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Developing trauma informed care in Northern Ireland: The education system

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**Adverse
Childhood
Experiences**

Be the Change



Developing trauma informed practice in Northern Ireland: The education system



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By Queen's University, School of Social Sciences, Education & Social Work.

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Contents

Page	
06	Trauma informed Care in the Child Welfare System
07	What is Trauma informed Care?
07	Understanding and defining Childhood Adversity, Trauma and Resilience
09	What are the Core Principles of Adversity/Trauma informed Care?
11	Adversity, Trauma and the Child Welfare System
12	Developments in Trauma informed Education Systems
16	How Can Trauma informed Care Benefit Pupils in the Education System?
17	How has TIC been implemented?
18	Workforce Development
21	Trauma-Focused Services
24	Organisational Change
28	What might adversity and Trauma informed care look like in Northern Ireland?
33	Conclusion
34	Resources
36	References

Figures

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

Tables

Page	
29-31	Table 2. Key Components of Cross System Trauma informed Implementation

Boxes

Page	
15	Box 1. The Attachment Awareness Programme
19	Box 2. HEARTS Model (Dorado et al., 2016)
20	Box 3. Early Childhood Mental Health Consultation Model (Shamblin et al., 2016))
23	Box 4. New Haven Trauma Coalition (Perry and Daniels, 2016)
25	Box 5. The Welsh ACE-informed Whole School Approach (Barton et al., 2018)

Trauma informed Care In The Education System

Background

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

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

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

What is Trauma informed Care?

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

Understanding and defining Childhood Adversity, Trauma and Resilience

Adverse Childhood Experiences

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

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

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

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

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being (SAMHSA, 2014 p.7).

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

or adaptations to their circumstances and are attempts (out of their awareness) to survive, manage and make sense of their experiences.

Resilience

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

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

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

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

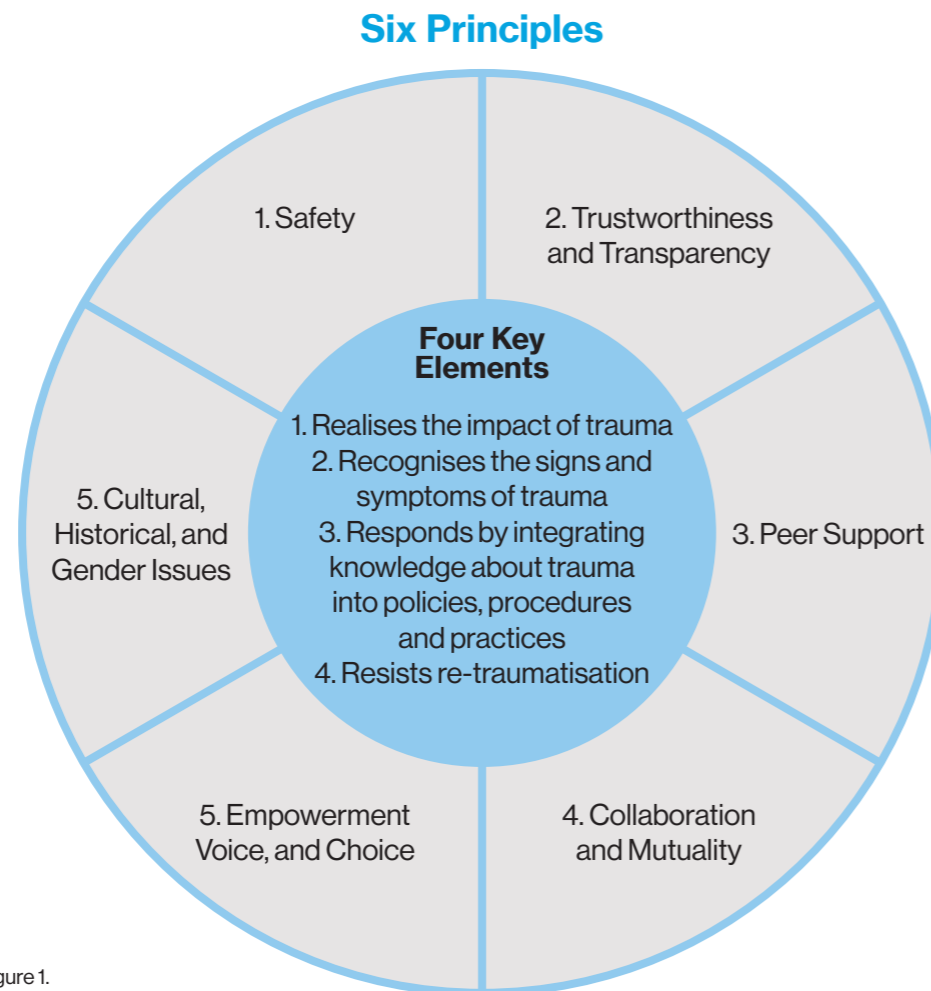


Figure 1.
SAMHSA's (2014)
Six Principles of Trauma informed Care

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

- (i) that all people at all levels within the system have a basic realisation about childhood trauma and adversity and how it can affect individuals, families, groups, organisations and communities
- (ii) practitioners are able to recognise the signs of trauma and adverse childhood experiences, which may be manifest by people accessing services as well as those providing services
- (iii) the system of care responds by applying the principles of adversity and Trauma informed care to all areas of functioning – from the receptionist to the chief executive – with policies, practices and language altered to appreciate the experiences of childhood trauma and adversity on service users and their families, and mitigate the risks of inadvertent re-traumatisation and secondary

traumatic stress experienced by the staff providing services. TIC is inclusive of adversity and trauma-specific interventions (such as dedicated services and interventions for substance misuse, domestic violence or post-traumatic symptoms), whether assessment, treatment or recovery supports, but also incorporates trauma principles into the organisational culture

