focus Group)

During the pandemic, a number of fundamental shifts were noted as significant by senior managers that were perceived to have assisted TIA implementation. These included a greater **appreciation of the importance of staff wellbeing** and the **use of digital communication technologies**, which were reported to have opened up the possibility of relationship-building, connection and shared learning and influence across the wider organisation. Examples discussed included the creation of the online staff wellbeing spaces and different forms of delivering training and support with the development of 'communities of practice online'. In addition, senior managers reported practice change that had emerged from the COVID era when homelessness services had to find a 'completely new way' to work. While challenging, and 'paralysing' for some, this was also noted to have prompted the introduction of more 'pioneering' and 'agile' ways of working and the 'throwing out' some 'old practices'. This was thought to have helped services start from a 'clean deck', creating an openness for change:

"...but there are benefits that have come out of... that time [the COVID pandemic]... in our homeless services, we had to work completely new way during COVID. And I think what that did was throw a lot of old practice out the window and be like, well, what are we actually going to do now?... it was a complete change of practice, so that was a chance for people, I guess I think to come in and say, look, why don't you think about this, this and this and almost get a lot of pioneering ways of working, really agile ways of working that hadn't been done before and it was almost like you were starting from a clean deck."
(Senior Management Focus Group)

Barriers and Challenges

A number of additional barriers and challenges to TIA implementation were noted by staff and senior manager participants. These were related primarily to the size, structure, history and ethos of the organisation.

While collaboration and relationship-building across the organisation was thought to have been enhanced (to some extent) via TIA implementation as well as more online wellbeing and training initiatives with concerted efforts extended to break down 'silos' and 'flatten' hierarchies and structures, it was noted that, given the **size and complexity of the organisation**, not all services or departments were at the same stage of development. In this regard, homelessness services were perceived to have made most progress embedding TIAs:

"[The SA] is a very big organisation which has different departments of work... there are still silos, even though we're trying to kind of break them down and make ourselves more flattened. And so we have work that happens within a core community services. We have the anti-human trafficking and modern slavery contract and we have homelessness services, older people services. Homelessness services is definitely the most advanced in terms of its understanding and embedding of trauma informed practice within its services.... we can only influence what we can influence... [Other areas] are doing it and they're starting to grow."
(Senior Manager Focus Group)

Even at the local or regional context, it was recognised that 'parts of the organisation are still very disjointed'. As a result, TIA implementation in a large multi-faceted organisation like the SA was likened to a 'very slow boat' or 'trying to turn the Titanic':

"So if you're looking across the whole of the organisation against each of the [SAMHSA domains], I would say that... we're doing small stuff and we're growing. (...) I think we're trying to look consistently at each of the different places... Leadership are getting it. We are starting to change the way that we write our policies and our processes... all these things are changing, but it's slower than it can happen locally because of the sheer size of it and the sheer different ways that the organisation has such a spread of the types of services that it runs... we're a very slow boat."
(Senior Manager Focus Group)

However, in spite of these challenges, senior managers felt that significant progress had been achieved with the national organisation having committed itself to making TIAs an 'essential' and 'primary area of work'. While change might be inevitably slow, such developments were understood to be highly significant given the subsequent changes in culture and identity of the organisation as a whole:

"Where we've got that commitment, and we're also at the stage where... the organisation seems to be committing to the fact that it wants to make trauma informed practice a kind of essential... a primary area of work within the next... however long... because... that's such a significant piece that if we support the organisation to become more trauma informed, our culture, our policy, everything around who we are changes yeah, absolutely."
(Senior Manager Focus Group)

When considering their TIA implementation trajectory, senior managers noted that the SA UK & Ireland, despite its size and longevity, had experienced very significant changes in recent years. Introducing a trauma-informed lens (and realising that some established practices may have been potentially re-traumatising) was noted as probably 'terrifying' for the well-intentioned leadership and workforce. Over time, the need for 'humility' and to 'modernise' was reported to have led to a 'levelling' of the organisational hierarchy. Fundamental **shifts in organisational identity, culture and leadership structure** were described as 'scary' and 'uncomfortable', leading to some inevitable resistance to change:

"I think one of the biggest barriers we've had internally is the history of the organisation, in the fact that [the faith-based mission] is very practical, they need to be doing things and... if I'm sitting around talking about how I feel... I think ... there was a real discomfort in that."
(Senior Management Focus Group)

In terms of getting buy-in, participants mentioned **the term 'trauma-informed' itself** can act as a barrier. Senior managers noted that the language of 'trauma' can be misunderstood as 'clinical' by the leadership who come from different backgrounds, with mitigation effort required to clearly distinguish between trauma-informed and trauma-focused services. They had found it helpful to 'reframe' TIAs as an 'engagement tool' to support a shared understanding that was 'less scary':

"[The term] trauma informed practice [is a barrier]... because for our organisation, sometimes we didn't.... understand it. [People] go to a place where they think... it must be more clinical or whatever else... So I think if it was called something else a bit less scary, it would have been easier for us to kind of manage with our organisation. So that's definitely been... a barrier. (...). And I think [consultant] has really helped us in that as well, in terms of us trying to reframe this as an engagement tool, because that's ultimately what this is."
(Senior Manager Focus Group)

Staff participants also noted that there is a danger that TIA can also **be dismissed by the workforce as 'just another fad'** without longer-term commitment:

"I think for me (...) and for all the frontline services, that sometimes [trauma informed approaches] can be hard to embed, because frontline staff just see it as something else that's new. Another fad (...) I'm sure that this isn't just the Salvation Army. I'm sure it's a lot of big organisations. It's like, you know, trauma informed practice, just another fad. We've done harm reduction... so this is just something else."
(Staff focus Group)

5.5.5 Lessons learned

Focus group participants noted several key messages that had been central to TIA implementation progress made at the local service level as well as the much wider organisation. Central to these was the message for service leaders or those leading TIA implementation to really **understand the project or service** before seeking to apply any new model or framework. Without such detailed appreciation of the service and 'what it's like on the ground' – from both staff and service user perspectives –, it was considered impossible to achieve meaningful change. Thus, implementation leaders would not be aware of the prior taken-for-granted service culture/beliefs/practice norms they were seeking to 'stick' the new theoretical or practice framework to:

"We need to understand what it's like within services before you apply anything to them, because in terms of coming along and applying trauma informed principles to a service... you need to understand socially what's it like on the ground. You need to be in services. You need to survey services. There's no point applying something when you don't understand what you're applying it to. It's almost like I don't know, how are you going to bond one material to another when you don't know what this is made of? Like you have to understand what you're sticking something to."
(Senior Manager Focus Group)

For the Salvation Army, both nationally and at the local level, a fundamental principle of TIA implementation was ensuring a 'bottom-up' approach, involving all levels of staff and service-users in building this understanding of service norms and complexities, and gleaning their ideas for change. This **'trauma informed inquiry' approach** was reported by the senior TIA implementation personnel in this case study as having enabled greater reflection at all levels in the organisation, and pushed forward the more 'different conversations' that can inadvertently block TIA progress if left unaddressed.

The staff who participated in this case study also emphasised the **critical importance of staff consultation and involvement** to achieve meaningful engagement, without which limited progress could be made:

"If it was looking at other organisations, I would be saying the staff consultation is really, really important, because if the staff are not sold, you can't really get the buy-in."
(Staff Focus Group)

"And plus, their staff will then just put their own narrative to what's happening, so if you can get the buy in, it just saves so much more trouble."
(Staff Focus Group)

"... just to add... that feeling of being valued as a staff member, and that is through being heard, being consulted, being involved... at every sort of element of our work due to the design and the delivery of the service, even just deciding what the service is, what kind of work we do..."
(Staff Focus Group)

'Starting somewhere' was another key message which emerged from case study participants. Advice was given to choose 'an easier place' with 'low hanging fruit' to help get TIA implementation off the ground in a local service context. In Thorndale PS, the starting point had been service-user pathway mapping and staff consultation which had, over-time, led to the refurbishment of one of their buildings:

"...it doesn't really matter where, as long as you start."
(Staff Focus Group)

"You know... it doesn't really matter where you start... as long as you're sort of starting somewhere, and sometimes that is the kind of lowest hanging fruit. It is the easiest place to really look at, for frontline services, and using that transformation model, looking at from entry to exit."
(Senior Management Focus Group)

'Starting small', even when full organisational support had not been achieved, was another key message:

"In large organisations like Salvation Army, even when the leadership is not yet fully on board and there is not a larger full organisational buy-in, you can still do things at a smaller scale and start from there, rather than wait until you get the full buy-in."
(Senior Manager Focus Group)

From small beginnings at the local level, it was argued that 'momentum' could be developed whereby similar initiatives start to grow and snowball as others in the wider organisation (as well as external agencies) get a 'taste and feel' for what can be achieved:

"...But I think just one of the points maybe for learning and for other organisations and things is even in the absence of that, when the big things look as if they can't happen, I think what was really important here was that actually, we just did it anyway. We just did something smaller anyway, and if nobody else wants to be a part of that, then that's OK or that's fine. For me, I think the more that happens and if little things start popping up kind of here and there, and the more people start to hear about them, and want to know more about it, and find out a bit about it, and then maybe try to replicate a little bit of that and things, you know, that kind of sense of at some point in time, all of that will start to join together. So even if we didn't have that bigger organisational buy-in...I don't think that should be always seen as a total barrier. (...) Absolutely. And it would never have got us to where we were, but things can still happen and things can still be done. And I think if people get a taste and a feel of that, they will want it for themselves, and I know that that's happening within the organisation, you know, people are wanting to come and see this or talk to me or oh my goodness, could we do that? (...) So you know, you

start something small and at some point in time hopefully that will start to grow a little bit of momentum and have a little bit of impact."
(Senior Management Focus Group)

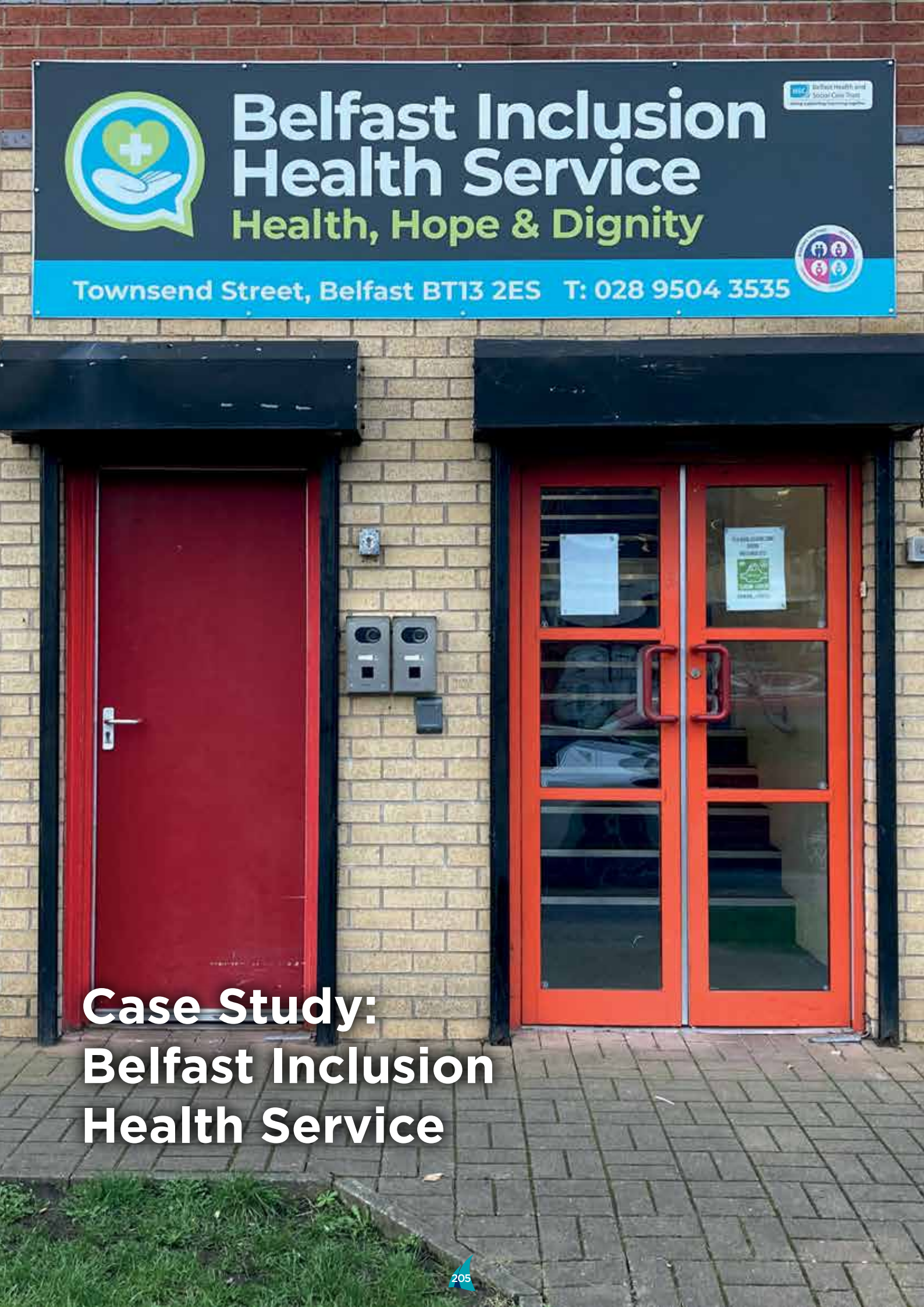
It was described how the TIA pilot at Thorndale would not have got off the ground if they had waited for 'full buy-in' and 'direction' at every turn, demonstrating the need for local leadership with vision and courage. However, in large multi-site/ service organisations like the Salvation Army, strategic alignment and robust inter-departmental relationships across the local and the national contexts is considered essential to cascade and embed the learning. In this way, the wider and longer-term benefits associated with TIA implementation can be achieved across a complex organisational system:

"If [we were] waiting on that connection... and for, you know, direction to be given and you know permission to be given for us all to do this, we probably wouldn't have even started this. (...) But the two things happening together [local and national developments], I think it's what is really working within the Salvation Army."
(Senior Management Focus Group)

And finally, the term **'intentionality'** was an oft repeated phrase in the senior manager focus group of this case study. Reviewing its use through the conversation pointed to the need for TIA organisational leaders to really understand and know what, as an organisation, they were aiming to achieve via TIA implementation. Often, the goals expressed were intangible or abstract, such as trust between service users and staff, or between different staff members and management, a sense of everyone feeling valued for their unique contribution to the collective, or efforts to avoid re-traumatisation. Such language acts as a reminder of **the importance of clearly naming desired outcomes** in order to be able to design initiatives to help achieve, assess and measure such goals.

Figure 5.8: Salvation Army UK & Ireland Trauma Informed Implementation

Figure 5.9: Thorndale Parenting Service Trauma Informed Implementation



Case Study: Belfast Inclusion Health Service

5.6. Belfast Inclusion Health Service

5.6.1 The Context

The Belfast Inclusion Health Service (BIHS) supports the health and social care needs of people experiencing homelessness. The service is hosted in a centralised hub and brings services out of the clinic setting onto the streets, to wrap care around people who need it most, where they need it. The BIHS Manager and Nurse Consultant has led the service from its inception in 1999. The service was the first of its kind in NI, with the subsequent development of similar services across the rest of NI. The current BIHS staff team encompasses 21 multidisciplinary professionals (see Table 2.1), who bring prior experience in acute mental health, accident and emergency as well as general population mental health, general health and podiatry care. The service has witnessed the sharp growth of homelessness and the impact this has had on increasing service demands.

Table 5.7: BIHS Team Structure

Team Structure: Total of 21 MDT Members
Service Manager/Nurse Consultant
General Practitioner Services
Psychotherapist
Nurses (Adult Nurses RGN and one mental health nurse RMN)
Senior Social Work Practitioner
Dentist
Podiatrist
Support workers (supporting blood born virus service users)
Administration staff

Two focus groups were undertaken as part of this case study, one with the service manager and the psychotherapist to explore TIA implementation from the leadership perspective (Senior Management Focus Group) and a further with four staff members, including the psychotherapist (Staff Focus Group). The BIHS service manager and staff reported how the profile of their service user population has changed over recent years, with a noted increase of younger women. Many of these young women were reported as having had care experience, with additional concerns related to sexual exploitation, human trafficking, drug use in conjunction with poor physical and mental health. Reasons for becoming homeless were thought to be varied for this population, including leaving the care system with no employment or income, breakdown of relationships, and living in areas with high levels of poverty and social deprivation.

Other issues of note for the more general BIHS population, included those who had lost rented accommodation as they could no longer afford to pay bills, due to the increase in the cost of living. Many homeless people were also known to suffer from mental ill health, sometimes as a direct result of being homeless. Staff were also aware that many had suffered significant adverse and traumatic experiences as children and in their adult lives. Some service users with severe and enduring mental illness were noted to have become institutionalised and were no longer able to look after their own needs independently, without supports in place, while others had experience of the prison system, often leaving the prison estate with no accommodation.

