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Trauma-informed care

Understanding the use of trauma-informed approaches within children's social care

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Dr Kirsten Asmussen, Thomas Masterman, Tom McBride, Donna Molloy

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About EIF

The Early Intervention Foundation (EIF) is an independent charity established in 2013 to champion and support the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes.

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Early Intervention Foundation
Evidence Quarter, Albany House
Petty France, Westminster
London SW1H 9EA

W: www.EIF.org.uk
E: info@eif.org.uk
T: @TheEIFoundation
P: +44 (0)20 3542 2481

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This report was first published in January 2022.

The aim of this report is to support policymakers, practitioners and commissioners to make informed choices. We have reviewed data from authoritative sources but this analysis must be seen as a supplement to, rather than a substitute for, professional judgment. The What Works Network is not responsible for, and cannot guarantee the accuracy of, any analysis produced or cited herein.

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Contents

Summary

Over the past 20 years, 'trauma-informed' approaches have become increasingly popular as a means for reducing the negative impact of childhood adversities and supporting child and adult mental health outcomes. These approaches are informed by a set of principles that recognise that experiences of trauma are prevalent and can negatively impact the daily functioning of many individuals. This awareness is then assumed to help practitioners offer services that are more welcoming and less likely to inadvertently retraumatise service users. Examples of common trauma-informed activities include trauma-awareness training, trauma screening, and service redesigns aimed at increasing client choice.

Trauma-informed approaches were originally developed to increase engagement in evidence-based, trauma-specific treatments offered through mental health services. However, trauma-informed principles have since been adopted by schools, the police and other frontline services to improve service quality more generally. Studies show that practitioners are often quite enthusiastic about trauma-informed principles and believe that awareness of them will substantially improve their ability to engage clients. However, studies also show that there is a notable lack of consistency in how trauma-informed principles are applied in practice, and their value to practitioners and clients is yet to be rigorously evaluated.

In our 2020 report, *Adverse Childhood Experiences: What we know, what we don't know and what should happen next*,[1] we urged that trauma-informed activities be robustly tested so that their benefits could be verified and strengthened. However, this testing cannot take place unless the intended benefits of trauma-informed care (TIC) are clearly articulated and linked to specific activities.

In this study, we consider how trauma-informed care principles have been adopted by English children's social care (CSC) teams to improve the quality of their service. Children's social care was chosen explicitly because reducing children's and parents' experiences of trauma is core to their work. We therefore partnered with What Works Children's Social Care to investigate the following four questions:

1. How prevalent is trauma-informed care within CSC teams?
2. What activities do children's social care teams offer under the guise of trauma-informed care?
3. How are TIC activities perceived to add value to children's social care, particularly in terms of their benefits for children and parents?
4. Do specific models of trauma-informed care exist within children's social care and are they amenable to rigorous evaluation?

We considered these questions through a mixed-methods study involving a mapping survey (completed by 58 CSC teams) and in-depth interviews completed by principal social workers (PSWs) from 10 CSC teams. PSWs were asked specifically to participate in this study because they have the lead responsibility for social work practice quality, so have the best understanding of how trauma-informed approaches were being used within their team.

We observed that TIC activities are prevalent, occurring in 89% of the teams participating in the study. 'Strengths-based' methods for engaging families were listed as the primary

1 Available at: **https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next**

trauma-informed care activity, followed by trauma-informed training. The participants also reported that TIC activities provide a wide range of benefits, with better treatment decisions and improved family engagement listed as the most prominent.

However, it was also clear that TIC practice was highly varied across CSC services, with no two teams offering the same components, or attending the same training. Additionally, TIC activities rarely led to evidence-based treatments but were more frequently offered alongside other social work practices that had also not yet been rigorously tested.

Although this study failed to identify a model of TIC delivered across multiple CSC teams, it is likely that one could be developed and tested through the components identified in this study. Examples of outcomes that might be tested in future evaluations include practitioners' awareness of trauma, improved family engagement and retention, greater practitioner satisfaction, and improved child wellbeing. This report concludes with several options for conducting these evaluations.

Key findings

1. Trauma-informed care is widely used and perceived to add value to children's social care.
2. No single model of trauma-informed care currently exists within children's social care teams in England.
3. There is a high degree of overlap between trauma-informed care activities and standard children's social care practice.
4. Trauma-informed activities rarely led to evidence-based interventions.

Implications and recommendations

1. We need a clear and consistent definition of trauma-informed care.

> **Recommendation:** Central government departments, including the Department for Education, the Home Office, the Department of Health and Social Care, and the Department for Levelling Up, Housing and Communities, should work together to agree a core definition of trauma-informed care.

2. The benefits of trauma-informed care must be identified and evaluated.

> **Recommendation:** Government departments should prioritise robust evaluation of models of trauma-informed training and practice in different service contexts.

3. Trauma-informed care should never be used as a replacement for evidence-based, trauma-specific treatments.

> **Recommendation:** The availability of effective, trauma-specific interventions should be prioritised and linked to any future investment in trauma-informed care.

Introduction

What is trauma?

> *Trauma is defined as an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*[2]

This understanding of trauma originated in the 1970s, when clinicians started to record similarities in Vietnam War veterans' reports of mental health problems related to their traumatic experiences during combat. Disturbing thoughts and behaviours were frequent among returning war soldiers, and clinicians noted that problematic psychological symptoms could continue for months, or even years after the traumatic events first occurred.[3] These observations eventually led to the formal recognition of post-traumatic stress disorder (PTSD) as a diagnosable condition, marking the first time in which external events were formally acknowledged in the *Diagnostic and Statistical Manual* as a source of psychological dysfunction.[4] Prior to this diagnosis, distressing psychological symptoms were commonly assumed to be associated with inherent personality disorders or neurological conditions.

The diagnosis of PTSD also made clear that distressing symptoms were not restricted to combat experiences but could occur in the aftermath of other traumatic events, such as natural disasters, serious accidents and witnessing a crime. Over time, it was additionally evident that a more complex form of PTSD (Complex PTSD or C-PTSD) could occur in individuals who were exposed to traumatic events on an ongoing basis.[5] Symptoms associated with C-PTSD include behavioural and concentration difficulties, a sense of extreme low worth, and problems forming positive relationships.[6] Examples of circumstances thought to increase the likelihood of C-PTSD included enforced imprisonment, domestic abuse and child maltreatment.

The formal recognition of PTSD and C-PTSD eventually led to the development of evidence-based treatments that helped survivors manage the disturbing feelings and thoughts associated with traumatic events.[7] Examples of effective treatments for PTSD include cognitive behavioural therapy (CBT), eye movement desensitisation and reprocessing (EMDR) and pharmaceutical treatments.[8] Examples of effective treatments for C-PTSD include child-parent therapy (CPP), which has evidence of reducing symptoms of trauma in child and parent survivors of domestic abuse.[9]

Over time, these treatments became viewed as 'trauma specific', as they were specific to the symptoms of trauma and were assumed to be effective when offered to individuals who needed them.[10] However, there were growing concerns that the efficacy of trauma-specific

2 Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a
3 Crocq & Crocq, 2000
4 American Psychiatric Association, 1984
5 Herman, 1992
6 Maercker, 2021
7 Harris & Fallot, 2001
8 Bisson, et al., 2015
9 The Early Intervention Foundation Guidebook entry: https://guidebook.eif.org.uk/programme/child-parent-psychotherapy
10 Harris & Fallot, 2001

treatments could be undermined if offered alongside practices that further traumatised vulnerable individuals. Examples of practices known to trigger symptoms of trauma include: the use of seclusion and restraints in mental health services; the abrupt removal of a child from his or her family when there were safeguarding concerns; invasive medical procedures; harsh disciplinary practices in schools; and police tactics used to intimidate or threaten witnesses or potential criminals. This resulted in a growing awareness that trauma-specific treatments should be offered within the context of a trauma-'informed' service, to reduce the likelihood of service activities inadvertently retraumatising vulnerable clients.

The negative impact of trauma gained further recognition in 1997 when findings from the first adverse childhood experiences (ACEs) study were published. This population health survey observed that 10 traumatic childhood events, which included experiences of abuse and neglect,[11] were commonly and consistently associated with life-limiting conditions in a graded, and potentially causal way. Although these findings were controversial, they suggested that traumatic events could have negative and long-lasting impacts, even when symptoms associated with PTSD were not evident. The implication was that many individuals could be negatively impacted through routine service use. The ubiquity of ACEs underscored the need for all services to be trauma-informed, not just those offering mental health care.

What is trauma-informed care?

The core components of trauma-informed care were first established in the late 1990s as part of the of the Women, Co-Occurring Disorders and Violence Study (WCDVS). This project was set up by the US Substance Abuse and Mental Health Services Administration (SAMHSA) to consider how comprehensive trauma-informed approaches might benefit women who experienced high levels of trauma through sexual or domestic abuse.[12] The study treatment sites were expected to offer trauma-specific treatments within a service context that adhered to a set of trauma-informed principles agreed through a Delphi consensus exercise convened at the start of the study.[13]

A key aim of the agreed principles was to help the study's treatment sites avoid practices that might inadvertently retraumatise clients, as well as empower them by providing them with a greater choice of treatments. In this respect, TIC was intended to support participation in trauma-specific treatments, but not replace them. While the staff in the participating sites were trained in trauma-informed principles, each site used their own discretion to put them into practice.

The study, which was originally set up as a randomised controlled trial (RCT), considered the impact of TIC on the female participants' substance misuse problems, mental health status, and continued exposure to stressful life events. However, the study had serious difficulties recruiting participants, making it challenging to ascertain whether any of the sites improved the initiative's intended outcomes. Nevertheless, the trauma-informed activities were perceived to add value, so TIC training continued and was expanded beyond the project through support from SAMHSA and other affiliated agencies.[14]

In 2012, SAMHSA conducted a second consensus-building exercise, this time including trauma survivors, to reagree a core set of trauma-informed principles. This resulted in the

11 These ten traumatic events or circumstances, also referred to as adverse childhood experiences (ACEs), traditionally include six forms of child abuse (physical abuse, psychological abuse, neglect, psychological neglect, sexual abuse and the witnessing of domestic violence) and family dysfunction (parental separation, parent incarceration, parental substance misuse and parental mental health problems).

12 McHugo, et al., 2005

13 Harris & Fallot, 2001; Elliott, et al., 2005

14 Cocozza, et al., 2005

'3 E's and 4 R's' framework,[15] which forms the cornerstone of much of the trauma-informed training delivered today (table 1). This trauma-informed approach encourages practitioners to ask clients 'What happened to you?' rather than 'What's wrong with you?' in order to reduce any stigmatisation that might be associated with past traumatic experiences and facilitate warm and sympathetic practitioner and client conversations.

TABLE 1

The three E's and the four R's of trauma

The three E's of trauma
Events: Circumstances and events may include the actual or extreme threat of physical or psychological harm (for example, natural disasters or violence) or severe, life-threatening neglect that imperils healthy development. These events and circumstances may occur as a single event or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), which requires all conditions classified as 'trauma and stressor-related disorders' to include exposure to a traumatic or stressful event as a diagnostic criterion.
Experience: An individual's experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic.
Effects: The long-lasting adverse effects of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. In some situations, the individual may not recognise the connection between the traumatic events and the effects.
The four R's of a trauma-informed approach
Realisation: In a trauma-informed approach, all people at all levels of the organisation or system have a basic realisation about trauma and understand how trauma can affect families, groups, organisations and communities as well as individuals. People's experience and behaviour are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances – whether these occurred in the past, are currently manifesting, or are related to the emotional distress that results in hearing about the first-hand experiences of another.
Recognition: People in the organisation or system are able to recognise the signs of trauma. These signs may be gender, age or setting-specific and may be manifested by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance and supervision practices.
Resist the retraumatisation: A trauma-informed approach seeks to resist the retraumatisation of clients as well as staff. Organisations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the wellbeing of staff and the fulfilment of the organisational mission. Staff who work within a trauma-informed environment are taught to recognise how organisational practices may trigger painful memories and retraumatise clients with trauma histories.