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

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

Adversity, Trauma and the Education System

The child welfare workforce interfaces with children and adults who have experienced trauma on an everyday basis. Indeed, it can be argued that no other child-serving system encounters a higher percentage of service users with trauma histories, whether it be in family support, child protection, foster, kinship or residential care. Replication of the Schools have long been identified as a natural social system within which to address the health and emotional needs of children (St Leger, 2001; Fazel et al., 2014). However, while education systems have often tried to mitigate the impact of specific traumas on a school community via the development of school crisis plans and by responding to particular traumatic events that have impacted schools (Ko et al., 2008), traditionally, school psychologists, counsellors and teachers received little formal training about the impact of trauma more broadly, or how to help traumatised pupils achieve better educational outcomes. Replication of the American ACE study (Felitti et al., 1998) with UK populations indicate that 8% of English adults aged 16-64 years (Bellis et al., 2014 and 14% Welsh adults aged 16-64 years (Bellis et al., 2015) had experienced 4 or more ACEs. In the absence of a Northern Ireland ACE population survey, the findings from the Welsh survey, arguably, provide the best comparison, sharing, as Wales does, similarly high proportions of deprivation. This

would suggest that 1 in every 7 people in NI has experienced 4 or more ACEs, indicating a substantial minority of children have been exposed to, or are at risk of exposure, to ACEs.

In considering the impact of childhood adversity and trauma, the most pertinent effects for the education system are impairment of cognitive functions including, IQ, memory, attention and language ability contributing to poorer academic performance, behavioural problems, poor attendance and higher dropout rates (Perfect et al., 2016). In the context of a burgeoning interest in childhood trauma and its widespread recognition as a major public health concern, schools are seen as a vital context in which the potential long-lasting effects can be identified and mitigated (Lang et al., 2015; Chafouleas et al., 2016). Due to the relatively long periods children consistently spend in school, education professionals are especially well-placed to support children with adversity/trauma and to help build the protective factors that enables them to be resilient against trauma. Developing a Trauma informed approach within schools can enable all staff to have the appropriate knowledge and skills to identify and respond appropriately, thereby providing a safe learning environment for children (Barton et al., 2018).

Thus, schools are increasingly trying to balance their primary mission of education with the reality that many pupils need help in dealing with traumatic stress in order to be able to attend regularly and engage in the learning process (Ko et al, 2008). Without a TIC approach being well-embedded in the education system, it is difficult to sustain Trauma informed interventions across wider societal systems. A common language, common experience, and common vision (Chalfouleas et al., 2106) are essential hallmarks of TIC systems, requiring substantial efforts given to engage multiple stakeholders from multiple systems, both within and without the school context.

Developments in Trauma informed Education Systems

The majority of the TIC evaluation literature has been generated within education systems in the USA, where there are provisions for Trauma informed practices in legislation via the Every Student Succeeds Act (ESSA, 2015), including grant support for services in schools using evidence-based interventions for childhood trauma. By 2016 there were 17 states where Trauma informed approaches at the school, district or state-wide level had been implemented (Overstreet & Chafouleas, 2016). It is also in this context that attempts have been made to clarify the key components of a tiered Trauma informed approach within the Education System, supported by the National Child Traumatic Stress Network (NCTSN) and SAMHSA. A three-tier model is espoused:

- Tier 1 is Universal and may involve changes in school policies, increasing teacher awareness and capacity, developing a strengthened social-emotional curriculum and ongoing mentoring practices for all teachers.
- Tier 2 is Selective and may include consultation to help teachers develop strategies and behavioural plans to address challenging behaviours in class in a way that takes account of the child's trauma history and prevents secondary traumatising or burnout.
- Tier 3 is Targeted and focuses on mental health assessment of specific children and, where appropriate, evidenced-based Trauma informed interventions for these children and their families.

The logic that underpins a Trauma informed Care Approach in schools also applies, perhaps to an even greater extent, to the pre-school system. Young children are exposed to trauma at a disproportionate rate compared with older children (Lieberman, et al., 2011) and this early exposure places young children at increased risk of continued exposure during the rest of their childhood (Grasso et al., 2016). Internalising and externalising symptoms, such as acting out, daydreaming and aggressive behaviour not only limits engagement with the learning process and may compromise a positive teacher pupil relationship, but are often responded to by disciplinary actions by schools increasing the risks of suspension or exclusion (Krezmien et al., 2006), which are higher for preschool children (Gilliam & Sharhar, 2006). Loomis (2018) draws attention to the relative lack of focus on the pre-school age group, highlighting the Head Start Trauma Start (HSTS) as the only programme designed specifically for preschool children.