5.6.2 Trauma Informed Implementation

TIA alignment with service ethos and practice

BIHS service managers noted how they had been formally introduced to trauma informed practice through training and ongoing support from the SBNI TIP team in 2021. Service managers had already been aware of and influenced by the Sanctuary Model, a trauma informed model of clinical practice and organisational development initiated by Sandra Bloom. They reported how trauma informed approaches (TIAs) fitted well with the service ethos and way of working with their service users, in particular the focus on 'safety' which was noted as 'elusive' for many homeless people:

"And when we started the... formal training with the Safeguarding Board back in 21, it was just kind of... in many ways empowering and reinforcing some of the approaches we were doing to focus on the person because for some of these young people.... this was things that [we] were very clear about was this safety, that people would feel safe coming to our clinic because that's one of the principles. And safety is something that is elusive for some of these individuals with rough sleeping and hanging around with certain peer groups."
(Senior Manager Focus Group)

While aware of trauma to varying degrees in previous employment, staff focus group participants spoke of how their awareness of service users' trauma histories had increased since joining the homelessness service and the introduction of TIP through the SBNI training:

"...and I guess in my previous post..., so [there was] a lot of complexity and complex issues in patients, although we never talked about trauma previously. I actually realise now we were probably doing a lot of trauma informed practice... because a lot of them were very, very unwell and a lot of them had a lot of trauma backgrounds. And again, we just never really thought about it until I really came on to this team."
(Staff Focus Group)

There was recognition of the very high prevalence of trauma experience in this population with staff noting how it would be 'very rare' to meeting someone who had not experienced trauma and adversity of some sort:

"I'm a mental health nurse... So trauma has always been part of my experience. It's always been very much talked about within work and probably more so since going to the prison and then coming here (...) And so you're very aware with everybody you meet that there's trauma, it would be very rare to meet somebody that has not endured some traumatic experience."
(Staff Focus Group)

While nurses had always worked with people with 'severe life experiences', participants remarked how the introduction of the language of adverse childhood experiences (ACEs), the trauma lens and trauma informed practice had brought new words, terms and 'a frame of reference' to describe their everyday practice:

"But I think all throughout your career you maybe didn't have the words to identify what trauma informed practice was, but you did kind of be aware that a lot of people came from different backgrounds and different sort of experiences in their life. And you kind of always maybe made your introductions or your assessments based on the person that was in front of you. And it's only now that you kind of hear with the [trauma] lens and... the theoretical background related to trauma informed [practice] that you realised that the role you were doing all those years was very, very practical in relation to dealing with people with severe life experiences. And as people talk about nowadays, adverse childhood experiences as well. So I think that's something we've always done as nurses throughout our careers, but maybe nobody kind of had a word or a term or a frame of reference to actually identify what you were doing on a daily basis."
(Staff Focus Group)

Focus group participants reported a range of ways that the TIA framework had influenced their service across all three implementation domains, i.e., Organisational Development, Workforce Development and Support; and Service Design and Delivery.

Organisational Development

In the organisational development domain, there was a recognition of the importance of adopting a **'multi-agency, multi-disciplinary approach'** to caring for the homeless population in the knowledge of their complex needs and co-morbidities, and their critical interface with other services. Over the years, this had led to the building of the **multi-disciplinary team at BIHS**, which had developed to meet emerging needs ensuring service users timely access to a range of health services that they might not otherwise receive 'if left to their own devices'. This included physical and mental health services, dentistry, podiatry and psychotherapy, when appropriate:

"...I think actually also being able to access the other services really quickly... it helps me within the team... [I can] say oh, I'm 'OK, I'm going to see [name] this afternoon. The mental health nurse. I will get her to give you a call. I'll also refer you to our dentist. Hopefully they'll be able to see you. And I'll say to [nurse] about needing to get your dressing done on your leg or whatever. (...) so being able to access everybody within the team helps me as a team member as well, it's all good when you can see all the work that can be done quicker than it would be within the normal health service, or maybe not at all for our client group if they were to be left to their own devices, you know."
(Staff Focus Group)

A recent **example of service innovation** was the development of the support worker team, which is dedicated to offering support to individuals with blood borne virus (BBV) and medication concordance, with a noted increase in screening and diagnosis, and changes in profile and practices. Research conducted by the team (Maisa et al., 2019) looked at the injecting behaviours of this population. Based on interviews with service users, this team developed a range of strategies to enhance engagement and raise awareness about harm reduction amongst service users and staff in other agencies. This included putting up BBV awareness posters into hostel facilities and providing hostel staff and service users with pocket sized harm reduction information leaflets.

Inter-agency collaboration was another key area for development aligned with TIA implementation. The BIHS Service Manager and Nurse Consultant explained how she had brought interfacing services together to undertake the SBNI TIP training in the knowledge that BIHS is 'not an island' and that one service was 'never going to solve' homelessness 'on their own'. Thus, the importance of the 'whole multi-agency multi-disciplinary approach' was affirmed and promoted:

"So whenever [SBNI] did the training at the first time, she did it with us as a team and then I invited her back. So I brought in all the agencies that we would work alongside. Now that would have been like the police and... the Northern Ireland Housing Executive. It was the community and voluntary sector. It was our own staff team here and there was some hostel staff that came along that day, and the ambulance service. So a lot of these services already had trauma informed training... but you know, if you ask them like, what was it like, nobody could really answer you. So it was really nice to bring that whole multi-agency, multi-disciplinary approach... because..., we are not an island and we're never going to solve this problem on our own. We need all those sectors around us to actually, you know, help us to deliver services and deliver them safely and meaningful."
(Senior Manager Focus Group)

In addition, the **development of pathways between services** was reported by the service manager as instrumental in effective service delivery for this highly vulnerable population. It was noted that service delivery for the general population did not fit the needs of this service user population with the need for a tailored and 'flexible approach' 'outside the normal box'. This involved working closely with other services and systems to advocate for their service users to challenge and change everyday practices with enlightening case examples provided to ensure homeless people received appropriate healthcare:

"Our pathways are very important... we've had to go first of all and lay the foundation and lay that advocacy at the door and... actually be quite assertive on how we challenge attitudes and how we challenge systems, set systems that our service users just don't fall into, like I'm thinking of, you know, you move into a hostel, you might stay there for a short time, you do something wrong. You'll be put out. You've been to hepatology. You've had your liver scan and they've sent you an appointment letter for your next appointment. But you never get it because you're not there. But it's easy to tick a box and say, well, they didn't turn up today and that's my targets, but that's not how you can work with this service user. We have to have a really flexible approach and we have to be like working outside the normal box."
(Senior management focus group)

A key example of service user advocacy and promoting service collaboration was a **quality improvement project** undertaken to improve the interface between the Accident and Emergency Department, the Ambulance Service and Alcohol Liaison Services. This had led to the development of a **pathway with the Emergency Department** (ED) with inter-agency agreements about how to offer compassionate, effective care for highly vulnerable individuals, while also seeking to manage over-use of services. The BIHS service manager noted a series of strategies that had been developed in this regard, including a BIHS ED in-reach/ outreach nurse, who could be contacted by ED administrators, as many of the more vulnerable clients could not manage the normal waiting required:

"... if you go into ED today, (...) and you book on and you've given them whatever scenario is wrong with you, you are then asked to sit outside and wait ... our service users have addiction issues, so they're not going to wait for hours, because they can't wait for hours on their next drug. So what the pathway looks like is - ED will then contact us if there are specific concerns. We have an in-reach/outreach nurse pathway to ED."
(Senior management focus group)

In addition, they had linked in with the ED IT system to ensure that hostel addresses were red flagged, which would alert the ED team to the person's status as experiencing homelessness:

"At the beginning, nobody knew that these people were actually in homeless hostels. (...) so we set up a meeting with the IT system in ED and we gave them all the addresses of the homeless [hostels]. So now that's a red flag."
(Senior management focus group)

Posters with the BIHS telephone number and the Housing Executive were also displayed as they raised awareness of BIHS with staff. It was noted, however, that due to the high turnover of ED staff, other strategies were required with BIHS staff attending regular ED meetings as a means of ensuring awareness of BIHS outreach services:

"We also put posters up in ED with the team contact numbers, and the NIHE Contacts should the staff need help re. housing for the person. As a team we have met with ED staff to raise awareness. (...) they do like a [team meeting] throughout the morning, every now and again, like a team where four people come in at a time and they're updated on different things. And so we've been to those meetings and I've also been to meetings with the consultants, and we've made real inroads with ED there."
(Senior management focus group)

Similar communication and referral pathways were developed with the Ambulance Service to try and limit the over-use of emergency services by vulnerable clients:

"And the same with the Ambulance Service. If somebody calls an ambulance like 30 times in the month, someone of them will ring us and say, 'this person's in [name of] hostel' and we will then go and find out from the person, why is it that you're ringing the ambulance every day? and then we'll try and explain to them, you know, this is why you don't need to do that."
(Senior management focus group)

A more recent example of inter-disciplinary and inter-agency work across the city of Belfast spoken about positively in the senior management focus group was the establishment of the new **'complex lives team'**, of which BIHS is a part. This 'whole systems approach model', adapted from Doncaster, England, is where different agencies meet every week to discuss the needs of complex service users, thus coordinating and promoting more effective responses to service users with complex lives and needs:

"There's a new complex lives team... it's a whole systems approach model from Doncaster... and we're trying to adapt it into Northern Ireland (...) where we are very different. So there's lots of different things, but there's lots of really good learning from that. So at the minute we have..., this happens like once a week. So we have what's called an MDT team, and that's the Housing Executive, Trust staff, the police, probation, social work staff and support workers. And they sit around a table every week and they are currently discussing about 80 of our very complex service users. And so from that comes tasks and actions."
(Senior management focus group)

Workforce training and development

Workforce training and development was reported by staff members as having been important in helping the team develop and maintain a trauma informed understanding of their service users, with a noted shift away from a 'medical approach to mental health' toward a much *greater appreciation of a person's life history:*

"... in terms of understanding and thinking about mental health, the understanding has vastly improved over the years where we had a very medical kind of approach to mental health, and even like maybe in acute mental health, the focus would have been on getting somebody on medication, getting them stabilised, getting them home, whereas now there's a lot more talk about what's led the person to be where they're at today, what could have been done differently, what services could they bring in now to make a change, so that's improved greatly."
(Staff Focus Group)

"Just saying what's wrong with somebody to asking what's happening (...) the language is shifting so much... from focusing on the person, something that has to be fixed to something different."
(Staff Focus Group)

Staff members spoke of how using the 'trauma lens', introduced during the SBNI training, had helped them become more *understanding of service users' presenting behaviours.* For some, this helped build greater insight and personal tolerance, particularly when responding to challenging behaviours from some service users who may have been 'frustrated' by how they were treated by previous services:

"...the training that we done on the trauma informed practice and some of the videos ... made you realise that you know, sometimes as a health professional, you might have taken it sometimes a bit personally when people might have been angry with you or brought out their frustrations on you, and this [training] maybe gives you a bit of insight into being aware and not taking things personally, that it is... the system, rather than you as an individual, that the person is frustrated with actually, and the way the system maybe has dealt with them over the years as well that has caused that level of maybe frustration and trauma to that person."
(Staff Focus Group)

This was reported to have led to the development of a different approach toward service users, with *much greater service tolerance* thought to be required to work with this client group, unlike the zero tolerance approach adopted by other Trust services:

"I think it also makes you approach things differently, (...) you know, the zero tolerance policy that the [HSC] Trust has, we can't have that with our client group. It has to be 100% tolerance, you know, otherwise we wouldn't see anybody if we had zero tolerance. So it does make you approach and look at everything differently as soon as you're meeting that person, you know your introductions, how you approach them."
(Staff Focus Group)

This was described by one staff member as a much 'softer approach', with effort required to 'take service users as they are on that day' and not take personal offence when met with challenging behaviours:

"Yeah, definitely,... it's just improved my understanding and my awareness of [trauma]. Just I definitely approach things a lot, a lot more softer I guess with this client group, and you just realise you have to take them as they are on that day and... you definitely don't take offence by anything that's said or yelled at you or screamed at you, or sometimes you're shoved out of the way,... You don't really take offence. That's just how they are on that day. So the training has definitely helped me. Yeah, because again, that wouldn't have been really in our backgrounds very much in the past."
(Staff Focus Group)

Working with service users with such complex needs and adverse life experiences was reported as demanding for staff in many ways which wasn't thought to be always appreciated:

"But I think sometimes people romanticise this job, (...) I think people don't fully appreciate, it's a job related to very hard graft."
(Staff Focus Group)

As well as regularly coping with challenging behaviours, this population of service users were reported as hard to engage with sometimes 'disappointing' results in spite of staff's best efforts. It was noted that this could be 'discouraging' for staff:

"Sometimes for the staff, that's really disappointing, because we are very often with service users, 20 steps forward and 25 steps back (...) and that can be discouraging."
(Senior manager focus group)

In addition, deaths of service users were reported as a relatively common occurrence given that the team work with people at times of crisis. The risk of a secondary trauma impact on staff members was evident:

"Yeah, sometimes it's like a video in my head of all the people who have died (...) and that's kind of challenging at times. I remember one time in one of the hostels, they used to keep a list of everyone who had died. And I think you know, it was maybe up to four A4 pages, so it was, at one point."
(Staff Focus Group)

Given the demanding nature of the work therefore, both senior managers and staff spoke of different **personal and workforce support strategies** needed to manage these demands. Staff spoke of how, over time, they had learnt coping strategies which allowed them to 'mentally park' or contain the work:

"You just get to a personal space where you just learn to mentally park it.... And then just leave your [work] and then you're on your home life. So my drive home, I have about an hour and a bit drive home. Yeah, I you know, that's my decompress time before I then enter my house with my husband and kids and stuff, you know? And you just learn a way of probably without even thinking about it, just that's it for the day and I'm not going to think about it again or try not to until I go back into work now (...) So I think... you'd be in trouble if you can't park it. ... I don't know how long you could stay in this job if you couldn't. Yeah. Or maybe any job if you can't learn to leave it.
(Staff Focus Group)

Senior managers and staff also spoke of the importance of **building trusting team relationships** as a means of managing demands, supporting staff wellbeing and talking with colleagues and senior staff about the impact on themselves to ensure everyone felt valued and supported in their role:

"And we talk out about the different impacts on ourselves. We do talk that out around the team." (Staff Focus Group)
"Because it's very important for all of us in this role. It's hard enough, and we need to make everybody in their role feel they are valued (...) and it is very important that nobody in the team feels that they failed."
(Senior manager focus group)

The service manager noted the importance of the annual service development review, team building days and staff consultation to help build team relationships and ensure staff concerns were listened to:

"We'd have a yearly service development review, and those one-to-ones, and even with team building, we've had several team building days, and also..., you know, we like, we ask for staff opinion because if staff are not happy with what they're doing, it's very important to ask staff, are they happy? and to get staff to have that trust in each other, to be able to... openly say, well, 'you know what? you know, I'm not happy with that' or 'how do you think I should...?' and to also allow staff that freedom to not work with somebody. Alright. Because... we have someone at the minute who has made threats against one of our support workers and it's saying, 'That's OK. I don't expect you to work with that person, in fact, my risk assessment would tell you that I don't want you to work with that person. Do you know? So it's all those things."
(Senior manager focus group)

A number of **formal and informal reflective practice and supervision opportunities** were reported as important workforce support strategies to manage such tensions to enable staff time to reflect on themselves and the service users collectively. The "Monday huddle" and morning check-ins were examples given of how the team meet collectively to check in with each other and discuss the service needs of the coming day or week:

"We have a team huddle every Monday morning and (...) we've a cup of tea every morning before we start, where we discuss things and how you're feeling and, you know, not just work sometimes, the normal things about home as usual, but you know, that's very important."
(Senior manager focus group)

As well as team meetings and group opportunities, senior managers also noted the importance of compassionate holistic one-to-one supervision:

"we also do one-to-one supervision. So sometimes people aren't feeling free in a group to, you know, say what they think or how they're feeling."
(Senior manager focus group)

Staff members also spoke of how they take time together as a team to remember people who have died or attend remembrance services at hostels, all of which were thought to make a difference to staff wellbeing:

"I know if there's been any deaths, you know, cause a lot of our clients will, you know, there will be young deaths. So,... somebody phones through [to alert the team to a death], then we all just sit down and come in here, whoever is here maybe have a wee cup of tea for 10 or 15 minutes and just sort of have a wee chat about the person, and then you just have to get up and get on with it then. But you know, it's just trying to take those very small moments to reflect on the person and just get on with it then,... but all those little things make a little bit of difference."
(Staff Focus Group)

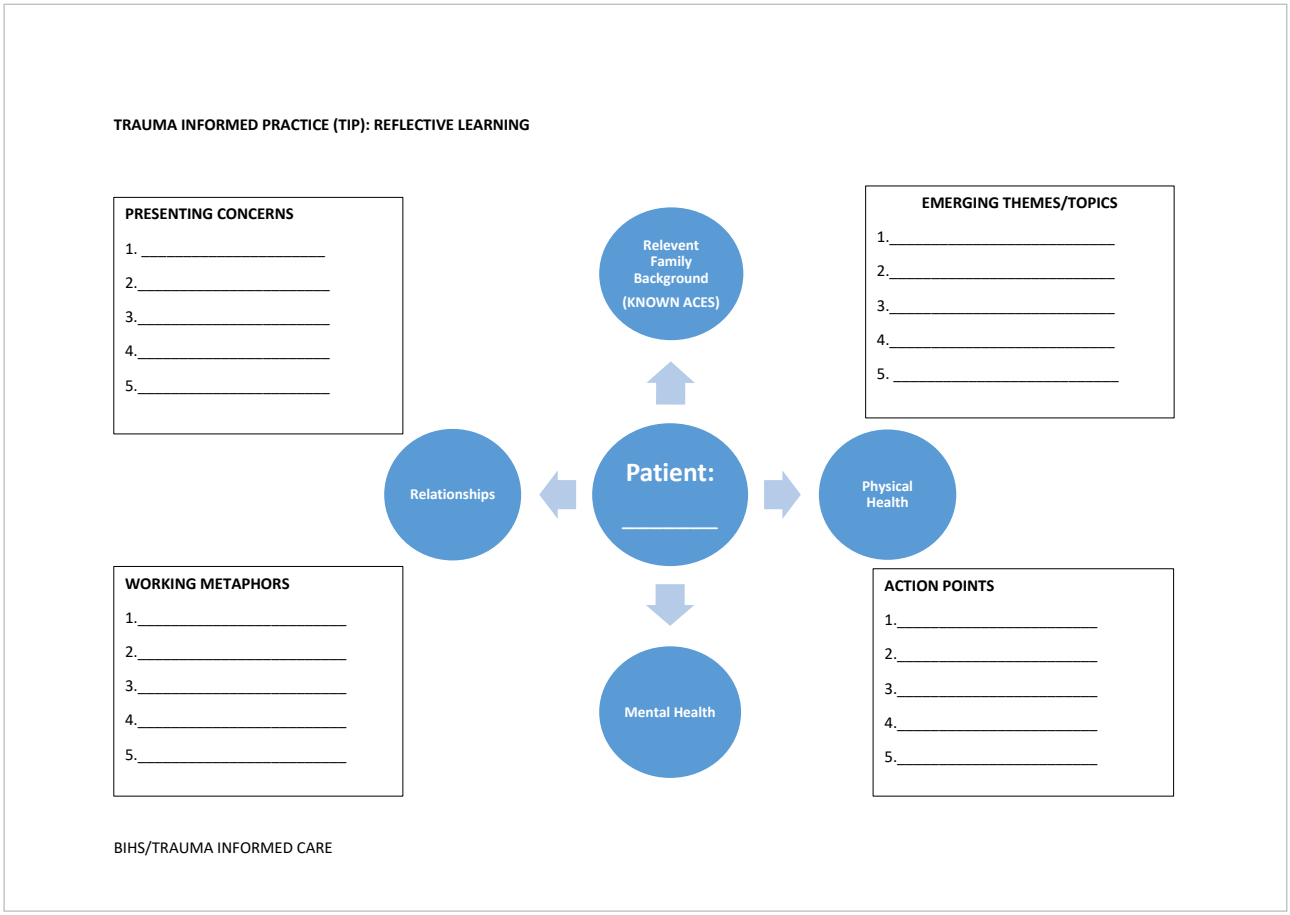
Given the complexity of the work, reflective practice opportunities were noted by staff as helping them 'take a step back', not get 'frustrated', share learning and work out how to take the work forward. This was thought to be particularly important for this client population given the complexity of presentation and need frequently encountered:

"I think sometimes we can all get bogged down by our clients because they're so complex and they're quite intense and they're so, they're coming to you with so many things wrong, and you're trying to pick that apart and figure out where you start. So to prevent you getting frustrated, sometimes it helps you to take a step back and look at it, and look at their life and what they've been through and what they've overcome. And it helps you then process why they maybe are the way they are, or how they communicate is the way they communicate." (Staff Focus Group)
"...that close interaction with your other team members and really trying to focus quite intensely on a patient is really good for the team as well I think you know."
(Staff Focus Group)

Reflective case reviews were reported to have been used for the 'most complex cases' whereby, using the reflective learning template (see Figure 2.1), staff were helped to build a better collective understanding of the service user's needs in different areas:

"We put the patient in the middle… and then there'll be three or four of us sit down and then… we'll look at the presenting concerns and then we look at emerging topics around that person. So… we work with some metaphors (…) and we'll have lots of images around that. And then we have action points, but we all build up around things like relevant family background and knowledge of ACEs, their physical health, their mental health and relationships. (…) So we take… like a flip chart paper, and we sit down and you have so many viewpoints, because the nurses might be working with the podiatrist. [Nurse consultant] might be overseeing them, and she's heard something from another agency about this person, say to do with housing, and we just kind of reflect on the person and how … are we doing the best for them with what we've got available."
(Senior manager focus group)

Figure 5.10: BIHS Trauma Informed Practice Reflective Learning diagram (provided by BIHS)



However, despite the value of such reflective practice opportunities and the 'wealth of wisdom and knowledge in the team', it was reported as difficult to get the protected time to undertake such activities as regularly as they would like due to the fast paced demands of the service:

"We don't have the time to do it regularly. That's the problem (…) That's one of the barriers at times for implementing [TIP]. It's just the busyness here, you know, so, we just don't always have this space and time for reflective practice. But when we do, it's really enlightening because there's such a wealth of wisdom and knowledge within the team."
(Senior manager focus group)

Service design and delivery

Focus group participants spoke of many ways they believed trauma informed principles were manifest in how they delivered their services at BIHS. This included enhanced service user engagement; enhanced assessment including an understanding of service users' trauma history; improved service access, enhanced interventions and outreach activities.

Enhanced engagement: Staff at BIHS described how adopting a 'trauma lens' had led them to develop a 'softer' 'compassionate' and 'empathetic' approach to their work with their vulnerable client group. While clients' behaviours could be frequently challenging, great personal and team efforts were extended to create a 'sense of safety' as people enter the service hub, thus avoiding retraumatising or repeating client's previous, often negative, service experiences:

"So it's a sense of even though we're not in the most glamorous part of the city, but when people walk through the door of the hub, there's a sense of feeling safe stepping out of the harshness of some of their daily world. And that was very evident and poignant for the individuals who are receiving, you know, having to come for multiple blood tests, and the care of the nursing staff (...) the empathy and the compassion, these values... and in no way was there any sense of going back, you know, to retraumatising people about what they'd been through."
(Senior management focus group)

Staff and service managers spoke of their tolerance for challenging behaviours, never barring service users, but instead seeking to de-escalate tensions and frustrations and ensure clients felt welcomed and safe from the outset:

"... we're certainly sensitive in our approach, we're certainly inclusive, even if people have like [presented in a challenging manner], we never bar them, you know, we'll say, now, go out and get yourself a cup of tea, calm down, come back. And I think how our tone, our body language, how we say things to them is all... how we make them feel the minute they come in the door, you know, and introducing yourself."
(Senior management focus group)

Staff described how the engagement process with this client group could not be rushed, requiring 'patience' and 'learning to listen' as a way of building the service user's 'confidence and trust' in the professional relationship over time:

"It's a question of patience, so it is... and just trying to, you know, engage on, you know, ... on a day when that person is ready to engage, you know what I mean, you learn on this job not to ask too many questions either. And you learn to listen, and by listening then the person gets the opportunity then to maybe build up trust and confidence in you. (...) And no judgment is right. Absolutely."
(Staff Focus Group)

Thus, building trust with service users was described as an essential every day and ongoing professional task to help service users engage with the service and their own needs:

"And then they you know, whether it's a fist bump or a hug at the end of the treatment, or just a wee rub on the shoulder, whatever... I feel that [the service users] need that and they like that, you know and again it just helps gain more trust, it just takes time with this client group to build up that trust."
(Staff Focus Group)

"Yeah, it's a challenge for people to throw off those layers as [staff member] was saying, you know what I mean and expose themselves definitely, you know."
(Staff Focus Group)

To effectively engage this most vulnerable service user group was recognised to require individual staff members to be able to adapt their service to 'the unique needs' of the person. Meeting 'the person where they are at' rather than a 'one size fits all' approach was considered essential to build 'rapport' with service users and thus enable effective engagement:

"It would break your heart sometimes (…) let's just call it at an individual level and we don't try to say one size fits all at all…. you have to really fit the unique needs of that individual… we always see them as a person. But it takes time for them… if we try to peel back those layers, it's never going to work. And what we discover is that with the rapport, they let the masks down and that's where the work happens."
(Senior management focus group)

Great emphasis was placed on the professional values of being non-judgemental, compassionate and empathetic which were thought to be at the heart of establishing this trust. Staff described how they explicitly expressed their 'no judgement' stance to service users as a means of supporting them to 'open up about the past' or address 'any other areas of their life':

"And no judgment either. And we would say that to them, 'just to let you know, there's no judgment here whatsoever, but if you're ready to discuss something else, feel free'. Or 'if you need any help with any other area in your life, there's no judgment. Just let us know. Doesn't have to be today or you can let us know another day'."
(Staff Focus Group)

"…, it's the values people trust. Without the trust, nothing's going to happen. And once the trust is there, they commit. And well, [staff members] said non-judgemental. Who are we to judge what's going on in their life, and… in that world of therapy over time, they begin to trust themselves to open up about the past, not just opening up to [nurse] and myself. They begin to trust to open up about their past, and then they're opening up to themselves. And that's sometimes, that's make or break … they'll come back and they'll stay with that or it's just too difficult to stay with."
(Staff Focus Group)

Enhanced assessment: Although listening and not asking 'too many questions' was deemed important during initial encounters, staff also discussed the importance of 'asking the right questions' in a 'direct' but 'sensitive'. This skill was noted as different to asking clients 'to repeat their story over and over'. In contrast, asking questions 'for the right reasons' in an 'open' and 'honest' manner was considered essential to getting the information to help clients 'move forward'. This was thought to be noticed and appreciated by service users:

"So you both said about not asking too many questions. And I think that what we mean by that is that our clients sometimes will have to repeat their story over and over and over again to different services, they feel they need to tell everything to get what they actually need to access things. But I think it's very important to be asking questions. I think it's just about asking the right questions, and I think to get as much information as possible about, as long as you're getting that information for the right reasons and you're going to do something with it… but I find that our clients are incredibly open, and I found that in prison and found that in this job too, that you're better just asking and being direct, being sensitive about it, but being direct about what you're asking, being honest with them and… explaining why you're asking certain things. I think they're incredibly responsive to that and appreciate that a lot more than other client groups would. And so I think it's important to get all the information that you can know about where somebody's been to help them kind of move forward."
(Staff Focus Group)

Enhanced intervention – 'small things make a big difference': The importance of touch was noted in the staff focus group as an important means to build trust. The podiatrist described her work with clients with a deeper understanding of the use of touch with this population, many of whom would have experienced previous harmful touch or aggression. The small everyday gesture of allowing someone to attend to their feet was reported therefore as symbolic for the homeless population and often a moment of breakthrough in the relationship:

"I think touch for a lot of our patients is very important as well. (…) Yeah. I just feel feet in particular are a very, very vulnerable part of the body and… I didn't really realise until I started doing the homeless team because, you know, patients coming into normal podiatry, they just got up and sit on the couch, they make their appointments and some of them are in a position where they have no choice. You know they have foot wounds, they

have to be seen regularly but... this client group, it's almost like you have to persuade them to let you see their feet. And it's all about this very, very, very vulnerable part of the body. And you know a lot of them will say I have never let anybody touch my feet ever before. So this is the first time and once you kind of get that, it's almost like a little trust thing between you and I also realised just by doing this post, especially when you're out on the medical bus that they need, they need that touch. (...) They like that touch, I feel. (...) You know, eventually when you realise they trust you, hugs, handshakes and so it's just, it's a very different client group, just the approach is different for me."
(Staff Focus Group)

In a similar vein, staff spoke of how seemingly 'small things' can make a 'big difference' with this vulnerable population, with service users reported to be very appreciative of when staff 'do what they say they are going to do'. This is perhaps indicative of clients' prior experiences of being let down by services, thus repairing some relational damage in these small everyday actions:

"I think they just appreciate the fact that they know, they can now come to us and hopefully everybody in the team, and they trust that we do what we say we're going to do when we say we're going to do it. I think that's really important, even if it's only making a telephone call to somebody or something about them. So it's small. It is the small things that make a big difference."
(Staff Focus Group)

Staff spoke of the importance of focusing on the 'small wins' (such as a person turning up for an appointment) as a means of managing their 'frustration' with the wider system failures which were perceived as making it very difficult for the service user to break out of 'the cycle' of homelessness and associated difficulties:

"It's very difficult... I think some days are harder than others. Yeah. And we see some, as you can imagine, some really sad cases and there are things that hit home with you or that you take home with you when you think about what people have been through and then a system that keeps that cycle going for them. And when you can't, you feel like you can't help to get them out of it. But whenever it's our job as healthcare professionals to, I know we try and fix things and in this job there is no fixing anything for anybody and, for me that's incredibly frustrating, I find that really frustrating and, we try and focus on the small wins I think most of the time, so if somebody turns up for an appointment, we see that as a win. If somebody stays off drink for or drugs for a couple of days, we see that as a win. And we try to focus on that as much as possible, yeah."
(Staff Focus Group)

Multi-disciplinary working - improved access to the right service: Focus group participants spoke of the importance of the multi-disciplinary team at BIHS so that clients could be redirected to other specialisms as need became apparent. Given the complex life experiences of the homeless population, staff described how addressing need in one area of people's lives could sometimes surface other needs with the combination of physical, social and mental health needs apparent over time. The usefulness of reflective practice in cases of complexity was noted with staff members able to pool their expertise and knowledge of the individual to ensure more effective service delivery. As an example, the podiatrist spoke of a client who had initially been contacting her every two weeks to get his toe nails clipped. This frequency of engagement and the client's desire to cut his toenails very low almost removing the nail bed, had led to a complex case discussion with team members. Understanding the client's nail clipping through the lens of trauma and self harm helped reframe service engagement with a referral made to BIHS psychotherapy for this client. As a result of his therapeutic engagement, this form of self harm reduced over time:

"This is very basic foot care, no issues. But actually the deeper that [we] sat down and looked into it.... and the deeper we looked and realised he was actually self harming through his feet, so he could never get his nails short enough. (...) So this is probably a perfect example of really looking through the trauma lens. What is this doing? Why is he walking 10 or 15 miles a day? In steel toe-capped boots in the middle of summer? and it was all to do with... once we went down the line of trauma and self harm through his feet."
(Staff Focus Group)

"We just sat down and mapped it down out on a piece of paper and sharing our learning. And then [nurse] was able to add in bits... as [nurse] would have known him from about 13 years ago before he went.... He had come out of prison and that added other layers of complexity onto the guy's life, but he had definitely had some neurological challenges himself because of his drug misuse over the years."
(Staff Focus Group)

Improving access to talking therapies: Staff members spoke with frustration about the perceived lack of trauma-focused therapeutic services for their client group, with long waiting lists reported or insurmountable hurdles in the eligibility criteria, such as clients needing to be substance-free for at least one year. Staff members spoke highly of the value of the 'flexible' and 'accessible' in-house psychotherapy service developed at BIHS which they could refer clients to when they were in 'a relatively stable place':

"...a lot of our clients wouldn't meet the criteria to access services, so if we didn't have [psychotherapist] here, there would be a lot less people getting talking therapy that they need. So [psychotherapist] is very flexible and basically all we really ask, is that somebody's in a relatively stable place. I wouldn't be referring anybody to [psychotherapist e] that I knew was really, really chaotic. And so there's been a lot of referrals went through and interestingly (...) but yes, [psychotherapist] will literally see anybody, there's never an issue, it is so easily accessible as a service, it is something that you wouldn't get like really anywhere else. So if we didn't have [psychotherapist], that would be a massive hole in our service provision."
(Staff Focus Group)

Interestingly, this service was reported to be well received by their clients. Given the chaotic lives of many service users, attendance was not left to chance but supported by several engagement strategies. This included referral being followed up by a text reminder to support clients to engage:

"They [service users] do engage, and yes, it's here in the building, and out of chaos, they still manage to be here. Now, we have a wonderful support team who contact them the day before, just as a reminder, you get people even phoning up asking when is their next appointments. So there's something about their commitment, and they honour their commitment... this isn't, you know, six sessions, this is long term therapy."
(Staff Focus Group)

Other engagement strategies, included co-facilitating initial therapeutic sessions with the mental health nurse whom clients had already built up a trusting relationship, thus facilitating 'warm handovers' and maximising the likelihood of engagement:

"These guys really come along and quite often... [mental health nurse] and I [psychotherapist] co-facilitate the sessions. We co-facilitate certain people and it just adds a layer of trust, as [nurse] has built up the relationship, the rapport and then when [nurse] comes into the therapeutic setting, it's almost as if [nurse] is gently moving them on to my world based on the trust and the relationships she has built with them."
(Staff Focus Group)

Outreach services: The importance of the service being accessible and inclusive for the population they serve was emphasised by focus group participants and is evident in how BIHS services are delivered. BIHS delivers their services in innovative and creative ways, outside the 'medical box'. For example, the outreach Street Mobile allows staff to take much needed services to the streets and hostels where their target population can be found, and provide a range of health services such as flu vaccines and general health checks. The team currently serve 27 facilities. Such facilities include general hostels as well as those with a specialist remit, such as "wet hostels" (first opened by De Paul in NI), addiction recovery, drug user, offender, and temporary hostel accommodation. This "doorstep" service is offered whereby the team bring the service to the hostel, rather than expecting the service users to come to them. Non-standard accommodations, such as boutique hotels, were also used during the COVID pandemic to ensure no break in service while facilitating social distancing:

"We have a very different model, so we do door to door, we call it doorstep delivery. So we go to the hostels, we bring services to the hostels, and this is very important because you need to be where they're at."
(Senior management focus group)

5.6.3 Outcomes and Perceived Benefits

Obvious **benefits for service users** were identified during the focus group interviews, in terms of *feeling valued, listened to and not judged.* Thus, staff stressed the importance of listening to and spending time with service users, as a core means of allowing different issues to emerge:

"...whether they're coming for a physical health or psychological health or just for a chat. They're just calling in for a chat. They really feel empowered that can talk about any aspect of their life."
(Senior management focus group)

"because of the approach... [the service user] started to open up more about other aspects of his life and then was volunteering how he had been feeling suicidal earlier in the week. Yeah. And with just... kind of valuing that he was an important person, suddenly things started moving with GP's and getting appointments and from being pretty glum and down on it. Yeah... when we were leaving... Yeah, there was a brightness and a lightness about him. ... and we just listened. We had just spent time with him."
(Staff focus group)

Staff also described *'holding hope' for service users,* as it clearly made a difference in empowering them to change their own situation, particularly when they felt 'hopeless' themselves:

"... sometimes [service users] might be feeling hopeless. And one of the things we try to do is kind of hold the hope for them... we're holding that hope that there's something can change... just recently we had one person in... he's getting accommodation and he's rethinking all his addictions and has increased his attending appointments."
(Senior management focus group)

However, it was also argued that some benefits for the service users of BIHS took time to be realised, especially, in terms of their mental health. Staff noted how over-time, progress can sometimes manifest in small changes or actions as service users in recovery re-discover their 'hopes and dreams':

"So we discover that you know, it's much as we might love solution-focused approaches, this is very much in the mental health side of things, it's a slow burner, but my goodness, the difference it makes over time where people come in moving from describing their issues to starting to reflect on them, and then maybe even taking some small actions... and it can be as simple as making the phone call to a parent or calling down to a parental house where they haven't been in years, and so... (...) when [staff member] and I talked about things, it's those who are well on in recovery move into another places, we're now calling it discovery, and the discovery is those hopes and dreams, you know, they still have them."
(Senior management focus group)

Another key benefit mentioned by staff was that, due to having such a multidisciplinary team readily available within BIHS, service users were *able to access all types of health services quicker* than would have been possible through the 'normal health service'. Indeed, it was thought that many service users would simply not have accessed those services 'if left to own devices'. This was reported to sometimes lead to acute health issues being discovered and onward referral:

"... so being able to access everybody within the team..., it's all good when you can see all the work that can be done quicker than it would be within the normal health service, or maybe not at all for our client group if they were to be left to their own devices, you know."
(Staff focus group)

However, focus group participants argued that sometimes it was hard to see big benefits for their service users, especially when staff and the service user may have different goals. An example was provided of how a service user had refused accommodation in spite of service efforts. This was noted as sometimes difficult to accept for the healthcare professionals who wish to help:

"last week we met ... to look at these four men around their housing, around what can we do for them?... so we're the nursing end of what we were doing, the nursing assessment, Housing Executive were there, and they were looking at what they could offer with regards to accommodation,

and with regards to like even emergency accommodation, and then the support workers were looking at... well how can we support them when they're out in the street and we bring the bus to them, so we'll still see them out there. Now, sadly, we got two of them actually accommodation, but ... one was in the hospital and when they got out last week, he wouldn't accept it. So there is that other issue that what we want for them is sometimes not what they want, and it's very difficult..., although I've learned to accept this over the years, but it's very difficult as a health professional when your ethos is to help, to cure, to sustain, to do whatever, and they don't want that."
(Senior Management Focus Group)

A range of **benefits for staff** were also identified, *including increased personal and job satisfaction.* Staff talked about feeling able to make a positive difference in people's lives and getting so much back from service users:

"I think [the service users] are just so grateful for what you do, that you get so much back from them, whether they're actually... loads of them are so charismatic and funny and witty, despite the circumstances that they have been put into, and as I say those wee hugs and all the rest of it, you feel, it just makes you feel so good... even just simple things that you can do for them."
(Staff focus group)

More general societal benefits were also identified, in terms of significant **cost benefits for public services**, particularly through the development of service pathways. For example, in the brief case vignette below, effective inter-agency liaison and focused intervention was noted to significantly *reduce the time and cost of emergency and other services:*

"There was one lady who had mental health issues and she arrived every day at ED with all her bag and baggage, and she was hanging stuff all around the ED and she was lying over three chairs and she would have been seen, but she may have been seen by me today, X tomorrow, Y the next day, and everybody was doing these assessments and everybody was doing the same bloods, but nobody actually was talking to each other about this person, and I mean psychiatric team..., (...) And you know, by us actually collaborating together, it stopped the ambulances being called. (...) And we talked to her, and she did listen now, and she didn't... (...) and then as taxis would leave her off, then the security men would talk to the taxi to say... so there was a whole group of people in there and eventually, we actually got her not to come to ED for maybe three, four months and the cost of that was phenomenal. (...) Like we're talking about thousands of pounds"
(Senior Management Focus Group)

5.6.4 Enablers, Barriers and Challenges

Both staff and senior managers spoke of factors that had assisted TIA implementation, as well as some barriers and challenges to progress. These are summarised in the table below, with key issues examined in further depth.

