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MONITORING THE IMPLEMENTATION OF TRAUMA-INFORMED CARE

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MONITORING THE IMPLEMENTATION OF TRAUMA-INFORMED CARE

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Abstract

This work, which unites the fields of occupational psychology, cultural anthropology, and complexity science, examines the novel and nebulous domain of trauma-informed care. Mere definitions of concepts like trauma-informed care, organisational culture, and culture change ignite discord between researchers, writers, and practitioners alike. Trauma-informed care is a system model which encourages system-wide adoption by all involved within the organisation. An organisational shift towards adopting this model requires fundamental change. Change not necessarily within practice and policy but within the individuals who occupy the organisation themselves. Introducing a system-wide model is practicable, but ensuring that adoption and adherence is challenging when faced with the dynamic nature of the human psyche.

When attending to organisational change, organisations must prioritise the sensitivities of individuals. Involving individuals and respecting the dynamics of change can smooth over the rough edges that make transitions difficult. Perceptions, attitudes, and behaviours change alongside correlating events, environments, and system stimuli. To be one step ahead of organisational fate, the organisation must adapt to the individual rather than the contrary. A whole-system approach is needed. The reflection on implementation requires a practical self-assessment. A whole-system approach utilises a network of interrelated systems that permits timely self-reflection and enables immediate action.

This research utilises both qualitative and quantitative data by means of primary and secondary sources through a pragmatic design: staff and service-user participants from the NHS and relevant references within the broader context. The research congregates opinions from both parties and co-produces an implementation framework for application in dynamic contexts. The Roots framework is adapted into a learning and growth training package that stakeholders at the NHS and broader audiences can adapt and redefine at will.

This work advances the fields of trauma-informed care and organisational culture change by co-producing a framework and drafting recommendations on how to co-produce a self-assessment that can monitor the implementation of trauma-informed care.

List of Publications

Thirkle, S.A., Kennedy, A. and Sice, P., 2018. A Case for TIC: A Complex Adaptive Systems Enquiry for Trauma Informed Care. International Journal of Systems and Society (IJSS), 5(2), pp.1-12.

Thirkle, S.A., Kennedy, A. and Sice, P., 2021. Instruments for Exploring Trauma-Informed Care. Journal of Health & Human Services Administration, 44(1).

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This PhD not only required the time, patience, endurance and willpower of the writer, it also came at a cost to everyone and anyone in any proximity of him. If my vocation were to be defined, then I would adopt the pursuit of adventurer. Another adventurer, going by Christopher McCandless, wished to escape the purposeless bore of human life and all of its associations and retreated into nature. Four months into his refuge, moose hunters found his body decomposing in an abandoned bus along the Stampede Trail in Alaska. Chris was genuinely lonely in life and could not find peace amid humanity. A book was found near Chris' remains which declared: *"Happiness only real when shared"*. Human intimacy and involvement are an integral part of living a meaningful life. This passage has followed and helped me throughout my PhD, and realistically, this PhD has only been possible with the assistance of others. Many others that only my subconscious serves me in reminiscing. All of the conversations, interactions, relationships, love, drama, and pain have contributed to the development of my person during these years as a PhD candidate, and ultimately, completion of this doctoral degree. I devote my PhD to those that have helped me along the way, I have only been able to achieve this because of you.

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My brothers: Richard, Jordan, Dylan and James - thank you for the childhood memories that sustain my happiness to this day. My parents, Richard and Tracey - it is thanks to you that I have this opportunity. I was a teenager in despair, a secondary school dropout, and a wounded child. My roots are humble - I am not ashamed to admit to growing up in a working-class family and living in social housing. Neither of you had any expectations of me - you were always proud, even of my most minor achievements. This lack of mentored direction puzzled and frustrated me for a while, but the space and freedom you gave me was chaotic enough for my individuality to self-organise. Dad, your life has been a roller-coaster of traumatic events. Your life is full of inspirational stories of survival and resilience. Spending your childhood at the Dr Barnardo's orphanage in Ryton inspired me to achieve so that you may live a different life vicariously through me. Mam, you decided to start a family at such a young age, without adequate financial or emotional capacities. I often feel sad that you might have missed out on some of the wonders of the world, but I know that you would not have had it any other way. You gave up your own life to give me mine, and I have completed this PhD through you.