An additional component of a Trauma informed preschool system is the 'psycho-education and supports to enhance relationships between parents and schools' (Loomis, 2018, p.6). It can be argued that this dimension should be added to the components of TIC approaches more generally, as it has been shown to be related to positive outcomes in Trauma informed interventions (Santiago et al., 2014) and in reality, many caregivers will have experienced trauma themselves (Toth et al., 2006). Including parents and carers in this way would be consistent with the recognised need for a continuity of Trauma informed care across all systems to most effectively address the needs of trauma exposed children (Ko et al., 2008).

Within the UK there have also been significant interest in ACEs research and developing Trauma informed approaches across different systems and service settings. The 2017/18 Scottish Programme for Government made a commitment to prevent ACEs and support children and adults in overcoming early life adversity (Scottish Government, 2017). NHS Scotland (2017) has recognised the impact ACEs can have on educational attainment, offering guidance on how to incorporate an understanding of ACEs and child development within schools, while further work by Education Scotland (2018) has linked ACE research and Trauma informed care with already existing educational frameworks, such as the Nurture approach, which seeks to utilise relationship-based approaches to support children and young people. In Wales, the Donaldson Review (2015) identified health and wellbeing as one of six areas of a child's learning experience which needed to be incorporated into every aspect of the national curriculum to enable children to thrive and engage successfully with their education, while the Welsh national strategy Prosperity for All (Welsh Government, 2017) aims "to create ACE-aware public services which take a more preventative approach to avoid ACEs and improve the resilience of children and young people" (p.23).

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

At a practice level, there are also examples of UK school-based initiatives which utilise Trauma informed approaches to education. For example, the Attachment Aware Schools Programme is based on the premise that all children in school need to be ready to learn and achieve and that children who have experienced trauma or neglect are often not able to do so (see Box 1). The programme entails implementation of specific targeted professional development for teachers to enable them to become 'attachment aware', and therefore better equipped to meet the emotional need of their pupils. Similarly, training on Attachment Awareness has also been delivered to a large regional consortium of school in Wales while an 'ACE-Informed Whole School Approach' has been developed as part of the 'Early Intervention and Prompt Positive Action Project' in South Wales (Barton et al., 2018). De Thierry (2018, p.269) asserts the need for alternative educational provision that is Trauma informed and focusing on recovery from childhood trauma, and not the management of behaviour and notes that the Trauma Recovery Centre has centres with teams of qualified art, music and play therapists in four cities in the UK providing alternative education for excluded children. Therapeutic rooms in mainstream schools are also provided with a Trauma informed psychotherapist attached to offer supervision and assessment of significantly traumatised children to avoid exclusion.

Box 1. The Attachment Awareness Programme

The Stoke-on-Trent and Leicester the Attachment Awareness Programme entailed a whole staff development day followed by a two-hour session with staff on Emotion Coaching. The Emotion Coaching was followed by activities and training on attachment, trauma and nurturing strategies run by the 'Attachment Lead Teacher' at senior level in each school (Fancourt & Sebba, 2018). The Virtual School of Bath & North East Somerset opted for a centralised one-day training event for two key staff from each school. These staff were then expected to coordinate and run activities and training on attachment, trauma and nurturing strategies regularly for all staff in their schools and the partner agencies with whom they work (Dingwall & Sebba, 2018b). Across these attachment awareness programmes the evaluations identified four areas that need to be targeted for more effective implementation of TIC in schools:

- Initial teacher training, as many of those in this evaluation expressed a severe lack of confidence in addressing attachment needs in schools and felt unprepared for this
- Professional development of all school staff (not just teachers) as they are involved in responding to behaviour
- Governors need to be engaged in the developments in school via training
- Adults outside school with whom vulnerable pupils are in contact i.e. parents, foster carers and social workers, so that they can adopt a consistent approach to that being implemented in schools.

How Can Trauma informed Care Benefit Pupils in the Education System?

The key messages report identified more than seventy papers evaluating organisation wide Trauma informed care implementation across child welfare, health, education, justice and social care. The studies were mainly from the USA and the generalisability of study findings was often limited by methodological shortcomings. In spite of these limitations, the review highlighted a growing body of evidence pointing to the positive impact TIC can have on service users across various settings through improved child mental health outcomes, improved patient-provider rapport, reductions in the use of seclusion and restraint, fewer substantiated child maltreatment reports, reduced caregiver stress, decreases in school disciplinary offences and suspensions, and reduced youth aggression (see 'Key Messages' report).

The review identified thirteen empirical peer-reviewed studies which evaluated TIC interventions within the education sector: four which focused on the implementation of TIC in schools; and nine which focused on the impact of Trauma informed training delivered within further/higher education to human services staff/students or the training of education professionals as part of wider Trauma informed initiatives. Findings from the four school-based TIC initiatives pointed to positive impact in terms of: better understanding of the effects of trauma, coping strategies and/or resilience among children who participated in whole classroom interventions (Perry and Daniels, 2016; Ijadi-Maghsoodi et al., 2017); improvements in trauma symptomology and/or emotional and behavioural functioning among children who participated in school-based therapeutic interventions (Dorado et al., 2016; Shamblin et al., 2016, Perry and Daniels, 2016), and decreases in disciplinary offences and suspensions (Dorado et al., 2016).