Source: SAMSHA, 2014

The 2012 exercise also identified 10 TIC components that should be considered when adopting a trauma-informed service approach. These components included staff training, organisational leadership, client choice, and trauma screening through tools that were validated to diagnose symptoms of trauma and inform treatment decisions.[16] SAMHSA also convened a group of experts to develop a TIC treatment protocol advising how these components should be implemented within services leading to trauma-specific treatments.[17] All trauma-specific treatments were expected to be underpinned by robust evidence, and TIC services were encouraged to implement models that were identified as evidence-based on the National Registry of Evidence-based Program and Practices (NREPP). NREPP was

15 SAMSHA's, 2014a

16 All of the tools recommended by SAMSHA have been rigorously validated and do not include the commonly used ACEs questionnaire or other non-validated trauma inventories.

17 SAMHSA, 2014b

established by SAMHSA as the first government-funded 'What Works' clearinghouse with the specific aim of increasing access to evidence-based, trauma-specific interventions.

Evaluations of trauma-informed care

Over the past 10 years, TIC activities have increasingly been adopted by schools, child protection services and the criminal justice system as a means for identifying practices that might inadvertently traumatise children (for example, school exclusions or the use of police cells) so that they can be eliminated or changed to reduce vulnerable children's experiences of trauma.

This expansion has, however, far outpaced any evaluation, meaning that the extent to which experiences of trauma are reduced by trauma-informed activities remains largely unknown. A key evaluation challenge is defining precisely what TIC is in these settings, as the risk of retraumatisation is likely to differ across services. For example, a recent investigation of TIC within children's social care in North America observed that definitions of trauma-informed care were often consistent with the 15 components identified by SAMHSA (table 2), but they were rarely delivered in a manner consistent with the SAMSHA protocol and their interface with trauma-specific treatments was highly inconsistent.[18]

TABLE 2

Common components of trauma-informed care within children's social care

Workforce development	Trauma-focused services	Organisational environment & practices
• Training of all staff on the impact of abuse or trauma • Measuring staff knowledge/ practice • Strategies/procedures to address/reduce traumatic stress (secondary trauma) among staff • Knowledge/skills in accessing evidence-based services • Defined leadership position for trauma services	• Use of standardised trauma screening/assessment measures • Availability of evidence-based, trauma-specific practices • Trauma history is always included in case/service plan	• Within agency collaboration/ service coordination • Outside agency collaboration/ service coordination • Positive, safe physical environment • Reduce risk of retraumatisation • Strengths-based/promote positive development • Written policies that include trauma • Consumer engagement/input in system planning

Adapted from Bunting, et al., 2019

More broadly, studies show that of the 15 TIC components, training is by far the most prevalent – and in many cases, the only – TIC activity.[19] Additionally, studies show that this training infrequently leads to changes in practice. While it is clear that practitioners are often quite enthusiastic about the TIC training and frequently learn new information from it, training rarely leads to practice improvements, in the absence of other TIC components.[20]

Additionally, studies observe that trauma-informed activities rarely lead to evidence-based support. For example, a recent review of 21 TIC services within children's social care services in the US state of Connecticut observed that only two included access to evidence-based

18 Hanson & Lang, 2016

19 Adapted from Bunting, et al., 2019; Lowenthal, 2020

20 Kenny, et al., 2017; Conners-Burrow, et al., 2013; Kerns, et al., 2016; Marsicek, et al., 2019; Williams & Smith, 2017

treatments. More commonly, trauma-informed activities were restricted to staff training, staff wellness activities or 'strengths-based' social care activities that were yet to be rigorously tested.[21]

The review also observed that the evaluation of TIC services rarely went beyond pre- and post-training assessments or surveys of client satisfaction.[22] An exception was the evaluation of the Massachusetts Child Trauma Project (MCTP) completed in 2018, which considered the benefits of trauma-informed care and treatment for children and families receiving child protection services.[23] Specifically, all child welfare services in northern Massachusetts counties received training and consultation support to implement the SAMHSA treatment protocol to help families access evidence-based, trauma-specific treatments.[24] These treatments included Trauma-Focused CBT and Child–Parent Psychotherapy. Both interventions have an established evidence base and are currently listed on the EIF Guidebook.

The study compared the outcomes of 342 of the children in the intervention sites to those of a carefully matched sample of children receiving standard child welfare services in the southern part of the state. The study observed that children receiving trauma-informed care had fewer total substantiated reports of child maltreatment in comparison to the children in the comparison sites by the end of the intervention year.[25] However, the trauma-informed care investigated in this study included participation in evidence-based, trauma-specific treatments, meaning that it was not possible to separate the benefits of the trauma-informed care activities from those associated with the evidence-based, trauma-specific treatments.

Aims of this study

The aim of this study is to consider how trauma-informed care is currently being used by English CSC teams so that its key components and intended benefits can be better understood, with the aim of informing future evaluations. In doing so, this study combines a mapping exercise with in-depth interviews to answer four specific questions:

1. How prevalent is trauma-informed care within children's social care teams?
2. What activities do children's social care teams offer under the guise of trauma-informed care?
3. How are TIC activities perceived to add value to children's social care, particularly in terms of their benefits for children and parents?
4. Do specific models of trauma-informed care exist within children's social care and are they amenable to rigorous evaluation?

21 Lang, et al., 2016

22 Purtle, 2020

23 Bartlett, et al., 2016; Fraser, et al., 2014

24 These interventions included two listed on the EIF Guidebook: Child–Parent Psychotherapy and Trauma-Focused Cognitive Behavioural Therapy.

25 Bartlett, et al., 2018; Barto, et al., 2018

Methods

Participants and procedures

This study adopted a mixed-methods design that combined a web-based mapping survey with qualitative in-depth interviews. The survey was sent via Survey Monkey software to 149 English local authorities (excluding Peterborough and Richmond which shared a principal social worker with another local authority area). The survey was completed or partially completed by representatives from 58 CSC teams. Twelve principal social workers or directors of children's services (representing 10 CSC teams) also took part in a one-hour in-depth interview. In two instances, the interview was attended by two social workers from the same team.

Measures

An 87-item mapping survey was used to consider the extent to which CSC teams engaged in 10 of the 15 TIC components described in table 2 of the previous chapter. Five activities were omitted because they were determined to be redundant or unnecessary during the pilot phase of the study.

For each of the 10 components, respondents were asked:

1. whether they engaged in the activity
2. whether they viewed the activity as a form of trauma-informed care
3. the extent to which they perceived the activity to add value to their work
4. the benefits of the activity for children and families.

The ten component categories, along with their respective follow-up questions are provided in **appendix A**.

These 10 components also served the basis for the topic guide developed for the in-depth interviews (**appendix B**). The interviews included an exercise during which the participants worked with the interviewer to identify the core components of their TIC activities and arrange them in a **theory of change diagram** linking core activities to potential short-, medium- and long-term outcomes.

Data analysis and storage

Descriptive statistics were used to analyse the findings from the mapping survey. Findings from the in-depth interviews were analysed through the 'framework' approach developed by Ritchie and Spencer.[26]

The in-depth interviews were digitally recorded with encrypted Otter software. All interviews were conducted with the participants' informed consent and stored confidentially within data protection guidelines. The need for any further ethics approval was waived by the Association of Directors of Children's Services.

26 Ritchie & Spencer, 1994

Findings

Characteristics of the participants

Local authorities

Fifty-eight representatives from 149 local authorities responded to the survey; 41 completed the entire survey and 17 part-completed it. This reflects a response rate of between 28 and 40%, depending on the survey question. This response rate is lower than what was initially anticipated, although it is typical of the rates of return observed in this kind of a study, and is likely low because the survey was conducted during the peak of the 2021 Covid pandemic, between the months of January and March.

It is nevertheless clear that the survey was completed by a representative cross section of English CSC teams, as confirmed through a comparison of the sample with the national average on key characteristics (table 3). This was particularly true when it came to level of deprivation, where the study sample and national average were virtually identical. However, it was also clear that the London region was somewhat under-represented in comparison to the South East and Yorkshire and the Humber regions.

TABLE 3

Characteristics of responding local authorities compared to the national average

Distribution of local authorities per English region	Sample (%)	National average (%)
East of England	5.3	7.3
East Midlands	5.4	6.0
London	16.0	21.3
North West	12.5	15.3
North East	8.9	8.0
South East	17.9	12.7
South West	10.0	8.9
West Midlands	8.9	9.3
Yorkshire and the Humber	16.1	10.0
Distribution of local authorities by ONS area classifications	**Sample (%)**	**National average (%)**
Affluent England	10.9	10.1
Business, Education and Heritage centres	10.9	11.4
Countryside living	12.7	11.4
Ethnically diverse metropolitan living	9.1	12.8
London cosmopolitan	7.3	7.4
Services and industrial legacy	14.6	14.8
Town and country living	16.4	11.4
Urban settlements	18.2	20.8

Level of deprivation per each local authority from most (1) to least (5) deprived	Sample (%)	National average (%)
1st quartile	14.3	20.0
2nd quartile	21.4	20.0
3rd quartile	17.9	20.0
4th quartile	21.4	20.0
5th quartile	25.0	20.0

Principal social workers

The characteristics of the principal social workers who responded to the survey suggest that the majority were highly experienced:

- 93% had worked as a social worker for 10 or more years
- 53% had a masters qualification or higher in social work; 95% had QCF 6 or higher
- 51% represented social work teams of 50 practitioners or larger.

The 10 practitioners engaging in the in-depth interviews were also senior members within their teams, working either as the principal social worker or an associate director of children's services.

How prevalent is trauma-informed care in children's social care teams?

Eighty-nine percent of the local authorities responding to this question (50 out of 58) reported that they engaged in at least one of the 11 TIC components listed in the survey. By contrast, only 11 (22%) said their team had a shared definition of TIC. Table 4 lists these 11 definitions.

TABLE 4

Definitions of trauma-informed care provided by English children's social care teams

1	Adverse childhood experiences.
2	Children can experience adverse childhood experiences (ACEs), if there are lots of these multiple ACEs, they are likely to have higher support needs as adults. Services need to take this trauma into account. They need a trauma-informed approach, to provide an environment where a person can feel safe and can develop trust. This approach can improve access to services and outcomes.
3	Many looked-after children will have experienced traumatic events in their life. Sometimes children just need a period of time and stability to process this trauma. Where the level and frequency of trauma has been high, children may find it hard to move forward without support. Trauma will often be shown as difficulties in sleeping, including nightmares, eating (both over- and under-), difficulties in settling at school and concentrating on work, finding it hard to make and maintain friendships, and volatile or destructive behaviour. In some cases, children may experience flashbacks and other symptoms associated with PTSD such as being stuck in flight or fight mode.
4	Team provide trauma-informed practice and Dyadic Developmental Psychotherapy (DDP) informed practice to foster carers and professional network. Practice includes strengths-based approach, rupture and repair support using restorative principals, promoting physical and emotional safety through the lens of the child in the context of their history. Exploring attachment history of carers and how this supports the parenting of children with developmental trauma.
5	The ability of practitioners to recognise and respond to adverse childhood experiences in a service user's life which may have led them to a position of being/feeling stuck now.
6	To approach and assess all our work through a trauma-informed lens.

7	Trauma-informed care recognises the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life – including service staff.
8	Trauma-informed practice is a strengths-based approach, which seeks to understand and respond to the impact of trauma on people's lives. The approach emphasises physical, psychological and emotional safety for everyone and aims to empower individuals to re-establish control of their lives.
9	We are striving for our whole children's workforce to work in a trauma-informed way, with the knowledge and skills to provide support to families in a compassionate and restorative way, and to help children and families to recover from experiencing trauma. We also recognise that our staff may experience secondary trauma, so are looking at ways to look after our own wellbeing.
10	Working with individuals in a manner which recognises the impact of trauma and exposure to adversity to the individual on their health and wellbeing.
11	When practitioners of all levels are able to recognise what these adverse childhood experiences are with the service user and collaborate on how best to help resolve them and develop resilience. This may require some form of therapeutic input.

Approximately half of these definitions are consistent with the definition provided by SAMHSA, which recognises that exposure to trauma can negatively impact individuals' daily functioning. One third of the responses also referenced ACEs in the definitions, with some viewing ACEs and trauma-informed care synonymously.

