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Engaging with complexity

Providing effective trauma-informed care for women

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The National
LGB&T Partnership

Association
of Mental
Health
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Overview

Who is the resource for?

The purpose of this resource is to provide insights, guidance and advice for public sector service providers and commissioners who are looking to adopt gender-sensitive trauma-informed approaches in their own organisations.

How is the resource organised?

Section one

Section one introduces the concept of trauma, including its causes, its impact (especially on women), its prevalence, and the role services can play in both perpetuating and preventing it. This section will be helpful to anyone looking for an overview of the theoretical background to trauma-informed care.

Section two

Section two discusses the concept of trauma-informed care in more detail. It covers the four essential aspects of trauma-informed care identified by our research – listening, understanding, responding and checking – considering what each of these looks like in practice. It also anticipates some of the challenges services might face on their journey to becoming trauma-informed. This section will be helpful to anyone who is interested in, or who is working towards, adopting trauma-informed care in their own organisation.

Section three

Section three lists some organisations in the UK with expertise in different areas that came to our attention in the course of the research as having an interest in trauma-informed approaches. Section three also provides links to resources that may act as a useful starting point for services aiming to become trauma-informed. This section will be helpful to services that are interested in sharing ideas and gaining further information from organisations working in their sector.

What does it mean to be trauma-informed?

- Trauma-informed services put people before protocols.
- They do not try to make women's needs fit into pre-specified boxes.
- Instead, they create a culture of thoughtfulness and communication, continuously doing their best to learn about, and adapt to, the different and changing needs of the individuals they work with.
- In order to do this, it is crucial that services are willing and able to engage with complexity.
- As a result, trauma-informed care is most usefully defined in terms of ongoing processes, approaches and values, rather than fixed procedures.
- Four processes emerged from our research as fundamental to trauma-informed care:
 - **Listening**
Enabling women to tell their stories in their own words.
 - **Understanding**
Receiving women and their stories with insight and empathy.
 - **Responding**
Offering women support that is timely, holistic and tailored to their individual needs.
 - **Checking**
Ensuring that services are listening, understanding and responding in a meaningful way.

Introduction

“The human response to psychological trauma is one of the most important public health problems in the world”

(Van Der Kolk, 2000)

In recent years, understanding of trauma has grown exponentially. There is both a greater awareness of its prevalence in society and deeper knowledge of its long-term effects on survivors (Jones & Wessely, 2007; Scottish Government, 2012; Becker-Blease, 2017). With this has come recognition of the role organisations and institutions often play in perpetuating trauma, inadvertently causing further harm to some of the most vulnerable people they work with. It has been argued with increasing strength that if public sector services are to end this cycle of traumatisation and retraumatisation, then trauma-informed care represents “a vital paradigm shift” (Harris & Fallot, 2001).

Trauma-informed care is fundamentally concerned with creating conditions that reduce harm and promote healing, especially in individuals who have already experienced trauma (Bowen & Murshid, 2016). It recognises that experiencing trauma in the past can affect the ways a person perceives and responds to their environment in the present. Aspects of a situation that may seem benign to someone with no history of trauma can trigger overwhelming feelings of distress in a trauma survivor, leading the individual to behave in ways that might be labelled as, for example, ‘oppositional’, ‘non-compliant’, ‘delinquent’ or ‘hostile’. If an organisation reacts to these behaviours with seclusion, exclusion, restraint or force, further trauma may result. Trauma-informed care is actively mindful that, in these ways and others, service design and delivery have the potential to perpetuate distress and disengagement in traumatised people. Based on this awareness, it endeavours to bring about

organisational changes that will, at a minimum, prevent services from reawakening individuals’ old traumas, or causing them new traumas; and, at best, create an environment that is sufficiently understanding and safe for healing to take place. Therefore, there are compelling reasons for trauma-informed care to be integral to all public sector services.

Context

In recent years, there has been a significant increase in mental ill health among women (NHS Digital, 2016; Mental Health Foundation, 2017). This has led to a call for women’s specific needs to be better taken into account by policy, strategy and services (Agenda, 2017). In partnership with Agenda and DHSC, Jackie Doyle-Price MP, Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention, responded by setting up the Women’s Mental Health Taskforce, with the aim of defining and addressing priorities for improving women’s mental health.

One of the key priorities it identified was the impact of trauma on women’s lives. Research has found that approximately one in every 20 women in England has experienced physical violence, sexual violence or abuse across their life course, compared to one in every 100 men (Scott & McManus, 2016). Of these women, more than half meet the diagnostic criteria for at least one common mental health disorder (Scott & McManus, 2016). Given the strong relationship between women’s mental ill health and their experiences of interpersonal violence and abuse, an understanding of trauma is crucial to any service supporting women. Yet, the Taskforce found evidence that such understanding is lacking (DHSC, 2018). In a series of focus groups, it heard from women who had experienced procedures that had been retraumatising or traumatic in their own right, such as physical restraint and one-to-one observation.

To redress this situation, the Taskforce developed a set of gender- and trauma-informed principles to guide service providers and commissioners in supporting women with mental illness (see section two). These principles were informed by the key themes that emerged through focus groups with women and provided a foundation for developing this resource.

How was this resource produced?