The on-line search of policy and practice literature identified additional international and UK Trauma informed education initiatives, examples of which are discussed in the previous section. This included three evaluations of the Attachment Awareness programme in England (Dingwall & Sebba, 2018a; Dingwall & Sebba, 2018b; Fancourt & Sebba, 2018), an evaluation of the ACE-informed whole school approach developed in New South Wales (Barton et al., 2018), and an evaluation of trauma sensitive school practices in Lincoln High, an alternative high school in Walla Walla, Washington (Longhi, et al., 2015). Four of these reports included child outcome data although, as with the academic literature, this was often based on small numbers, qualitative methodologies, and/or research designs lacking a control group. The evaluations of the Attachment Awareness programme in Leicestershire noted difficulties making links between the programme and quantitative outcomes such as school attendance, primarily due to national

changes in recording practice, but highlighted how qualitative findings which suggested improvements in student wellbeing as evidenced by staff surveys and interviews with both staff and pupils. Evaluation of the programmes in Stoke-on-Trent and Bath and North East Somerset demonstrated improvements in attendance (Dingwall & Sebba, 2018a; Dingwall & Sebba, 2018b), as well as improvements in the percentage of primary pupils achieving expected levels in reading, writing and mathematics (Dingwall & Sebba, 2018b), although findings for secondary schools were more mixed. Similarly, pupils in the Lincoln High initiative in Washington reported higher levels of resilience which was, in turn, linked with improved school performance and attainment.

How has Trauma informed Care been implemented?

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

Workforce Development

Training – The most commonly evaluated element of TIC implementation across initiatives and settings was, by far, training. Although limited by the preponderance of pre and post-test designs with short follow-up periods and a reliance on self-report measures, studies invariably demonstrated increases in staff knowledge, awareness and confidence in Trauma informed principles and practice. In the education literature there was an emphasis on whole school approaches which included school-wide training to establish a common language and understanding around the effects of complex trauma and to support broader changes to the school culture. For example, the Healthy Environments and Response to Trauma in Schools (HEARTS) model, involved half-day trainings with all school staff four kindergarten and elementary schools in the southeast sector of San Francisco (see Box 2). Dorado et al.'s (2016) evaluation was an exception to the brief follow up periods used in most training evaluation designs with follow-up at 1 and 5 years post intervention showing significant positive changes in staff knowledge and use of trauma sensitive practices as well as pupil engagement. Similarly, in the UK policy and practice literature, the provision of Trauma informed training to all school staff in three Welsh primary schools improved understanding of the underlying causes of bad behaviour in the classroom, increased awareness of how to communicate with children and increased staff confidence to work in an ACE-informed to support children experiencing trauma to better succeed in school (Barton et al., 2018).

Nine papers focused on higher education or professional training initiatives involving social work students (Layne et al., 2011; Strand et al., 2014; Wilson & Nochajski, 2016), clinical health students (Strait & Bolman, 2017), dental students (Raja et al., 2015), community professional working with gangs (Dierkhising & Kerig, 2018), and education professionals participating in multi-professional part of wider Trauma informed initiatives (Counts et al., 2017; Damian et al., 2017; Suarez et al., 2014). All demonstrated improvements in knowledge, awareness and/or confidence in Trauma informed principles and practice. Several training initiatives emphasised the use of case studies or vignettes to apply learning to practice situations and common components of Trauma informed education curricula included:

- understanding the prevalence of trauma and adversity
- understanding the effect of trauma and adversity (often with reference to neuroscience and neurobiology)
- relating trauma to specific client group or discipline
- the principles of Trauma informed care
- how to apply TIC principles to specific client groups or disciplines
- identifying and assessing trauma
- developing confidence in discussing trauma with service users

Box 2. HEARTS Model (Dorado et al., 2016)

- Tier 1 universal supports - half-day trainings with all school staff that established common language and understanding around the effects of complex trauma on learning-readiness and teaching readiness, behaviour, interactions, relationships, systems, and communities, as well as an overview of strategies for addressing these effects that could be implemented regardless of one's role in the school system. Initial trainings were then augmented and deepened through a series of follow-up trainings and collaborative consultation
- Tier 2 interventions - HEARTS clinicians became embedded in the school's Coordinated Care Team providing a Trauma informed lens to school staff's development of behavioural support plans for at-risk students, as well as to the school's development of disciplinary policies that were less punitive and more supportive
- Tier 3 interventions - HEARTS clinicians provided on-site, trauma-specific, culturally congruent therapy for trauma-impacted students based on ARC model

On-going staff support – Various initiatives stressed the importance of on-going staff support as crucial to maximising the impact of initial training and embedding TIC in practice. Across settings, this included the use of learning collaboratives, coaching, mentoring and monitoring of fidelity to the Trauma informed model through supervision, on-going consultation and coaching from model developments/trainers or other experts and continuous staff training, booster sessions and/or recertification processes. For example, Shamblin et al. (2016) evaluated the Early Childhood Mental Health Consultation Model, implemented in five community pre-schools in the Appalachian counties of South-eastern Ohio, USA during 2011-2012. The model included universal trauma consultation and

training for staff, targeted consultation focused on strategies that teachers could use for individual children and the provision of on-site mental health interventions delivered to children (see Box 3). Two programmes used the model, the Partnerships Program and Head Start. The Partnerships Program utilised embedded consultants in schools to increase capacity and positive supports for teachers combined with on-site mental health interventions delivered to children. The Head Start programme used the same model but differed in that consultants were available on request rather than embedded in the school setting. Evaluation findings (Shamblin et al., 2016) indicated that teacher confidence and competence were significantly higher post intervention and that independently observed negative teacher practices were significantly reduced. Although pre-test child functioning did not differ significantly between the programmes, post-test resilience scores were significantly higher in the embedded model, indicating this was more effective than the 'as needed' model. Although, limited by the small number of participating schools, classrooms and teachers, particularly in relation to the 'embedded' model, this supports the view that the provision of on-going, easily accessible support not only benefits staff, but students also.