Definitions provided during the in-depth interviews similarly recognised the influence of adverse childhood experiences on children and adults' current functioning, although some also defined a trauma-informed approach as a less judgemental means of gaining a family's trust:

> *It's working alongside families far more so that they feel less judged and they can think about that their past because it's a very judgmental profession as well. People are very judgmental.*
>
> *Because if you can get in there at the beginning and make a meaningful relationship with somebody, you can often stop things escalating, because you've got that trust, and you can get on board with a family and be saying, right, be absolutely upfront and honest, this is what needs to change. And this is how we're going to support you to do it. Whereas I think sometimes at the moment, because of that lack of understanding for some people about trauma that they don't necessarily try to build that relationship in a way that's meaningful.*

While in-depth interview participants also viewed TIC principles as helpful for practice, some remarked that they were not necessarily new for CSC, but rather a reframing of the work they had been providing all along:

> *Sometimes you get into social work, you get, like buzzwords almost, and it's all become very much at the forefront of thinking over the past few years in terms of the ACEs and the trauma-informed. But I think I have had an awareness of it throughout my career. As part of being a social worker, and before I became a manager, I spent a lot of hours talking to people and I would say that I come from a really person-centred place. I'm really interested in people and their experiences, and then making that link in my own analysis ... but actually,* [ACEs are] *a bit deeper than major events that people think about. It's like repeated exposure to difficult situations. It's like been a gradual sort of realisation throughout my social work career. And there's something more concrete around that now.*

What components of trauma-informed care do children's social care teams offer?

A primary aim of the survey was to consider the use of TIC components in English CSC teams. Nearly all 39 respondents stated that their teams engaged in some form of strengths-based working. TIC training was also highly prevalent, with 33 of the teams participating in the survey (81%) stating that their staff had attended some form of TIC training.

TABLE 5

Prevalence of trauma-informed components within local areas (n = 41)

	Component	Prevalence
1	Strengths-based approach	96%
2	Training	81%
3	Increasing the safety of the physical environment	57%
4	Recording the child's history of trauma in their case files	56%
5	Screening for trauma or adverse childhood experiences	53%
6	Support for secondary trauma	47%
7	Increased within agency collaboration	47%
8	Cross-agency collaboration and referral systems	37%
9	Adopting a trauma-informed ethos and written policies	20%
10	Trauma-informed leadership	15%
11	Additional trauma-informed activities	15%

Over half (23) of the local authorities also reported engaging in activities that increased the physical safety of the working environment or recorded the child's exposure to trauma in their case files. Increased collaboration within teams and support for secondary trauma were also frequently mentioned (19 mentions each).

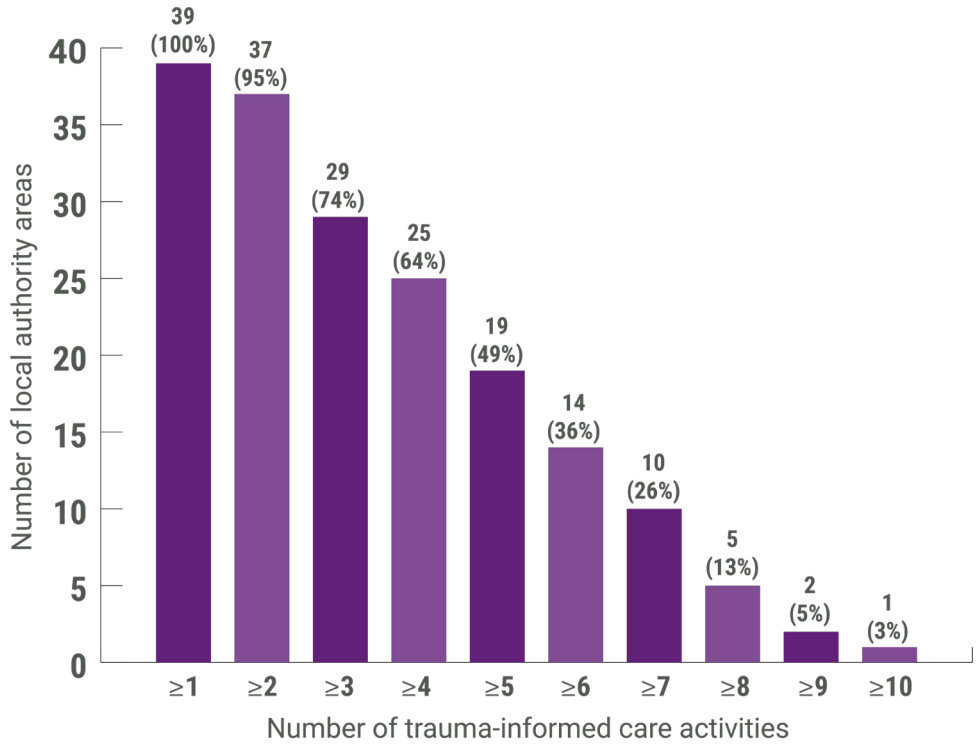
Cross-agency referrals and collaboration were less common (occurring in only 15 of the teams) and rarely led to evidence-based treatments, and one fifth made use of written policies or protocols. Trauma-informed leadership was also less frequent, with only six of the respondents stating that their teams had a specific trauma-informed lead.

A second aim of the survey was to consider the extent to which a specific model of TIC practice could be identified based on the combination of components delivered. Figure 1 provides an overview of the frequency with which one, two, three or more components were delivered in the 39 areas who responded to the question.

Most teams offered at least two of the 10 TIC components, with the most frequent combination being strengths-based practice combined with TIC training. Three-quarters of the respondents indicated that they engaged in at least three of these activities, with the most frequent combination involving strengths-based practice, training and improved interagency working. Two-thirds of the teams engaged in four or more activities, but at this point specific combinations were more difficult to identify. Only one area stated that they delivered all 10 of the TIC components, but interestingly did not view many of these activities as a form of TIC when explicitly asked in the survey.

FIGURE 1

The frequency of the number of TIC components delivered by CSC teams (n=39)



Two local authority areas reported they did none of the TIC components identified, as such they are not included in this graph.

Further information about each trauma-informed care component

Free text boxes within the survey prompted the respondents to provide further details about each TIC component delivered by their team. A summary of the responses to these questions is provided below.

1. Adopting a strengths-based approach

Adopting a strengths-based approach was by far the most common TIC component offered by English CSC teams. Ninety-six percent (39) of the respondents indicated that their teams engaged in strengths-based activities, and 86% (35) said that they had sent staff on training and had developed specific guidelines to implement them. Interestingly, only 31% (13) identified strengths-based working as a form of TIC.

By definition, strengths-based working assumes that all clients, no matter how vulnerable, have strengths and resources that will support their resiliency in the face of adversity.[27] While strengths-based methods were introduced to social work practice independently of TIC during the mid-1990s, they were rapidly embraced as a TIC practice in the years that followed.[28]

Within the UK, a strengths-based approach is explicitly encouraged through the Adult Care Act which recommends that practitioners 'consider the person's own strengths and

27 Rapp, 1997

28 SAMHSA, 2014

capabilities, and what support might be available from their wider support network or within the community to help' when determining the support that is made available to vulnerable families.[29] However, the term 'strengths-based' is often applied to a wide variety of practice models, and no single model appears to have dominated. Examples of strengths-based activities identified by the survey participants included the Signs of Safety model, restorative practice models and motivational interviewing.

However, the effectiveness of these models remains unknown as few have been rigorously evaluated; and when they have been, their benefits are unclear. For example, a recent evaluation of the Signs of Safety model failed to verify improvements in staff retention, case management, or child outcomes in comparison to local authorities not using the model.[30] Similarly, restorative models have not yet been shown to reduce the need for going into care or to improve child or parent wellbeing, although very few have undergone a robust evaluation.[31]

There is, however, consistent evidence showing that motivational interviewing can lead to improved child and parent outcomes, although this is only when it is used in conjunction with other evidence-based treatments.[32] For example, motivational interviewing is viewed as an effective component of the Child First intervention, where it is used to increase engagement in childparent psychotherapy (CPP).[33] However, there is currently no evidence that motivational interviewing – in conjunction with CPP or any other kind of therapy – has led to reductions in child maltreatment or improved placement outcomes.[34]

2. Training

Training was the second most prevalent TIC component identified in the survey, with 31 of the participants agreeing that their team had participated in some form of TIC training. Table 4 provides an overview of the topics covered in this training and their frequency.

TABLE 6

Topics frequently covered in trauma-informed training (n = 38)

Topic	Frequency
Building resilience	33%
Strengths-based working	33%
Adverse Childhood Experiences (ACEs) and their impact on children's development	32%
Attachment security	27%
The importance of building a trusting and safe relationship	26%
Building trust	24%
Strategies for increasing emotional safety	22%
Creating a shared language	22%
Toxic stress	21%
Strategies for avoiding retraumatisation	19%
Strategies for increasing physical safety	16%

29 SCIE, 2015

30 Baginsky, et al., 2021

31 Williams, 2019; Nurmatov, 2020

32 Frost, 2018

33 Lowell, et al., 2011

34 Hall, et al., 2020; Forrester, et al., 2018

The responses to the training question once again emphasised the value of strengths-based methods within CSC teams, with training aimed at increasing trust and emotional safety within the social worker–family relationship emerging as a common theme. Training content covering ACEs and attachment security also featured strongly in the survey responses, as well as in the content of the in-depth interviews. Surprisingly, strategies for avoiding retraumatisation, which are central to the purpose of trauma-informed care, were less common.

Findings from the survey also revealed a high degree of variation in the intensity and amount of TIC training received. For approximately half of the teams, TIC training involved a full-day session (or less) provided by an external training organisation. For the other half, training was more comprehensive, taking place over multiple days throughout the course of the year. In these instances, training was often coordinated on a bespoke basis by an external consultant or clinical psychologist seconded to the team.

Reviews of this training were somewhat mixed with 61% reporting that the training had been highly valuable, and just over one third agreeing that the training was somewhat valuable. When asked to identify the primary benefits of this training, 83% identified child and parent outcomes, followed by staff wellbeing (14%) and increased job satisfaction (3%).

Findings from the in-depth interviews provided further insight into how the training was perceived to add value. For some CSC teams, knowledge about ACEs and the impact of trauma provided the business case for the support social workers provided children and parents. As one social worker put it:

> *Understanding that …children's brains develop fairly rapidly in the first two years of life and certainly within the first five years of life is important. The impact of trauma within that period has lifelong impacts on physical health, mental health, and contributes, as you know, to entry into the justice system. And so if you acknowledge that, and understand that, then obviously getting in earlier and taking on this sort of approach makes sense for everybody's outcomes.*

TIC training was therefore often used as the springboard to initiate multiagency work, by providing a shared rationale and language. Findings from the in-depth interviews also made clear that TIC training did not just cover traditional TIC components (including the ten covered in the survey), but other common social work practices, including systemic family therapy and restorative practice. A full list of the training providers is provided in **appendix C** and further details of these activities will be described in later sections.

3. Increasing the safety of the physical environment

Increasing the safety of the physical environment was the third most prevalent TIC component identified in the survey, mentioned by 57% of the 30 respondents who answered the question. Interestingly, 26 of these respondents (82%) did not view increasing the safety of the physical environment as a TIC activity but rather as a means for making their work environment more comfortable and inviting. Additionally, it was clear that the respondents' answers to this question included activities aimed at increasing the emotional safety of the environment in addition to physical safety.

Examples of changes made to the physical environment included changes to the furniture used in children's residential care facilities and the artwork put on the walls of the family group conferencing rooms. Digital, or hybrid methods for meeting with families were also mentioned, although these were likely introduced in response to the Covid pandemic, not as a form of trauma-informed care.

Sixty-five percent of the participants identified children and families as the primary beneficiaries of these changes, in comparison to 29% of the respondents who felt that staff primarily benefitted from recent changes involving remote working.

4. Recording the child's history of trauma in their case files

Fourteen of the 25 survey participants who responded to this question indicated that information about a child's trauma history was routinely included in their case files. However, only two of these respondents viewed this activity as a form of trauma-informed care. Sixty-eight percent (17) viewed it to be highly valuable and nearly all (24 out of 25) felt that children and families were the primary beneficiaries.

Interestingly, only one respondent stated that staff had been trained in trauma history-taking methods. In this instance, the social worker felt strongly that information about a child's trauma history was essential for improving the quality of support provided to the child and the family, as it increased the coordination between agencies (for example, Early Help and CSC teams) and was also useful for auditing practice:

> *So if you've got a challenge, and it's all recorded on the file, it will be a discussion with a social worker, and they would be expected to say, so I'm aware of this, this and this, but when I've looked at your assessment, there's nothing in there around how, you know, have you considered the trauma on this family? So if we're driving something we do it, and as a way of like making sure that that's done and raising it if it's not.*

5. Screening for ACEs and the child's trauma history

Screening for trauma has always been considered a key component of trauma-specific treatments. Historically, social work teams were encouraged to use validated screening tools to assess for trauma history, although increasingly these practices have been replaced or augmented by universal screening activities taking place in frontline services (for example, schools or general practitioner surgeries) resulting in an ACE score.