Enablers

Training, workforce development and reflective practice opportunities were reported as important to the implementation of trauma informed approaches in BIHS. Even though staff had expertise in dealing with trauma, the openness and willingness to continue to learn and reflect on practice had allowed for a dialogue of ongoing shared learning as a service. Significant additional benefits were also thought to be gained from bringing services together to undertake joint training as a means to promote inter-agency communication and collaboration, in the knowledge that clients engage with multiple services and that no one service was ever going to be enough on its own to meet service users' complex needs.

Table 5.8. Enablers, Barrier & Challenges (BIHS)

Enablers	Barriers & Challenges
Bespoke training for staff & inter-agency groups	Systemic barriers to accessing services including stigma
Ongoing reflective practice opportunities to support staff wellbeing, practice development & targeted intervention	Bureaucracy in navigating healthcare systems
Service user consultation	Lack of specialist services for particular client group e.g. dual diagnosis services, step down facilities
Stable staff team	Current threshold criteria for therapeutic services too high for service users with complex needs
The integration of multi-disciplinary skills in the team	Long waiting lists for trauma-focused services
Outreach & advocacy with interfacing agencies & services – pathway development	Housing, education, justice and social care system failings
Knowledge exchange with other agencies & governmental departments	Need for early intervention with children and families
	High staff turnover in public services
	Lack of funding, resources & governmental commitment

Ongoing reflective practice opportunities were noted as essential in order to support staff wellbeing, avoid burn out and promote more targeted intervention, particularly when working with crisis or complex presentations:

"You want to be the best and you want to do the best and you want to do everything. But then suddenly you get burnt out... and you know you absolutely need to step back. We step back and just say, you know what is really important. Sometimes we're firefighting and we're sticking on plasters. Sometimes we just need to...[step] back and say, right, you know what? What's really the priority? What do we need to do?"
(Senior Management Focus Group)

Another key enabler that was stressed in the senior management focus group was **consultation with service users** when designing service delivery. It was argued that consultation ensured that services were accessible and meaningful, and met the particular needs of their targeted groups. This appeared to have been undertaken in BIHS using a range of informal approaches as well as more formal structured methods such as questionnaires and focus groups:

"There's no point in arranging services and nobody coming to them, and they have to be meaningful, and in order to set up those services, we do discuss this with the service users. It's absolutely paramount that (...) you know, we ask the service user. I'll give you an example. When we had our first outbreak of hepatitis C and heroin use. (...) I didn't know what it really was like for you as a person. So the best place to start was actually to go and to talk to the service user. 'You tell me what it's like to be a heroin user, because I don't know'. And they really respected that, and we got a lot of rich data from that, that really helped us then to set up meaningful services that would help them."
(Senior Management Focus Group)

"We've set up focus groups, and the reason was because none of us understood the cocaine, and it suddenly came in like a tsunami, and we were left with all these comorbidities of health problems. And... so we needed to understand. I'm sure we went round half of our hostels, but we specifically picked hostels where we knew people injected drugs, and we sat down with them. We had focus groups (...) and again, we learned loads from that taking out ACE quesionnaire
(Senior Management Focus Group)

Stability within the staff team and consistency of staff was perceived as another strength of the service while had assisted TIA implementation. Staff spoke of the importance for service users to 'know people by name' and have the same professionals available to them. This was contrasted with the instability that they had encountered in other services:

"... it's a different type of stability here. The stability is for example knowing [names of staff members]. Some of the team are available and they're known by name, so... they're not getting a different social worker every time, they're meeting the consistency of people on the team and that consistency, you know, people really appreciate that."
(Staff focus group)

In addition, the **multi-disciplinary skills mix** within the BIHS team was noted as a key strength which enabled the service to meet the many different needs of their clients as they emerged during the course of engagement. It also helped enrich case discussions with each staff member bringing insight to their area of specialism as a means of better understanding service user presentations.

Central to the success of the BIHS was the development of pathways and working agreements with interfacing agencies. This had involved consistent **outreach efforts** from BIHS, building relationships and connections over time and advocating on behalf of their vulnerable service user population in order to effect change. Knowledge exchange with other service providers and governmental departments about the homeless population and their needs was considered an essential task in advancing trauma informed approaches with perceived misunderstandings about the work with this population of service users. The service manager spoke of using anonymised vignettes at such events as a way to help other agencies understand the complexity of service users' lives:

"... just this week, I've been to two conferences... people do not understand about homelessness. And you know afterwards.... I was amazed at the questions, and that was from Commissioners, from Department of Health, you know, and so it's really good to like advocate for your service users. And I always talk about, you know, trauma informed stuff. I always talk about their [adverse childhood experiences]."
(Senior Manager Focus Group)

Barriers and Challenges

Key systemic challenges were identified, relating to the fact that, in general, the national health service was not designed to be inclusive or accessible to the homeless persons that the BIHS serves. It was argued that despite BIHS best efforts and the introduction of trauma informed approaches, other service providers were not used to working in this way, thus jeopardising the sustainability of such care provision:

"... it's like accessibility, availability, and approachability. And so we [at BIHS] try and have all three, but then we encounter other services where they're inaccessible and they're unapproachable, and sometimes unavailable. And that's where, you know, things probably fall down in that trauma informed practice, being sustained because we tried to sustain it, but sometimes it's, you know, you just can't sustain it because you're not getting the buy-in from other people (...) what we discover is other people [are] applying criteria or other assessment factors... to see whether that... onward pathway referral will be appropriate and even if it does go, we might never hear."
(Senior Management Focus Group)

A range of **barriers to accessing healthcare** were thus identified for the homeless population. These included not having a fixed abode, follow-up appointments not reaching the patient, and early discharge from services as a result of nonattendance or perceived disengagement. While BIHS attempted to be very flexible and approachable, this was not the case for all services. Challenges navigating the 'bureaucracy' of the system were reported as frustrations for both staff and service users:

"You know being fit to navigate through the bureaucracy (...) it is very frustrating for us to navigate the bureaucracy as well to try and get help for people as well. It is so frustrating. I will give you an example, I'm trying to get [a person] to a fracture clinic. I had phoned at least three or four times. I've been on the call 10 minutes and sometimes I don't have that 10 minutes to sit any longer, how frustrating is that for our service users... who are not articulate, maybe to try and negotiate and get through to the Royal Hospital to get follow up appointments and that as well. So that's the frustration."
(Staff focus group)

Limited flexibility was also a noted barrier to accessing healthcare with facilities generally closing at 5pm. In addition, the homeless population was reported to suffer stigma when seeking to access alternative services, with even BIHS staff members feeling unwelcome:

"We've got these lovely, huge health and wellbeing centres and they're closed at five o'clock at night, and they're never open for anything else to the next morning again, and there's all these beautiful spaces. But they're not a space that wanted our service users ever. And we had actually disputes. (...) So it was awful that we, you know, it was almost like we had to hide our service users, you know, we couldn't bring them in"
(Senior Management Focus Group)

Focus group participants also spoke of their frustration about the **lack of specialist services** for their particular client group, with a plea to 'do something different'. While noting that many of their clients would need trauma-focussed therapeutic interventions at some point, they reported that the **current threshold criteria to access such services were often too high** for this group. Criteria such as being a year substance free were seen as 'artificial barriers' to service users accessing services which they might benefit from. It was argued that services needed a different, more flexible approach to enhance service accessibility:

"... we need to do something different I think is the answer and... for example, when I was in the prison there was a whole team of psychotherapy in the prison, CBT service in the prison, but nobody could access it because the criteria was so high that none of the guys met it. So they're sitting in [prison], they're wanting them to be free from substances for, you know, a year before they will even consider to start in any form of therapy. That's them. And so of course that's a road to nowhere for the clients."
(Staff focus group)

"One of my frustrations would be that there, yes, there's an awful lot more talk about trauma now and a lot more talk about trauma informed practice, but there's no services there for people. So we're talking about all these things and we know what people need, but we have no services or resources there for them and all of our clients, probably at some stage in their life, will need some form of trauma informed therapy. And unfortunately, a lot of our clients would not even come anywhere near to meeting the criteria to get that sort of therapy because of the other difficulties that they have, mainly alcohol and drugs. So they are at a disadvantage before they even start, for us trying to even get our clients to the point where they might be ready to do something like that, you're years and years down the line to getting them stabilised."
(Staff focus group)

"...this whole different way of working and artificial barriers about being free from substance misuse for a year, they're just artificial made up barriers, there could be much better ways..., they're just man-made or person-made barriers to [service access]."
(Staff focus group)

This lack of onward services that their client group could readily access was described as a source of 'sadness' and 'frustration'. Even when service users did meet the entrance criteria, **waiting lists for trauma-focused services** were reported as extremely lengthy (up to three years), which often led to re-lapse:

"I think our clients don't fit in any particular box and so, there's so many complexities with them and we do understand like if you have somebody who is heavily misusing drugs or alcohol they are in no place to start any form of therapy and that would be dangerous and you wouldn't even try to approach that. But for anybody that is in a stable place and is ready to deal with issues from the past, the waiting, the waiting lists are absolutely horrendous. So you could be sitting on it on a list for three years before you would even get called to get that ...I have a client who went through the whole process with community mental health, community addictions and got a referral to the trauma team, which was the right referral for him, got an assessment and now is sitting on the waiting list and has been told 'Well, maybe get back to you in about 3 years.' And so that client has relapsed now."
(Staff focus group)

"And you know, just the sadness of that story..., where somebody had got into a stage of recovery where they were needing to move on, and they relapsed because the system couldn't facilitate them. You know ... we never see it as if it's going back to square one, we know we've made some progress, but it just is a bit harder to sustain."
(Staff focus group)

As well as barriers in accessing services, gaps in service provision to meet the complex needs of service users were also noted. Staff voiced frustration regarding the lack of development of Dual Diagnosis services and step down care models with a call for the development of other forms of service delivery when people were 'relatively stable'. Such service gaps were reported to leave staff feeling as if they were 'firefighting continuously' but 'getting nowhere':

"And so I think the services need to look at maybe can we do something different. So if we had somebody who was relatively stable and who was maybe not abusing substances to a dangerous level, could there be some form of groups or... other techniques that we could be doing to try and get guys engaged and keep working with them and try and deal with..., like dual diagnosis, there's a service that's needed as well that they've been promising for years that has not been forthcoming in this country to..., you know, that's the frustration. I think for us that we feel like we're firefighting continuously and we're getting nowhere with our clients.... how [our clients] must feel."
(Staff Focus Group)

"There's no proper step down care models for people to come to work on that trauma of the past or the present. There's nowhere that you go into... You're going to rehab for three months or five or six months, but we're talking somewhere, when you're in recovery, that you then have... There is no in-between. (...) You're just back a revolving door"
(Senior Management Focus Group)

In addition to these service gaps, focus group participants spoke of most of their clients had been **failed by other systems** earlier in their lives. Examples provided included leaving the care system with insufficient support, excluded from school at an early age or coming out of prison with no accommodation. The lack of sufficient appropriate social housing was also noted as a key challenge which kept people 'trapped' in a 'cycle' of homelessness. Such systemic failings were reported to leave staff and service users feeling both 'powerless' and 'hopeless':

"... most of our clients have fell through the net at some stage or another, whether it be at the early ages in school, or Social services, the care system, then coming into mental health services, prison... there's so many experiences that they've had when they have been failed, for want of a better word. And it's not about putting blame on anybody or systems or anything. But things are not working, and there needs to be conversations around why they're not working and what can we do to fix those things for people otherwise, you know, especially in prison when you talk about with clients. Whenever I was working in prison and clients here too, they just go in and out of prison continuously, in a cycle and they nearly become labelled, but nobody actually looks at, why are they coming into prison again? What's not working here? What can be done differently? ... and we're talking about petty crime, we're not talking about people who are committing really serious offences, but people are being arrested on a Friday for drunk and disorderly, you know, getting put back out on the Monday, getting rearrested again, and then you have the clients that have been in prison for maybe 18 months..., got their life sorted out. (...) they have been doing some education in prison, have been working, have been abstinent and then they get released on Friday with no home to go to. That's wrong as well."
(Staff Focus Group)

"It's probably worth saying about the housing situation that we're having to deal with as well. So for a lot of our clients, they can't get out get out of this cycle that they're in, because there's not really any housing for them to go to. So they're trapped in a cycle of going from hostel to hostel. Non-standard accommodation that's not fit for purpose. So you wouldn't put like an animal in, never made a human being, and that's been signed off on by all agencies to say that that's OK, because there's no other options. So you're putting people into really dire environments sometimes, and you wonder why their mental health deteriorates, why they're feeling suicidal, why they're taking alcohol and drugs. Like if you put me into one of those places, I would probably be an addict as well. And you're up against it constantly with the Housing Executive and you're fighting... that's a losing battle every day for us, we do not have any power to help with the housing situation. And sometimes there's literally no options for our clients to go to, and that it is kind of like a self-fulfilling prophecy. Then they just go further and further into that cycle. And there's no way out. So hopelessness, a real powerlessness over the whole situation for us, as well as them."
(Staff Focus Group)

Early intervention for children and families was a noted service gap with focus group participants identifying the need for different forms of intervention earlier in the life course, before individuals reach adult services:

"...by the time folks come into our world and we're firefighting the adult adverse experiences and the aspect of all the stuff that's maybe behind it and all the learned behaviors dealing with life and community from their childhood. So it would be a case to say while we're at our end, it's the resources much earlier in these people's lives... needs all the resources. You know... before you ever get to this stage in life."
(Staff focus group)

In addition, focus group participants spoke of their frustration about **misconceptions about the work** in the media and other services:

"And it's very difficult, unless you're actually working within the team and you're hands on sometimes... to really get people to understand how difficult the client group can be at times, just even in terms of engaging and. just trying to get them to appointments, trying to get them to engage so what you're talking about and that's... you almost need hands on to really, really appreciate it. And so like when I hear stuff on the news and that now about homeless and that, I just think you haven't a clue, because you're not sitting, you're not actually working within that population or that group of people. You need to be doing that. It's like any disease or any illness. So I think that... you can read about it, but actually unless you're experiencing it first-hand yourself or with the family member or something, you really don't. You just don't get the real depth of how desperate it is, you know."
(Staff Focus Group)

The high turnover of staff in many health and social care contexts was noted as a challenge to promoting trauma informed approaches. This constant turnover was thought to detrimentally impact development 'momentum' with professional relationship networks and understanding having to be constantly re-built:

".... some of the barriers are... (...) such a turnover of staff... like you could maybe have a different staff team next month than you had this month. And you know it's the same like... [in] community children's services, it was [name] who sort of championed that we would have this. Then, [name] is now retired. So I'm not saying the appetite is not there, but I'm not sure the momentum is just the way it was. [But] I think that's life and it's the same like if you're talking about [staffing in] Emergency Departments, you know, you get a whole set of people like thinking your way and then a new set come along and you have to try and do that over again."
(Senior Management Focus Group)

Finally, focus group participants reported the **lack of funding, resources, and governmental commitment** to meeting the needs of the homeless population as a significant barrier to progress:

"So I think it's great that there's a lot more talk and understanding and education across the board and the Health Trust generally, but still, no funding, no commitment to making any resources to help people actually address all these difficulties. That would be my frustration with it."
(Staff Focus Group)

5.6.5 Next Steps

BIHS reported their intention to continue to develop their service as the main team providing bespoke healthcare to the homeless community in Belfast. There are plans in place to provide training for new members of staff as well as offer support to other homelessness services across Northern Ireland. The team recognised their development with implementing trauma informed approaches and suggested that TIA training should be rolled out across all professionals working in health and social care. Queen's University Belfast School of Nursing and Midwifery plans to work alongside the BIHS team in further developing case studies for use in undergraduate nursing training.