**Box 3.
Early Childhood
Mental Health
Consultation
Model (Shamblin
et al., 2016)**

The Partnerships Program Early Childhood Mental Health (in collaboration with Project LAUNCH) and Head Start (in collaboration with Hopewell Centres).

- The Partnerships Program
- Embedded consultants in schools to increase capacity and positive supports for teachers combined with on-site mental health interventions delivered to children
- Consultants employed a relationship-based approach to training, team building, modelling and wellness activities for teachers so they are better able to promote healthy social-emotional development in their students.
- Consultants offered three tiers of early childhood mental health services—universal consultation, targeted consultation and intensive services in tandem with workforce development trainings provided by Project LAUNCH
- A total of 11 teachers received consultation and workforce development services to enhance their capacity to teach the 217 students under their care. Three ECMH consultants provided services. Head Start and Hopewell Centres collaboration
- Used the same model as above but consultants were available on request rather than embedded versus consultant-as-needed services.
- The By-Request Model involved 550 Head Start children in 28 classrooms involving 28 teachers and home visitors

Self-care - Self-care also featured as a component of TIC implementation in a number of initiatives, although it was not as widespread as the practice related supports discussed above. In some instances, this entailed the creation of specific teams to provide peer support to colleagues but more often took the form of emphasising self-care strategies in TIC training. For example, Wilson and Nochajski 's (2016) social work curriculum incorporated a specific clinical self-care component so that vicarious traumatisation and/or re-traumatisation among practitioners could be avoided or properly managed. Similarly, implementation of the HEARTs model in schools (Dorado et al., 2016) included a series of follow-up trainings and collaborative consultation which focused on understanding and addressing burnout and secondary trauma in school staff via self-care and organisational strategies. While not evaluated within the school context, evaluation of the impact of TIC initiatives on staff trauma or stress in other settings produced mixed findings. Both Baker et al. (2012) and Damian et al. (2017) noted that experiences of vicarious traumatisation increased after TIC training, likely due to increased awareness, while Dierkhising & Kerig (2008) found that no significant differences in levels of secondary traumatic stress in comparison with a group of similar professionals who did not complete the training. However, in addition to increases in secondary traumatisation, Damian et al., (2017) also found that, post-training, social services, health, education and legal professionals reported significant improvements in organisational culture and climate, as well as increased compassion satisfaction (being able to derive pleasure from their work).

**Trauma
Focused Services**

Screening and Assessment – Review findings involving implementation of trauma screening within the child welfare and health systems (Lang et al., 2017; Lotzin et al., 2017; Miller et al., 2017; Decker et al., 2017; McGee et al., 2015), showed that screening was generally perceived favourably by professionals, leading to increases in identification of adversity/trauma exposure amongst service users and increases in service user perceptions of support and confidence in service providers. However, various challenges related to routine inquiry and assessment were also noted. These commonly included systemic issues such as the size and scope of the system, the number of staff, competing demands, staff turnover etc., as well as specific issues around buy-in, local availability of evidence-based treatment/services and problems with information technology systems (Akin et al., 2017; Lang et al., 2017). In one UK study, three services piloting routine inquiry through the use of a standalone implementation pack (Quigg et al., 2018) eventually decided not to continue the initiative post pilot.

Although reasons for this were multi-faceted, it was noted that the implementation pack, and potentially the academic literature, did not provide sufficient information on how to use the information gathered from routine enquiry on ACEs to inform service provision and the support offered to clients, particularly within the types of services included in the pilot. Overall, it was felt that clearer theoretical foundations, more developed guidance on responding to disclosures, particularly from children, and broader approaches beyond the provision of a standalone implementation pack, were required to ensure services and practitioners were ACE-informed.

While no education initiatives involved universal screening, Perry and Daniels (2016) showed encouraging results in their evaluation of tiered model of provision which entailed universal staff training, followed by whole class psychoeducation where teachers identified behaviour problems. The whole class psychoeducation element involved a screening component which allowed for the targeted identification of pupils with PTSD symptoms, who were then referred for trauma specific therapeutic intervention.

Evidence-based treatment, adversity and trauma-focused services – A number of school-based initiatives (Dorado et al., 2016; Perry and Daniels, 2016; Shamblin et al. 2016) incorporated strategies to build evidence-based treatment/intervention capacity in-house or increase access to evidence-based treatments. Intervention took the form of ‘culturally congruent therapy’ for trauma-impacted students based on the ARC model (Dorado et al., 2016), Cognitive-Behavioural Intervention for Trauma in Schools for pupils with specific trauma symptoms (Perry and Daniels, 2016); and Parent–Child Interaction, Trauma-Focused CBT and Parent–child psychotherapy (Shamblin et al., 2016). These school-based initiatives were well evaluated and students who received these trauma specific interventions showed significant improvements in symptoms, including adjustment to the trauma/adverse life experiences, affect regulation, and decreases in intrusive images and dissociation (Dorado et al. 2016), improved resilience (Shamblin et al., 2016) and reduced PTSD symptoms (Perry and Daniels, 2016), although none of the three study designs utilised a control group.