ACE scoring involves counting the number of different ACEs a child or parent may have experienced before the age of 18. Scores higher than four are often viewed as problematic and predictive of future psychological risk.[35] While scoring is perceived as easier to implement than a diagnostic tool, which frequently requires administration by a trained and qualified practitioner, most of the ACE scoring tools in current use have not been validated, nor has their efficacy for making treatment decisions been tested.[36] Additionally, recent studies have found that highly vulnerable individuals are often uncomfortable answering questions about past traumatic events, including their history of ACEs, and may not always answer them truthfully.[37] These findings suggest that ACE scores may not be an effective means for identifying the children or parents who are at greatest risk.[38]

Our survey considered whether English CSC teams screened for trauma and if so, the kinds of screening tools that were used. Of the 32 practitioners who answered this question, 17 (53%) stated that their team actively screened for trauma, but only six (35%) viewed it as a form of TIC. When it came to ACE screening, only two of the 17 practitioners whose teams screened for trauma stated that this activity resulted in an ACE score. In the in-depth interviews, it was clear that there were concerns about the value of ACE scoring for making referral decisions:

35 Koita, et al., 2018

36 Danese, 2019; Lacey & Minnis, 2019

37 Mersky, et al., 2019

38 Baldwin, et al., 2021; Anda, et al., 2020

> *I and the trauma team had a look at* [routine enquiry] *and we thought probably wasn't for us because it was more of a – it is a checklisty kind of set of questions about adverse childhood experiences, and then – I suppose – for a referral on to other* [agencies] *if you need to. And we felt that our practitioners were probably working at a higher level than that already* [and the tools] *might work to dumb* [them] *down rather than increase their skills.*

Responses to this question also made clear that many of the teams (41% of the 17 where screening was taking place) were, in fact, using validated tools to screen for trauma. Examples of validated screening tools identified in the survey included the Strengths and Difficulties Questionnaire (SDQ), which was the most widely implemented tool, and the Trauma Symptom Checklist for Children.

In some instances, it was clear that these assessments resulted in referrals to evidence-based treatments such as CBT, EMDR and trauma-focused CBT. However, referral to specific, evidence-based interventions was uncommon, with most trauma support provided by the CSC team, through standard social work practice and practitioner judgment. We describe the nature of these internal and external arrangements in the following sections.

6. Support for addressing secondary or vicarious trauma

Secondary trauma is the term used to describe the negative emotions practitioners might experience when hearing about the traumatic events experienced by their children and parents. Support for secondary trauma is regarded as an essential component of TIC, as it is assumed that practitioners need to feel psychologically safe to be able to create a psychologically safe environment for their clients. As one of the in-depth interview participants explained:

> *What we're teaching our workforce is that it's really important that you are not that secondary part of the trauma. So, by understanding and learning those skills you're not repeating that trauma. And I know that, ultimately when we remove children, we are a massive part of that trauma anyway, but it's about being really careful when we're talking with families not to retrigger that trauma.*

Just under half (21 or 47%) of the 45 survey participants responding to this question indicated that their team had adopted measures to help staff cope with secondary trauma. Activities implemented to help practitioners cope with symptoms of secondary trauma included opportunities that encouraged practitioners to reflect on the emotional impact of their work and access therapeutic support when needed.

7. Changes to within-agency working and collaboration

SAMHSA has advocated that within-agency working is frequently considered a critical component of TIC, as changes in communication and collaboration are often required to implement the other components of TIC, especially when it comes to making treatment decisions and providing greater client choice. Twenty-one out of the 44 survey participants (48%) answering this question indicated that TIC activities resulted in increased collaboration, service coordination, and information sharing within their team.

Examples of within-agency working provided by the survey participants included changes to how information about families was recorded and shared through case records and supervision meetings. However, it was also clear that some of the respondents interpreted this question to mean between-agency collaboration, so also provided examples of processes that facilitated multiagency working through referral protocols and developing a shared language. In this respect, 12 of the survey respondents provided examples of how this collaborative working included referrals to specific interventions or treatments, although it was not always clear whether these treatments were delivered within CSC teams,

or by external agencies. Examples of the interventions or activities implemented through this collaborative support included the Fast Feet Forward programme (a sports-based, therapeutic service), Signs of Safety and multisystemic therapy (MST). MST is considered to have a strong evidence base, whereas the effectiveness of both Fast Feet Forward and Signs of Safety are less established.

The in-depth interview respondents also provided examples about how an understanding of trauma, or a trauma-informed 'lens' potentially improved collaboration and communication within their teams:

> *All of our activity is around that understanding of trauma and ACEs. So, it's in our conversations. If we're having a core group, for example, everyone's speaking the same language. When I say everybody, it's our partners, anybody who's attending those meetings – we all come from the same place in the same understanding.*

Some of the respondents also described how internal measures were necessary to ensure that the language used to describe children and parents was strengths-based not only when they were working with families but also when they shared information about families within the team:

> *We've done some work with staff, we've looked at other research that nationally people have done and come up with some words or phrases that we might want to try and refrain from using. Rather than labelling children and families under a category, we want people to use descriptive language by finding out from the family and then using those terms rather than [for example] 'disguised compliance'. Well, why? What does that actually mean? Does it mean you're too frightened to talk to me? Or does it mean that you've spoken to so many people? So, it's to try and understand some of that reasoning. So rather than using generalistic terms, actually, we want [staff] to be descriptive. But that means they're going to have to really find out the answers rather than using generalised terms.*

8. Changes to between-agency working and collaboration

Increased collaboration between agencies is commonly viewed as a critical component of TIC, especially when it involves referrals to effective trauma-specific treatments that might be provided by clinical psychologists or other professionals external to the CSC team.

Sixteen out of the 45 practitioners responding to this question (35%) indicated that their team had recently introduced new procedures to improve the communication and collaboration with external agencies to improve their response to child and family trauma. In just over half of these cases (9 out of 16), the respondents stated that this included access to treatments provided externally. These interventions included the same three activities mentioned for within-agency working (for example, MST, Fast Feet Forward and Signs of Safety), but also Circle of Security, Theraplay and compassion-focused therapy. It was also not uncommon for CSC teams to include a clinical psychologist who either offered therapeutic support to children and parents as needed, or coordinated referrals to Child and Adolescent Mental Health Services (CAMHS) offered by the NHS.

It was also clear that cross-agency working included activities aimed at improving the quality of referrals into children's social care. These activities included 'front door' models, whereby specially trained social workers assessed all referrals into children's social care and then triaged them depending on need. One interview participant believed that this level of expertise was 'essential' for not only ensuring that children were not being unnecessarily referred into CSC, but also that they remained safe:

It's a much more immediate response and the impact of it is that it does allow us to screen in and out the cases where we really do need to get involved, and we need to get involved very quickly in order to put in effect a more comprehensive multiagency response to that child, or family, where there's a very clear risk, and to intervene very quickly in order to mitigate and reduce the risk. So that's enabled us to improve our assessment timeliness, and it's also enabled us to improve the volume of work flowing into the service. I can also see another benefit is that anybody who's having these conversations and are asking questions, and you're having that dialogue – it's refining their own understanding about child protection issues. In the absence of those conversations that's just information on a piece of paper and you can't interrogate a form. A form requires the person receiving it to do the work to populate it. And a form isn't a proper partnership response.

While the respondent did not view these referral arrangements as a form of trauma-informed care per se, they did feel that a shared language and knowledge about trauma did improve referrals and conversations taking place between front door practitioners and CSC social workers. In this example, a shared TIC understanding was facilitated by training provided to all frontline children's services staff across the area.

9. Adopting a trauma-informed ethos and written policies

The TIC literature has always assumed that a commitment to organisational change is essential for TIC activities to be effective. While this commitment might be expressed through leadership or training, written policies and protocols are recognised within the SAMHSA protocol as essential for trauma-informed principles to become 'hardwired' into the activities of the organisation.[39]

Evaluations of trauma-informed activities suggest, however, that organisational policies are rarely implemented in comparison to the other TIC components identified in the literature. It is therefore not surprising that only eight of the 41 survey participants responding to this question stated that their team had formally adopted a trauma-informed ethos, and only six had written and implemented specific TIC policies. Examples of these policies included principles of collaborative working and guidelines involving the language that should be used by families and children.

10. Trauma-informed leadership

Strong leadership is consistently identified as central to the effectiveness of any trauma-informed practice.[40] However, findings from the survey suggest that less than a quarter of the areas responding to the question (six out of 41) had a named leader. In four cases, this individual was a clinical psychologist who was responsible for coordinating the work between the CSC team and CAMHS. In the remaining two cases, the individual was responsible for coordinating the interagency working between the CSC team and schools.

11. Additional services and activities delivered as part of trauma-informed care

At the end of the survey, respondents had the opportunity to mention any other activities implemented by their service that they considered to be a form of TIC. New activities identified in this section included a social media campaign about trauma to show 'the world and our workforce that we are a caring and compassionate organisation,' as well as ACE awareness training for parents. Two teams also mentioned that they were working with

39 Elliott, et al., 2005; SAMHSA, 2014b

40 Lowenthal, 2020

consultants to conduct a diagnostic exercise to better understand the effectiveness of their relationship-building activities, including the quality of relationships between managers and practitioners, as well as practitioners and families.

How are trauma-informed activities perceived to add value to children's social care?

In-depth interviews were conducted with leads of 10 CSC teams to better understand the benefits of TIC from the perspective of social workers. Participants were first asked to describe the history of TIC activities within their team, and then create a theory of change diagram with the interviewer to identify the following elements:

1. the problem or need TIC activities aimed to address; in other words, why it was needed
2. assumptions as to why TIC activities could add value to CSC practice
3. any training that practitioners may have attended
4. practice changes that could be linked to the TIC training
5. therapeutic work, that may include trauma-specific treatments
6. any short-, medium- and long-term benefits for staff, the service or children and families.

Figure 2 below provides a composite summary of their responses. Elements highlighted in bold are elements mentioned three or more times; those depicted in plain text are those mentioned only one or two times.

1. Why were trauma-informed care activities needed?

At the beginning of the in-depth interviews, participants were asked to describe how TIC activities were first introduced to their team. In several cases, TIC practices were initiated to address a specific issue that had been identified through a service audit or Ofsted review. Examples of these issues included higher than precedented numbers of looked-after children, high levels of referrals to children's social care, or high numbers of Section 47s. Issues with staff retention were also commonly mentioned. As one participant explained, the CSC team was 'overheating' as staff were becoming overwhelmed by high caseloads.

Interestingly, it was also not uncommon for TIC training to be initiated as the result of an external recommendation or the principal social worker's previous experience. In these cases it was clear that TIC activities were introduced as a result of area-wide training involving all frontline staff, rather than any need identified within the CSC team.