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Perhaps Christopher McCandless was onto something. Perhaps happiness is only real when it is shared because there is no possible way to experience the world without the help of others.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others. The work was done in collaboration with the *Tees, Esk and Wear Valleys Foundation NHS Trust*.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the *Faculty Ethics Committee on 23/01/2019* and *The Integrated Research Application System on 04/12/2019*.

I declare that the Word Count of this thesis is 60934 words.

Name: Steven Anthony Thirkle

Signature: SAT

Date: 25 October 2021

Chapter 1

Introduction

1.1 Background

The Tees, Esk and Wear Valleys Foundation NHS Trust has been implementing trauma-informed care (TIC) for many years. Earlier implementation efforts took the form of care pathways. Pathways are frequently diagnostic and evidence-based, rather than flexible and user-centred, and may not always account for differences in staff capabilities. The broader role of trauma found in mental healthcare would not be covered by pathways unique to post-traumatic stress disorder. In 2009, the trauma-informed pathway was designated as the first clinical link pathway. This pathway differed from clinical routes in that it was relevant regardless of the diagnosis of trauma. A user handbook with mind maps and explanations of good practice or evidence was developed to provide guidance and resources. The user manual served as a resource for training and staff to use in their encounters with service users and leaders to organise and manage their teams and services. Attachment is the subject of the accompanying instruction and training. Instead of encouraging talents that the workforce cannot supply, the trauma-informed pathway encourages staff to use their skills in trauma-informed ways. Staff were empowered when they realised that this meant they could offer something critical to service users. A business case was developed by the trauma-informed care lead, Angela Kennedy, for a formally funded project to embed trauma-informed care into services. A goal of the project was to integrate trauma-informed care into policies, programmes, and local systems and contribute to the evidence base for trauma-informed care. Creating a trauma-informed mental health service is more than just completing a checklist. The outputs of trauma-informed

care are numerous, varied, and complex. Iterative tasks to get there change over time in response to local needs, workforce pressures, and functional capabilities (Thirkle et al., 2018).

The trauma-informed care system model is simple yet complex. It is a simple shift in thinking, a swift move towards awareness. It is the enlightening fact that most individuals will more likely than not have a history of trauma. Trauma survives with individuals and interactions can be the negotiating factor to recovery. Often, small interactions have large impacts. They can either be redeeming or damning for an individual. Trauma-informed care is the realisation that all parts of human service are involved in the recovery of service users. This realisation requires a sustained effort from all concerned to engage in this system-wide recovery. The application of a system-wide paradigm is where complexities arise. There exists no precise methodology to navigate the application of a system model like trauma-informed care. For an organisation to be trauma-informed, all involved must be aware and actively participate in sustaining implementation (Fallot and Harris, 2015). The critical change to be made is not strictly an organisational change but a personal change on a large scale. Trauma-informed care is an administrative request on the individual; to begin and sustain the practice of trauma-informed principles. Admittedly, many might disagree or disapprove of pre-constructed principles, and few might even distrust the ethos of trauma-informed care. Therefore, an approach that generates trust, loyalty, and ambition is required to sustain the implementation effort (SAMHSA, 2014*a*; Fallot and Harris, 2001; Richardson et al., 2012; Baker et al., 2016; Bassuk et al., 2017).

Trauma-informed care is socially constructed in the environment by its inhabitants. It is manifested in thought and expressed in behaviour. Services implementing trauma-informed care might find a bottom-up approach to be helpful. Trauma-informed care can request many changes, and some are adamant. Being trauma-informed might suggest that the awareness of all areas of the service be made sensitive to the service user and their potential traumas. However, service users interact with more than just staff when they enter and use the service. They interact with media, posters, the reputation of the organisation, and clinical and non-clinical environments. These interactions impact the service user's perception of the service, the treatment they receive and even the likelihood of recovery. All elements of the service are responsible for the recovery of the service user. When working in human services, this awareness can be beneficial to both staff and service users. Ultimately, trust, honesty, and compassion found in positive relationships provide

opportunities to heal (Sweeney et al., 2018). These ”healing” relationships offer the individual the potential to recover from trauma and live in the world without experiencing the layered effects of an unresolved traumatic experience (Van der Kolk, 2015).

