NOTTINGHAMSHIRE POLICE & CRIME COMMISSIONER

VRP Violence Reduction Partnership
Nottingham City and Nottinghamshire

Nottingham City and Nottinghamshire Violence Reduction Partnership

Trauma Informed Strategy

2022-2025

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Introduction

At the time of writing this strategy (in March 2022) there has been deep pain, instability and chaos as the world continues to face and respond to the Covid 19 pandemic. Over the past two years, people using and working within our services may have experienced the death of family, friends and colleagues, suffered profound social isolation and financial hardship or even contracted Covid 19 themselves, with many people continuing to live with the effects of this virus. Many services will still be feeling exhausted and overwhelmed, having suffered a collective moral injury as a consequence of both this pandemic and the previous erosion of services resulting from many years of austerity.

This context is critical when considering the timing and implementation of a trauma-informed strategy: many of the organisations involved in the creation of this strategy and eventually in the implantation are human services, made up of people and communities who in many varying ways have been affected by a collective trauma.

As such, it could be argued this is the most critical time for a strategy that considers the impact of trauma on people using and working within our services.

The Violence Reduction Partnership would like to express my thanks to those who participated in workshops, the trauma-informed cross-organisational steering group and lived experience groups and whose contribution has supported the development of the strategy.

Key concepts related to trauma, adversity and trauma-informed care

Across the literature there are varying definitions of trauma, but the following definition beautifully interweaves the physical, emotional, and psychological impacts of trauma:

“Trauma is much more than a story about the past that explains why people are frightened, angry or out of control. Trauma is re-experienced in the present, not as a story, but as profoundly disturbing physical sensations and emotions that may not be consciously associated with memories of past trauma. Terror, rage and helplessness are manifested as bodily reactions, like a pounding heart, nausea, gut-wrenching sensations and characteristic body movements that signify collapse, rigidity or rage… The challenge in recovering from trauma is to learn to tolerate feeling what you feel and knowing what you know without becoming overwhelmed. There are many ways to achieve this, but all involve establishing a sense of safety and the regulation of physiological arousal” (Bessel van der Kolk,2014)

Gabor Mate helps us consider that “Trauma Is Not What Happens to You, It Is What Happens Inside you” https://www.youtube.com/watch?v=nmJOuTAk09g

From its Ancient Greek roots, “trauma” translates to “wound”. The very act of living can expose us all to events that leave physical and psychological wounds. Often those wounds will heal with love, nurturing, and time – not all experiences of trauma and adversity will have long lasting impacts - but some wounds will fester and grow, causing pain and terror both within the individual and across family systems and

communities until more help has arrived. What defines an event as traumatic is dependent on how it is experienced. In turn, how we experience and recover from traumatic events is likely to be shaped by a number of factors: pre-existing vulnerabilities following childhood neglect and trauma; whether we are coping with multiple and/or enduring traumas; the availability of support and resources; any additional physical and psychological conditions; any concurrent life stresses.

Trauma and neglect that occurs during our childhood from our beginnings in the womb until our early 20s can shape our developing brains, our internal worlds of emotion and bodily sensation, and our external relational and behavioural patterns and interactions. Within secure, safe and loving primary attachment relationships, a child's developing brain and body is co-regulated, building a sense that the world is safe and predictable, and that people are trustworthy. Within these secure attachments, children learn that they too are loveable, and develop a sense of self-worth and belonging. When attachment relationships are disrupted through early traumatic separation or abuse, or as the result of pervasive relational traumas, children can find it difficult to regulate their physiological and emotional arousal, limiting their opportunities to build and access executive functioning skills, for example, consequential thinking.

"Instead of believing that the world and other people are predominantly positive and that they themselves are good, their core constructs become shaped by the traumatic experience and children come to believe that they are worthless and the world hostile and dangerous" (Cairns, 2002)

Without the experience of being co-regulated, many traumatised people will understandably search for ways to regulate their distress -anything to stop the night terrors, flashbacks or constant sense of danger, or feeling shut down, disconnected and/or disassociated. This might be through socially sanctioned mechanisms such as overworking, constant distraction with social media or in searching for the drugs that help us feel soothed when people cannot be trusted, cutting in order to feel alive or to focus the pain onto something tangible, or fighting to keep people away as, after all, it was people who caused their traumas.

Trauma reactions

At the point of perceived threat for our lives, survival or bodily integrity, or that of our loved ones, our inbuilt survival mechanisms become activated. These trauma reactions are critical and are a healthy human response. Many people who go through traumatic and adverse events will have initial trauma reactions and these reactions will then begin to diminish over the coming weeks. However, it is important to recognise that we should not expect trauma reactions to diminish when someone is still in danger; it is those trauma reactions that will help the person to survive. Additionally, when considering trauma reactions in children, it is helpful to think about the relationship between their experiences and how this might be shaping their development neurologically, relationally and behaviourally.