2. Why might trauma-informed care add value to children's social care practice?

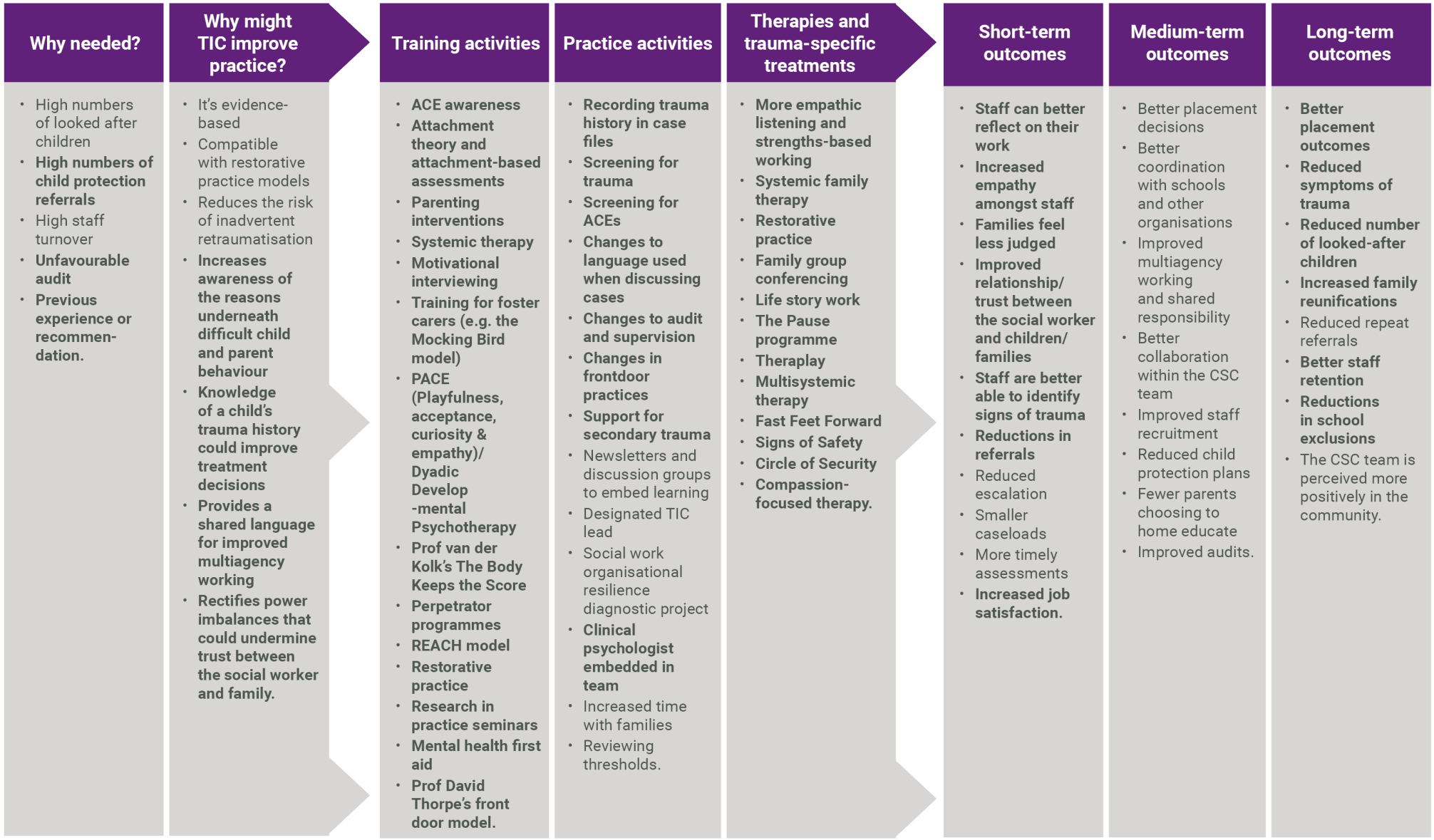
When considering this question, most interview participants felt that an increased awareness of the impact of trauma on children's development would result in better treatment decisions:

> *Not only just addressing the behaviour but addressing the underpinning drivers* [equips practitioners] *to see things differently and deliver interventions that are more in line with the issues that the children are experiencing.*

Additionally, many respondents believed that adopting trauma-informed principles could potentially rectify power imbalances between families and social workers, which would in turn facilitate trust between the social worker and the family:

FIGURE 2

A composite theory of change for trauma-informed care within children's social care teams



Elements highlighted in **bold** are elements mentioned three or more times; those depicted in plain text are those mentioned only one or two times.

> *It's starting with the family and where they are, and how you enter into your communication and how you build trusting relationships. And it's the 'what's happened to you?' rather than the 'what's wrong with you?' approach. And then starting with that in the hope that you're empowering the child or young person's family to — through a strong relationship with, with the workers who are supporting them — find their own way through to develop that resilience, and hopefully to reduce and stop that cycle of re-entry and referral across the family.*

Many of the interview participants also felt that TIC training provided them with a shared language that improved the quality of their multiagency work:

> *I think that we have a shared language, at least in our* [local] *team, we know what we're taught, we know what we mean, when we say that's a strength-based approach that you've taken there. We'll all know what we mean. And in the medium term, our partners will know what we mean. And they'll be using the same language too.*

In two of the in-depth interviews it was also clear that TIC principles were adopted because they were perceived to be evidence-based. In other words, the social workers assumed that TIC principles had a strong likelihood of improving practice because they had been previously tested.

3. Training activities

Findings from the in-depth interviews made clear that social workers engaged in a wide variety of training activities on a regular basis, with participants identifying between five and 12 different activities taking place within their teams. It was also clear that TIC/ACE principles were only one of many different topics covered during the training. Training about TIC/ACEs was most often provided by UK developers (for example, the REAch[41] programme developed by Warren Larkin Associates), although US providers were also mentioned (for example, Dan Hughes' PACE model,[42] and Professor Bessel van der Kolk's 'How the Body Keeps the Score' training[43]). Information about child–parent attachment was also commonly included in training covering ACEs and trauma-informed principles.

It was also clear that many social workers received training to deliver parenting interventions (for example, the Incredible Years or the Solihull Approach) and specific therapies (for example systemic family therapy). These models are described in greater detail under section 5 below. A full list of the training providers is available in **appendix C**.

4. Practice activities

The in-depth interview participants identified a wide variety of practice activities that they considered to be a form of trauma-informed care. These activities included the 11 TIC components covered in the survey, as well as changes to thresholds, caseloads and time spent working with families. In some interviews, it was clear that these activities were viewed as a core part of children's social care, and not necessarily specific or unique to TIC. However, most agreed that the trauma-informed principles added value to their core work by providing them with a perspective that could enhance the quality with which core social work practices were delivered:

41 Routine Enquiry about Adversity in Childhood (REACh) programme. Available at **https://warrenlarkinassociates.co.uk/portfolio-items/routine-enquiry-about-adversity-in-childhood-reach-programme/**

42 Hughes, 2014

43 Van der Kolk, 2021

[The TIC] *training provides opportunities to enhance that continuous professional development. So, people are trained on adverse childhood experiences, how that might influence and impact on a child's development, on how they might communicate, how they might react in certain situations. That then informs how we look at appropriate placement choice – matching.*

I just think that understanding trauma will help us to build better relationships with children, young people and families so that we absolutely understand their daily experience, their lived experience, their historical experiences, and that we can work in a different way. And I think, ultimately, that will hopefully lead to different decisions in the longer term being made for children.

5. Therapeutic work with families including trauma-specific treatments

Although the in-depth interviews primarily considered activities traditionally associated with trauma-informed care, participants also frequently mentioned other social work activities aimed at changing problematic parent and child behaviours. For example, systemic family therapy was frequently identified as a strengths-based activity aimed at reducing child maltreatment and other problematic family interactions. Systemic family therapy assumes that child behavioural problems and maltreating parent behaviours have their roots within family interactions, rather than the characteristics of any one specific family member.[44] Therapists therefore work jointly with all available family members to identify solutions to reduce problematic interactions. Common solutions include strategies for improving family communication and resolving ongoing conflicts.

One in-depth interview participant remarked that systemic principles were rarely taught in UK social work programmes, despite being essential for family social work to be effective. It is worth noting that while systemic family approaches are widely viewed to be evidence-based, their effectiveness for reducing child maltreatment is limited.[45]

Restorative practice and other shared decision-making models were also frequently mentioned as a social work practice aimed at changing problematic behaviour. Restorative therapeutic models are also informed by systemic principles but are perceived to place a stronger emphasis on family strengths in comparison to more traditional forms of systemic work. A core component of restorative models is the family group conference (FGC), through which the social worker brings key family members together to consider how they are jointly and individually affected by problematic family interactions. When possible, the social worker then works with the family members as a group to develop a plan to improve family functioning in a way that meets every member's needs. The social worker's role during these conferences is to work with family members in a way that empowers them to create positive solutions, rather than do things 'to' them or 'for' them.[46]

The evidence for restorative practices is currently less established than that of systemic therapy, as few activities have been robustly evaluated.[47] However, WWCSC is conducting a randomised controlled trial (RCT) of the Leed's 'Family Valued' restorative model to determine whether it is effective in reducing the number of children going into care or being placed on the child protection register.[48] A RCT is also under way to understand the value of

44 Minuchin, 2018

45 Euser, 2015

46 Wachtel, 2013

47 Nurmatov, et al., 2020

48 What Works Children's Social Care- (WWCSC). The Family Valued Model – Trial Evaluation. Available at https://whatworks-csc.org.uk/research-project/family-valued-model-trial-evaluation/

family group conferencing prior to pre-proceedings for reducing looked-after status within 12 months of the pre-proceeding.[49]

Trauma-specific treatments, such as creative life story work (CLSW), were also frequently mentioned during the in-depth interviews. CLSW encourages children to create a book, film or audio recording as a means of coping with a traumatic experience, out-of-home placement or adoption.[50] Although studies show that children and parents often value CLSW activities, few have considered their long-term impact on children's emotional wellbeing or behaviour. WWCSC is currently conducting an RCT of the Blue Cabin CLSW model, and knowledge about the programme's impact on children's behaviour and placement stability should be available in 2022.[51]

Other trauma-specific treatments mentioned in the in-depth interviews included trauma-focused CBT, Theraplay and Circle of Security. In all examples, it appeared that this support was offered to children and parents by agencies external to the CSC team, including CAMHS. Trauma-focused CBT has strong evidence of improving the mental health outcomes of children exposed to high levels of trauma. There is also evidence showing that Theraplay might similarly improve mental health outcomes associated with trauma, although it has yet to be rigorously evaluated.[52] Circle of Security was assessed by EIF as having preliminary (level 2) evidence for improving children's behaviour, although its impact on symptoms of trauma is yet to be tested.[53]

6. Short-, medium- and long-term benefits of trauma-informed care principles and activities

All in-depth interview participants agreed that TIC principles and activities had been beneficial for their team and identified a range of short-, medium- and long-term outcomes for their staff, service and clients.

Staff

Nearly all the in-depth interview participants remarked that knowledge of the TIC principles had the potential to improve the quality of their practitioners' work and job satisfaction in the short term. This was because the social workers would feel better supported and find their work more rewarding:

> *I think* [this] *knowledge is really powerful for people because they feel that they can put that into practice. It's more about job satisfaction then, isn't it, because if you're just constantly going around in circles and dealing with the same thing, and you can practically predict some of your* [poor] *outcomes. I think if you can start to see a difference when you're working in a different way, it gives you that little bit of a boost. And I think that will really help, particularly with staff feeling rewarded with the work that they're doing. And that would hopefully also impact on retention.*

Many also felt that increased job satisfaction would lead to increased staff retention in the medium or long term. In this respect, some of the in-depth interview participants also felt that TIC training could increase the team's success in recruiting new social workers:

49 WWCSC. Evaluation of Family Group Conferences at Pre-proceeding Stage. Available at https://whatworks-csc.org.uk/research-project/evaluation-of-family-group-conferences-at-pre-proceedings-stage/

50 Aust, 1981

51 WWCSC. Evaluation of Creative Life Story Work. Available at https://whatworks-csc.org.uk/research-project/evaluation-of-creative-life-story-work/

52 Money, et al., 2020

53 Cassidy, et al., 2017

This kind of approach would possibly help with recruitment. When we train and offer this real commitment to invest in the model and all the training that comes with it, it would help us to become more attractive.

Service

Many of the in-depth interview participants were also quick to link TIC activities to benefits for their service. In the short term, most believed these benefits would include the quality of support social workers provided to children and families. In the medium term, improvements would be evident at the level of audit. In the long term, some participants were optimistic that their service's reputation would be strong enough to recruit social workers at the national level:

I think it would be good to be able to say that social workers will want to come and work in [our local authority] *and stay in* [our local authority].

Children and families

The in-depth interview participants were consistently clear that the primary beneficiaries of their TIC approach were children and parents. Specifically, participants felt that a deeper awareness of trauma would help practitioners better understand the needs of their children and families, which would increase service satisfaction in the short term, as families would feel less judged and therefore more motivated to engage in the service. In the medium term, family members engaging in services would demonstrate greater resilience, leading to permanent reductions in trauma, and improvements in child and parent functioning:

And then, I suppose the longer-term outcomes would be them feeling like they're able to move on from the trauma and, and I suppose other general outcomes, improved outcomes. So it's a nice stability in relationships, or being able to go back to work or whatever the situation might be.

Are specific models of trauma-informed care offered by children's social care teams, and are they amenable to rigorous evaluation?

The fourth aim of this study was to consider the extent to which clear and consistent models of TIC were sufficiently specified, so that a robust evaluation could be conducted. The short answer to this question is no, as this study was unable to identify any single model of TIC that was shared by multiple CSC teams. Instead, TIC activities appeared to be highly varied, in terms of their intensity, and the combination of TIC components delivered.