Many models are bespoke in their approach to mental healthcare. However, it is essential to note that while there are many different models, they all look to answer the same question; *”what must be done to achieve recovery?”* The recovery approach in mental healthcare is very similar to trauma-informed care. Like the trauma-informed approach, the recovery model is a holistic and person-centred approach to mental healthcare (Cruwys et al., 2020; Oades et al., 2017). Trauma-informed care manifests the change from *”what is wrong with you”* to *”what happened to you”*. This change is necessary to begin the narrative of care (Sweeney et al., 2018). This change needs to permeate the entire organisation and is not as simple as changing the physical environment but instead focuses on changing systems and care processes (Evans, 2017). Raising awareness and teaching staff the sensitivities of trauma are small requirements compared to the tidal wave changes necessary to become trauma-informed. Humans are individuals with needs, and if basic needs are not met, then other areas of life begin to decline, and attending to the needs of others becomes less important. These needs span a complex scale of impossible unknown. These approaches must consider those that hold power over service implementation. It is the organisation's responsibility to prioritise the well-being of its staff so that service users receive the trauma-informed treatment and interactions they deserve.

Individuals need to learn how to identify and care for their personal systems to manage their energy wisely (Childre and Cryer, 1996). The human being is an energy system, feeding to sustain, resting to recover, and using energy to fulfil various complex needs. The trauma-informed care model identifies all interactions as elemental to the recovery of service users. For staff to practice delicacy in all interactions, organisations must offer that same delicacy to their staff members. Any paradigm shift to increase peace and intelligence must include managing emotions. Managing emotions can build emotional power capable of managing rapid change (Childre and Cryer, 1996). The management of emotions is much more than just controlling a state of anger or another blatant display of emotion. All the minor hurts, disappointments, anxieties, fearful projections about the future contribute towards how the individual responds to the environment. These subtle emotional states drain more vitality and intelligence capacity beyond initial expectations. In some cases, this

might all occur before arriving at work, perhaps an outburst by a partner, an unresponsive child in the morning, or an irate bus driver. If a staff member has experienced an exhaustive event before interacting with a service user, the appropriate conditions for applying trauma-informed principles are not present. The staff member will attempt to preserve what little energy remains rather than offering it to another, prioritising the self. Trauma-informed care is not only awareness of the trauma of others. It is an awareness of one's own trauma.

Individuals should be able to seek and meet their own needs. Organisations should not expect their staff to deliver quality service if their basic needs are unmet; it is impossible to provide quality service if starved or dehydrated. However, just as the organisation is responsible for the well-being of their employees at work, the individual must also take some accountability for their well-being. Affective organisations demonstrate compassion and understanding for their employees' well-being, not only whilst they are at work (Smollan and Sayers, 2009). Well-being at work and well-being at home are the same. The ability to separate work life and home life should no longer be expected, as complexity would affirm that the latter influences the former and vice versa. Each individual lives in a different world and the quality of that world depends on how the data received is managed. To manage the influences that home and work provide, a setting that fosters mental and emotional balance and provides the information and motivation needed to help people build new self-management abilities is required (Childre and Cryer, 1996). Emphasis should be applied to the growth and well-being of employees for trauma-informed care implementation.

Organisations that do not consider their staff members' needs are generally ill-spoken of by the same staff members. This does not translate well to a healthcare service where employees are trained to deliver high-quality services. Staff working in healthcare, or any setting for that matter, develop an intuitive connection to their workplace. Whether through personal relationships with service users, building interactions, or navigating through the organisation's politics. A lack of consideration to staff members' needs can foster rebellion and resentment, making it very difficult for service changes to occur. Staff that stay within the service understand it well and discover beneficial "shortcuts". A compassionate staff member knows how to deliver efficient and effective care working with their service knowledge. The service user benefits from the knowledge of well-trained and well-maintained staff members. However, business is not strictly black and white. Trauma-informed care can exist in all organisations, staff considerate or otherwise. It is

a well-known truth that a certain level of comfort is required to ensure a state of contentedness in life. Should this level of comfort be a contending factor within service delivery as a matter of personal preference or subjectivity? With this in mind, all individuals can demonstrate kindness. Demonstrating kindness to one's self is perhaps the apex of this fundamental sacrificial act. To that end, the application of trauma-informed care is kindness to others and kindness to one's elf. After all, the treatment delivered should be nothing less than the treatment expected. An organisation should be encouraging self-care to all employees above the considerations of business.