The research that forms the basis of this resource aimed to capture a range of voices and perspectives. It began with a review of the literature on trauma-informed care. Information was gathered from published academic and professional literature, and from grey literature, including online information, practice guidance, government documents, evaluations and reports. The review gave special consideration to women, especially those who experience the greatest inequalities and barriers to effective help, including members of BAME communities and those who identify as LGBT+. It also sought information on services key to appropriate care and support, such as mental health and housing services, and the criminal justice system. Where information on these groups and services was lacking in the literature, experts in these fields were contacted directly.

After this, two workshops were held, one in the north of England and one in the south. Twenty-six people participated: fourteen women who were experts by experience, and twelve professionals with experience of researching/ commissioning and/or working with trauma-informed approaches. Several participants had both lived experience and professional experience. Although participants were sought who had knowledge of trauma-informed care in different settings, for a large majority, their experiences were predominantly of mental health services. The workshop discussions focused on:

- What trauma-informed care meant to the participants;
- Participants' thoughts and feelings about trauma-informed care;
- The availability of trauma-informed care in different settings;
- Best practice in trauma-informed care.

The findings from both parts of the research were combined to form the basis of this practical guidance.

What is trauma and how does it affect people?

Trauma takes place when people are in real or perceived danger

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a traumatic experience as one in which there is "actual or threatened death, serious injury, or sexual violence" (APA, 2013). The Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the US Department of Health and Human Services, adopts a broader definition of a traumatic experience as "an event, series of events, or set of circumstances that is experienced by an individual as physically or 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).

Trauma makes it hard for people to feel safe, even after the original danger has passed

Traumatic experiences shatter the assumption that the world is essentially safe (Janoff-Bulman, 1992; Edmondson *et al.*, 2011). Such experiences alter the way an individual perceives their environment and relationships, leading them to expect danger, especially from situations that are similar to the context of the original trauma.

Traumatic situations trigger a stress response (e.g. fight-flight-freeze)

Physiologically and psychologically, individuals who have experienced trauma are primed for threat detection. They frequently show heightened sensitivity to danger

(hypervigilance) and rapid reactivity (the fight-flight-freeze response). As a result, at the slightest sign of threat, these individuals are flooded by a stress response, which enables them to take rapid protective action (Schneiderman, Ironson & Siegel, 2005).

Triggers and stress responses vary from individual to individual

The situation that activates the stress response (the trigger) and the effects of this activation (the response) vary from individual to individual. For a child repeatedly exposed to domestic violence, raised voices might be the trigger, and running away the response. For a sexual abuse survivor, intimate physical contact might be the trigger, and dissociation the response. For an individual who has experienced hate crimes, certain words might be the trigger, and attack the response. As these examples demonstrate, triggers are shaped by the context in which trauma has taken place. The individual learns to associate aspects of the context of the original trauma with danger and responds accordingly.

Activating the stress response when danger is present has short-term survival value

In a dangerous environment, this stress response can sometimes be beneficial. From the perspective of evolutionary psychology, those quickest to detect and respond to threat were the most likely to live for long enough to pass on their genes (Nesse, Bhatnagar & Young, 2007; Cantor, 2009; Mobbs *et al.*, 2015). Therefore, when there is a real and present danger, the survival value of the stress response outweighs its long-term costs.

The stress response takes a toll on mental and physical health, and day-to-day functioning

The problems arise when these threat detection systems remain on high alert long after the original danger has passed (Kemeny, 2003; Sapolsky, 2004). The stress response takes a toll on mental and physical health, and day-to-day functioning. This may include, but is not limited to, sleep disturbances, impulsive behaviour, mood swings, impaired judgement, poor memory, dissociation, intrusive thoughts, lowered immune system functioning, greater risk of cardio-vascular disease, greater risk of mental health disorders and greater risk of substance misuse issues (Bremner, 2006; McFarlane, 2010; Gupta, 2013; Sareen, 2014; Scaer, 2014; Li *et al.*, 2017). Therefore, anything that activates the stress response of a trauma survivor has the potential to cause them harm.

Trauma survivors are vulnerable to retraumatisation (reactivation of old traumas)

For trauma survivors, harm from activation of the stress response can take at least two forms.

First is retraumatisation, which refers to the reactivation of feelings and/or memories from a negative past experience (Butler, Maugin & Carello, 2018). Retraumatisation occurs when individuals not only remember the trauma but also emotionally and physiologically re-experience it. As a result, they can be said to “suffer from memories” (Van Der Kolk, 2014).

Trauma survivors are vulnerable to revictimisation (experiencing new traumas)

Another source of harm is the way in which other people may instinctively react to the trauma survivor’s behaviour. For example, when an individual is acting aggressively, a person’s response may be to physically restrain them; but the experience of being physically restrained can be traumatic in its own right (Strout, 2010). Therefore, if a trauma survivor is in an environment that reactivates a negative past experience, perhaps triggering a fight-flight-freeze response, and if the people around them react instinctively, they are highly likely to experience harm. As a result, trauma survivors are a vulnerable population who are at high risk of harm from further trauma (Fallot & Harris, 2009; Goetzlitz & Stewart-Kahn, 2013, p. 50).

Who is affected by trauma?

The majority of people in society are affected by trauma

Trauma is prevalent in society today. It has been estimated that more than 70 per cent of the general population has been exposed, either directly or indirectly, to a traumatic event, where a traumatic event is defined as actual or threatened death, serious injury or sexual violence (APA, 2013; Benjet *et al.*, 2016).