Trauma-focused services provided as part of these initiatives included embedding clinicians in the school’s Coordinated Care Team to provide a Trauma informed lens to the development of behavioural support plans for at-risk students (Dorado et al., 2016) and whole class psychoeducation in classrooms with identified

difficulties and challenging behaviours (Perry & Daniels, 2016) [see Box 4]. Additionally, Ijadi-Maghsoodi et al. (2017) detailed the application of the Resilience Classroom Curriculum, delivered to whole classrooms by social workers. The curriculum covered resilience skills, emotion regulation, communication, problem-solving, goal-setting, and managing stress reminders. Evaluation showed significant improvements in empathy, problem-solving and overall internal assets following delivery of the curriculum with improved school support and lower PTSD symptomology also reported, although changes were not statistically significant. Focus groups indicated that students and social workers felt that the curriculum fostered a sense of support, although students acknowledged that talking about feelings could be hard.

Box 4. New Haven Trauma Coalition (Perry and Daniels, 2016)

- A partnership between New Haven Public Schools (NHPS), The Mayor’s Office, United Way of Greater New Haven/BOOST!, and Clifford Beers Clinic (CBC) aimed at addressing the negative mental health and social effects of adversity, trauma, and chronic stress on families and school-aged children
- Implementation covered three domains:
 - Professional Development: - aimed to promote a culture shift by building staff capacity through training. It consisted of a two days training which included one large group didactic portion to introduce the Trauma informed paradigm, followed by workshops to facilitate conversation about applying the paradigm to classroom and other staff-student interactions
 - Care Coordination: - aimed to provide individualised, family-driven, and youth-guided collaboration to address the needs of families with complex challenges. This consisted of: A Care Coordinator attending every monthly SSST meeting to receive referrals; follow up needs assessment with referred families; a three to six-month plan of care to address identified target areas; weekly meetings with families to achieve objectives and monthly Child and Family Team (CFT) meetings with the family and school staff
 - Clinical Services: consisted of the provision of classroom-wide workshops to classroom with identified difficulties; and provide trauma screening and small-group clinical interventions to students (Cognitive Behavioural Intervention for Trauma in the Schools (CBITS) - a manualised, ten-week small group intervention students)

Organisational Change

Leadership buy-in and strategic planning - Many of the initiatives were part of broader, organisation wide Trauma informed implementation strategies aimed at changing organisational culture and practices. Key elements of implementation across settings focused on establishing leadership buy-in, often through providing initial training to agency directors and senior management, establishing implementation teams, developing strategic implementation plans and structures, and assessing organisation readiness (Fraser et al., 2014; Kramer et al., 2013; Lang et al., 2016; Henry et al., 2011; Hendricks et al., 2011; Elwyn et al., 2015; Elwyn et al., 2017). For example, participation in the HEARTS model (Dorado et al., 2016) required application to the San Francisco Unified School District (SFUSD) and schools were selected on the basis of principal buy-in, as well as assessed need and having good-enough infrastructure to support the intervention. Initial implementation also involved close collaboration with the district wide Student, Family, and Community Support Department (SFCSD) and delivery of a series of 'Training the Trainer' (TOT) sessions to key SFCSD personnel aimed at building their capacity to bring Trauma informed practices to their school sites. In the New Haven Trauma Coalition model (Perry and Daniels, 2016), the workforce training component was developed in coordination with school leadership, while in the Welsh ACE-informed whole school approach (Barton et al., 2018) [see Box 5], Head Teachers completed an ACE Readiness Tool which captured current approaches to wellbeing and existing assets in each school (i.e. policies, procedures and resources already in place) for pupil wellbeing, and identified any gaps which might impede the adoption of an ACE-informed approach. In the Stoke-on-Trent Attachment Awareness Programme (Dingwall & Sebba, 2018) schools were required to designate an 'Attachment Lead Teacher' at senior level to coordinate activities and training on attachment, trauma and nurturing strategies. Participants in the Leicestershire Attachment Awareness Programme also highlighted the commitment of senior leadership in schools, and their participation in the training, as a significant element of successful implementation (Fancourt & Sebba, 2018).

Box 5. The Welsh ACE- informed Whole School Approach (Barton et al., 2018)

- 1. ACE Readiness Tool:** Consists of 13 questions to be completed by the head teacher in collaboration with the Education ACE Coordinator. This tool captures the current approaches to wellbeing and existing assets in each school (i.e. policies, procedures and resources already in place) for pupil wellbeing, and any gaps which may impede the adoption of an ACE-informed approach.
- 2. Staff training:** To be delivered to all school staff to provide a universal knowledge of ACEs. The training will also include the PATH processes to enable schools to plan how they are going to develop an ACE--informed school. The training will be delivered by the Education ACE Coordinator, co-facilitated by the ACE Coordinators for Police and Partners and Education Psychology Service.
- 3. Action plan:** An action plan will be developed for each school, identifying the support needed to work in a Trauma informed way, and requirements to enable a sustained approach. This will be developed following the completion of the training, incorporating gaps identified in the Readiness Tool and goals set by the school through the PATH process. This will outline which members of staff will lead the work, timescales and outcomes for the work, and what resources and support the school needs to adopt an ACE-informed approach.
- 4. Resources:** A resource pack including lesson plans, training materials, the ACE Readiness Tool, and resources from other Trauma informed programmes to support schools to maintain the ACE approach beyond the life of the project.