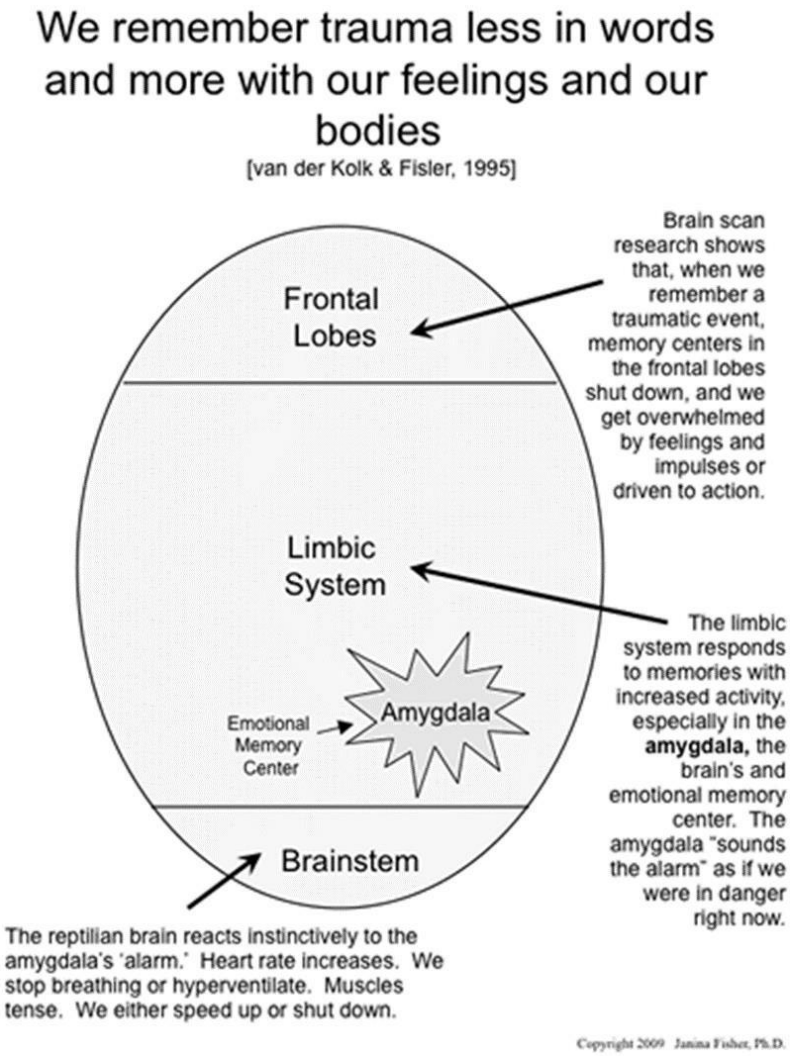
There are some great videos and resources on the following link if you would like further information on developmental trauma https://beaconhouse.org.uk/resources/

Sympathetic Nervous System: Hyper arousal - Fight/Flight Fleeing, running, agitation, restlessness, difficulty concentrating, easily startled, heart racing, sweating, feeling sick or vomiting, urinating, dizziness, rapid breathing, difficulty sleeping, waking up frequently. Thoughts racing, mistrust, feeling unsafe/in danger, difficulties in maintaining eye contact. Anger, shouting, quick tempered, pushing people away (people do not feel safe).
Ventral vagal: Social Engagement - Feeling Safe. Feeling safe, able to regulate emotional and physical arousal, social connectedness, able to trust, able to regulate between periods of activity and rest, able to concentrate, talk, and move freely.
Parasympathetic shutdown: Hypo Arousal - freeze-faint Feeling sleepy, very low energy, numb, cut off from bodily sensations and feelings, time feels slowed down. Can faint, feel floppy, dizzy, foggy headed, legs feel weak or like jelly, not able to think, withdrawn, low voice or unable to speak, shallow breathing, limited movement, difficult to reach out to other people.

Once the danger or threat has passed, for some people trauma reactions continue and start to cause difficulties in daily life. Trauma survivors experience the world through the feeling brain, or the limbic system, and there can be a reduced capacity to process events through the prefrontal cortex. This reduction in access to executive functioning limits our capacity to plan, reason, reflect and undertake decision making processes. Additionally, many trauma survivors with ongoing symptoms may describe wanting to avoid anything that triggers their trauma reactions, this could be people, places, objects, sensory stimuli or talking about traumatic memories. This is completely understandable, why would we want to be reminded of the pain, horror, loss, grief and overwhelm of physical sensations?

Trauma survivors may describe re-experiencing symptoms which can include night terrors and flashbacks where the trauma feels like it is happening again, and we may lose connection to our present moment. They can also experience strong memories and intrusive thoughts about the trauma(s) and feel very distressed but are aware they are memories and remain connected to the present time. Many trauma survivors will experience dissociative symptoms which can include feeling emotionally numb when telling other people what happened, feeling outside and/or disconnected from the body, loss of time and disorientation. All of these above symptoms can impact how we feel about ourselves after trauma, how we respond within our relationships and other people in our daily lives, how we react at work/education, in social situations and how we make sense of the world around us. Trauma can shatter our core feelings of trust, safety and predictability.

For some people trauma can awaken their appreciation for life and strengthen relationships. They may describe post traumatic growth in many areas of their life following trauma and adversity.



The following link provides further information related to trauma symptoms and diagnostic criteria for trauma-related diagnoses in adults and children, differential diagnosis and screening questionnaires.
https://cks.nice.org.uk/topics/post-traumatic-stress- disorder/diagnosis/diagnosis/

Organisational trauma

Trauma and adversity can shape generations of families, organisations, communities and countries. Organisations and services have a context: they are situated in communities comprising many generations of humans and reverberating the shifting social and political landscapes. They have their own trauma histories and narratives, their own signs and symptoms of becoming traumatised and overwhelmed. Many services and organisations are centered on a principal function of helping individuals and communities at the point or aftermath of trauma – such as the police, fire service, physical and mental health services, adult and children's social care, domestic and sexual abuse services. The risk and increasing reality is that these services can themselves become trauma soaked and

overwhelmed. Consequently, and understandably, there is often an increased organisational trauma symptomology:

- Perception and reality of working environments as traumatic, unsupportive and uncontained
- Workers self-protecting by numbing, minimising, withdrawing or displaying increased aggression and reactivity
- Relational damage: us vs them – conflict between team and management and between organisations
- Loss of hope and direction – the gap between what is hoped for and what can be achieved feels unrealistic
- Feelings of powerlessness and helplessness
- Higher rates of staff sickness (digestive disorders, higher rates of infection, mental health disorders, headaches, increased pain, lack of sleep, eating related problems, increase in accidents)
- Capacity to "think" and reflect compromised, impacting decision making
- Spaces to feel and process emotions reduced or eradicated
- People fleeing the organisation leading to mass turnover of staff

To deliver trauma-informed and responsive services we need to have reflective and emotional capacity to contain and make sense of traumatic experiences so that they can be tolerated, processed and integrated.

"What is needed is a form of holding, such as a mother gives to her distressed child. There are various ways in which one adult can offer to another this holding (or containment). And it can be crucial for a patient to be thus held in order to recover, or to discover maybe for the first time, a capacity for managing life and life's difficulties without continued avoidance or suppression" (Casement, 1985, p.133).

When organisational trauma is not processed or reflected upon, the past is more likely to keep repeating. Organisations become unable to think, reflect and learn. This is evident in the repetition of the same recommendations following serious case and domestic homicide reviews.

Prevalence of trauma and adversity

There are differing approaches to quantifying the prevalence of trauma and adversity. All of these approaches have some limitations. The methods include quantifying: Traumatic events, Diagnoses of mental health (including for post-traumatic stress disorder) and Adverse Childhood Experiences (ACEs).

When focusing on events that have the possibility to create traumatised people and communities, many of these prevalence statistics are for reported incidents, often recorded according to the type of crime, and do not account for intersectionality or detailing the clinical picture of multiple or enduring trauma events. It is well documented that some crimes are likely to be under-reported, such as hate crimes and domestic and sexual violence. Additionally, not all people experiencing these events will go on to have trauma related adverse outcomes.

The Crime Survey for England and Wales estimates that 1.6 million women experienced domestic abuse in the 12 months to March 2020. (Women's Aid, 2021)
618,000 women and 155,000 men experienced rape or sexual assault in the same period (Rape Crisis UK, 2022)
Police recorded 46,239 incidents involving a knife or sharp weapon in England and Wales in the 12 months to September 2021
In the year ending March 2021, there were 124,091 hate crimes recorded by the police in England and Wales https://www.gov.uk/government/statistics/hate-crime-england-and- wales-2020-to-2021/hate-crime-england-and-wales-2020-to-2021
According to UNHCR statistics, as of mid-2021 there were 135,912 refugees, 83,489 pending asylum cases and 3,968 stateless persons in the UK https://www.unhcr.org/uk/asylum-in-the-uk.html
The MOD estimated that in 2021 there were 2.07 million UK armed forces veterans residing in Great Britain https://commonslibrary.parliament.uk/research-briefings/cbp-7693/
In the year ending March 2019, the police in England and Wales recorded 73,260 sexual offences where data identified the victim as a child https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childsexualabuseinenglandandwales/yearendingmarch2019
As at 31 March 2019, 2,230 children in England were the subject of a child protection plan (CPP) and 120 children in Wales were on the child protection register (CPR) for experiencing or being at risk of sexual abuse https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childsexualabuseinenglandandwales/yearendingmarch2019

Another way of measuring the prevalence of trauma and adversity is to consider the number of children and adults with a mental health diagnosis or requesting mental health services. Although this can provide some insight, it is not without its complications, with the introduction of the complex post-traumatic stress disorder diagnosis in ICD-11. This diagnosis covers multiple relational event trauma in child and adulthood: until this diagnosis was accepted, it is likely that many trauma-related presentations of human distress would have been labelled as myriad mood or other disorders. The ICD-11 was released in 2018, with the diagnostic codes being accepted for morbidity and mortality reporting internationally in February 2022. This represents just one thread in the growing awareness of trauma as the underlying causative factor in much of the social and healthcare burden.

PTSD Prevalence statistic https://cks.nice.org.uk/topics/post-traumatic-stress- disorder/background-information/prevalence/

> "In Nottinghamshire, using national estimates, there are around 10,215 children and young people between the ages of 5 to 16 years that have 'any mental health disorder' and 87,191 people between the ages of 16 to 74 years experiencing common mental disorders (CMD) such as depression and anxiety, approximately 58,203 people experiencing post-traumatic stress disorder (PTSD), approximately 39,359 people experiencing an eating disorder, and over 3,000 suffering from severe mental illness. However, in deprived districts such as Bassetlaw, Mansfield and Ashfield where there are higher levels of risk factors for poor mental health contribute to higher levels of mental health problems"
>
> *No Health without Mental Health, Nottinghamshire's Mental Health Framework for Action 2014-2017.*

The national and local context

The following information highlights the impact various aspects of mental health have on society, highlighting the scale of the problem and the need to prioritise resources to address mental health.

One in four adults experience at least one **diagnosable mental health problem** in any given year (22).