5.6.6 Lessons learned

A number of implementation priorities emerged from focus group discussions which participants felt were central to TIA service development. Primary amongst those was **the need for close collaboration with other interfacing service providers and the establishment of agreed service user pathways** to meet the needs of the homeless population:

"I think the developing of pathways and the signpostings and making those connections with... other services that are meaningful and make a difference to the homeless are the most important of all."
(Senior Management Focus Group)

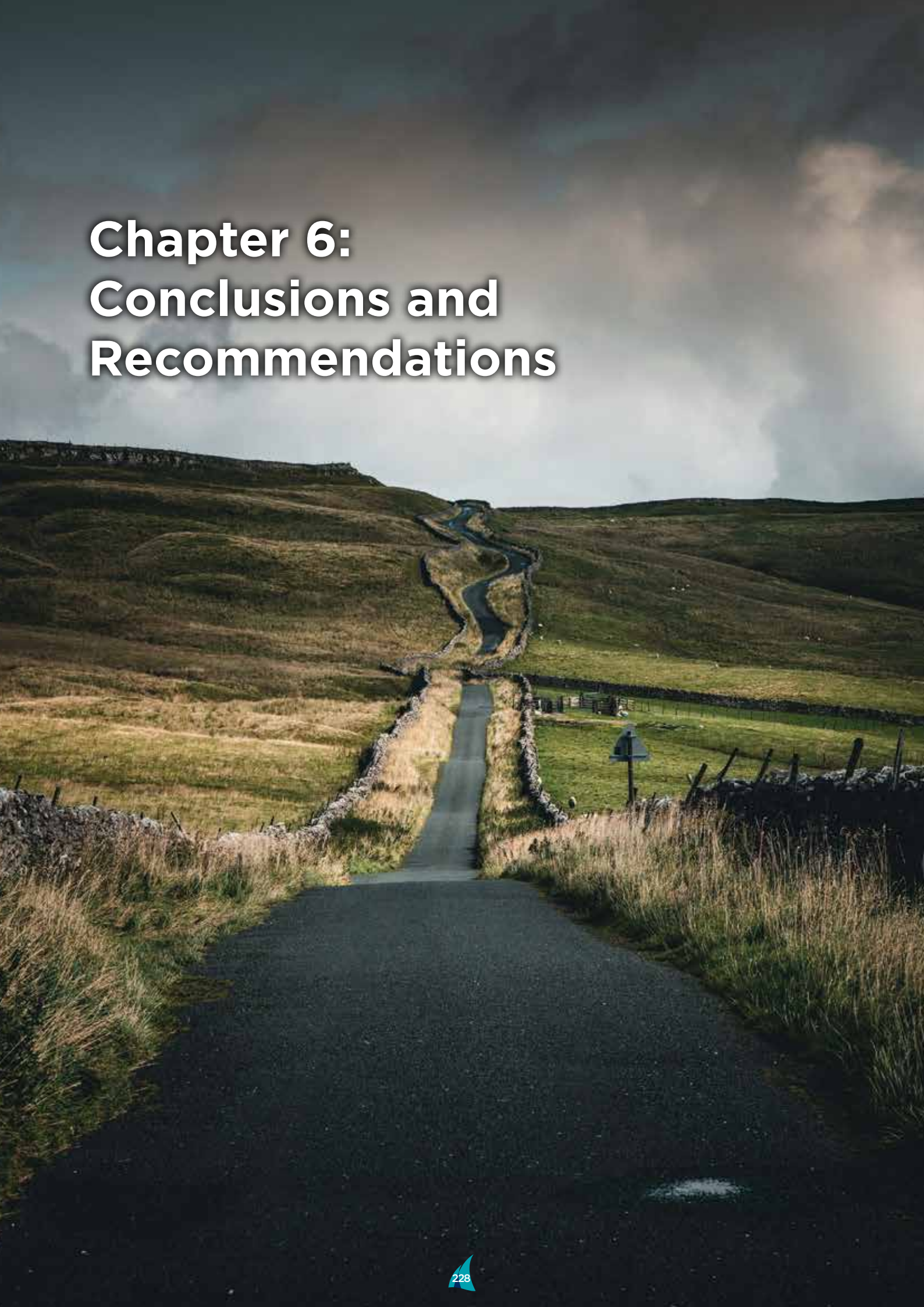
'Getting to know your service user' was also reported as key to any TIA developments, with evidence through focus group discussions of staff interest in service users' lives (beyond the presenting issues) and desire to use their engagement, even in small ways, to repair some of the harm many clients had and continued to experience in their everyday lives. For this service user group, it was also noted that building trust was central to effective engagement with staff patience and tolerance needed. As a result, effective workforce support strategies and reflective practice opportunities were required to help sustain the practitioner in light of the emotional demands of the work.

Finally, there was a plea for policy makers to become more interested in understanding the lives of service users whose needs do not always fit neatly 'into a box'. By doing so, BIHS staff members envisaged **the creation of more flexible and accessible services** that could meet the needs of the most vulnerable:

"[There is a] clash of cultures between policy and policy makers and people and practitioners... So you know, who listens in terms of, from grassroots up from the healthcare professionals that help shape perceptions of proper policies, because the services..., they just don't exist, you know, they just aren't there for the people that we meet here. You know, where do people go in our world if they've got a drug debt and they're under a life threat, you know, and statutory services are great when things are, you know, fit in a box. But there's so many other variations. Or young people out of care? So when they're 18, they're suddenly an adult and you've got young women on the street here who are very, very vulnerable, you know. And so, if the policies don't meet their needs first, the most vulnerable, then it's just a piece of paper and... we deal with people, not paper."
(Staff Focus Group)

Figure 5.11: Belfast Inclusion Health Service Trauma Informed Implementation

Chapter 6: Conclusions and Recommendations



6.1. Conclusions

The following conclusions have emerged from a combined analysis of the different elements of this organisational review of the implementation of Trauma Informed Approaches in Northern Ireland. This includes the rapid evidence assessment (REA) of international literature (Chapter 2) as well as the empirical work undertaken in the NI context (Chapters 3-5, i.e., online survey of current TIA implementation in NI; strategic focus groups with senior managers and professionals; NI case studies). The conclusions are structured to provide an overview of the five core thematic areas explored across all elements of this report: TIA conceptualisation; TIA implementation; outcomes and perceived benefits; enablers, barriers and challenges; and NI future vision and priorities.

6.1.1 TIA Conceptualisation

- While recognising the lack of definitional consensus, the international literature reviewed argues that TIAs are best understood as a framework to guide an organisational transformation process to enhance service user engagement which requires systemic culture change and ongoing work at all levels of the organisational hierarchy.

- The empirical work undertaken in NI indicates that there exists some confusion about the meaning of trauma informed approaches in NI. Participants fear that TIAs risk being perceived as tokenistic in the absence of clarity.

- Specific areas were identified as in need of further clarification in order to ensure a shared understanding of TIA implementation as sustainable whole system transformation. These included:
  i. the distinction between trauma, trauma-informed and trauma-focused services;
  ii. an understanding of how TIAs take account of structural issues (such as poverty), social inequalities (e.g., gender, race, ethnicity, disability, social class) and their intersection;
  iii. the relevance of TIAs for *all* organisations engaged in service design, delivery and policy development including the adult sector and non-frontline services; and
  iv. how TIAs align with other strategic imperatives (e.g., restorative relationship-based practices, service user/caregiver involvement, early intervention, reducing restrictive practices, staff wellbeing and Outcomes Based Accountability).

- TIAs were thought by study participants to have particular resonance to the NI context, given the collective history of political conflict and its pervasive impact.

6.1.2 TIA Implementation

- While noting the need for greater conceptual clarity, the international literature reveals that TIAs are being adopted across different settings in health, justice, education and social care, with early indication of positive impact for service users, staff and organisations.

- The empirical work undertaken in this review demonstrates that TIAs are currently being implemented across all sectors (statutory, voluntary and community) and diverse service settings (education, justice, health and social care) in NI, including regional, Council-area, Trust-wide and more local services. Implementation progress was found to vary widely across the organisations and agencies which participated in this study.

- TIA initiatives are being undertaken in different types of organisations in NI including frontline service provision and non-frontline strategic development, policy, support, advisory, governance and commissioning organisations. However, TIA implementation to date has been largely associated with frontline service provision, with further work thought to be required to conceptualise and support implementation in non-frontline organisations.

- While TIA initiatives were reported in both child and adult services in NI, there appears to have been more progress in child and family settings. The relevance of TIAs to adult services was not thought to be universally recognised, with the perception that TIA implementation in the adult sector was lagging behind.

- Whole-system TIA implementation is found in the international literature to require work across three core implementation domains adopted by this study, i.e., (i) Organisational Development; (ii) Workforce Development and Support; and (iii) Service Design and Delivery. It should be noted that these implementation domains are frequently interlocking, with initiatives requiring attention in more than one domain to sustain change.

- The international research considers the ***organisational development*** implementation domain to be of primary importance to effective TIA implementation in order to embed sustainable whole-system change. Components include: governance and leadership; financing and resourcing; policy and procedures development; service user/caregiver involvement in service development; the physical environment; intra and inter-agency collaboration; progress monitoring, review and evaluation.

- NI organisations and service leaders commonly reported that implementation progress had been achieved in some elements of TIA organisational development, including senior leadership engagement, the development of implementation structures and some level of service user/caregiver involvement. The need for further attention to financing and policy development as a means to embed a strategic organisational commitment to TIA implementation was reported, alongside the physical environment, progress monitoring and evaluation. Participants also noted the need for greater alignment across organisations, including integration with governmental strategic priorities.

- ***Workforce development*** is generally considered in the international literature to be one of the first implementation steps for an organisation to become trauma-informed. However, training alone, especially when short and one-off, has been found to be insufficient to embed lasting practice change, with the critical importance of ongoing ***workforce support*** strategies and policy development to embed practice development. International research indicates that TIA training practices and curricula varied significantly across sectors and settings, despite arising from the same foundational context.

- *Workforce development* was identified as the primary area of TIA implementation progress in NI. This was particularly apparent in the high levels of universal training reported, with greater attention now thought to be required to ensure access to different levels of TIA training, including context-specific implementation support.

- In contrast, *workforce support* was identified as an area with more limited progress in NI, with inconsistent provision of supervision, reflective practice and incident de-briefing articulated. Although the COVID pandemic was thought to have enabled greater attention to staff wellbeing, this remains an area where further progress is needed in NI. Staff retention was identified as a critical issue.

- ***Service design and delivery***: International TIA implementation research highlighted the central importance of enhancing everyday relational practices to improving service user outcomes across settings. Reported service developments in the NI context included: enhanced positive and holistic engagement with service users (and their family/caregivers); greater appreciation and integration of service user (and family) life histories; and some level of enhanced service user/caregiver participation and involvement in service development. Further work was deemed necessary to consider the potential for service user re-traumatisation, and ensure timely access to specialist trauma-focused services when appropriate.

- International research notes that effective TIA implementation demands multiple strategies utilised over longer time periods to embed sustainable changes in the broader service system, organisational culture, and policy.

- Whole-system transformation is recognised as difficult to achieve, irrespective of the size of the organisation. The additional challenges of implementing TIAs across large, complex multi-site/disciplinary/departmental organisations and systems of care (e.g., Health and Social Care Trusts) was clearly acknowledged in this study.

- Service leaders noted the central importance of message consistency across the service system in order to effectively implement TIAs, while recognising that initiatives themselves are context-dependent and thus likely to vary. Promoting such message consistency was thought to demand building connections and relationships with aligned initiatives across the organisation.

- Other key messages for successful implementation included:

  - developing a shared leadership vision;
  - having a detailed knowledge and understanding of the service system, and thus a sense of what steps are required for successful implementation in a particular agency context;
  - making a small start (somewhere) and building on these foundations to cascade the learning;
  - understanding implementation as a 'journey' with the need for constant revision in light of learning; and
  - recognising the central importance of staff involvement and support throughout.

6.1.3 Outcomes and Perceived Benefits

- Although TIA implementation has in general been found to generate positive outcomes across diverse settings, international research identifies significant methodological limitations to the evidence gathered, in terms of study design, measurement and analysis. This includes a noted research gap on the economic impact.

- Outcome measures used to assess TIA effectiveness in international research are varied across settings. They commonly include staff outcomes (e.g., knowledge, skills and wellbeing); service-user and family/caregiver outcomes (e.g., service satisfaction; symptoms; service user and family functioning, wellbeing) and organisational outcome variables (e.g., use of seclusion and restraint; critical incidents; suspension/exclusion; service engagement).

- TIAs were universally perceived by NI study participants as offering a wide range of potential short and longer-term benefits to service users and caregivers, staff/service providers, organisations and wider society. Cost savings to public sector financing were also envisaged in the longer term. The urgent need to develop a robust evidence base was articulated by many participants.

- In general, however, in many contexts, perceived benefits did not appear to have been systematically named, collected or analysed with the gap between perceived benefits and evidenced outcomes noted. Participants expressed concern that some TIA-related benefits are difficult to measure in numerical terms (e.g., organisational culture) with change not always evident over short time periods (e.g., longer term wellbeing impacts). Others stated that they were thinking differently about outcomes. The need for assistance to address these issues, and develop and implement an effective and coherent TIA organisational and regional research strategy was expressed.

- TIA implementation was perceived to offer the potential to bring about enhanced partnership working between service settings and sectors, since many organisations provide services to the same individuals and families. Improved inter-agency collaboration may offer the opportunity to improve service consistency and enhance the quality of service users' experience. This remains an area of challenge in NI.

- Given NI's collective history of political conflict and its pervasive impact, TIA implementation was thought by some to create an opportunity to address some of the legacy of the conflict.

- Importantly, participants in this study reported no disadvantages associated with TIA implementation, bar expectations being raised that cannot be met due to inadequate resourcing or services not being available or accessible.

6.1.4 Enablers, Barriers and Challenges

- International research identifies different types of enablers, barriers and challenges to TIA implementation including individual factors (e.g., staff buy-in, knowledge and skills); organisational factors (e.g., the provision of staff training and ongoing workforce development); and external or wider context factors (e.g., alignment with the wider political, strategic and financial context). Common individual, organisational and external factors were identified in the international literature reviewed and also articulated by study participants as key to supporting or hindering TIA implementation progress.

- *Common enablers* noted included: senior leadership buy-in and vision; TIA 'champions' across the system; the need to embed TIA advancement as 'core business', connecting with other aligned strategic initiatives; the development of TIA planning/implementation structures and processes; staff buy-in and involvement; the provision of enhanced and tailored workforce support and development opportunities (such as supervision, advanced training and reflective practice) to build staff confidence, skills and wellbeing; leadership support and context-specific networking opportunities; adequate resourcing and capacity to support meaningful TIA developments.

- Common implementation *barriers and challenges* reported included: staff fear and reticence; staff burnout and turnover; the absence of 'time' in systems perceived as already over-stretched; the problem of service silos; perceptions of some TIA elements as tokenistic; and the perceived lack of TIA relevance for adult and non-frontline services.

- Factors related to the *external or wider context* centred on the need to achieve a governmental TIA mandate and the current political hiatus in NI without a functioning Assembly (at time of study fieldwork); prioritisation challenges in a stringent economic climate; the absence of trauma-informed commissioning; dealing with the aftermath of the COVID pandemic; the absence of a coherent research and outcomes strategy to clearly evidence TIA benefits and the potential for cost-savings; addressing regional workforce recruitment and retention challenges; and the need for knowledge exchange opportunities to advance cross-sector TIA standardisation, implementation learning, and collaboration.

- The central resource provided by the SBNI TIP project was cited by study participants as an important enabler in the NI context to date. A need for further centralised networking and context-specific implementation support was also articulated.

6.1.5 Future Vision and Priorities

- According to study participants, further advancement of TIA implementation in NI depends largely upon a governmental mandate to provide cross-departmental support to create a trauma-informed strategy for NI. This would include designated resources and trauma-informed commissioning to create sustainable change.

- To achieve such strategic commitment, an over-arching research strategy was considered vital to enable the development of a robust evidence base, including the potential for cost savings.

- Further context-specific TIA implementation learning and networking initiatives were deemed essential for organisational leaders to share transferable best practice, and bridge the theory-practice implementation gap.

- It was thought important that TIA training be embedded in all professional programmes in NI, with the proposed development of a national trauma-related training framework akin to the developments in Scotland.