If the organisation employs trauma-informed principles, the individuals working within should also be championing them at home. Trauma-informed care is a greater deal of intelligence surrounding compassion and awareness, and organisations should offer individuals opportunities for learning. Mistakes can happen, and organisations should implement certain boundary conditions to allow for this. Organisations should put adequate risk-management plans in place to avoid worst-case scenarios. It can be challenging to practice patience, kindness, compassion, and empathy under the pressure of stress. It requires a great deal of effort, and sometimes it is easier to be quiet or retreat from the situation with a very swift and explosive defence mechanism; anger. All interactions require energy. This energy is used to navigate the interaction to achieve success carefully. Complexity theory affirms that the best outcome is not always the one that requires the least effort. A self-checkout register is an excellent example of this. It is quick and easy most of the time until something goes wrong. Placing items on the scale before the machine is ready to receive them results in an error message and a delay of success. The user rushing through the check-out process has involved delay, more delay than if the user had waited until the machine was ready to receive the item. Therefore, feedback and communication are both critical. Effective self-communication is of the utmost importance in organisations and individuals. Prompts, signals, and networks allow for an effective self-assessment that can monitor both process and progress.

An organisation should be able to self-assess to understand its current state just as an individual uses one of the five senses to self-assess, touch to experience pain, or sight to examine appearance in a mirror. Both provide the opportunity for reflection and change. The former, removing a splinter, the latter, combing hair. The organisation also must look into a similar mirror of self-reflection. Organisations can act similarly with the help of human sensor networks that can feel, think, and

act just as organically as human beings. Organisations can self-assess by listening closely to both staff and service users. In reflection, being honest and disclosing the truth can promote genuineness, honesty and truthfulness, building trust and generating mutual respect. Trust is essential in all relationships. Relationships with partners, friends, employers and even in relationships with the environment. Trust is required to feel safe when vulnerable. Vulnerability is present when dedication, talent, energy and honest thoughts are shared. Trust leads to a willing contribution. It inspires people to want to be a part of a relationship or a group with a common goal and is willing to rely on either party. During the implementation of trauma-informed care, trust is crucial.

Low levels of trust are associated with limited involvement, low levels of activity, and low levels of sharing (Dietrich, 2012). In contrast, when trust levels are high, people are more likely to be involved, act, and share. However, reporting on this distrust is uncommon, and so leaders may not discover this loss of trust for some time. A loss in trust can cause distance, and while the issue remains unaddressed, the relationship grows more distant. An organisation must be trustworthy and earn the trust of staff. However, trust can be quickly lost, and restoring trust is not as easy as building it from the beginning. People prefer to move on rather than invest their time in a relationship where trust has been broken. Trauma-informed care is heavily dependent on developing trust, monitoring it and healing it when it becomes damaged, as this particular system model requires mass involvement and critical commitment. Trust is delicate and is dependant on certain qualities. According to Peppers and Rogers (2012), trust is earned through two places: intent and competence. This entails operating with pure intentions to create a trustworthy environment in the best interests of the consumer. It is also necessary to have the ability to carry out these pure intentions. Dietrich (2012) contributes to Peppers and Rogers (2012) initial suggestions by constructing the six building blocks of trust. The six building blocks of trust can be seen in Figure 1.

Genuine intentions emerge from showing empathy, being transparent, and demonstrating accountability wherever possible. Service user needs are a priority, and this should be evident in practice. Health services should be anticipating the needs of service users by using forecasting methods. A strong focus on demonstrating an understanding of the other's point of view is needed, which indicates high empathy skills being present (Lynch et al., 2019). Experts by experience are often employed within trauma-informed services for this very reason. Empathy comes naturally if both individuals have similar experiences. Lynch et al. (2019) suggest that individuals who use higher

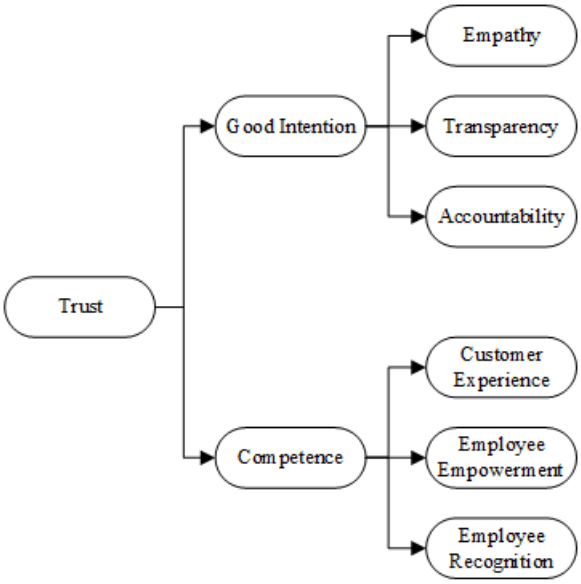

Figure 1: Six Building Blocks of Trust (Dietrich, 2012)

levels of empathy use more questions and reflections in their communications whilst demonstrating curiosity about and making an effort to understand difficult experiences focusing on emotions. Synonymously, relationships are critical in every healing journey.