Trauma disproportionately affects people from marginalised populations

To discuss trauma as a universal experience, although valid, conceals the fact that it is not

evenly distributed in society (McLaughlin *et al.*, 2013; Magruder, McLaughlin & Borbon, 2017). Trauma disproportionately affects marginalised populations and is inseparably bound up with systems of power and oppression (Burstow, 2003; Bowen & Murshid, 2016; Becker-Blease, 2017). For example, research has shown that traumatic and other stressful events tend to be more frequent in individuals of low socio-economic status, racial and ethnic minorities, and younger age groups (Hatch & Dohrenwend, 2007). This relationship between trauma and marginalisation points to the fact that trauma is not only an individual phenomenon, but also a systemic one.

Trauma can be caused and perpetuated by organisations and institutions

Systemic trauma refers to “the contextual features of environments and institutions that give rise to trauma, maintain it, and impact posttraumatic responses” (Goldsmith, Martin & Smith, 2014). It is a broad concept that includes both abstract structures, such as societies, cultures and families, and more concrete institutions, such as hospitals and schools. However, the field is unified in recognising that systems of any type can give rise to and perpetuate trauma in the form of, for example, racism, sexism and poverty. For many individuals, especially those in marginalised communities, feeling unsafe and threatened is not a groundless ‘symptom’ but a justified response to their experience of society and its institutions (Burstow, 2003). By recognising this relationship between environmental factors and psychological wellbeing, the field of systemic trauma challenges traditional conceptualisations of trauma.

Organisations and institutions can play a role in healing and preventing trauma

Traditionally, trauma has been understood using a medical model (most recently labelled as PTSD), and its treatment was the responsibility of trauma-specific services and mental health services. The concept of systemic trauma, on the other hand, is based on an understanding of trauma as an adaptive response to external conditions. As a result, it moves the conversation about trauma beyond the walls of the clinic and out into wider society. If systems of any type can give rise to and perpetuate trauma then, by extension, they also have a role – and, some have argued, a responsibility – to play in its prevention and healing (Elliott, *et al.*, 2005). From this it follows that addressing trauma is not only a question of delivering trauma-specific services to individuals with a PTSD diagnosis, but of trauma-informed care delivered universally.

Women and trauma

Women’s trauma is often different from men’s

There are widely recognised and well-established gender differences in trauma. These include: the types of traumatic experiences women and men are more likely to be exposed to; their reactions to these experiences; and the long-term implications of these experiences.

Women’s trauma is often bound up with relationships, intimacy and disempowerment

Women’s traumatic experiences are significantly more likely to take the form of interpersonal violence and sexual abuse than men’s (Scott & McManus, 2016). These experiences are likely to happen at the hands of someone to whom the woman is closely connected (either as a child, adult, or both), such as a partner or a relative. The abuser is also likely to have power over the woman, such as physical strength, age

(in the case of childhood abuse), control over her money or housing, or access to her children. This creates a situation in which women may have little choice but to remain in a context that is causing them significant harm. As a result, women’s experiences of trauma are often bound up in complicated ways with their experience of relationships and of their own agency (Briere & Jordan, 2004).

Women may react with a ‘tend-and-befriend’ stress response, using social support to cope with trauma

There is evidence that women may have a different first response to threatening situations than men. This difference has been termed ‘tend-and-befriend’, in contrast to fight-or-flight (Taylor *et al.*, 2000). ‘Tend-and-befriend’ refers to an emotion-focused and palliative coping

style, with women more likely to seek social support in stressful situations (Olf, 2017). That is to say, relationships are not only a potential cause of trauma, they also have potential to protect women from the consequences of traumatic experiences.

Without social support, women are more likely to psychologically withdraw (dissociate) in the wake of trauma

By virtue of the same logic, women experience more negative outcomes following trauma if social support is not available (Olf, 2017). As discussed above, for women the power dynamics of the traumatic situation may limit their options for fighting or fleeing. If they are also unable to reach out and connect to others (to ‘tend-and-befriend’), the only ‘escape’ from the distress may be psychological withdrawal. Hence, women have higher levels than men of dissociative symptoms, such as memory loss and experiencing events as if they are unreal (Christiansen & Elklit, 2012; Olf, 2017).

Following trauma, women are more likely to suffer from eating disorders, self-harm and other internalising disorders

The long-term impact of traumatic experiences also differs by gender. Women are more likely than men to experience psychological harm from trauma, and they are more likely

to develop internalising disorders following trauma exposure (Kessler, 1995). Self-harm, eating disorders and emotionally unstable personality disorder, which are more common among women than men, have all been associated with experiences of violence and abuse (Ball & Links, 2009; DHSC, 2018).

The differences between women and their experiences of trauma are as important as the similarities

In understanding the implications of these findings for trauma-informed care, it is essential to bear in mind that none of them are true for all women all of the time. Many of them are not necessarily true for most women most of the time. They are simply more often true for women than they are for men. Therefore, knowing about women's experiences of trauma in general is not the same as knowing about a particular women's experience of trauma. The former is only important insofar as it facilitates the ability of a service to listen to, understand and respond to the latter.

Section two

Women’s Mental Health Taskforce: Gender- and trauma-informed principles

Guided by the principles developed by the Women’s Mental Health Taskforce (see below), this section discusses the workshops in more detail, and the importance of listening, understanding, responding and checking. It

outlines some of the ways in which services can embed these practices in their work, and also anticipates some of the challenges services might encounter in making these changes.