6.2 Recommendations

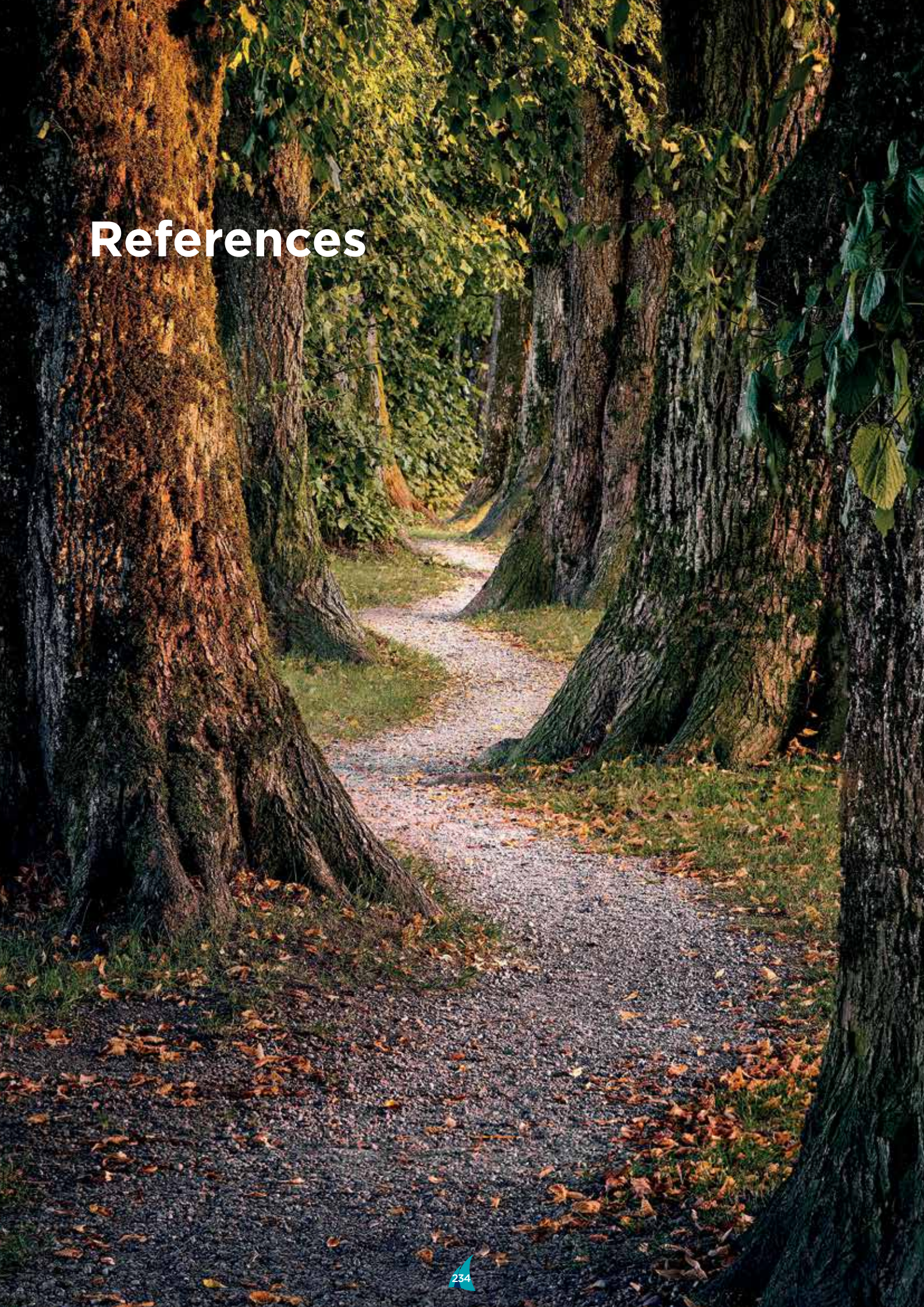
1. TIAs are a useful framework to hold together and drive forward a range of strategic priorities across child and adult services in health, social care, justice and education across statutory, community and voluntary sector provision. Such priorities include: early intervention and support to prevent and mitigate the lasting effects of adversity and trauma; enhanced service user, caregiver and community involvement; rights-based, nurturing, restorative and relationship-based approaches to service delivery including the reduction of restrictive practices; school in the community/ community in school; staff wellbeing; quality improvement initiatives and outcomes-based approaches. As such, **TIAs have the potential to underpin current policy developments providing a consistent theoretical framework** (e.g. Mental Health Strategy 2021-31; Preventing Harm, Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use 2021-31; Strategic Framework to End Violence Against Women and Girls (in process); Children and Young People's Strategy 2020-30; Infant Mental Health Framework for NI).

2. A governmental mandate and **trauma-informed strategy for NI** is now needed to advance coherent and meaningful TIA implementation across sectors and settings. This should be accompanied by designated resources and trauma-informed commissioning requirements to create sustainable change.

3. There is a need for the development of a **regional inter-departmental research and outcomes strategy**, and independent evaluation to track TIA implementation progress and evidence outcomes. The development of such a research and outcomes strategy should be undertaken in consultation with organisations to ensure new and existing data collection tools and processes are consistent across NI, considered relevant to participating organisations, and capture the full range of perceived benefits of TIA implementation over time.

4. A **regional NI trauma informed resource hub or centre** would be of benefit to facilitate organisational leadership, networking, best practice resources and specialist interest groups and conferences. Such a hub would provide ongoing support for cross-sector, context-specific TIA implementation, and enable learning to be cascaded. Further clarification and support to organisations should also be provided to ensure a consistent understanding across NI of the underpinning principles of TIAs and their implementation in specific settings and sectors, including the relevance for adult services and strategic, governance and commissioning bodies.

5. A **regional training framework** should be developed building on learning from the Scottish National Trauma Transformation Programme. This will ensure clear differentiation between trauma-informed and trauma-focused service provision and enable organisations to develop workforce development and support strategies, aligned with TIA implementation and commensurate with their role and responsibilities.



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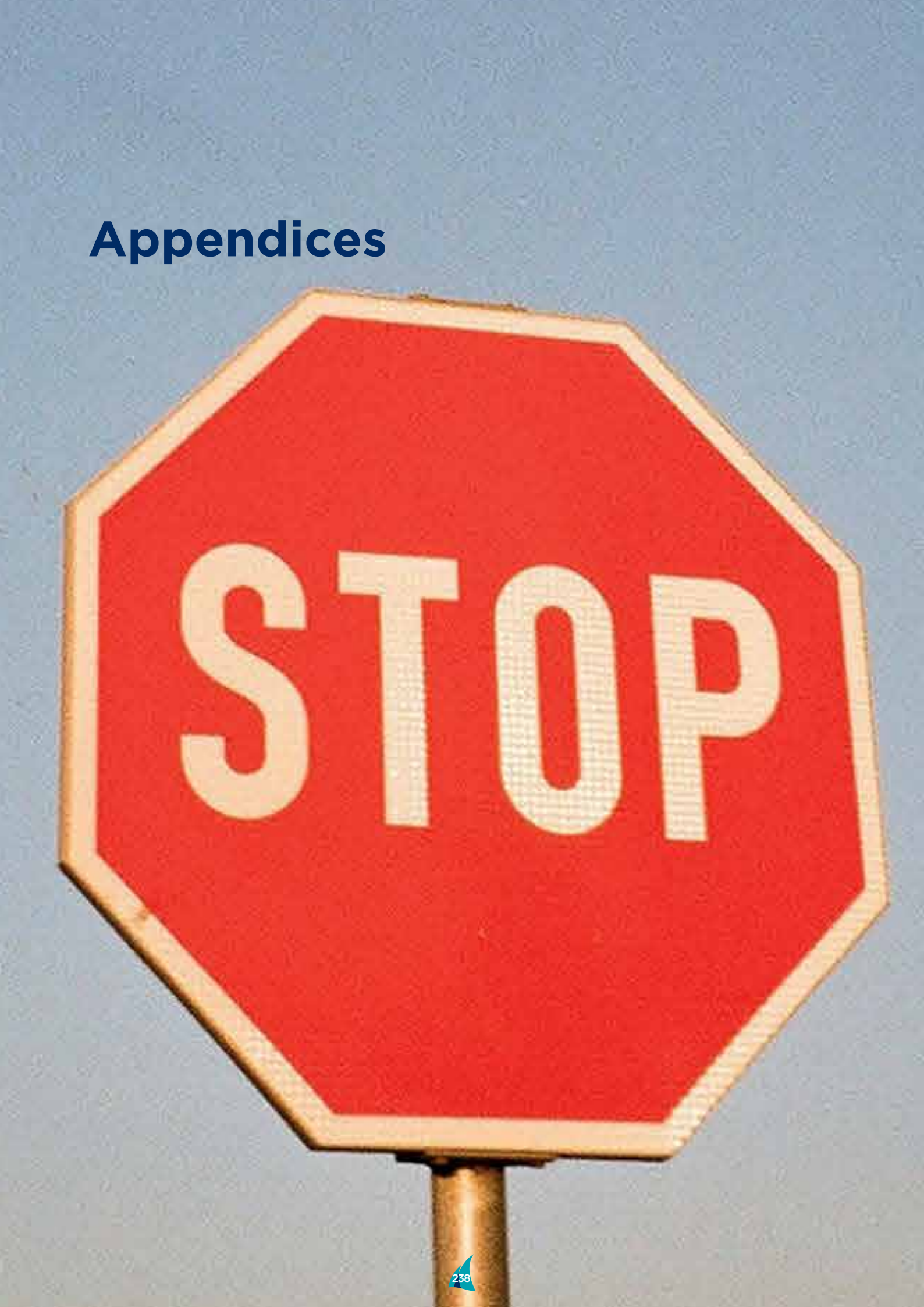
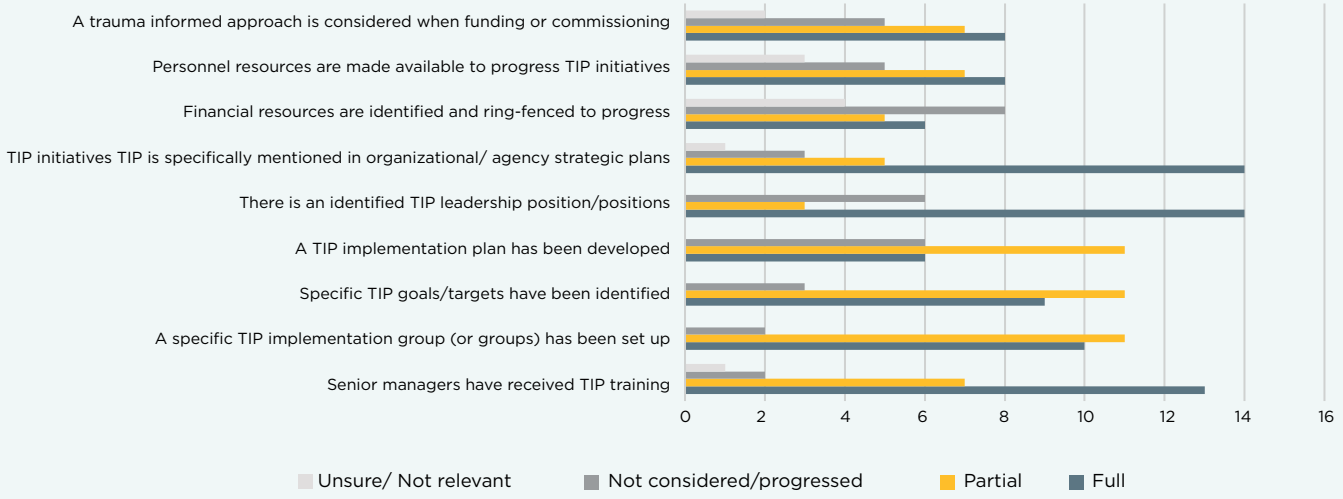
Appendices



Survey TIA implementation graphs

Governance, Leadership & Resourcing (Frontline Organisation)



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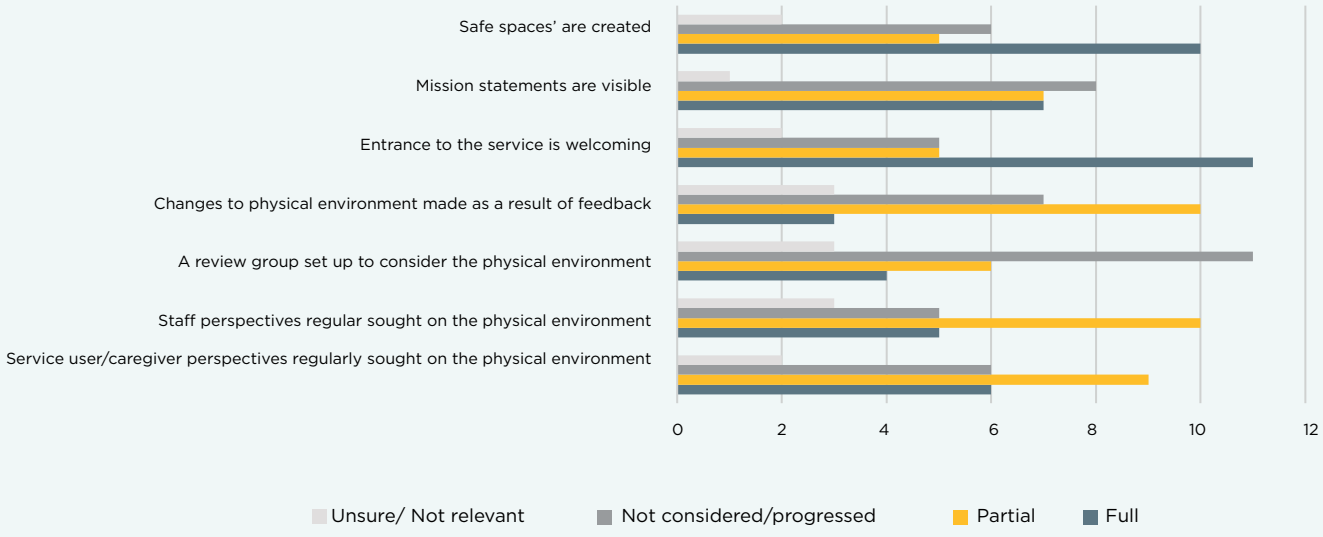
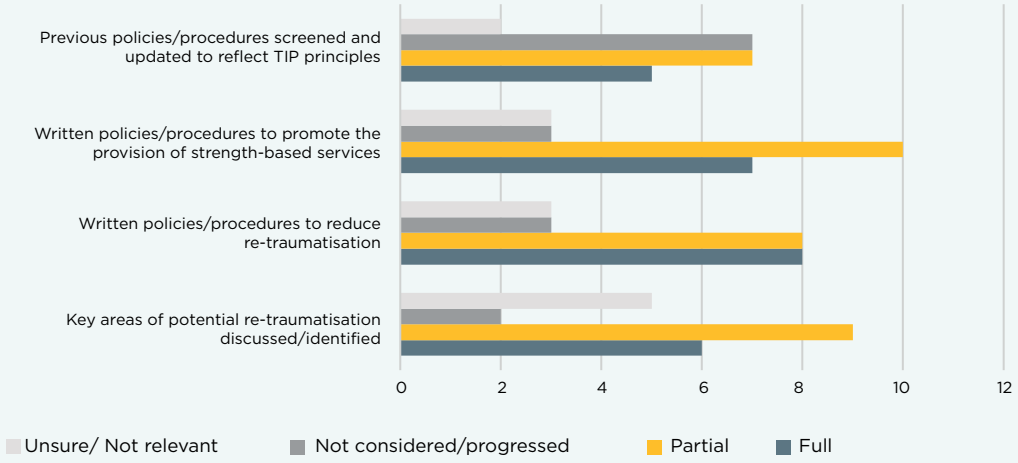


Policy and Procedure (Frontline Organisation)



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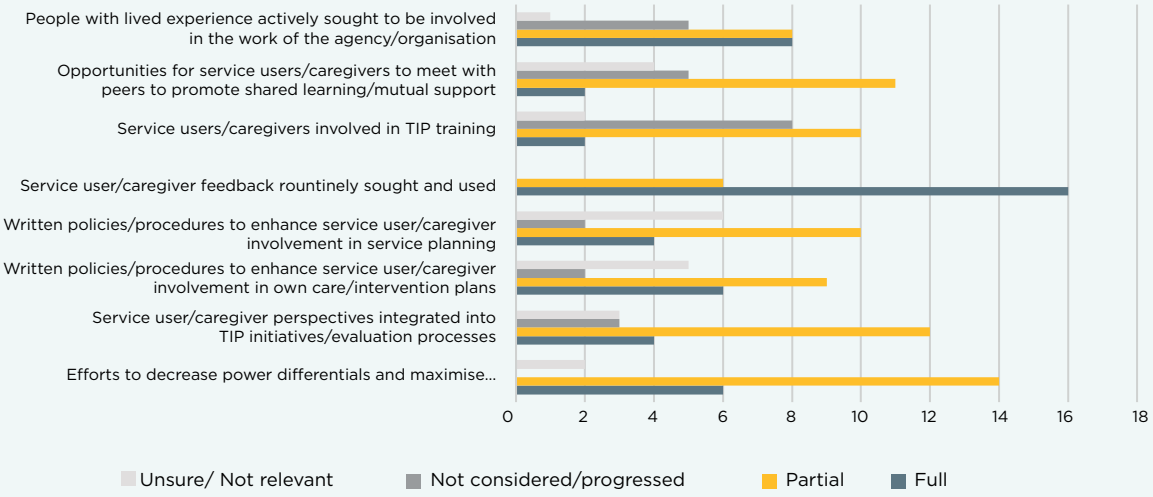
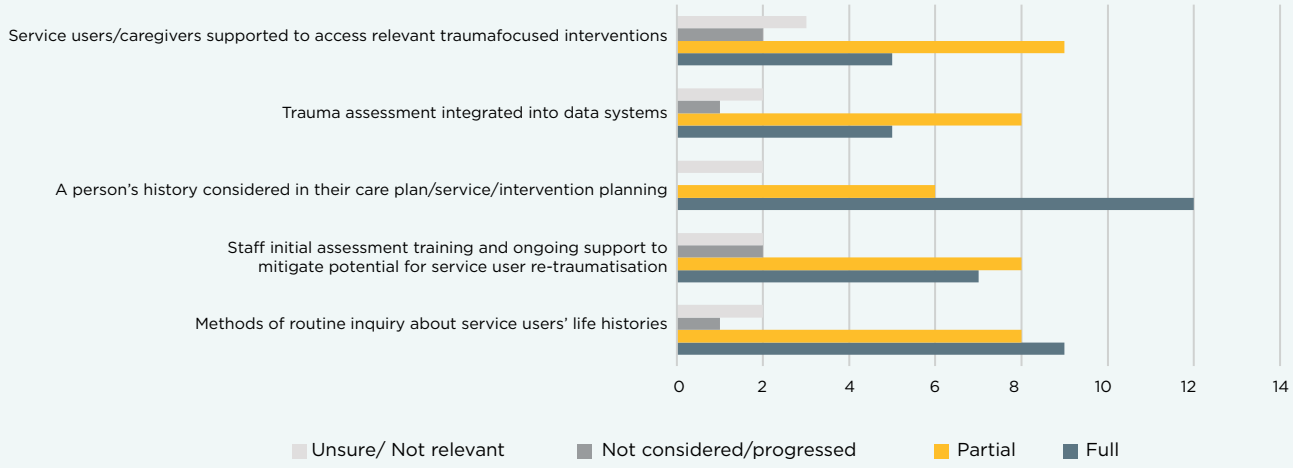


Workforce Development and Support (Frontline Organisation)

Assessment and Intervention (Frontline Organisation)