Mental health workers are often placed in fragile environments under acute conditions. Uncertainty can mean life or death. In community elderly care, inadequate healthcare has been reported in terms of unmet needs, adverse occurrences, and other challenges to care quality (Bing-Jonsson et al., 2016). Lack of training, self-reflective opportunities and organisational support are a few factors that negatively influence competence. Organisations can assist in the competence of their staff members by recognising their efforts, empowering them with involvement and decision making, and providing opportunities for reflection and growth. The displayed competence of all staff members can build trusting connections between the service and the individual.

Communication is paramount to trust. Practical self-assessments are crucial to gauge staff and service user involvement in implementation efforts. These instruments, frameworks and reflective tools allow the organisation to adapt the change effort to suit individuals so that the organisation and individuals move in the same direction together.

The field of trauma-informed care is relatively new, and so there is a lack of consensus on what can be achieved or how it can be measured. Healthcare providers and policymakers require guidance on how to collect data and track outcomes specific to trauma-informed care (SAMHSA, 2014*a*).

One of the first steps to changing the healthcare culture is to build awareness and competency. This is fostered by building recognition around trauma and the lifelong impact it has on people's physical health, behavioural health, and social outcomes. Today, the healthcare and wider communities are recognising the long-term negative consequences of trauma as a public health crisis (SAMHSA, 2014*a*). Investments in research and evaluation are critical to achieve consensus around standardised measures related to trauma and in supporting the production of effective approaches.

In a trauma-informed care context, an organisational self-assessment evaluates the presence and the effectiveness of current trauma-informed practices across each service and level of the organisation (SAMHSA, 2014*c*). This allows an organisation to observe its functionality within the context of trauma-informed principles and can use the feedback to inform future development or revision of the implementation plan for trauma-informed care. This serves as a blueprint for change and as a benchmark of compliance with and progress in implementing trauma-informed practices across time (SAMHSA, 2014*c*). It collects information on strengths, weaknesses, opportunities and threats related to the implementation and maintenance of trauma-informed care.

Feedback should be collected from key stakeholders, particularly service users, family members, referral sources, community organisations, and all levels of the organisation's staff, including nonclinical and clinical staff, supervisors, and administrative personnel (SAMHSA, 2014*c*). Using the feedback obtained from a self-assessment, an action plan should be produced to highlight the goals, objectives, steps, timeframe, and staff members responsible in overseeing the specific objective. For quality improvement, self-assessments should be scheduled regularly to assist in maintenance.

There are several self-assessment tools designed specifically to evaluate trauma-informed care implementation efforts. However, these can be difficult to access. Many of these instruments do not emphasise the importance of language. Language is a crucial aspect of trauma-informed care as people want to have control in their lives - this is particularly relevant for service users undergoing treatment in service. The language used in the self-assessment must share the sentiments with those using it. Therefore, self-assessment maintenance must occur for the instrument to be up-to-date and for fair representation of trauma-informed care values. The instrument must be inclusive, and so must the instrument development process. Roots underwent a co-productive approach to

development. Surveys, focus groups, expert meetings, and secondary data were all consulted in the development process. Progression was made on consensus being met on definitions. Domains were cross-compared with literature, and items emerged from trauma-informed care leads meetings. The framework underwent translation and refinement with experts for both staff and service user forms. The service user form was pilot tested for further articulation, and the staff form was pilot tested for implementation and effectiveness. The end product, Roots, was published open-access for public use. It serves as a reflective framework for mapping the implementation journey of trauma-informed care.

1.2 Research Questions

The research questions were:

RQ1: *What barriers restrict the implementation of trauma-informed care into mental health services in the United Kingdom?*

RQ2: *How are mental health services in the United Kingdom able to overcome barriers to sustain trauma-informed care implementation?*

1.3 Aims and Objectives

As with the research question, the aim of this study remained relatively consistent. That aim was **AIM1:** to produce an integrative framework for data collection, analysis, and interpretation.

The objectives to reach the aim fluctuated throughout the project, as opportunities fell away and stakeholders lost interest. The experimental nature of the study and the ambiguity of the subject matter meant for unfolding objectives. The objectives listed are the finalised objectives and carried out, not the objectives eliminated from the study. The research outcomes influenced each stage. However, objective one remained static from the beginning of the project. The first objective then established foundations for the following objectives.