Theme	Principle
Governance and leadership	There is a whole organisation approach and commitment to promoting women’s mental health with effective governance and leadership in place to ensure this.
Equality of access	Services promote equality of access to good quality treatment and opportunity for all women.
Recognise and respond to trauma	Services recognise and respond to the impact of violence, neglect, abuse and trauma.
Respectful	Relationships with health and care professionals are built on respect, compassion and trust.
Safe	Services provide and build safety for women.
Empowerment through co-production	Services engage with a diverse group of women who use mental health services to co-design and co-produce services.
Holistic	Services prioritise understanding women’s mental distress in the context of their lives and experiences, enabling a wide range of presenting issues to be explored and addressed, including a focus on future prevention.
Effective	Services are effective in responding to the gendered nature of mental distress.

For full details of how each principle should be applied, see The Women’s Mental Health Taskforce Final Report (DHSC, 2018, pp.35-42) which is available from:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

Trauma-informed care: Putting people before protocols

What came across most strongly from the discussions in the workshops was the crucial importance of being – to borrow a distinction made by the National Collaborating Centre for Mental Health – person-centred, not protocol-centred (NCCMH, 2018). Protocols are only beneficial to trauma-informed care to the extent that they enable a service to more effectively listen to, understand and respond to the women using the service at a given time. If, however, protocols take precedence, requiring people to express their experiences and needs in pre-specified ways, then the service is likely to gain standardisation at the expense of being genuinely trauma-informed.

The workshops highlighted the inescapable necessity of services being willing and able to engage with complexity, remaining receptive to the different and changing needs of people who access services, rather than seeking to specify these needs in advance. On the whole, it was not possible to identify specific interventions that would be helpful to all women, or even to a single woman, all of the time.

Instead, it follows that best practice in trauma-informed care is most usefully defined in terms of ongoing processes, approaches and values, rather than fixed procedures. Those identified by workshop participants as important to trauma-informed care include:

- Listening to the experiences of people accessing, and working for, the service;
- Seeking to understand and respond in ways that are appropriate to a particular person, or a particular situation;

- Welcoming dialogue;
- Being willing and able to have difficult conversations;
- Reflecting on what is working and what is going wrong, in order to learn and improve;
- Being open to change when things are no longer working.

These processes require services to commit to a culture of thoughtfulness and communication in which they are continuously doing their best to learn about, and adapt to, the different and changing needs of the individuals they are working with.

As noted above, these needs cannot be specified in advance with any level of accuracy. The participants at the workshops were a diverse group of individuals who made it clear that they wanted and needed to be understood on their own terms. When services tried to take a shortcut, making assumptions about their needs based on generic labels, such as their gender, their ethnicity, their sexual orientation or their diagnosis, women experienced this as “silencing” and uncaring; moreover, their experiences showed that these assumptions were often wrong. Best practice in trauma-informed care starts when a service makes an effort not to avoid this complexity, but to fully engage with it consistently and in all aspects of its work, listening, understanding and responding to each woman as an individual person.

A trauma-informed service: Listening, understanding, responding and checking

We asked women with lived experience of trauma what trauma-informed care meant to them. From their answers, four processes emerged as fundamental: listening, understanding, responding and checking. This section provides a more detailed account of what is meant by these terms and considers some of the ways in which a service's design and delivery could help to embed these aspects of trauma-informed care into its working practices.

Listening

Women told us that trauma-informed services were ones that listened to and valued their stories, even if these stories were messy, upsetting and/or out of the ordinary. Being enabled to tell their own stories in their own words was strongly connected to feeling valued and empowered as an individual, as opposed to feeling marginalised, silenced and required to fit into 'boxes' defined by others.

Actions for a 'listening' service

Theme	A 'listening' service is one which:
Environment	<ul style="list-style-type: none"> Creates an environment that feels sufficiently safe, both physically and emotionally, for conversations to take place. For example, the service provides confidential settings for appointments and builds trusting relationships between staff and the people who use the service.
Choice	<ul style="list-style-type: none"> Gives women a choice of people to talk to. For example, the service recruits staff from a range of backgrounds and provides interpreters.
Women's voice	<ul style="list-style-type: none"> Actively creates opportunities for women to talk, while respecting their boundaries. For example, the service has a member of staff available for drop-in conversations. Puts mechanisms in place to make conversations a priority. For example, if a staff member is available for drop-in sessions, the service ensures that this time is used either to have conversations or to find other ways of connecting with people using the service.
Flexibility	<ul style="list-style-type: none"> Adopts a flexible approach to screening and assessment. For example, the service allows time for a long conversation, but does not expect women to tell their stories unless they want to and, if standardised screening tools are used, it ensures that this is in addition to, not instead of, a genuine conversation.
Staff training	<ul style="list-style-type: none"> Trains all staff in active listening skills.
Staff wellbeing	<ul style="list-style-type: none"> Puts practices in place to promote staff wellbeing to help ensure they are able to have emotionally demanding conversations without experiencing burnout.

Understanding

Women told us that trauma-informed services were ones that received them with insight and empathy. ‘Insight’ meant that services would be sufficiently knowledgeable about trauma

and its effects to make sense of how a woman’s current problems might be connected to her past experiences. ‘Empathy’ referred to services listening to their stories with acceptance, respect and validation, not judgement and/or dismissiveness.