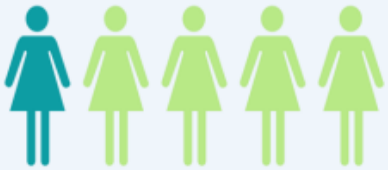
In Nottingham this would be **64,539 adults****

10% of children aged 5 - 16 have **significant mental health problems** (23)

This would be **4,243 children** In Nottingham**

50% of long-term mental health problems emerge by the age of **14**;

75% by the age of **18** (9)



A fifth of women under 24 years of age report 'ever' **having self-harmed** (10)

In Nottingham this would be **12,407 women****

1 in 10 new mothers experience **postnatal depression** (5)

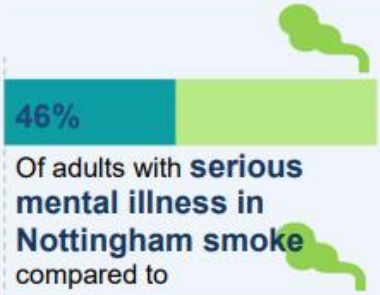
In Nottingham this would be **431 new mothers****

Around **25%** of mental health patients who die by suicide have a **major physical illness** (24).

Approximately **50%** of people who have died by suicide have a **history of self-harm**

About 1 in 100 people in the population have a **serious mental illness** (5).

In Nottingham this would be **3,253 people****



Of adults with **serious mental illness in Nottingham smoke** compared to

Of the general population *

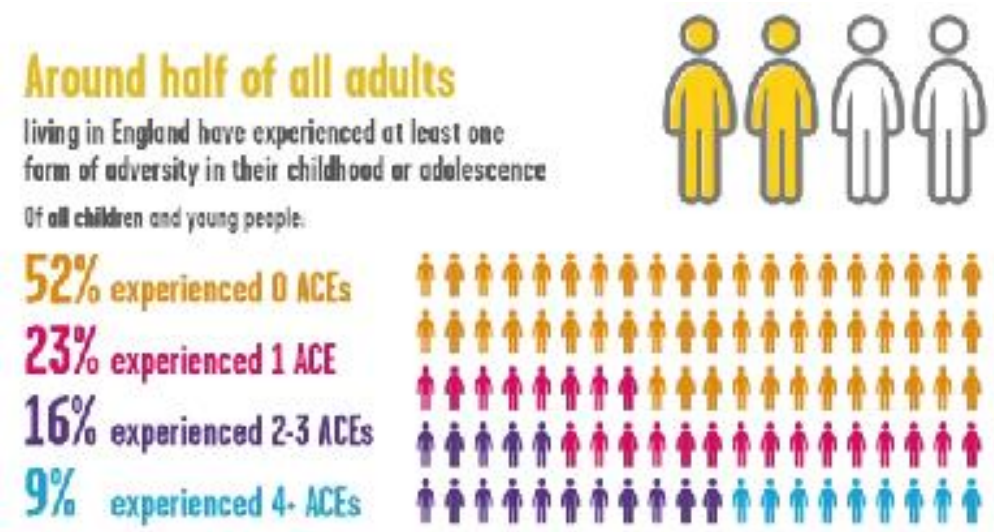
90% of all prisoners are estimated to have a **diagnosable mental health problem** (22).

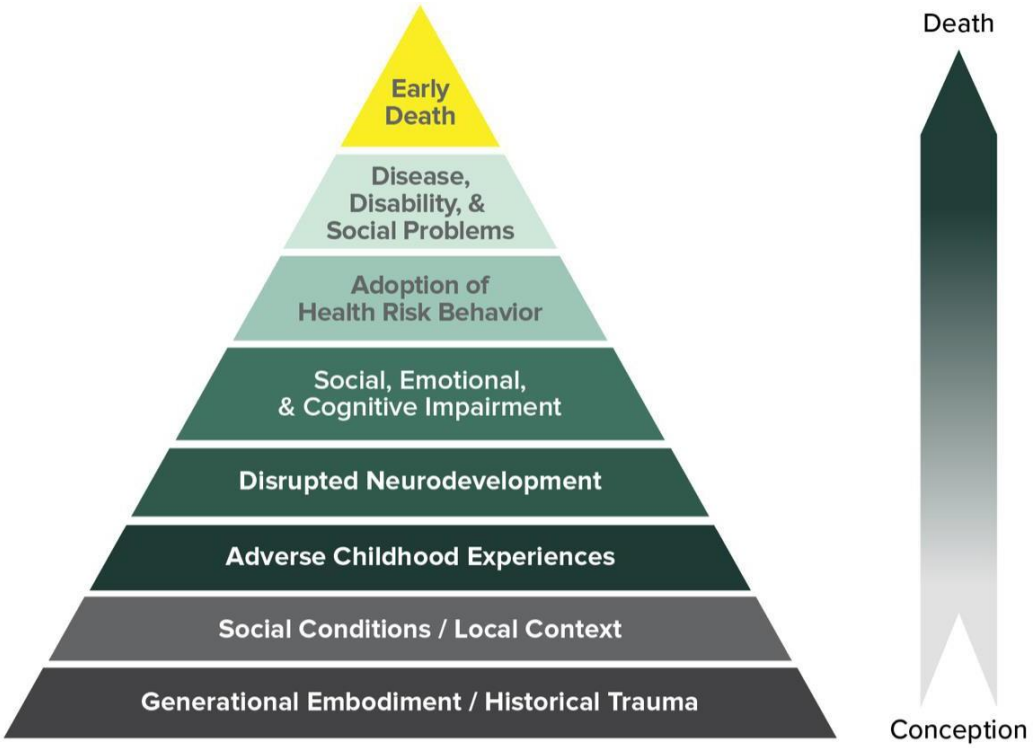
This would be **954** of Nottingham **inmates*****

committee.nottinghamcity.gov.uk

In 1995, Dr Vincent Felitti conducted the Adverse Childhood Experiences (ACE) Study. Over 17,000 Health Maintenance Organization members from Southern California received physical exams and completed confidential surveys regarding their childhood experiences and current health status and behaviours. The predominant findings suggest a close dose- dependent relationship between the number of ACEs and the increased risk of negative health outcomes.