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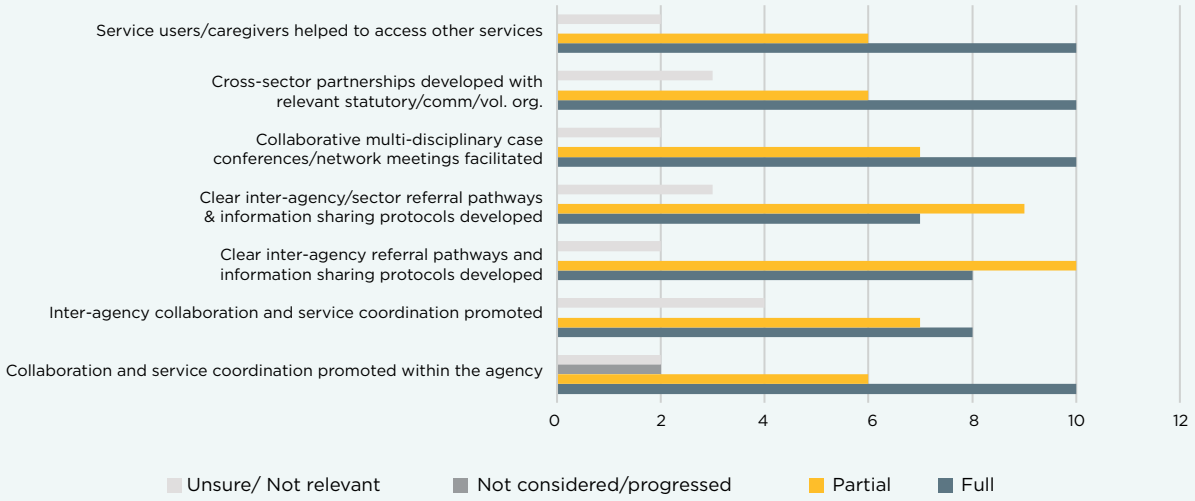
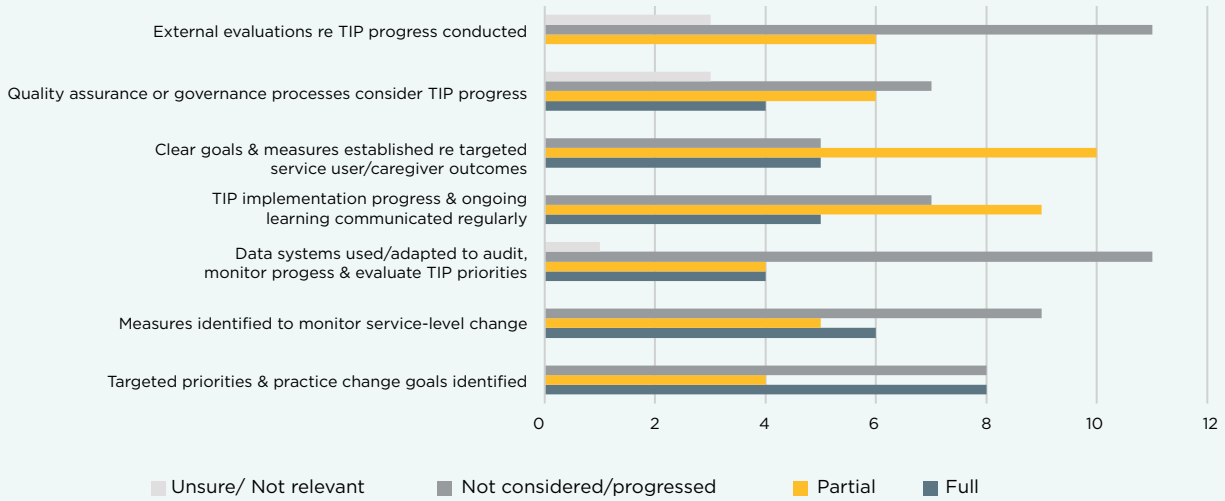
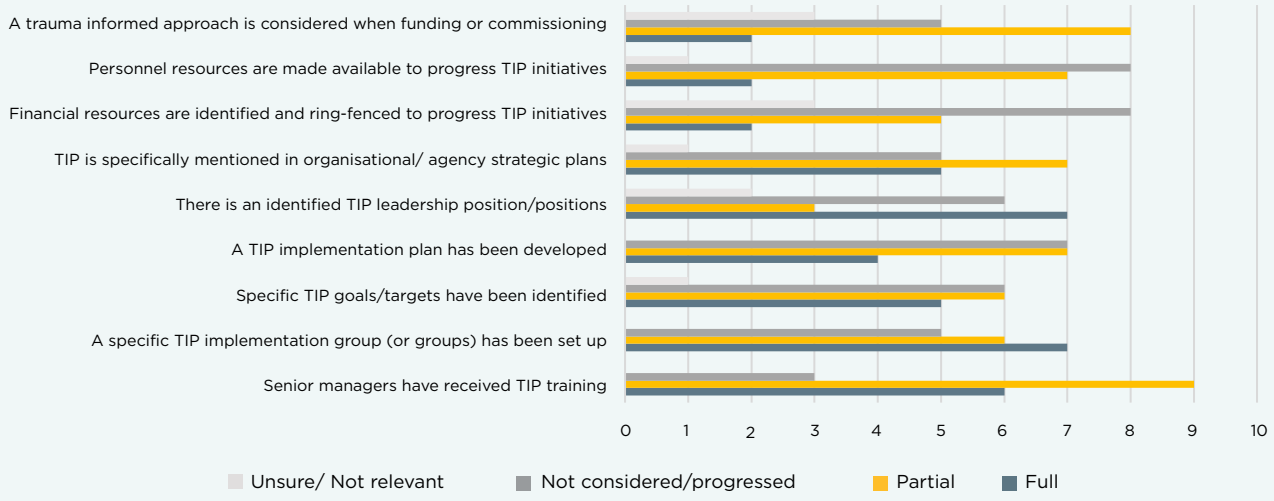


Progress Monitoring, Service Improvement & Evaluation (Organisation)



Governance, Leadership & Resourcing (Frontline project/service)



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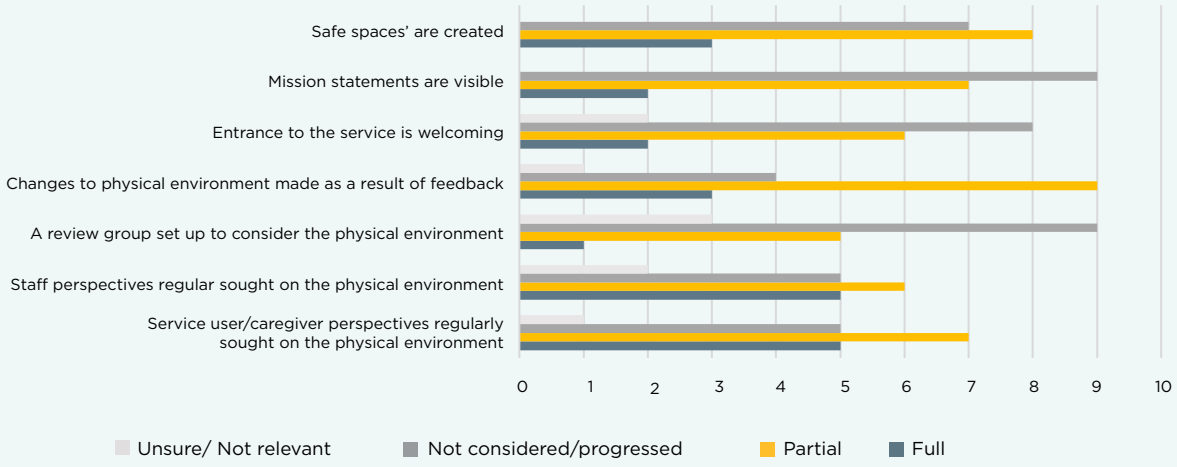
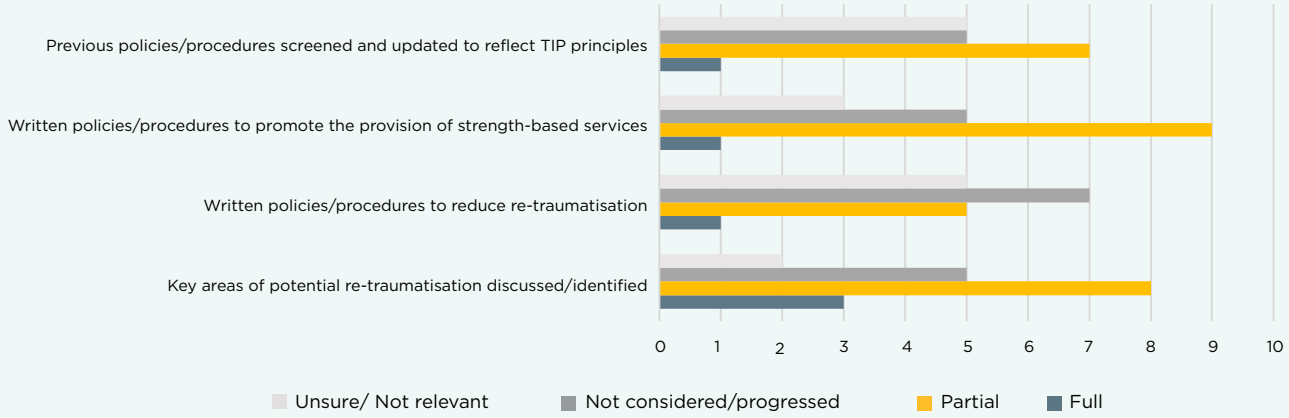
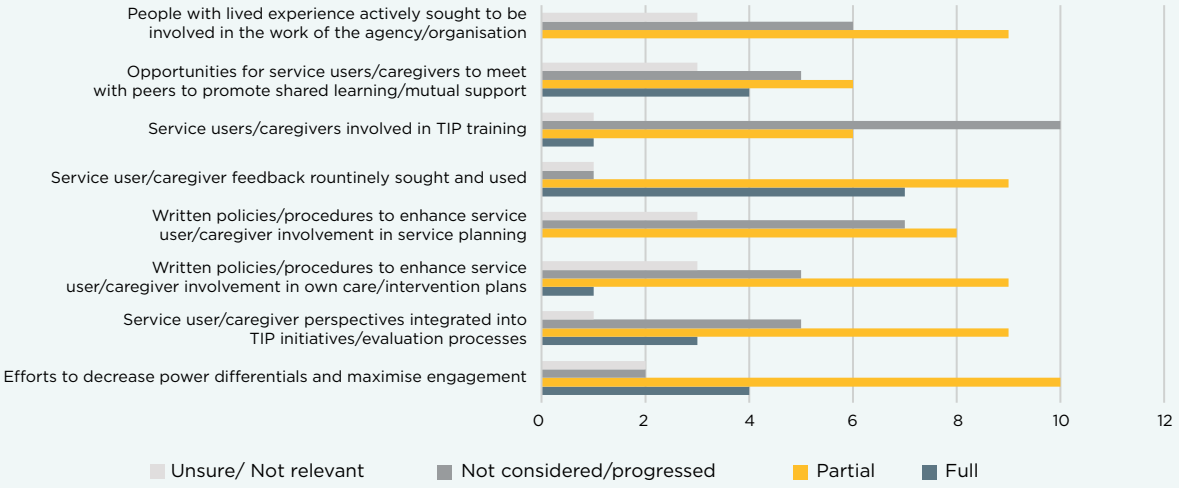


Policy and Procedure (Frontline Projects/Service)



Engagement and Involvement (Frontline Project/Service)



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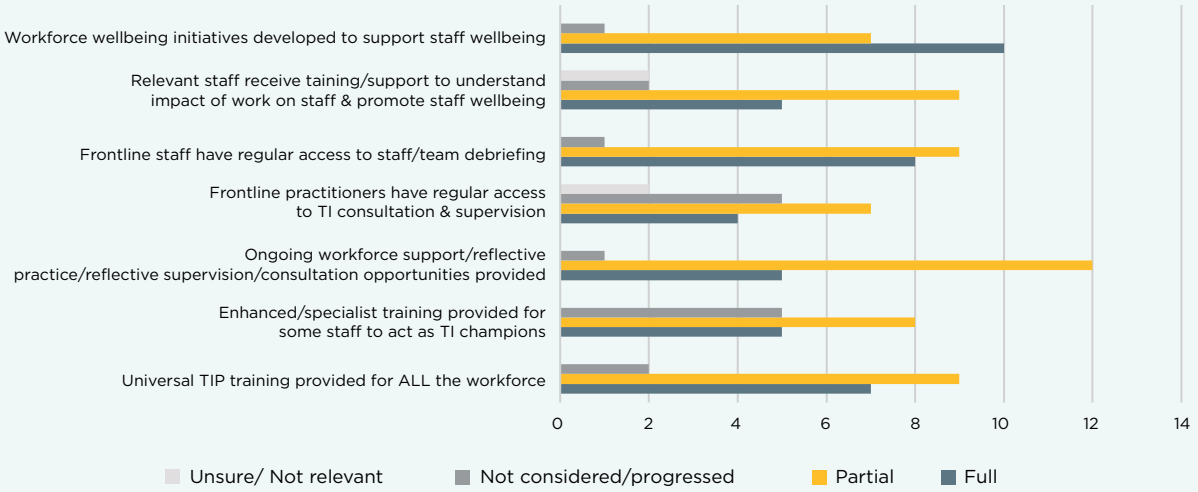

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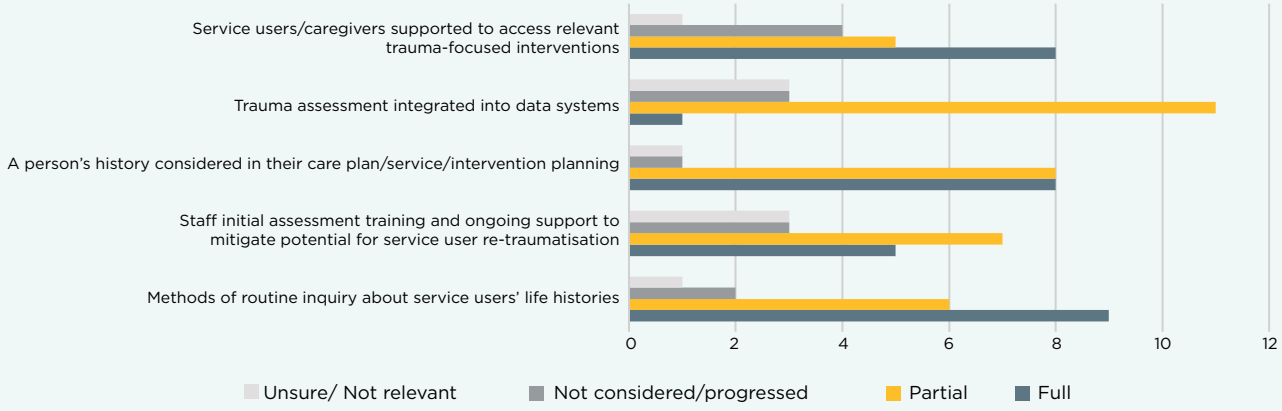

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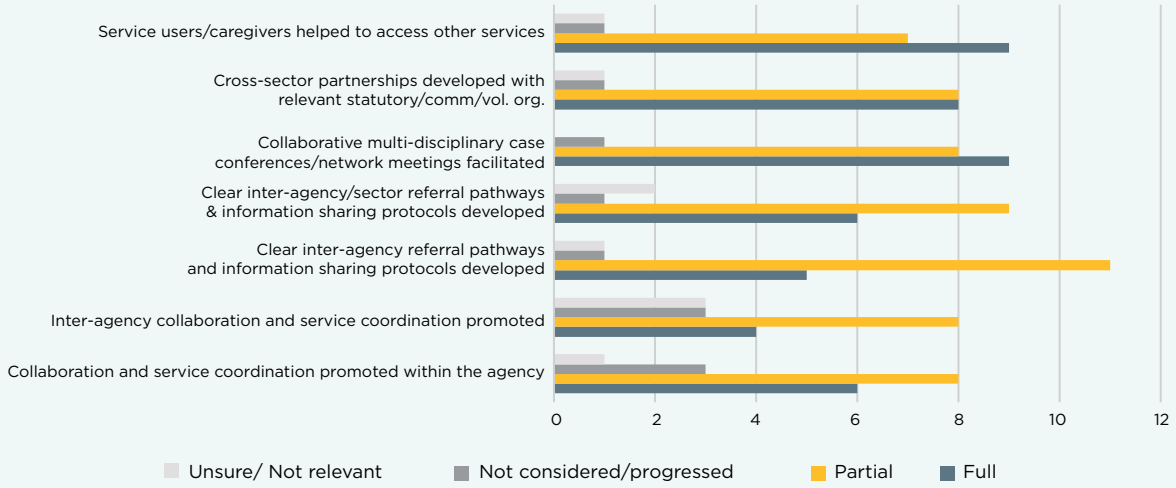
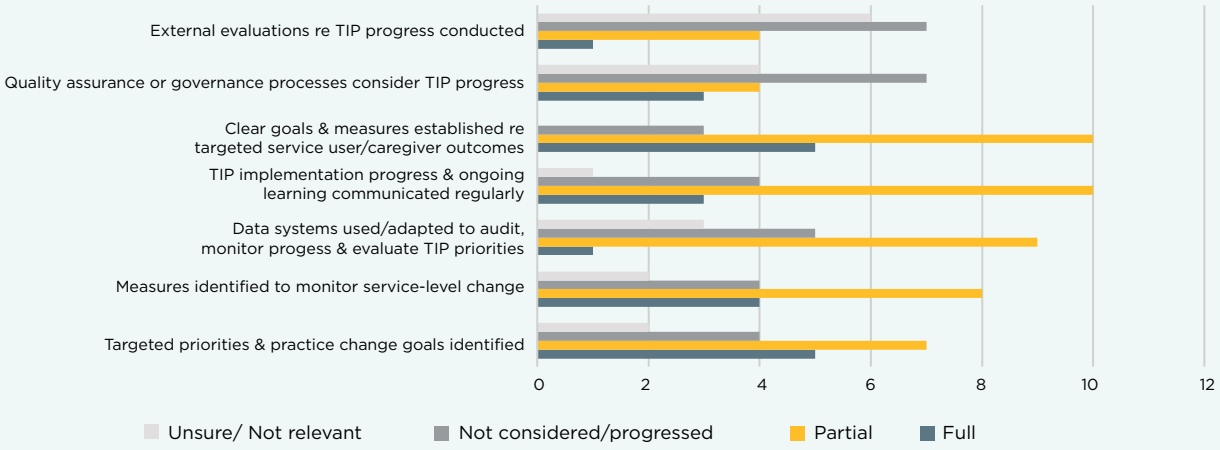
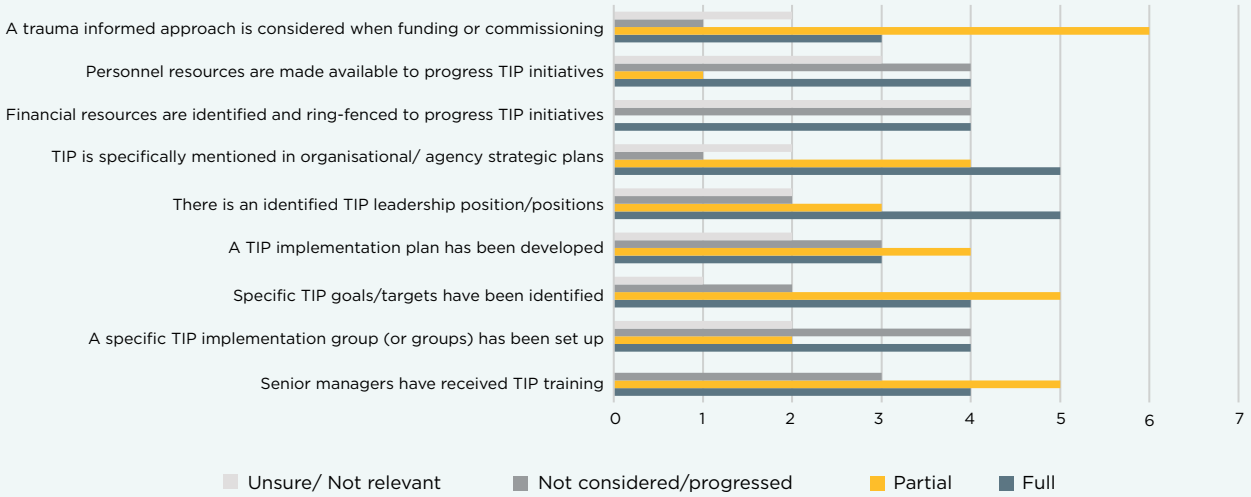