Actions for an ‘understanding’ service

Theme	A ‘understanding’ service is one which:
Staff training	<ul style="list-style-type: none"> • Provides all staff, not just clinical staff, with knowledge of trauma and its impact on people’s lives. • Trains staff in issues relating to difference and diversity, especially the issues most relevant to the women they work with.
Reflection and learning	<ul style="list-style-type: none"> • Provides staff with opportunities to make sense of what might be going on for the women. For example, the service provides supervision, working groups and debriefings after incidents.
Staff recruitment	<ul style="list-style-type: none"> • Recruits staff who reflect the diversity of the people accessing services. • Uses values-based interviewing to help ensure that the professionals recruited hold the necessary values to deliver trauma-informed care.
Organisational structure	<ul style="list-style-type: none"> • Works to create a flat organisational structure in which staff do not exercise power over women, but respect them as experts in their own experiences.

Responding

Women told us that trauma-informed services were ones that responded to individuals when they needed a response, rather than, for example, putting them on a waiting list. Moreover, trauma-informed services were ones that responded to them holistically and individually, offering different types of support (practical, emotional, social, etc.) in the same place and endeavouring to tailor this support

to meet the needs of each individual at that moment in time. Participants felt that the way in which the services were provided was as important to trauma-informed care as the types of services available, if not more so. The values participants identified as underpinning a trauma-informed response included respect, mutuality, accountability, openness and reflection. Above all else, a trauma-informed response was characterised as one that is non-traumatising.

Actions for a ‘responding’ service

Theme	A ‘responding’ service is one which:
Women’s voice	<ul style="list-style-type: none"> • Gives women who use the service a voice in all decisions about design and delivery • Finds ways to give women a voice even when their behaviour might be challenging. For example, the service creates advance directives or safety plans in which women can let staff know how they would like staff to treat them if they disengage from the service or if they are acting aggressively. • Creates effective mechanisms for feedback. For example, the service makes clear how women can raise questions or report incidents on a day-to-day basis, and it provides regular scheduled ‘clinics’ for addressing issues.
Choice	<ul style="list-style-type: none"> • Offers women genuine choice in the type of support they receive and endeavours to make this happen by, for example, fostering connections with a range of services within the community.
Flexibility	<ul style="list-style-type: none"> • Exercises ‘elastic tolerance’, applying rules and regulations in a flexible way that recognises the difficulties of women using the service. For example, the service understands that missed appointments may be a sign that further support is needed.
Access	<ul style="list-style-type: none"> • Enables women to access the service. For example, the service offers out-of-hours appointments for women in work, an on-site creche for women with children, and adaptations for disabled women.
Treatment pathways	<ul style="list-style-type: none"> • Creates pathways to trauma-specific services for women who would find it helpful to work through their past experiences. • Engages in outreach, in recognition of the fact that the effects of trauma might make it difficult for some women to take the first step towards engaging with services.
Staff training	<ul style="list-style-type: none"> • Trains staff in non-defensive communication skills in which criticisms can be understood as an opportunity for understanding and change.
Policy and practice	<ul style="list-style-type: none"> • Has procedures for debriefing after incidents to provide staff with space for reflection and learning. • Has no practices or policies that are likely to be traumatising or re-traumatising. For example, the service does not use physical restraint.

Checking

It is important that a service monitors its work in order to maintain high standards and to help catch problems in their early stages.

‘Checking’ procedures ensure that listening, understanding and responding are taking place in a meaningful way.

Actions for a ‘checking’ service

Theme	A ‘checking’ service is one which:
Women’s voice	<ul style="list-style-type: none"> Actively seeks feedback from women using the service and from staff.
Reflection and learning	<ul style="list-style-type: none"> Has structured and regular reviews. Arranges peer reviews with other trauma-informed services for mutual evaluation, learning and support.
Responsibility	<ul style="list-style-type: none"> Has a named person responsible for ensuring that standards are upheld and that the service keeps up to date with developments in evidence-based practice.
Regulation	<ul style="list-style-type: none"> Advocates for the creation of a regulatory body to ensure that trauma-informed care is a meaningful label that guarantees certain standards and ways of working, not an empty ‘buzz word’.

The challenges of adopting a trauma-informed approach

Trauma-informed care is not a strategy that can be adopted piecemeal. Instead, it is an approach that requires a wholesale change in an organisation’s ideology and approach, touching all aspects of its design and delivery (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018). As a result, significant barriers to its implementation exist (Sweeney, Clement, Filson & Kennedy, 2016). However, these barriers are not insurmountable, as existing trauma-informed services have demonstrated (Schulman & Menschner, 2018; Sweeney *et al.*, 2018). Moreover, if trauma-informed care prevents the cycle of traumatisation and retraumatisation – a cycle that is both ethically and economically problematic – it has been argued that the benefits of introducing this approach would outweigh any costs (Bowen &

Murshid, 2016; Sweeney *et al.*, 2016; Becker-Blease, 2017). The following challenges to adopting trauma-informed care are adapted from Sweeney *et al.* (2016, pp. 183-4).

1. Resistance to acknowledging the social and systemic determinants of trauma

People can find it difficult to acknowledge that trauma is caused by harmful experiences (Sweeney *et al.*, 2016). To acknowledge the social and systemic determinants of trauma is to be confronted by the prevalence of, for example, child abuse, racism and domestic violence. People are motivated to maintain their beliefs in a world that is safe and just and, thus, to defend against evidence to the contrary (Lerner & Miller, 1978; Janoff-Bulman, 1992).