This study also observed a high degree of overlap between TIC activities and activities core to CSC. Indeed, several social workers commented that the term 'trauma-informed' had become a rebranding of many activities traditionally considered standard CSC practice. It may therefore be difficult for future evaluations to determine the extent to which TIC activities could add a measurable value to CSC services, unless a case can be made that they are sufficiently different from standard practice. A key challenge for any future TIC evaluation will therefore be to identify activities that are sufficiently different from standard CSC practice and sufficiently intensive so that a measurable difference can be observed. We consider three options below where this might be feasible.

1. A robust comparison group evaluation

Although the current study did not identify any specific model of TIC, it did identify five areas where eight or more TIC components were delivered. In two cases, it was clear that these

activities resulted in referrals to trauma-specific treatments. Hence, a future evaluation could compare the benefits achieved by trauma-specific treatments delivered within the context of TIC to those delivered in TIC's absence. Examples of the short-term outcomes that might be investigated include the extent to which TIC activities improved the engagement and retention of vulnerable families in evidence-based treatments, as well as the extent to which TIC activities contributed to the greater practitioner satisfaction and retention. Longer-term outcomes might include more stable placement decisions and improved child outcomes.

Although an RCT would represent the most robust test of TIC, it is unlikely to be feasible because of the strong overlap between TIC and standard social work practice. The cost of conducting an RCT would also not be warranted given that a specific model of TIC does not yet exist. However, a robust comparison study could be conducted at considerably lower costs and still provide valuable information about the potential benefits of TIC activities. Before such an evaluation took place it would be necessary to clearly specify the ideal TIC model in terms of each of the components being delivered. This would mean clearly identifying what each component was, how it would best be implemented, and specific short- and long-term outcomes it aimed to achieve.

2. A pre- and post-study of individual trauma-informed care components

A second evaluation option would be to select a single TIC component and evaluate its impact in isolation of the other TIC components. This would require establishing a baseline of service performance in the absence of the TIC component which would provide a point of comparison after the component was added. While this evaluation design would not be sufficient for testing causal assumptions, it would be adequate for considering the potential of individual TIC components for enhancing practice if they represent a significant departure from what was delivered before.

For example, this study observed that 89% of the CSC teams participating in this study received some form of TIC training. It would therefore be possible to evaluate what had been learned through this training through a pre- and post- training test, as well as whether this training changes practitioners' attitudes towards the families they worked with. The impact of this training could then be further evaluated against specific service outputs, including greater family retention and improved practitioner satisfaction.

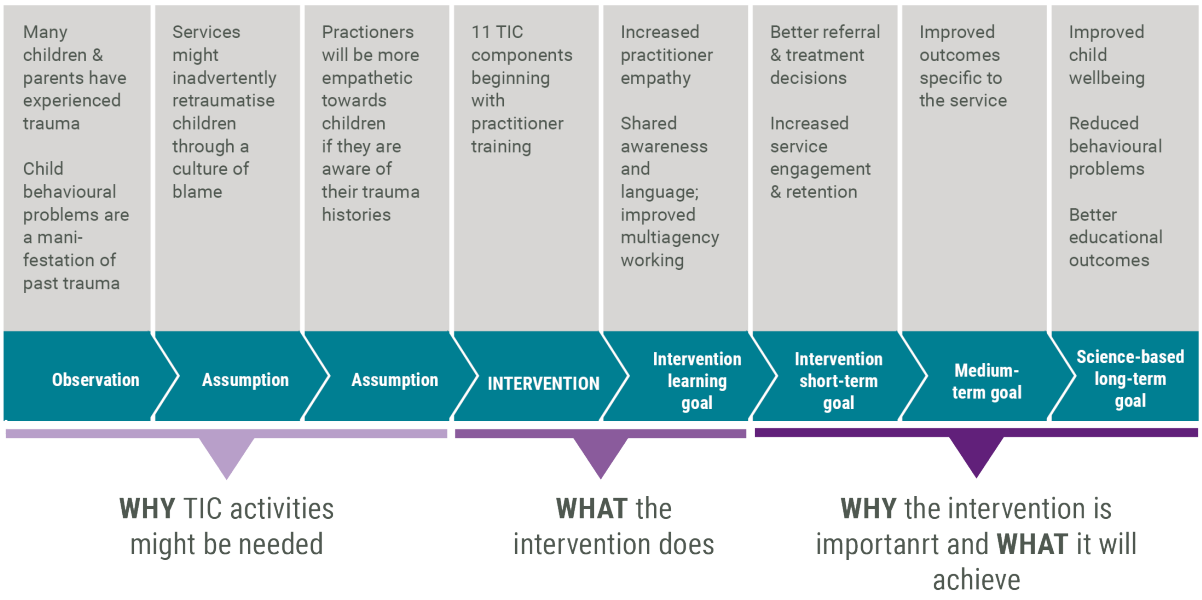
3. A quasi-experimental study of area-wide trauma-informed care activities

This study identified several instances where trauma-informed training was delivered to all frontline children's services staff within a single local authority. It might therefore be possible to conduct a large-scale study that compared population outcomes in 'high intensity' TIC areas to areas where there was less TIC activity.

Figure 3 below provides a generic TIC theory of change informed by the dominant views of the social workers participating in this study that could be tested.

FIGURE 3

A generic theory of change for trauma-informed care



This theory of change assumes that children and families may inadvertently be retraumatised through practices which are a result of a lack of practitioner awareness and judgmental attitudes. It also assumes that an increased awareness of trauma and its impact might help staff identify practices that are potentially harmful and replace them with activities that would improve their ability to understand and support the needs of vulnerable individuals.

Training might therefore be introduced to improve practitioners' awareness of trauma, their empathy for vulnerable families, and their skill in implementing various strengths-based practices. Additional training aims might also include a shared interagency language that could lead to improved multiagency working.

Each of these short-term learning goals could be explicitly tested, although it would also be necessary to develop suitable measures, as few validated measures of TIC practice currently exist. These measures do not need to be complicated; validation could take place as part of the first phase of the study.

Improved service outcomes could also be explicitly tested, although these will need to be specific to the service. Longer-term measures of child wellbeing also could be tested through validated surveys of child wellbeing conducted in schools. Administrative outcomes, such as school attendance, school achievement and referrals to the criminal justice system also could be compared, although it is unlikely that this information would be sufficiently sensitive enough to measure differences in children's mental health outcomes.

Although such an evaluation would be expensive, it provides several advantages over the previous two options. First, it would provide insight into how TIC activities might add value to other children's services where there is less of an overlap between TIC and standard practice, as there is with CSC. Second, such an evaluation would provide an opportunity to robustly test the causal relationship between TIC activities and their intended outcomes, as it would provide a sample that was sufficiently large to observe a measurable change. Third, area-wide training across all of children's services is taking place already. A sufficiently robust evaluation of this training is therefore justified, given the time and money already currently being invested in these activities.

Conclusions and recommendations

What have we learned?

In this study, we investigated the perceived benefits of TIC for improving the outcomes of children known to children's social care. Four key findings stand out:

1. **Trauma-informed care is widely used and perceived to add value to children's social care.** Eighty-nine percent of the study participants reported that their team engaged in at least one trauma-informed activity, and all were confident that TIC practices would improve the likelihood of positive family outcomes. Common benefits associated with trauma-informed care included a shared language that could be used across children's services, increased family retention and engagement, and improved treatment decisions.
2. **No single model of TIC currently exists within children's social care teams in England.** While many of the CSC teams engaged in activities consistent with those traditionally associated with TIC, there was little consistency in how these activities were delivered. Only one-fifth of the study participants reported that their team had a shared definition of trauma-informed care or made use of written guidelines or protocols.
3. **There is a high degree of overlap between TIC activities and standard children's social care practice.** Many social workers viewed TIC as a strengths-based activity that would help them better engage families and reduce child maltreatment behaviours. In this respect, several observed that many TIC activities did not represent a significant departure from standard social work practices, meaning that TIC did not necessarily represent new ways of working in CSC.
4. **Trauma-informed activities rarely led to evidence-based interventions.** Although this was the original intention of trauma-informed care, our study observed that trauma-informed care led to evidence-based treatments in only two instances. More often, TIC activities were offered alongside social work practices that had a less established evidence base. These activities included front door practices used to assess child maltreatment risk, as well as shared decision-making activities aimed at helping families find solutions for their current problems. WWCSC is currently evaluating many of these activities, and knowledge about their efficacy should be available within the next two years.

What should we do now?

There are three implications from these findings.

1. **We need a clear and consistent definition of trauma-informed care.** This study observed a high degree of variation in how trauma-informed care was defined and used within children's social care. We believe that a lack of a clear definition could increase inconsistencies in practice and reduce the overall quality of social work services.

Given the growing popularity of trauma-informed care in schools, the criminal justice system and other frontline practices, we feel that clarity about what trauma-informed care is and is not, is essential. We believe that clarity will not only improve commissioning decisions, but also increase the standard of what is offered in terms of trauma-informed training.

Recommendation: Central government departments, including the Department for Education, the Home Office, the Department of Health and Social Care, and the Department for Levelling Up, Housing and Communities, should work together to agree a core definition of trauma-informed care.

This definition should be rooted in the original definition developed by SAMHSA, with a clear understanding of its relationship to trauma-specific treatments. Local areas should then be encouraged to use this definition when commissioning trauma-informed training and delivering services.

2. **The benefits of trauma-informed care must be identified and evaluated.** Given the popularity and public investment in trauma-informed care, it is essential that we know what its intended public health benefits are. This not only means knowing the benefits for children's social care, but also in schools, the criminal justice system and other frontline practices.

Recommendation: Government departments should prioritise robust evaluation of models of trauma-informed care training and practice in different service contexts.

Departments should build on the current work they are doing to support trauma-informed practice by working to get a robust evaluation of the strongest models off the ground in the different settings in which these models are being used. Any future funding of trauma-informed approaches should be linked to this and designed and delivered in a way that enables robust evaluation of impact.

The current study was successful in identifying several potential benefits resulting from trauma-informed care contributing to improved treatment decisions. Examples of these benefits include a deeper awareness of child trauma, a shared language that might facilitate multiagency working, and increased family engagement. It would be useful to further specify what these benefits are so they can be tested and then respecified, to ensure consistency and quality in their delivery.

3. **Trauma-informed care should never be used as a replacement for evidence-based, trauma-specific treatments.** In this study, we observed that most trauma-informed activities were offered in the absence of interventions with established evidence of reducing the negative impact of trauma. This finding is striking, as trauma-informed care was never intended as a replacement for evidence-based treatments, but rather as a way of increasing engagement in them.

Recommendation: The availability of effective, trauma-specific interventions should be prioritised and linked to any future investment in trauma-informed care.

There is no question that traumatic experiences have negative, long-term consequences, particularly when they involve maltreatment behaviours that are frequent and intense. In these circumstances, children risk developing a range of mental health problems that could negatively impact their life chances. We therefore owe maltreated children access to treatments with the strongest evidence of reducing the impact of trauma and improving their overall wellbeing. Perhaps most important, we should not lose focus on this need as we investigate the potential of trauma-informed care.

Our 2020 report, *Adverse Childhood Experiences: What we know, what we don't know and what should happen next,*[54] identified 33 interventions with evidence of preventing childhood adversities or reducing their negative impact. Four of these are trauma-specific treatments, but the findings from our study suggest that these interventions are available in only a handful of areas. This study has provided more evidence that treatments with evidence of reducing trauma are often not being provided or linked to models of TIC. Future investment in TIC training and related activities either nationally or locally should therefore include access to these evidence-based, trauma-specific treatments. We need to return TIC to its rightful place and enable it to make its contribution to increasing engagement in treatment, as originally intended through greater availability of interventions with established evidence of reducing the negative impact of child trauma.

Conclusion

Trauma-informed care was originally introduced to help engage vulnerable individuals in evidence-based mental health treatments. It has since been expanded to a broad set of principles that have been adopted by schools, child protection services and the criminal justice system. This expansion reflects widespread enthusiasm for the trauma-informed principles and optimism that their use will lead to measurable benefits for children and adults.

However, we still do not yet know if these benefits can be realised, especially in the absence of trauma-specific treatments. Given the growing enthusiasm and investment in trauma-informed approaches, we believe this knowledge is essential for guiding future national policies and local practice decisions aimed at supporting vulnerable families through public services.