In 2014, Bellis et al undertook the National Household Survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England. Bellis and his colleagues did a study on almost 4000 English residents, aged 18 to 69 years old (n = 3885) between April and July 2013. They found that:





Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

ACEs research has significantly contributed to our understanding of the inter-relationship between adversity, brain development and health outcomes. However, as with all research, there are great examples of public health approaches and there are examples of limitations and risks for misapplication. Below is a summary of emerging themes:

- Demographics not generalizable – UK and US studies were conducted within a high majority white population
- The original questionnaires used in the studies within the US and UK did not ask about other types of trauma/adversity that could impact outcomes (racism, traumatic bereavement, community violence, refuge/asylum etc)
- Misuse of ACEs score for inclusion and exclusion into services, for example, a school stating a child's needs cannot be met due to high ACES score or a mental health service saying an adult does not met threshold due to low ACES score
- The research does not provide the full clinical picture and consequently we do not know what the outcome would be for the people we work with based on the ACEs score alone
- The research does not provide an understanding of current symptomology and how best to reduce impacts
- The research does not tell us how to work with someone with 4 or more ACEs to promote recovery from trauma and adversity
- Deficit model and limited focus on mitigating factors
- Whilst working towards an early intervention and prevention model, we need to be clear that not all adversity and trauma can be prevented – for example, traumatic bereavement. This requires a two-pronged approach: early intervention to prevent adversity or trauma from occurring, and, when this is not possible, exploring how best to support children and adults following adversity and trauma to reduce the likelihood of them developing PTSD or other mental health complications

Trauma informed frameworks

Trauma-informed approaches have been applied and documented across the US from the 1980s. There are some key components that unify differing trauma-informed models.

Below are guiding principles and key themes which are often a core element across approaches, and these are recommended for organisations across Nottingham and Nottinghamshire. How these principles are applied need to be tailored from one context/organisation to another.

1. **Recognition**: To be trauma informed we need to recognise trauma within ourselves, families, adults, children and workforce, and be able to identify when an organisation is becoming traumatised. Organisations should consider common barriers that workers may experience in relation to asking colleagues and those using our services about trauma/ACEs. To consider use of evidence based screening tools or adapting assessments/processes to enable the recognition of trauma and to develop an understanding of how trauma and adversity has impacted the person working within or requiring a service.

2. **Safety**: Building physical and psychological safety for people using and working within services.

3. **Resist re-traumatisation**: We need to consider what systemic structures, practices and policies may re-traumatise our families, children, adults and workforce. To consider how language can re-traumatise. What we say and write becomes a part of a person's narrative, a narrative that begins to tell their story, a way to understand who they are in the world. Language can be used to shame, blame and humiliate, or it can be used to develop empathy, compassion and to help make sense of chaotic and painful memories.

4. **Trustworthiness and transparency**: When trauma has been interpersonal, we need to rebuild capacity to trust individuals and organisations.

5. **Collaboration and mutuality**: communicating and proactively *'doing with'* a person rather than *'doing to'*. It is important to see the human behind the behaviour, label or crisis. This helps to better understand what is driving behaviour (formulation) so that we can offer the most helpful interventions. "Every interaction is an intervention" (Triesman, 2017). Formulations and Interventions are co-produced with the family, child, adult or workforce.

6. **Empowerment, choice and control**: Organisations empower staff and service users alike - understanding the power dynamic, and how those who have experienced trauma and adversity have been diminished in power, voice and control, is important, and, as such, we support service users and workforce in decision making and goal setting within individual, group or service level plans.

7. **Peer support & mutual self-help**: utilizing lived experience to build hope and compassion, and promote recovery and healing

8. **Cultural, historical and gender issues**: It is important that organisations recognise and respond to historical and current racial trauma, persecution of the LGBTQ community, and violence towards, and the disempowerment of, women. We need to consider how trauma can and does disproportionately impact whole communities.

9. **Pathways to trauma-specific care**: Organisations are able to offer trauma-specific interventions, and pathways are developed to enable access to trauma-specific treatments.

*"A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**." (SAMHSA 2014)*

Where we are now

Development of the Strategy

In 2021, there was agreement at the Nottingham and Nottinghamshire Violence Reduction Partnership (VRP) board that a trauma-informed strategy would be helpful in developing a shared understanding, language and trauma-informed framework across social care, health, police, fire and voluntary sectors.

The hope for this strategy is to meaningfully engage and bring together organisations to journey towards becoming trauma-informed on all levels (social/political, organisational leads, workforce, families/patients/communities) whilst acknowledging that many organisations have started this journey (this is further expanded within the section below). The strategy covers both children and adult services in the recognition that all humans can experience trauma and adversity during the life course.

Initial collaboration phase

The creation of this strategy was underpinned with the values and principles of trauma- informed practice. We have tried to build safety and trust through holding collaborative events across organisations and with those who have lived experience of trauma and adversity and are interfacing with, or working within, our services. Within these collaboration events it has become apparent that many organisations have started to grapple with and consider the need for trauma-informed and responsive care and have begun making steps in this direction.