Acknowledging the social and systemic determinants of trauma is also, for many, to be confronted by their own role in cultures or organisations that have caused harm to others (this is especially true for individuals who belong to the dominant class in society, and/or those who come from cultures that have benefited from colonialism) (Klein, Licata & Pierucci, 2011; Cohen, 2013). Moreover, from an acknowledgement that trauma has social and systemic determinants, it follows that all members of society have a role to play in the healing of trauma. Elliott *et al.* (2005) express the implication of this in stark terms, arguing that not being trauma-informed is tantamount to being trauma-denying.

It will be difficult for a service to work in a trauma-informed way until everyone who is involved in the organisation is willing and able to make the connection between the experiences people have had and the difficulties they face (i.e. to move from “what is wrong with you?” to “what has happened to you?”). As discussed above, this is not only a matter of providing people with information, but also of recognising and working through the difficult feelings this may stir up.

2. Difficulties in bearing witness to trauma

Although many trauma survivors choose not to share their experiences, some do. Being fully present and listening to the suffering and cruelty people have experienced in their lives is challenging (Lewis & Manusov, 2009). Individuals who routinely bear witness to the trauma of others often go on to experience distress themselves, unless they receive adequate support (Sweeney *et al.*, 2016). This phenomenon is so widely recognised as to have warranted at least four different labels: ‘professional burnout’, ‘secondary trauma’, ‘vicarious trauma’ and ‘compassion fatigue’ (Newell & MacNeil, 2010).

Therefore, it is crucially important that services have mechanisms in place to support staff wellbeing. These include robust systems for supervision and debriefing; education about self-care; a culture of trust in which staff are able to say when they are struggling to

cope, without fearing that they will be judged or penalised; and sufficient resources to ensure that staff are not expected to shoulder unrealistic workloads. While some of these aspects of support may be difficult for small services working with limited resources, their value should not be underestimated.

3. Resistance to implementing new initiatives

As Sweeney *et al.* (2016) note, UK public services face continuous change and upheaval. As a result, many who work in them are weary and wary of new initiatives. Moreover, it may be difficult for public services to see how trauma-informed care differs from, and can be integrated with, similar initiatives they have been required to implement in recent years (Sweeney *et al.*, 2016). It is hard for public services to fully invest their energies and resources in an initiative when experience has taught them that a year or so later it may have been replaced by something different. Moreover, there may be fear of moving away from established procedures: for example, some prison officers may believe there is a conflict between maintaining order and providing emotional support (Tait, 2011).

It is important that staff work in a trauma-informed way because they believe it has value, not simply because policy obliges them to do so. Therefore, concerns and scepticism should be taken seriously and engaged with in a meaningful way. If an organisation engages in listening, understanding and responding with people who access its services, but not with its staff, then it is unlikely to be able to deliver true trauma-informed care.

4. Scarce resources and low morale

Public sector services in the UK are subject to frequent cuts with many staff working long hours for low wages (e.g. Local Government Association, 2018). Few service providers have the time to critically evaluate the initiatives that they are being asked to adopt, let alone to consider how best to integrate these initiatives with their existing models of care. Few staff have the opportunity to attend training, resulting in lack of confidence with

new approaches; and few staff have access to the regular, structured supervision required if trauma-informed care is to be effective (Sweeney *et al.*, 2016).

To some extent, this is a systemic problem that requires a top-down solution. As the value of trauma-informed care is more widely recognised by commissioners and its tenets come to be enshrined in policy, it is likely that more funding and training opportunities will follow.

5. Difficulties in putting the principles of trauma-informed care into practice

For trauma-informed care to work, it cannot be reduced to a standardised set of procedures that can be rolled out by a service with minimal thought and effort (Kubiak, Covington and Hillier, 2017). Every decision and interaction that takes place within a service should be informed by the ways in which trauma affects people's lives; all aspects of service design and delivery should be orientated towards reducing harm and promoting healing. But, to complicate matters further, what helps one individual might not help another, and changes that have worked for one organisation might not work for another. As Kubiak *et al.* (2017) have noted, "Each individual has a unique history and specific triggers. There is no single profile." However, the skills and approaches needed to respond to this variety of experience, and how it manifests, are consistent.

The hallmark of trauma-informed care is a "culture of thoughtfulness" in which organisations engage in a continuous process of adaptation and reflection (Tomlinson & Klendo, 2012). Therefore, services face two obstacles to instituting trauma-informed principles: first, the difficulty of knowing what these principles look like in practice because, to some extent, they need to be tailor-made for each service and each service user; and, secondly, the amount of ongoing thought and effort required to wholeheartedly adhere to trauma-informed principles (Bloom & Farragher, 2013, p. 118).

As discussed above, there are no shortcuts. Being trauma-informed means engaging with

complexity. However, it is also important to note that the processes entailed by this engagement, such as listening, understanding and responding, are not unique to trauma-informed care but synonymous with good practice in any service, in any setting. Moreover, it is not only women who have experienced trauma who stand to benefit from these processes, but all people who use the service, and all members of staff. Therefore, many of these difficulties are likely to be faced by any organisation seeking to effectively support individuals, not only by those adopting the approach to meet the needs of women who have experienced trauma.

6. Low adoption of trauma-informed care in the UK

Once a 'critical mass' of services has adopted an intervention, a virtuous circle tends to be created in which greater uptake leads to even greater uptake. This virtuous circle is partly the result of familiarity and knowledge: when an approach has been widely adopted, there is greater awareness of it, a larger body of supporting evidence and more understanding of how it works in practice. Furthermore, when an approach has been widely adopted, professional networks and training programmes begin to take root. However, owing to the somewhat piecemeal adoption of trauma-informed care in the UK, this critical mass is yet to be reached (Sweeney *et al.*, 2016).