Developing policy, procedures and data systems - A number of papers drew attention to the specific changes made to policies, processes and data systems as part of the implementation process (Lang et al., 2016; Hummer et al., 2010; Caldwell et al., 2014; Akin et al., 2017). In one child welfare initiative (Lang et al., 2016) this entailed establishing subcommittees to review policy and data systems. In residential treatment facilities, policy and procedural changes took the form of integrating TIC principles into the residents' handbook and treatment plans; and posting signs detailing the TIC principles around the facility (Elwyn et al., 2017); developing policies to identify child and youth preferences regarding de-escalation (Hummer et al., 2010); and amending procedures to include systematic debriefings following staff use of seclusion and restraint, (Hummer et al., 2010; Caldwell, 2014). Within the education literature there tended to be more of a focus on disciplinary policy and procedures. For example, in the HEARTS model (Dorado et al., 2016), consultants worked at

both a school and district level to re-examine and revise discipline policies and procedures, and alternatives to suspension. Several of the schools in the Stoke-on-Trent and the Bath and North East Somerset Attachment Awareness Programmes (Dingwall & Sebba, 2018a; Dingwall & Sebba, 2018b;) highlighted the introduction of restorative justice meetings following detentions or periods of isolation, while Leicestershire evaluation (Fancourt & Sebba, 2018) identified the need to align the programme values with wider behaviour management policies.

Changes to the Physical Environment - Bryson et al.'s (2017) systematic review of in-patient and youth residential treatment noted that in the therapeutic community model, the environment and culture of the organisation are seen as therapeutic tools in themselves. Thus, organisations were encouraged to make changes to the physical environment of the unit to make the treatment/residential space feel safe and welcoming for patients/service users (both children and adults) and staff; and to include Trauma informed principles in mission and vision statements and to post these visibly to act as reminders for staff and service users of TIC goals. For example, changes made to physical environment in a paediatric psychiatric hospital included repainting walls with warm colours, placement of decorative throws, rugs and plants, and rearrangement of furniture to facilitate increased patient-patient and patient-staff interaction (Borckardt et al., 2011). Interestingly, a multiple-baseline evaluation with random implementation of intervention components, found that these environmental changes were uniquely associated with a significant reduction in the rates of seclusion and restraint (Borckardt et al., 2011) suggesting that fairly minor and inexpensive changes can make a significant difference.

While changes to the physical environment were less frequently discussed in the education literature, a number of the schools in the Stoke-on-Trent and the Bath and North East Somerset Attachment Awareness Programmes (Dingwall & Sebba, 2018a; Dingwall & Sebba, 2018b;) reported the creation of 'drop in' or 'safe haven' areas with dedicated members of staff as a means of providing spaces in which children can calm down, self-regulate, and receive support. Described by one young person as 'a proper chill out room', the drop-in centre in one primary school was reported to have been used over the year by more than 75 children, six of whom used it daily. Staff interviewed in another secondary school participating in the programme, described students coming up to the rooms where the SEN team were based to prepare for the day and calm down, if necessary, before or during the day. Students indicated that they felt supported in

the new spaces and that this helped them with either returning to school (e.g. following absences or exclusions) or into lessons (Dingwall & Sebba, 2018a).

Engaging with Families – Engagement with children, young people, parents/ caregivers and extended networks was also an important element of the implementation process in a number of initiatives. Service user involvement across systems and settings took a variety of forms: including patients/young people and/or caregivers in training initiatives (Fraser et al., 2014; Holstead et al., 2010); parent/caregiver involvement and systematic debriefing of young person following the use of seclusion or restraint (Hummer et al., 2010; Caldwell et al., 2014); getting service user perspectives on the use of restraint (Holstead et al., 2010; Caldwell, 2014); employing a peer specialist to act as a patient advocate and liaison with the treatment team and administration (Goetz & Trujillo, 2012); engaging family members and other supportive adults as part of permanence planning for young people in foster care (Hall et al., 2018); engaging psychiatric patients/young people and their parents/caregivers in treatment planning (Borckardt et al., 2011); conducting focus groups with service users as part of a community Trauma informed site assessment (Hendricks et al., 2011); and including service user representatives (young people and families/caregivers) in TIC leadership teams (Fraser et al., 2014).

In the academic education literature, the New Haven Trauma Coalition initiative (Perry and Daniels, 2016) placed a particular emphasis on working with families, completing needs assessments and developing a plan of care with referred families and following up with weekly meetings with families and monthly Child and Family Team (CFT) meetings with the family and school staff. In the HEARTS model (Dorado et al., 2016), implementation included psychoeducation and skill-building workshops for parents/caregivers on coping with stress as well as working collaboratively with parents/caregivers when providing therapeutic intervention to their child. In the policy and practice literature, the Attachment Awareness programme required that schools support parents and carers to learn about attachment, trauma and nurturing strategies. Although some teachers noted ways in which their work with families had changed, through increased meetings, and training parents in emotion coaching, this has been highlighted by evaluators as an area for further development (Dingwall & Sebba, 2018a; Dingwall & Sebba, 2018b; Fancourt & Sebba, 2018).