54 Available at: **https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next**

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Appendix A
Mapping Exercise – Practitioner survey

Purpose of the survey

Thank you for agreeing to participate in the Early Intervention Foundation's survey on the use of trauma-informed care within English, local authority based, children's social care teams. EIF is an independent charity which champions and supports the use of effective early intervention for children at risk of poor outcomes. As a member of the UK's What Works Network, we are a key source of evidence and advice on effective early intervention for children and young people.

This mapping exercise has been developed in partnership with What Works Children's Social Care, to better understand how trauma-informed activities are being used in children's social care teams through England. In particular, we are interested in understanding more about the perceived value of these activities for children and parents. The information gained from study will then be used to identify outcomes that can be tested through further evaluation.

Our aim is that every principal social worker or quality assurance lead from each local authority complete this questionnaire, so that we can have a complete understanding of the use of trauma informed care in the England and its potential benefits.

Our pilot testing suggests that it will take between five and 15 minutes to complete this questionnaire, depending on the extent to which trauma informed care has been implemented within your team. It is also not necessary to complete this questionnaire in one sitting, as it is possible to save your responses and return to it when needed.

We would be grateful if you could complete this survey before January 22nd, 2021. We appreciate that this is a very busy time of year, so are providing a £20 gift voucher upon completion of the survey as a thank you for your time.

There will also be further opportunities to tell us more about your trauma activities. If you would like to participate in a further interview, please check 'yes' in the box provided at the end of this survey.

All responses will be anonymised by EIF and stored on our secure web server, in compliance with current GDPR standards.

If you have any further questions about this questionnaire or how your data will be used, please do not hesitate to contact Dr Kirsten Asmussen at kirsten.asmussen@eif.org.uk.

Part I: Demographic information

Q1. Using the Qualification and Credit Framework, what is your highest qualification?	
	QCF Level 5 and below (Foundation degree, Diploma, A-level, or equivalent)
	QCF Level 6 (Undergraduate degree or equivalent)
	QCF Level 7 (Masters degree or equivalent)
	QCF Level 8 (Doctorate studies or equivalent)

Q2. How many years have you practiced?	
	Less than 12 months
	1 year to 2 years
	3 years to 5 years
	6 years to 10 years
	Over 10 years

Q3. How large is your social care team?	
	Less than 5
	5 to 10
	11 to 20
	21 to 50
	More than 50

Part II: Definitions of trauma-informed care

Q4. Does your practice engage in any activities considered as trauma-informed care?	
	Yes
	No

Q5. Does your service have a specific definition for trauma-informed care?		
	Yes	
	No	Skip to Q7
	Not sure	

Q6. If yes, what is this definition?
Open text box

Q7. If no, can you please tell us in your own words what you think trauma informed care is? Also, please feel free to tell us if you are unsure.
Open text box

Part III: Trauma-informed care activities

We are interested in understanding the extent to which children's social care services engage in the following activities and whether they are viewed as a form of trauma-informed care.

A. Training
B. Secondary trauma
C. Cross-agency collaboration and referral systems
D. Within-agency collaboration
E. Screening for trauma history and adverse childhood experiences
F. Recording trauma history or adverse childhood experiences in case files
G. Strengths-based support
H. Increasing the safety of the physical environment
I. Adopting a trauma-informed ethos
J. Trauma-informed leadership
K. Additional trauma-informed care activities.

The next section of this questionnaire focusses on these 11 activities that are frequently described as forms of trauma-informed care. We will ask you a series of questions on each activity exploring the statements below:

1. If your practice has engaged in this activity.
2. Whether the activity is defined or implemented as a form of trauma-informed care.
3. Whether training took place to inform the delivery of this activity.
4. The benefits you believe this activity provides your team.
5. The extent to which this activity has resulted in specific changes within your service.
6. The extent to which you this activity has provided benefits for children, parents and other family members.

A. Training

Q8. Staff have undergone training to increase their awareness of ACEs and the impact of trauma and abuse on children's development		
	Yes	
	No	Go to Q21
	Not sure	

Q9. If yes, what did the content cover? (please check all that apply)	
	The impact of adverse childhood experiences on adult outcomes
	Toxic stress
	Attachment security
	Building resilience
	Strength-based working
	Building trust
	Creating a shared language
	The importance of trusting and safe relationships
	Strategies for avoiding re-traumatisation
	Strategies for increasing emotional safety
	Strategies for increasing physical safety
	Other
Open text box	

Q10. What was the length of this training	
	Two hours or less
	A half a day
	A full day
	Multiple days
	Other
Open text box	

Q11. Who attended this training?	
	A selection of staff
	Frontline staff only
	The management team
	The entire team
	Staff external to the organisation (if so, please write in).
Open text box	

Q13. How much money was spent on this training?	
	Less than £100 per staff member
	£100 to £500 per staff member
	£501 to £1000 per staff member
	Over £1000 per staff member
	A fixed fee (if so, please write in)
Open text box	
	Don't know or can't remember

Q14. Who was your training provider?	
Open text box	
	Not sure

Q15. Has your practice received further consultancy support from this training provider?	
	Yes
	No
	Not sure

Q16. How valuable do you feel this training has been for your practice?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

Q17. What do you feel are the primary benefits from this training (we recognise that they are like-ly to be multiple benefits, but please select which one you feel is the primary benefit in comparison to the others).	
	Child and parent outcomes (for example, improved well-being, reduced violence or mal-treatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satis-faction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff re-tention)
	Other
Open text box	

Q18. What do you view as the most important secondary benefit from this training (please select a second potential benefit from the training)	
	Child and parent outcomes (for example, improved well-being, reduced violence or mal-treatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satis-faction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff re-tention)
	Other
Open text box	
	No additional benefits

Q19. Has this training led to specific changes within your service?		
	Yes	
	No	Go to Q21
	Not sure	

Q20. If yes, what are these changes?	
Open text box	

B. Secondary trauma

Q21. My practice has introduced strategies and/or procedures to address or reduce secondary traumatic stress among our staff		
	Yes	
	No	Go to Q25
	Not sure	

Q22. If yes, please briefly describe what these strategies are	
Open text box	
	Not sure

Q23. Did the staff receive specific training in these strategies and procedures?		
	Yes	
	No	Go to Q25
	Not sure	

Q24. How valuable do you feel activities aimed at reducing secondary trauma amongst staff have been for your practice?
Highly valuable
Somewhat valuable
Not sure
Limited value
No added value

C. Cross-agency collaboration and referral systems

Q25. Trauma informed activities has led our children's social care team to introduce new proce-dures to improve the communication and collaboration with external agencies with the aim of improving our response to child and family trauma.		
	Yes	
	No	Go to Q31
	Not sure	

Q26. If yes, please briefly describe what these procedures are, as well as the external services and interventions involved in this increased collaboration.		
Open text box		
	Not sure	

Q27. Does any of this cross-collaboration involve the delivery of evidence-based interventions or services? By evidence-based, we mean manualised activities that are underpinned by robust evaluation evidence.		
	Yes	
	No	Go to Q29
	Not sure	

Q28. If yes, what is the name(s) of this/these evidence-based service or intervention(s)?	
Open text box	
	Not sure

Q29. Did the staff receive specific training to increase this collaboration or establish specific referral procedures?		
	Yes	
	No	Go to Q31
	Not sure	

Q30. How valuable do you feel this cross-agency collaboration has been for your practice?
Highly valuable
Somewhat valuable
Not sure
Limited value
No added value

D. Within-agency collaboration

Q31. We have explicitly increased the collaboration, service coordination, and information sharing among staff within our own service to prevent or reduce the trauma experienced by children, parents and other family members		
	Yes	
	No	Go to Q36
	Not sure	

Q32. If yes, please briefly describe the nature of this collaboration	
Open text box	
	Not sure

Q33. Has any of this increased collaboration resulted in the delivery of evidence-based interven-tions by members of your team? By evidence-based, we mean manualised activities that are underpinned by robust evaluation evidence.		
	Yes	
	No	Go to Q36
	Not sure	

Q34. If yes, what is the name(s) of this evidence-based service or intervention?	
Open text box	
	Not sure Not sure

Q35. Was it necessary to increase the number of practitioners within your team with the skills and qualifications to deliver the intervention(s)?	
	Yes
	No
	Not sure

E. Screening for trauma history and adverse childhood experiences

Q36. Does your practice actively screen or assess each child's trauma history or trauma-related symptoms or problems?		
	Yes	
	No	Go to Q51
	Not sure	

Q37. Have screening activities been introduced explicitly as a form of trauma-informed care?	
	Yes
	No
	Not sure

Q38. Do you routinely ask children and parents about their history of adverse childhood experiences?		
	Yes	
	No	Go to Q40
	Not sure	

Q39. Do adverse childhood experiences history taking activities result in child or family members receiving an ACE (adverse childhood experiences) score?	
	Yes
	No
	Not sure

Q40. Does your practice use any validated diagnostic tools (other than ACE scores) to screen children or families for trauma and trauma-related symptoms?		
	Yes	
	No	Go to Q44
	Not sure	

Q41. If yes, what is/are the name(s) of this/these tool(s)?
Open text box

Q42. Is training necessary to use the(se) assessment tool(s)?		
	Yes	
	No	Go to Q44
	Not sure	

Q43. How are staff trained to use your assessment tool(s)?
Open text box

Q44. Do screening activities lead to a referral to a specific treatment/intervention?		
	Yes	
	No	Go to Q46
	Not sure	

Q45. If yes, what is/are these treatments or interventions? (Please put “N/A” if you’re unsure or can’t remember)
Open text box

Q46. Are screening activities used to inform placement decisions?		
	Yes	
	No	Go to Q48
	Not sure	

Q47. If yes, how are these screening activities used?
Open text box

Q48. How valuable do you feel your practice's assessment activities are for improving child or family outcomes, or greater efficiencies within your practice?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

Q49. What do you perceive as the primary benefit of your practice's assessment activities? (We recognise that they are likely to be multiple benefits, but please select which one you feel is the pri-mary benefit in comparison to the others).	
	Child and parent outcomes (for example, improved wellbeing, reduced violence or maltreatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satis-faction; increased efficiency)
	Service (for example, increased efficiencies in terms of time and cost; increased staff retention)
	Other
Open text box	

Q50. What do you perceive as the most important secondary benefit of your practice's assess-ment activities? (please select a second potential benefit)	
	Child and parent outcomes (for example, improved wellbeing, reduced violence or maltreatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satisfaction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff retention)
	Other
Open text box	
	No additional benefits

F. Recording trauma history or adverse childhood experiences in case files

Q51. Is the child's trauma history included in his or her case record/file/service plan?		
	Yes	
	No	Go to Q56
	Not sure	

Q52. If yes, was this activity introduced explicitly as a form of trauma-informed care?	
	Yes
	No
	Not sure

Q53. Did the staff receive specific training on how to record the child's trauma history in his or her case files?	
	Yes
	No
	Not sure

Q54. How valuable do you feel this activity is?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

Q55. What do you perceive as the primary benefits of recording children or family member's trauma history in his/her case file? (we recognise that they are likely to be multiple benefits, but please select which one you feel is the primary benefit in comparison to the others).	
	Child and parent outcomes (for example, improved well-being, reduced violence or mal-treatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satis-faction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff re-tention)
	Other
Open text box	

G. Strengths-based support

Q56. We aim to provide services that are strength-based and promote positive child develop-ment		
	Yes	
	No	Go to Q63
	Not sure	

Q57. If yes, has a strengths-based approach been introduced explicitly as a form of trauma-informed care?		
	Yes	
	No	
	Not sure	

Q58. Can you please briefly describe the nature of your strengths-based activities?
Open text box

Q59. Have you introduced specific procedures or guidelines to ensure that a strength-based approach is adopted by your staff?		
	Yes	
	No	Go to Q61
	Not sure	

Q60. If yes, can you please briefly describe what these procedures and guidelines are?
Open text box

Q61. Was any specific training used to help your staff adopt a strengths-based approach or implement strengths-based activities?	
	Yes
	No
	Not sure

Q62. How valuable do you fell adopting a strengths-based approach has been for your practice?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

H. Increasing the safety of the physical environment

Q63. We have made changes to ensure that our physical environment is safe and provides a pos-itive and welcoming atmosphere		
	Yes	
	No	Go to Q70
	Not sure	

Q64. If yes, have these changes been made explicitly as a form of trauma-informed care?	
	Yes
	No
	Not sure