As part of our research, we reviewed the availability of trauma-informed care in different sectors, including mental health services, education, the criminal justice system and the workplace. We found that the strongest adoption of trauma-informed care, or approaches informed by similar principles, has been in mental health services and in the criminal justice system. However, even in these sectors its adoption is fragmentary. Therefore, with a view to facilitating connections between services, the following section provides a short directory of organisations in England which we know to have an interest in providing trauma-informed care.

Section Three

Trauma-informed care directory

The previous sections have discussed ideas and challenges that are likely to be encountered by all organisations as they work towards offering gender- and culturally-sensitive trauma-informed services. However, some issues will be specific to certain sectors, regions and demographics. With this in mind, there is value in establishing an informal network for sharing experiences and gaining information between like-minded services.

The final section of this resource brings together the names of some of the services and organisations that came to our attention during our research and that, at the time of writing, were interested in trauma-informed care. Some of them are working towards adopting trauma-informed approaches in their own practices; others are contributing to thinking about, and training in, trauma-informed approaches. In addition, this section provides links to several resources that may act as a useful starting point for services aiming to become trauma-informed.

Women's services

A Way Out

A Way Out is an outreach and prevention charity which aims to engage, empower and equip vulnerable and excluded women, families and young people to live lives free from harm, abuse and exploitation and to reduce life limiting choices and behaviours. It delivers a trauma-informed asset based approach providing support to young and adult women with complex needs addressing issues around abuse, sexual exploitation, adverse childhood experiences, poverty and addiction.

www.awayout.co.uk | info@awayout.co.uk | 01642 655071 | The Gate, 1-2 Castlegate Quay, The Riverside, Stockton-on-Tees, TS18 1BZ

Amy's Place

The purpose of Amy's Place is to provide a life-changing, personalised service which supports young women (18-30 years old) on the path to a full and lasting recovery from addiction. Amy's Place focuses on health and wellbeing.

www.amywinehousefoundation.org | www.centragroup.org.uk | amysplace@amywinehousefoundation.org | 020 3784 5178 | 079 6688 7346 | 07876 002637

Anawim

A Birmingham-based women's centre working with women from a range of communities to assist them with their trauma issues/history and to help them with their goals. Anawim offers a range of interventions, including ones for women coming through the criminal justice system and women displaying mental health issues, that give women a chance to understand the impact of trauma in their lives, heal, and learn to thrive despite past wounds.

Joy Doal, CEO | Sabrina Hussain, Project Development Officer | Emily Johnson, Fundraising Officer

www.anawim.co.uk | 0121 440 5296 | Facebook @anawim.wwt | Twitter @Anawim_WWT

Changing Lives Amber Project

Based in Doncaster, the Amber Project works with women (and men) who are involved in sex work, survival sex and/or sexual exploitation. It supports them through a journey of 'being, becoming and belonging' to meet immediate needs, validate trauma, learn new skills and develop healthy relationships.

www.changing-lives.org.uk | 01302 309 810

Nelson Trust Women's Community Services

Nelson Trust Women's Centres in Gloucester, Swindon and Somerset provide a women-only space where a wide range of support needs can be addressed in a safe and supportive environment. Services are trauma-informed and gender-responsive, providing holistic support to women and their families.

www.nelsontrust.com | 01453 885633 | The Nelson Trust, Port Lane, Brimscombe, Stroud, Gloucestershire, GL5 2QJ

Nelson Trust Sex Worker Outreach Project

Outreach services supporting women across Gloucestershire, Swindon and Wiltshire to exit sex working and addiction. It provides individualised and holistic support through trauma-informed approaches, that responds to women's life experiences and current challenges.

www.nelsontrust.com | 01453 885633 | The Nelson Trust, Port Lane, Brimscombe, Stroud, Gloucestershire, GL5 2QJ

WomenCentre

WomenCentre, based in Calderdale and Kirklees (West Yorkshire), supports over 3,000 women (aged 13-80+) each year. It aims to provide high quality trauma-informed services, advice and information anchored in a core ethos which is consistently woman-centred, holistic, co-produced, and open to learning and improvement. Its main areas of service delivery are domestic abuse and women's health and wellbeing.

www.womencentre.org.uk | info@womencentre.org.uk | 01422 386 500

Women and Girls Network

A London-based charity whose aim is to promote, preserve, and restore the mental health and wellbeing of women and girls to empower them to make a sustainable recovery

from experiences of gendered violence. Services include therapeutic services, groups, helplines, young women's services, advice, advocacy, training services and the Indigo Project, an innovative service that supports women with 'complex needs' who have experienced problems accessing mainstream support. All of WGN's services work from a trauma-informed, intersectional and empowerment focused approach.

www.wgn.org.uk | WGN Advice Line: 0808 801 0660 | Sexual Violence Helpline: 0808 801 0770 | Indigo Project: 0203 725 5098

Children and adolescents

YoungMinds

YoungMinds fights for a future where all young minds are supported and empowered, whatever the challenges. It campaigns for young people's mental health and provides training. It also runs a helpline for parents and a Crisis Messenger text service for young people in need of urgent support.