Cross-organisational steering group

In 2021, we convened a cross-organisational steering group. The function of this steering group was to bring together organisations on a senior level to consider the following:

- Organisational buy in to build a collective trauma-informed framework
- Explore ongoing governance arrangements
- Undertake a mapping exercise to establish what currently exists in relation to trauma-informed care across partnerships and develop an understanding of current gaps and challenges

- Develop a shared TIP framework and cross reference how this aligns with areas of work already undertaken across organisations

The steering group has been attended by members of Nottingham and Nottinghamshire Local Authorities, Nottinghamshire Police, Nottinghamshire Healthcare NHS Foundation Trust, the Voluntary Community Sector, Nottinghamshire Fire and Rescue Service, Nottingham CityCare Partnership and Nottingham University Hospitals Trust. In addition to the steering group, we have held separate meetings with organisations to build collaboration on this strategy.

Cross-organisational themed workshops

A number of workshops were delivered over February and March 2022. These were attended by statutory and voluntary organisations. Themes ranged from trauma informed commissioning, developing shared language and trauma informed frameworks, exploring gender, race, disability and Trauma Informed responses and a review of trauma specific pathways within Nottingham.

Workshops were also undertaken with the following boards - Nottingham Adults Safeguarding, Childrens Partnership and Nottingham Violence Reduction Partnership. Each board was encouraged to consider the following reflective questions:

1. How can trauma-informed practice benefit your organisation?
2. What unique challenges would you anticipate your organisation facing on the journey?
3. How can we make trauma-informed care systemically embedded – enabling a cultural and systemic shift in thinking, practice and responses?
4. What are the specific needs and challenges for senior leadership in creating a trauma-informed system change?

Where do we want to get to?

Discussions within the collaborative workshops recognised that we are not all starting from the same position on our journeys to becoming trauma responsive. Many organisations and areas of Nottingham have already made steps in their journey ranging from offering training, clinical and reflective supervisions, building capacity to recognise trauma through use of varying screening tools and considering trauma-informed interventions.

Additionally, each organisation across the statutory and voluntary sectors has its own organisational trauma narrative, cultures, beliefs and structures and may have varying needs when considering organisational trauma. Whilst acknowledging that we are all starting from differing positions, the destination for each service may also vary.

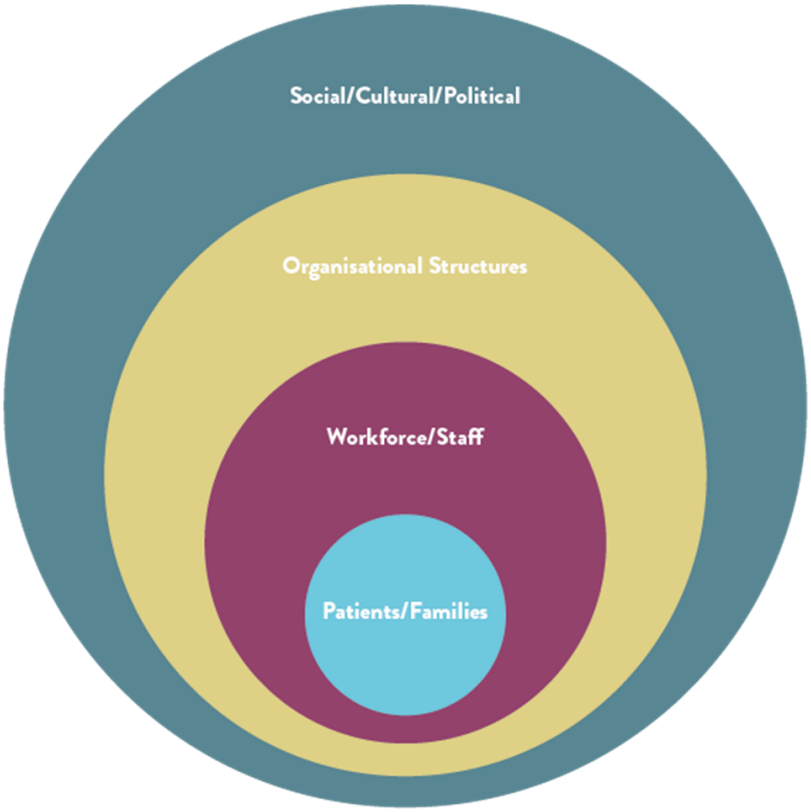
For some organisations, becoming trauma aware will be sufficient whilst for others there will be a greater need to focus on organisational trauma to create a culture of stability and safety for both frontline workers and people using the service. The image below may help us reflect on where we are now and where we

would like to get to whilst also bearing in mind that organisations are alive, dynamic and evolving. To become trauma informed and responsive requires that we continuously reflect and respond to the changing landscape of people, communities, policies, political and social systems.

Vision

During the initial collaboration phase, it was evident that there is a shared vision for a trauma-responsive Nottingham and Nottinghamshire. From this wider vantage point, there is hope and energy for cultural and systemic changes to bring our organisations and communities to a place of safety and nurture, to recognise trauma and adversity in those using and working within our services and on an organisational level by responding with compassion, containment and co-creating trust and safety across the nested systems.

How are we going to get there?



There are important layers and overlaps in developing trauma-informed practice in every aspect of practice in Nottingham and Nottinghamshire. These can be represented in a 'nested' diagram which highlights these layers and might be described as a 'nested system'. Each part of the nested system needs to become trauma informed and responsive, recognising the bidirectional ripples of trauma across the systems. With this in mind, this section considers "How are we going to get there?" using these headings.

Social, cultural, political

Developing a trauma-informed culture requires education, campaigning and changes in public policy and structural systems. Organisations could reflect on what structures/wider systems create re-traumatisation and/or prevent trauma-informed and responsive practice. Below are some reflective questions that could be considered.