Q65. Please briefly described the kinds of changes that have been implemented?
Open text box

Q66. How long ago were these changes implemented?	
	Within the past 12 months
	Within the past five years
	Within the past ten years
	Not sure

Q67. How valuable do you these changes in the physical environment been for your practice?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

Q68. What do you perceive as the primary benefit of implementing these changes to the physical environment (we recognise that they are likely to be multiple benefits, but please select which one you feel is the primary benefit in comparison to the others).	
	Child and parent outcomes (for example, improved well-being, reduced violence or mal-treatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satis-faction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff re-tention)
	Other
Open text box	

Q69. What do you perceive as the most important secondary benefit from increasing the safety of the physical environment? (please select a second potential benefit)	
	Child and parent outcomes (for example, improved wellbeing, reduced violence or maltreatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satisfaction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff retention)
	Other
Open text box	
	No additional benefits

I. Adopting a trauma-informed ethos

Q70. We have developed and implemented written policies that explicitly support a trauma-informed ethos and principles		
	Yes	
	No	Go to Q76
	Not sure	

Q71. If yes, please briefly describe what these policies and principles are.
Open text box

Q72. Have you introduced specific procedures or guidelines to ensure that these policies or principles are adhered to?	
	Yes
	No
	Not sure

Q73. How valuable do you feel these trauma-informed principles are for your team and your service?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

Q74. What do you perceive as the primary benefit of these trauma informed principles? (we recognise that they are likely to be multiple benefits, but please select which one you feel is the primary benefit in comparison to the others).	
	Child and parent outcomes (for example, improved wellbeing, reduced violence or maltreatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased wellbeing and job satisfaction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff retention)
	Other
Open text box	

Q75. What do you perceive as the most important secondary benefit from adopting these principles? (please select a second potential benefit)	
	Child and parent outcomes (for example, improved well-being, reduced violence or mal-treatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satis-faction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff re-tention)
	Other
Open text box	
	No additional benefits

J. Trauma-informed leadership

Q76. Our service has a defined leadership position or job function specifically related to TIC.		
	Yes	
	No	Go to Q84
	Not sure	

Q77. What is the specific title? (Please put "N/A" if you're unsure or can't remember)	
Open text box	
	Not sure

Q78. What are the specific duties associated with this position? (Please put "N/A" if you're unsure or can't remember)	
Open text box	
	Not sure

Q79. Is the position associated with any specific training, qualifications, or experience?		
	Yes	
	No	Go to Q81
	Not sure	

Q80. Please describe briefly what the experience, training or qualification is. (Please put "N/A" if you're unsure or can't remember)	
Open text box	
	Not sure

Q81. How valuable do you feel this leadership role is for your practice?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

Q74. What do you perceive as the primary benefits of this leadership position? (we recognise that they are likely to be multiple benefits, but please select which one you feel is the primary benefit in comparison to the others).	
	Child and parent outcomes (for example, improved wellbeing, reduced violence or maltreatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased wellbeing and job satisfaction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff retention)
	Other
Open text box	

Q75. What do you perceive as the most important secondary benefit of this leadership position (please select a second potential benefit)	
	Child and parent outcomes (for example, improved well-being, reduced violence or mal-treatment, reduced trauma; improved placement stability)
	Practitioner outcomes (for example, reduced stress, increased well-being and job satis-faction)
	Service (for example, increased efficiencies in terms of time and cost; increased staff re-tention)
	Other
Open text box	
	No additional benefits

K. Additional trauma-informed care activities

Q84. Does your service engage in any other trauma-informed activities not covered in the previous section?		
	Yes	
	No	Go to Q87
	Not sure	

Q85. If yes, please tell us briefly what these trauma-informed activities are
Open text box

Q86. How valuable do you feel these trauma-informed activities are for your team and your service?	
	Highly valuable
	Somewhat valuable
	Not sure
	Limited value
	No added value

Further Contact with the EIF.

Thank you for taking the time to complete this survey, we greatly appreciate it.

Below you will find an option to tell us if you would consent to being contacted by the EIF for a follow-up in-depth interview exploring your teams use of trauma-informed care. We would appreciate the opportunity to talk to practitioners to gain a greater understanding of the answers to the questions asked in this survey.

Q87. I consent to being contacted by the EIF for an in-depth interview.	
	Yes
	No

Appendix B
Topic Guide - interviews with practice leads

1. Introduction

- EIF is an independent charity which champions and supports the use of effective early intervention for children at risk of poor outcomes
- Earlier this year it published a review of the Adverse Childhood Experiences evidence, which included a summary of trauma informed care.
- The review identified that there is no single definition of trauma informed care, and its use and benefits are perceived differently across sectors and workforces.
- The Early Intervention Foundation (EIF) and What Works for Children's Social Care (WW-CSC) are now working together to explore how trauma-informed care (TIC) is defined and used within children's social care teams and how it is perceived to add value to services and provide benefits to children and families.
- You have been contacted because you or your manager agreed to participate an in-depth interview designed to explore these questions.
- *The interview will be divided into two parts. The first is to understand the history and use of trauma informed care within your service. The second is will consider more deeply your perceptions of the potential benefits of trauma informed care for the families your team works with, as well as potential benefits for your staff.*

- Consent for digital recording – phone/Zoom/Otter
- Reassure about confidentiality and how views will be reported
- Explain that their participation is voluntary
- Check interview length 45 mins
- Any questions before starting.

2. Brief introduction

- Briefly describe role and length of time in post

3. Understanding perceptions of TIC

- What is your understanding of trauma informed care?
- How would you describe trauma informed care? (refer back to the definition provided and ask if they still agree with that).

For those with an approach to TIC

Let's begin by you providing me a history of the trauma-informed care within your team.

Probes:

- What are you doing that has been named as/branded as trauma informed care?
- What (if any) activities do you engage with that might be described as trauma informed care?
    - » What are these activities?

    - What do they involve?

- **Why were these activities initiated?**
- How do trauma-informed activities your team is engaging in now compare to what you what the team was doing previously?
- How has an awareness impact of trauma and abuse on children's development been raised amongst staff?
- What training has been offered to your staff?
    - Who delivers this training?
    - Who is it offered to?
- What was the content of this training?
- What did you find the most interesting or beneficial about this training?
- How has this training influenced your practice?

What do you perceive to be the core components of your trauma informed approach?

- Who does the approach apply to; which families; which parts of the workforce (children and adult services)?
- When was it developed/launched; who developed the approach?
- How is approach to TIC described/defined?
- What are the primary intended outcomes associated with your TIC approach?
- **What do you perceive as the core components of your team's approach?**
- Which areas of work does their TIC approach cover (staff support and development, screening/assessing families and children, delivering services to families and children)?
- How (if at all) have existing activities/services/practices been adapted to support a more ACE and trauma informed way of working/approach?
- How if at all have staff job descriptions/roles changed to support your approach?
- Have you increased staff capacity to support the delivery of your TIC approach; in what way?
- What additional costs/funding needed to adopt a TIC approach?
- What plans to evaluate your TIC approach?

4. Working with families and children

- Does your team routinely assess children for ACE or trauma related symptoms or problems?
- How do these assessment procedures differ from what your team did previously?
- How is this more than just being sensitive/taking the wider context and family history into consideration?
- What (if any) new procedures/interventions/trauma specific support have been introduced?
    - What do they involve; who delivers them?
- Why these procedures/interventions?
    - How did you know they would be effective?

- How else has the way services are delivered been changed to be more trauma informed (e.g. changing the physical environment, case records, monitoring)?
- How (if at all) has your approach to trauma changed the way you are working with other teams/services (e.g. the way you collaborate and share information)?

5. Primary benefits of TIC

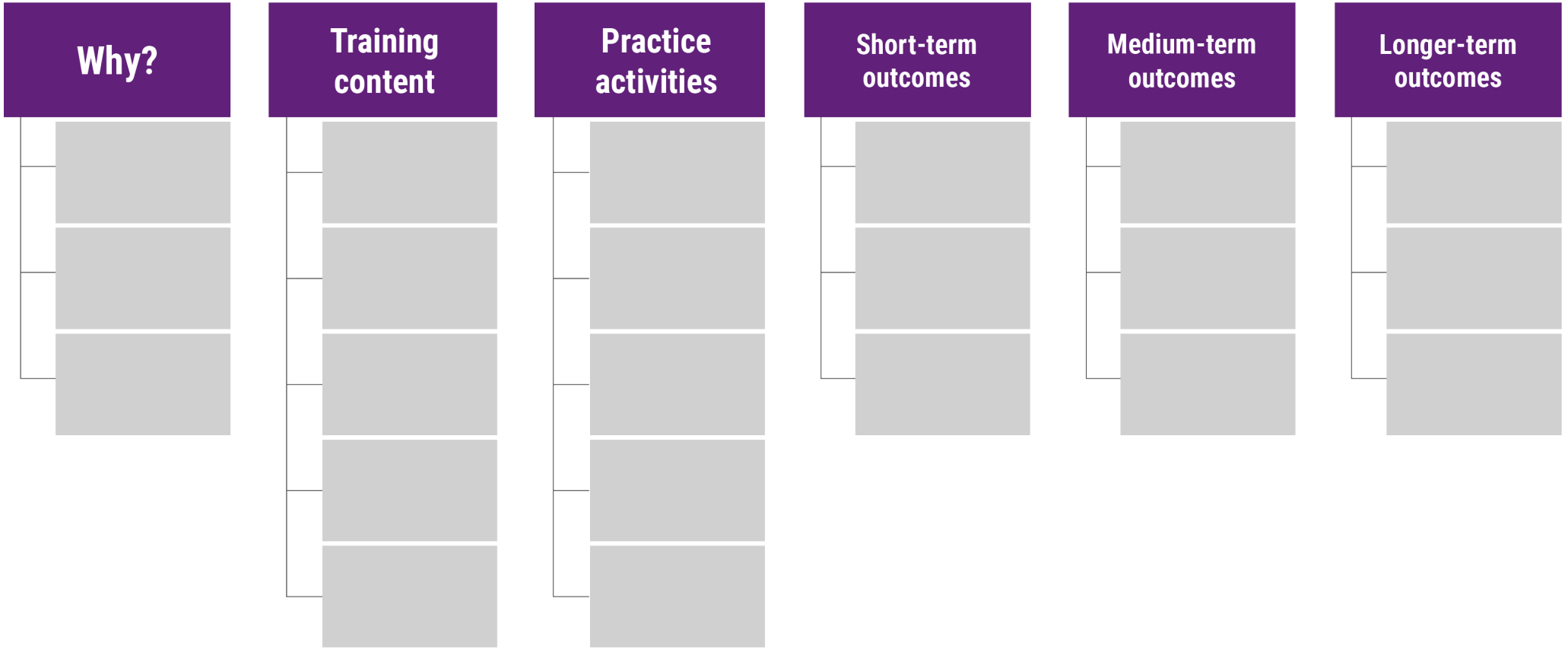
- A potential outcome of this exercise is to understand how best to evaluate the outputs and benefits of trauma-informed activities. In this second part of the survey, I am going to ask you to work with me to fill out the following diagramme.
- *(Introduce* **theory of change diagram***. Fill out from left to right).*

6. Reflections on the importance of TIC

- What do you see as being the main role and value of being more trauma informed in the way you work with families?
- How well is your current approach to trauma working?
- What is working well/less well?
- What do they see as being critical to being more trauma informed in the way you work with families and children?
- How well does the training and support equip staff to be more ACE and trauma informed?
- What (if any) other training is needed to ensure they are more ACE and trauma informed?

- What (if any) difference has being more trauma informed made to child, parent and family outcomes?
- What (if any) difference has being more trauma informed made to staff?
- What (if any) difference has being more trauma informed made to the way they deliver services?

Theory of change diagram - linking core activities to potential short-, medium- and long-term outcomes



Appendix C

List of training providers

- Internal providers (for example, local authorities' staff members)
- Research in Practice
- Dr Karen Treisman
- PACE (Dan Hughes)
- Warren Larkin
- Rockpool
- Kate Cairns
- Beacon House
- West London Alliance
- Professor van der Kolk (treating trauma series)
- Professor David Thorpe
- Safe and Together Institute
- Professor David Shemmings
- Kate Benham and Tavistock
- Artefacts
- Smash life
- Alix Brown
- Polly Burns
- Betsy De Tiery
- Change to Choose
- Centre for Systemic Social work
- Interface.