Progress Monitoring, Service Improvement & Evaluation (Frontline Project/Service)



Governance, Leadership & Resourcing (Non Frontline)



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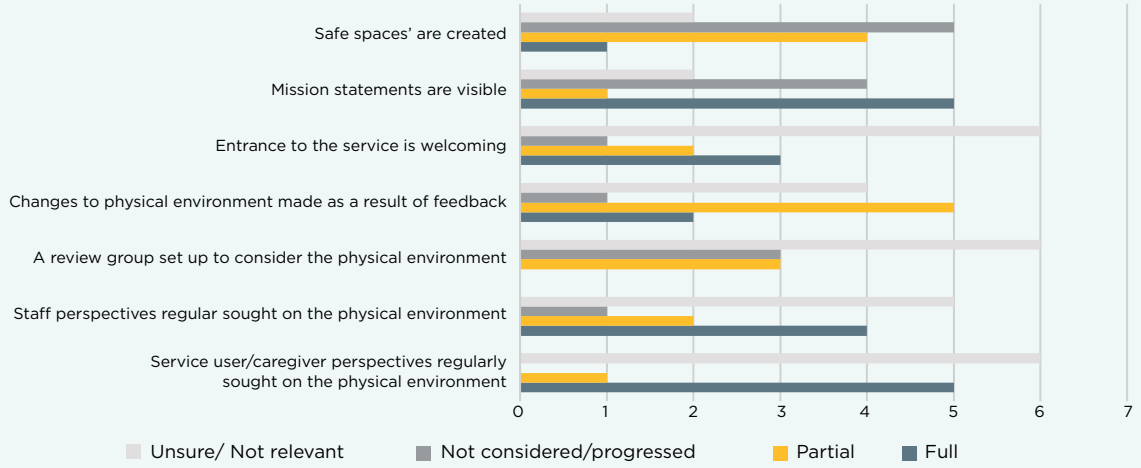

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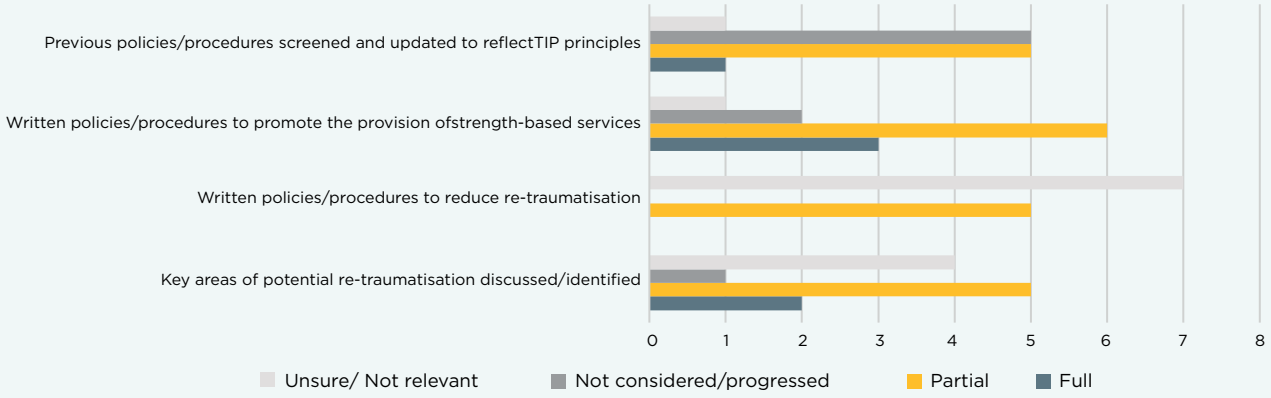

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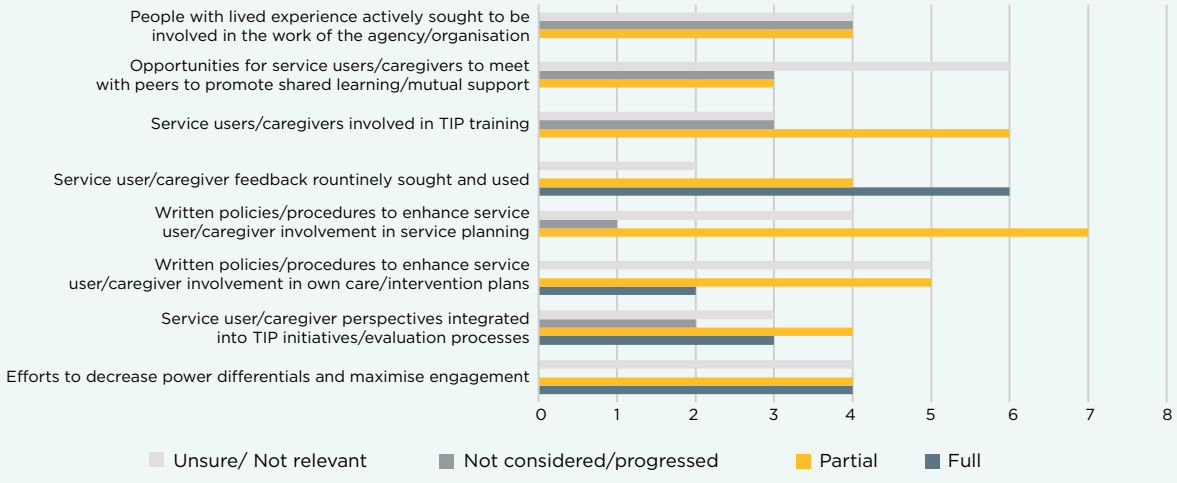

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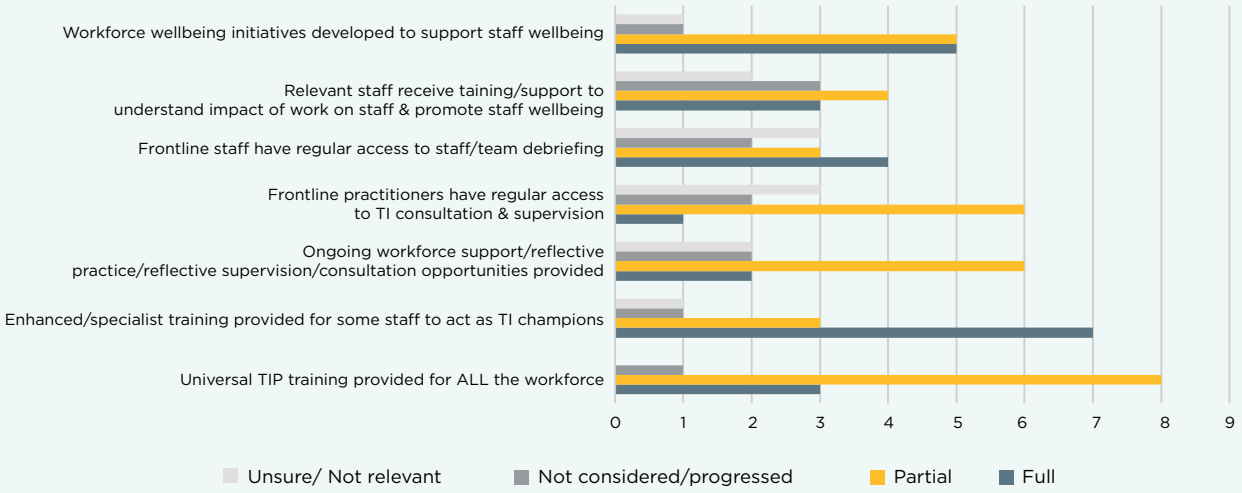

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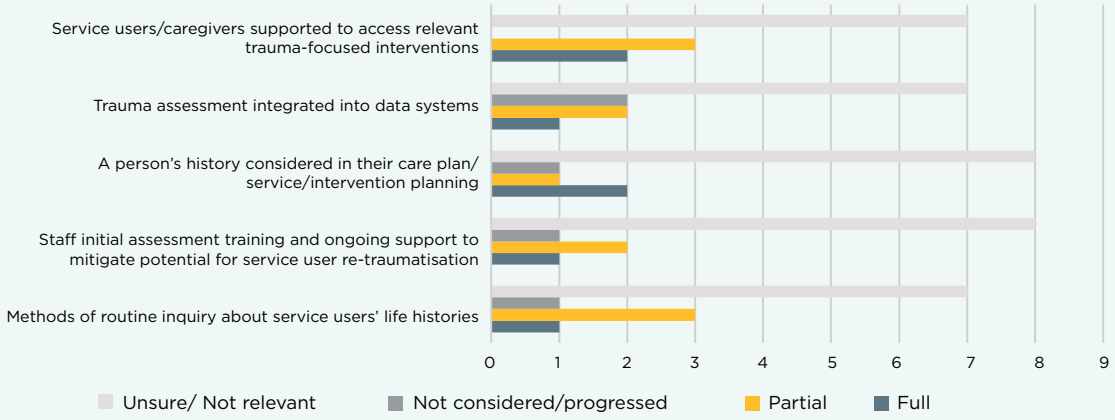

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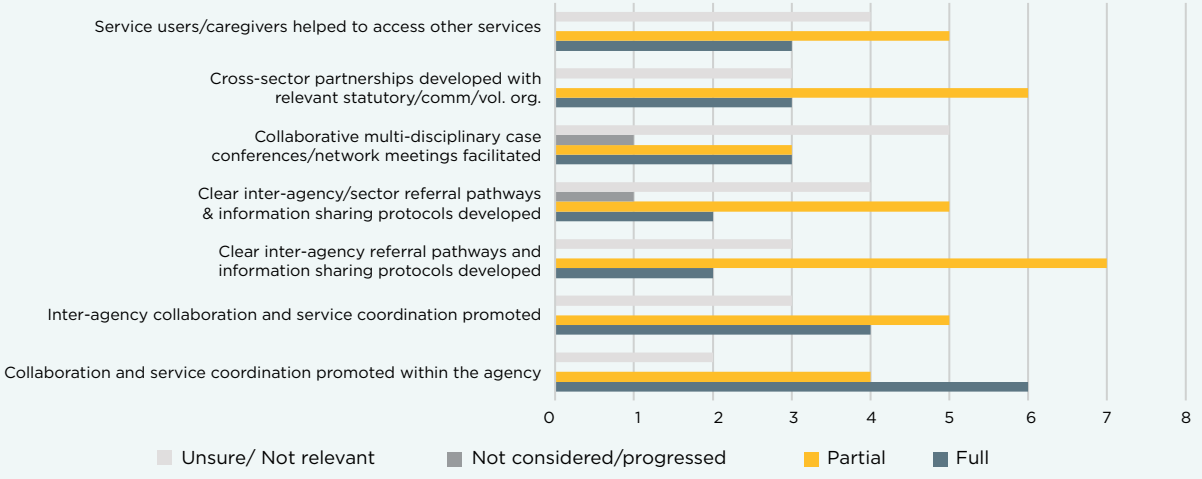
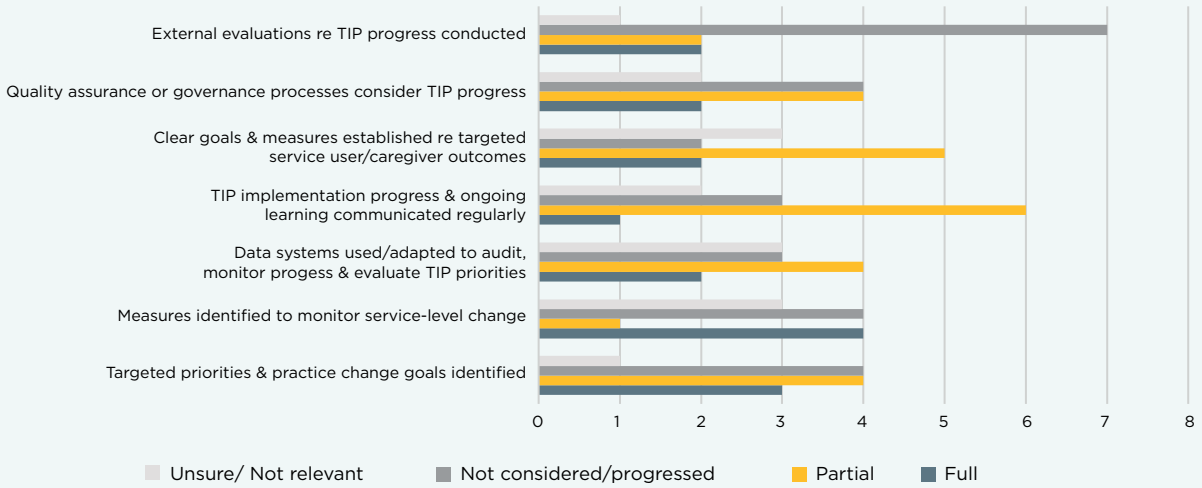


Progress Monitoring, Service Improvement & Evaluation (Non Frontline)



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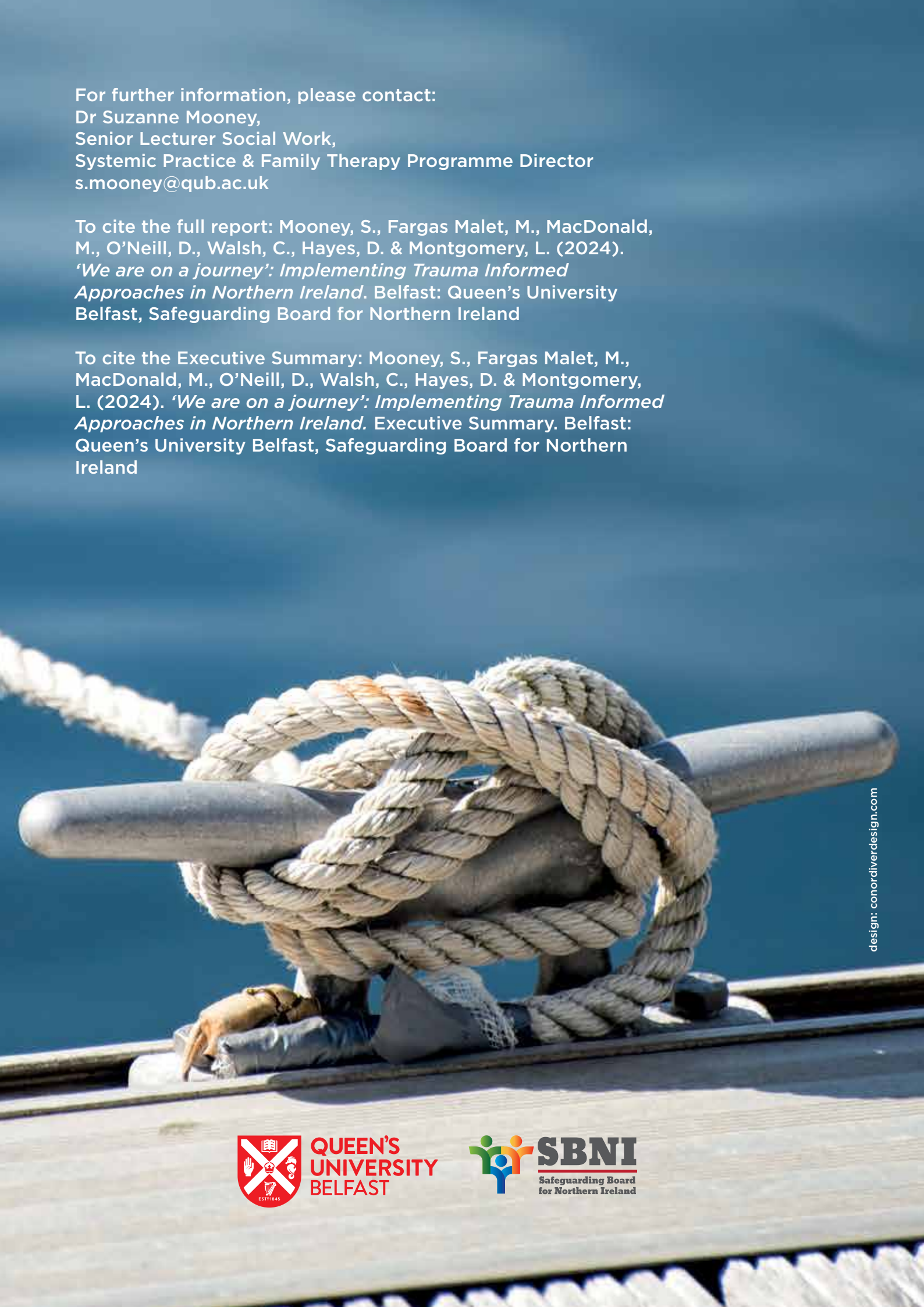

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