www.youngminds.org.uk | ymentquiries@youngminds.org.uk | 020 7089 5050

Blackpool Better Start

Better Start aims to improve the life chances of babies and very young children by delivering a significant increase in the use of preventative approaches in pregnancy and the first three years of life.

www.blackpoolbetterstart.org.uk | 01253 476789

Useful resource

Supporting children and young people after a traumatic experience (Tees, Esk and Wear Valleys, 2017). Available online at: <https://www.tevv.nhs.uk/services/supporting-children-and-young-people-after-a-traumatic-experience/>

BAME

Nafsiyat

The Nafsiyat Centre was the first in the UK that took account of the cultural background of the patient and therapist and recognised its importance in therapy. Today it offers free short-term intercultural therapy to people from diverse religious, cultural and ethnic communities in London. It also has a fee-paying therapy service called Choice and runs regular Cultural Competence training workshops. Nafsiyat provides therapy in over 20 languages.

www.nafsiyat.org.uk | admin@nafsiyat.org.uk | 020 7263 6947

Latin American Women's Rights Service

LAWRS's mission is to reach out and provide tools to empower Latin American women in the UK to pursue personal and social change. It helps women to assert their rights to be free from all forms of discrimination and violence, lead empowered and fulfilled lives, enjoy their human rights to the full and become central actors in achieving social change.

www.lawrs.org.uk | 020 7336 0888

Learning difficulties

Respond

Based in London, Respond exists in order to: lessen the effect of trauma and abuse on people with learning disabilities and/or autism their families and supporters. It provides psychotherapy for people with learning disabilities and/or autism, advice and support for staff and families, training for support staff and professionals and psychosexual education for people with learning disabilities and/or autism. It also undertakes research to raise awareness of the needs of people living with learning disabilities and/or autism.

www.respond.org.uk | admin@respond.org.uk | 0207 383 0700

Mental health and health care

Tees, Esk and Wear Valleys NHS Foundation Trust

TEWV is a large mental health provider in the North of England. It has a programme to develop trauma-informed services throughout its adult division.

www.tewv.nhs.uk

Mental Health Concern

A charity based in the North East providing a range of specialist services, including 24-hour adult and dementia nursing care, supported housing, community wellbeing, and social prescribing. Its mission is to improve the mental health and wellbeing of the people it serves.

www.mentalhealthconcern.org | enquiries@concerngroup.org | 0191 217 0377

Harrow Acute Mental Health Service Trauma Informed Approaches (TIA) Project

A project providing training and psychological case formulation sessions for staff of all disciplines on inpatient adult mental health wards based on trauma-informed approaches to care.

Mental Health Centre, Northwick Park Hospital, Watford Road, Harrow, HA1 3UJ | 020 8869 5450/2690

The Nightingale Project

A charitable project within the NHS that enhances and humanises the environment in hospitals and health centres through the visual arts and music, aiming to enable the user to experience the healthcare environment as less austere and more welcoming.

Nick Rhodes, Director

www.nightingaleproject.org | 020 8869 5450/2690

Useful resource

Trauma-informed care (Tees, Esk and Wear Valleys, 2018). Available online at: <https://www.tewv.nhs.uk/services/trauma-informed-care/>

Criminal justice

One Small Thing

A charity working to bring trauma-informed care to the criminal justice system. It facilitates and funds trauma-informed treatment programmes and provides training.

www.onesmallthing.org.uk | info@onesmallthing.org.uk

Useful Resource

Becoming trauma-informed. Tool kit for women's community service providers (One Small Thing, 2016) www.mappingthemaze.org.uk/wp/wp-content/uploads/2017/08/Covington-Trauma-toolkit.pdf

Housing

Nelson Trust Residential Services

Residential addiction treatment programmes provide a holistic, person-centred approach. Services are delivered within a therapeutic community setting where the physical, mental and emotional well-being of people seeking to recover from addiction can be addressed.

www.nelsontrust.com | 01453 885633 | The Nelson Trust, Port Lane, Brimscombe, Stroud, Gloucestershire, GL5 2QJ

One Housing

One Housing creates homes for people who struggle to afford a place to live. It provides care and support to thousands of people in the community and helps people to get work and stand on their own two feet.

Marta Banet, Senior Clinical Lead
www.onehousing.co.uk | mbanet@onehousing.co.uk

Useful resource

Promising practice from the frontline: Exploring gendered approaches to supporting women experiencing homelessness and multiple disadvantage (Homeless Link, 2018) https://www.homeless.org.uk/sites/default/files/site-attachments/Women%27s%20research_March%2019_1.pdf

Other

Changing Lives

Changing Lives supports over 14,500 people a year. It works with people who face multiple disadvantage in society, providing specialist services in, for example, housing and homelessness, employment, domestic abuse, the criminal justice system, sex work/survival sex/sexual exploitation, and addiction. It works in the following regions: Durham/Tees Valley, East Midlands, North East, Northumbria, West Midlands, and Yorkshire and Humber.

www.changing-lives.org.uk | central.office@changing-lives.org.uk | 0191 273 8891 | Unit D13, Marquis Court, 10th Avenue West, Team Valley, Gateshead, NE11 0RU

Hestia

Hestia supports adults and children across London in times of crisis. Last year it worked with more than 9,000 people including women and children who had experienced domestic abuse, victims of modern slavery, young care leavers and older people. From giving someone a home to helping them to get the right mental health support, it aims to support and enable people at the moment of crisis.

www.hestia.org | 020 7378 3100

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