- Within our organisation, what do we do already that is trauma-informed and responsive?
- Within our organisation, what do we do that re-traumatises people using and working within our services? Which of these could be reduced by a change in practice, process, policy, legislation etc?
- What barriers exist internally and externally when attempting to create a trauma- informed and responsive organisation?

- Continued public and social health campaigns to increase curiosity about the inter- relationship between trauma, adversity, behaviour and health. Campaigns to move from risk management only models to relational models for human facing organisations
- Local trauma-informed commissioning structures to be developed that recognise the potential for commissioning arrangements to re-traumatise people using and working within services. For example, short term contracts prevent workers from developing the trusting relationships that are often a prerequisite for those recovering from relational trauma. Additionally, such arrangements can result in workers feeling unsafe and without a secure base whilst they wait to hear if they will be re-funded – this can trigger a survival response in workers whilst they are repeatedly becoming anxious about being able to provide for their own families and simultaneously attempting to emotionally contain the people needing their services
- Develop reflective spaces through workshops/seminars to critically evaluate current commissioning arrangements and consider the mechanisms required to build a framework of trauma-informed commissioning
- Develop trauma-informed evidence-based practice and systems change through local and national research
- Identify gaps within existing bodies of research nationally, regionally and within local organisations
- Gather evidence-based examples of current best practice in using trauma-informed frameworks and interventions locally, developing an understanding of how differing contexts use these frameworks and trauma-focused interventions to detail similarities and differences across organisational settings
- Build skills, knowledge and confidence working within, and creating, trauma-informed systems through training, conferences and seminars
- VRP to continue to build collaboration with University of Nottingham and Nottingham Trent University to deliver conferences and seminars on themes related to trauma-informed and responsive care
- Build collaboration with health and social care professional training providers and interweave trauma-informed and responsive practice into core modules

Organisational structures

We want to develop cross-organisational trauma-responsive networks which offer supportive structures to share learning and resources, helping each other implement the strategy and building on our connectedness, thus reducing isolation.

- Develop a cross-organisational implementation group comprising both statutory and voluntary sectors
- Create shared working groups/workshops on identified themes for development.

Trauma-informed frameworks need to be embedded within each part of an organisational system.

Reflective questions to consider:

1. Is there agreement within the organisation at different levels to embed a trauma- informed and responsive approach?
2. What are the different areas of the organisation and their related functions? Have they been thought out in relation to the embedding – senior management teams, HR departments, front door non-clinical staff, IT facing systems, and so forth?
3. Within each area of the organisation, what do they do already that is trauma-informed or is trauma-inducing?
4. Some organisations may have an ambition for each area of the organisation to embed and work towards becoming trauma-responsive. Some may agree to focus on a specific area or task

Organisations will need to build trauma-informed and responsive physical environments.

- Consider how physical and virtual environments could be experienced when those using or working within services are traumatised, stressed and distressed. For example, hot-desking or not having dedicated space to work, leads to questions about necessary spaces for connectedness, sharing, and being brought together as teams and colleagues. Imagine what the experience is for a traumatised child, young person or adult when interacting with the organisation from initial contact through to structured support – what are the transitions of physical and virtual environments?

Workforce staff

Developing a workforce that feels contained, safe and reflective in turn increases the possibility that workers are able to embody a trauma-informed and responsive practice.

- Provide training on trauma, trauma-informed practice, vicarious and organisational trauma, trauma-informed assessments/formulations, and trauma-focused interventions, navigating trauma-specific pathways
- Structure multiple spaces for reflection across the working day
- Build many opportunities for self and co-regulation throughout the working day (encouraging a culture of having breaks and noticing individual and co-workers physical and emotional needs)
- Develop trauma-focused interventions for people using and working within the service.
- Provide clinical and reflective supervision
- Build connectedness and safe spaces between colleagues, within and between teams, across departments and organisations

People using our services – families, young people, children, adults, community

This part of the nested system can be thought about in relation to the trauma-informed principles and key concepts outlined in the introduction section. Below are some additional considerations/expansions from the lived experience groups.

Whilst building capacity to recognise how previous and current life events may be contributing to our internal sense of self, emotions, health, inter-personal relationships and externalised behaviours, it is crucial that we consider how we ask about, assess, formulate and enquire about past and current trauma. Repeatedly in the lived experience groups, people identified that they needed to be asked in the following ways:

- By someone with whom they have spent some time building a trusting relationship
- By someone who has the time to listen to their response
- To understand what will happen once they have spoken about their experiences, whether they will see this person again, who else will be told, and how this information will shape the care they receive
- To be believed and validated and not judged, disregarded, or have their previous experiences used against them for some other purpose

Many people spoke of having to re-tell their stories due to staff turn-over within organisations, being passed between teams, and when requiring support from multiple organisations. This was often described as traumatising, not because of being asked but “how” they have been asked and for what purpose.

All humans require a holistic assessment, recognising there is interconnection between our emotional/mental health and physical health. We exist in relationships with other beings, communities and physical environments. When assessments focus on only one aspect of the whole person, it is more likely that we are offering interventions that at best are ineffective and at worst have the potential to do further harm.

Within the workshops, it was repeatedly identified that the current trauma specific pathways are difficult to navigate. Many people described being passed from service to service, each time re-telling their stories and being told their needs were “too complex” for primary care, yet they have been unable to access secondary care without a diagnosed mental illness. When people do eventually find themselves at an appropriate service they often have long waiting times. Trauma symptomology is not routinely taught within primary or secondary mental health, and we do not have a trauma specific pathway that is easily accessible to help us all navigate a complex and changing system. Routine training and clear guidance on navigating pathways would improve access to trauma specific care when this is required.