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

The complexity and range of TIC initiatives makes comprehensive evaluation a difficult task and, generally, the literature was not able to isolate which implementation elements contributed to implementation success. However, various systematic reviews, (Purtle et al., 2017; Branson et al., 2017), point to Trauma informed organisational interventions which incorporate multiple components as having the most meaningful impact upon service user and caregiver outcomes. Initiatives identified in the rapid evidence review commonly targeted the implementation domains of workforce development, the provision of trauma-focused services and organisational change. Consistency was evident with regard to implementation components within these domains, although the extent to which they were incorporated within individual initiatives varied. Advocates have helpfully developed guidance for implementing a Trauma informed approach. Building on Harris and Falloot's (2001) preliminary work, SAMHSA (2014) identified ten implementation domains and proposed a series of questions to consider in each domain (see Table 2) offering a framework for developing and benchmarking Trauma informed initiatives within the NI context.

WORKFORCE DEVELOPMENT

Training	<ul style="list-style-type: none"> • Basic and/or advanced training dependent upon staff role • 'Train the Trainer' as a method of cascade training • Use of group forums (such as Learning Collaboratives) to embed models of reflective practice, and consolidate learning and practice change • Team access to on-going Trauma informed consultation and supervision • Evaluation processes are embedded within TIC training initiatives
Staff Safety and Wellbeing	<ul style="list-style-type: none"> • Relevant staff training to understand vicarious traumatisation and promote self-care strategies • Access to staff wellbeing support services • Availability of regular staff/team debriefing, learning and support forums, in particular after significant incidents

TRAUMA-FOCUSED SERVICES

Screening and Assessment	<ul style="list-style-type: none"> • Where appropriate, develop appropriate methods of routine inquiry about adverse childhood experiences and trauma, including availability of protective factors • Staff receive initial training and ongoing support in utilising trauma screening tools or assessment models • Frontline practitioners are clear why and how routine screening information will be used and how to discuss ongoing need with service users • Availability of local trauma and adversity-specific services, and referral processes are considered • Incorporation of TIC screening/assessment results into existing data systems or assessment processes e.g. systematic recording of current or past adverse experiences of child/young person and key resources and relationships • TIC screening/assessment is routinely discussed at team meetings and senior management fora, identifying service challenges and developments
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Table 2. Key Components of CROSS SYSTEM Trauma informed Implementation

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

ORGANISATIONAL CHANGE

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

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

Physical Environment

- Establish a shared multidisciplinary staff/service user/caregiver team to undertake a review of the physical space and relevant residential unit policies/procedures
- Use staff/service user/caregiver ideas to create a welcoming physical environment where peer and patient/service user/caregiver-staff interaction is encouraged
- Publicly post mission statements which highlight awareness of service user adversity and trauma, and commitment to TIC principles
- Create 'safe spaces' where service users/care-givers and frontline staff can go to calm down and allow tensions to be de-escalated

Service User Involvement and Peer Support

- Establish a commitment to decreasing agency-young person/caregiver power differentials and maximising service user involvement (children/young people and their parents/caregivers) in all agency policies and procedures
- Include young people and parents/families/caregivers in TIC training, either directly or via integrating their perspectives in training materials
- Involvement of service user perspectives (both children/young people and their families/caregivers) in Trauma informed organisational assessment, leadership/implementation teams, service development initiatives and evaluation processes
- Establish routine service user (young person and family/caregiver) feedback mechanisms
- Create opportunities for young people and their families/caregivers to meet with others experiencing similar circumstances to promote shared learning and mutual support

Monitoring and Review

- Establish clear goals with regard to practice/outcome changes desired
- Utilise or adapt current systems to audit, monitor progress and evaluate TIC implementation/service development priorities to address practice challenges and capture critical practice learning
- Regular communication with staff and service users about TIC implementation progress and on-going learning
- Monitor model/implementation fidelity (dependent upon TIC initiative)

Table 2. Key Components of CROSS SYSTEM Trauma informed Implementation cont.

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

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

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

and justice settings (Sweeney et al., 2018) need to be recognised and addressed in training content. Involving staff and service users in the design and delivery of training content is one of a number of ways this might be achieved.

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

Conclusion

Despite various limitations, this comprehensive evidence review has highlighted a growing body of evidence pointing to the positive impact TIC can have on service users across various systems and settings. The development of a TIC approach within the education system has the potential to improve students’ resilience, engagement with the learning process, empathy and problem-solving, reduce discipline problems, suspensions and exclusions. It can also improve staff awareness of the impact of trauma and help them feel more confident and supported in managing this in their practice. Students in need of specific trauma treatments can benefit greatly when these are accessible within the education system or through referral to a linked mental health service. However, any move towards TIC in the education system should not be seen as a partial or short-term experiment. Success will depend on sufficient groundwork being done to ensure genuine buy-in from all stakeholders and the release of sufficient resources (financial and human) to realise the vision. It is the whole system commitment to adopt a TIC orientation that is the key to effective change, and if this can be part of a larger cross-systems approach, then the benefits will be maximised.

RESOURCES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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