When considering trauma recovery, it is helpful to reflect on Herman’s three stages of trauma recovery. Recovery is not linear, often we osculate between the stages. Trauma recovery is also supported in many ways within and outside of psychological services.

Stage 1: Safety and Stabilisation: Overcoming Dysregulation

The first step is to comprehend the effects of trauma: to recognise common symptoms;

- Establishing bodily safety: e.g., abstinence from self-injury
- Establishment of a safe environment: e.g., a secure living situation, non-abusive relationships, a job and/or regular income, adequate supports
- Establishment of emotional stability: e.g., ability to calm the body, regulate impulses, self-soothe, manage post-traumatic symptoms triggered by mundane events

This stage is often worked through within many organisations and is not limited to psychological services.

Stage II: Coming to Terms with Traumatic Memories

At this stage, the focus is to overcome the fear of traumatic memories so they can be integrated. This is normally carried out within psychological services with the use of mind/body therapies.

Stage III: Integration and Moving On

Developing a greater capacity for healthy attachment, focus on reconnection with everyday life, working to reduce fear and shame. This stage is also worked on across many organisations and again is not limited to psychological services.

How will we know when we get there?

Progress on trauma-informed practice can't simply be quantified, as it is about cultural and organisational change and transformation. In the past two decades, there has been a shift from criminalising children and to safeguarding, alongside changes in legislation and policy to protect children and to hold perpetrators to account. It is possible to see retrospectively the mechanisms of cultural and social change in relation to child sexual exploitation.

However, there are key markers that will indicate that across Nottingham and Nottinghamshire we are becoming trauma-informed and responsive.

Examples of possible indicators/markers

- Organisations being able to recognise and consider how trauma and adversity is shaping behaviours that lead to services being required
- Organisational and workforce-related trauma being recognised and systems integrated into organisations to help support and contain workers
- Reflective and clinical supervisions for helping professionals
- Organisations being transparent and non-defensive about practices/systems that are re-traumatising for people using and working within the services and are demonstrating how they plan to reduce re-traumatising processes
- People with lived experience in positions of change, power and collaboration
- Safe and connected physical and virtual environments

These markers could be captured through the use of case studies, and the triangulation of narratives of people working and using services with objective data such as the number of clinical and reflective supervisions provided.

Each organisation should work towards completing their own measures using a pragmatic approach as described below. These could be brought together across the integrated pathway to help build a bigger picture of systemic change.

"Identify a system: If you want to talk about whether a system has changed, you must first be clear what 'system' you are talking about. Identifying the system includes identifying the most important interconnected systems too.

Work out your starting state: You cannot assess 'change' without knowing how things are working in the first place.

What's your vision, what's your plan? By explicitly laying out your desired state for the system and a plan for system change, you build a foundation to later assess against. That assessment, in turn, provides critical information for revising the vision and plan.

Track the intervention: To work out whether or not a change is becoming embedded in the system, you will need to track its sustainability and scale". https://www.springfieldcentre.com/a-pragmatic-approach-to-measuring-system-change/

This evaluative process would need to occur during the implementation stages and then to be repeated over many years to test if there is indeed a systemic and cultural shift that sustains over time and with the changes in organisations, social and political systems.

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Robert F. Anda, MD, MS et al: Aug 2020: Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications: American Journal of preventive medicine

Web links

https://uktraumacouncil.org/resources/childhood-trauma-and-the-brain

https://www.cdc.gov/violenceprevention/aces/resources.html?CDC_AA_refVal=https%3A%

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https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

https://beaconhouse.org.uk/?section=welcome-to-beacon-house

https://www.google.com/url?esrc=s&q=&rct=j&sa=U&url=https://restoreourschools.wordpress.com/2020/06/12/traumabyannagregory/&ved=2ahUKEwijhLzQ8LH2AhUViFwKHQlNCH YQFnoECAAQAg&usg=AOvVaw0vJadBeHvTRuSKCLO_cSjk

https://cperguk.wordpress.com/2020/07/17/restore-a-lens-for-covid-19-and-more/

Appendix A:

Readiness Assessments

Trauma Informed Belief Measure: https://www.traumaticstressinstitute.org/resources/tsi-measures-related-to-trauma-informed care/#:~:text=TRAUMA%2DINFORMED%20BELIEF%20SCALE%20is,been%20done%20on%20this%20measure.

Organizational Readiness to Change Assessment (ORCA) tool:
https://www.nccmt.ca/knowledge-repositories/search/187

Creating Trauma-Informed Care Environments: An Organizational Self-Assessment:
https://www.hca.wa.gov/assets/program/trauma-informed-care-organization-self-assessment-university-south-florida.pdf

Trauma Informed Readiness Tool:
https://surveygizmolibrary.s3.amazonaws.com/library/113599/TraumaSystemReadinessToolMarch2017electronic.pdf

Standards of Practice for Trauma Informed Care in Healthcare Settings:
https://traumainformedoregon.org/wp-content/uploads/2016/01/Healthcare-Standards-of-Practice.pdf

Secondary Traumatic Stress-Informed Organisational Assessment:
https://www.nctsn.org/resources/secondary-traumatic-stress-informed-organization-assessment-stsi-oa-tool

Trauma Informed Program Self-Assessment Planning Protocol:
https://www.theannainstitute.org/TISA+PPROTOCOL.pdf

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