1. **OBJ1:** Investigate similar approaches that evaluate trauma-informed care implementation

Objective one required an extensive literature review to be undertaken. This involved identifying a relevant body of knowledge and the general trauma-informed care literature, alongside specific searches for literature concerning the application and evaluation of trauma-informed care.

2. **OBJ2:** Develop a trauma-informed care framework bespoke to the United Kingdom

   Objective two required a collaborative approach to development. Data collection was pragmatic, comprising a mixed-methods process utilising surveys, expert consultations, team meetings, and focus groups.

3. **OBJ3:** Produce documentation for Tees, Esk and Wear Valleys Foundation NHS Trust to continue with the implementation effort

   Objective three required the production of a framework, user manual, and a compilation of evidence.

1.4 Overview of Thesis

This body of work attempts to investigate the application and evaluation of trauma-informed care as a practical system model. By working in the trauma-informed care programme at the Tees, Esk and Wear Valleys Foundation NHS Trust, the researcher became immersed in the subject matter. This thesis serves as supporting evidence for the time and work conducted. In this thesis, an extensive literature review was undertaken in organisational psychology, organisational culture, human behaviour, and complexity theory. The research project used complexity theory as a pragmatic toolkit to assist with research design, data collection, data analysis, research outcomes and future recommendations.

This thesis is structured to follow the PhD narrative. Chapter one begins with a background into trauma-informed care and its application. Trauma is introduced, and information is provided on how an individual can be accompanied by traumatic experiences, re-affected by their external environment, or how they might be harmed by a service that is supposed to be a safe place that offers hope and healing. The research questions are stated alongside initial aims and objectives.

Chapter two introduces the literature review, which examines organisational culture and its rele-

vance to trauma-informed care. Trauma-informed care is an organisational culture and is helpful to be seen as one for system-wide adoption. Shared values, beliefs, and behaviour are critical to a trauma-informed organisation. Becoming trauma-informed is likened to a culture change, which is complex and challenging. Within this context, sub-cultures are identified as essential considerations regarding implementing trauma-informed care, as different groups have their own cultures. Emotions are also seen as critical considerations as a culture change is emotionally taxing. Emotional responses are seen to be strong determinants of change. Support is also raised as being significant in the realisation of greater organisational commitment. Leaders that serve as solid support systems can encourage employees, and this can act as mitigation against negative emotions that may arise in numerous cultural and operational aspects. Values are discussed as being at the core of organisational culture. Trauma-informed care has a prominent set of human-focused values, and this is seen widely across the literature. Values that are co-constructed are seen to be embraced strongly by all, this contrasts the opposition ignited by a set of values forced upon employees. An alignment in values is a favourable contribution to positive organisational change. After that, culture is discussed to be dynamic - changes with time and staff turnover are seen to be a considerable contribution to organisational change. Finally, the possibility of managing culture is discussed with a few different perspectives offered.

The complexity sciences are explored next which favour qualitative insights into organisational behaviour. A range of metaphors are discussed as being helpful considerations when acknowledging healthcare organisations. Emergence, being one of the critical characteristics of complex systems, is discussed in detail, focusing on how emergence can operationalise organisational change. Another critical characteristic, self-organisation, is prioritised with its relevance to ordered networks and its emergent feature of local interactions. The third characteristic of complex systems, sensitive dependence to initial conditions, is discussed, and a complexity ontology is proposed. Trauma-informed care is introduced next in the literature review. Frameworks of implementation are investigated with prevalence resting on principles of trauma-informed care. A rationale is made for the implementation of trauma-informed practice into mental health services, although it is noted that all human services are applicable. The implementation of trauma-informed care is detailed further with the evaluation of various approaches. A variety of instruments and frameworks created to evaluate trauma-informed care in practice were examined. Chapter two ends with

conclusive recommendations.

Chapter three states the research problem and the methodology used to approach the problem. The research philosophy adopted is introduced, and the research epistemology and ontology are defined. The research process is discussed alongside the Delphi method and the participant selection process. The framework development process is identified here with details provided on the research methods used. A short data analysis section is provided to instruct on the process. Chapter three ends with a definition for a trauma-informed methodology. Chapter four presents the results from data collection, which documents the framework, domain and item development process. Submitting the information collected from the leads meetings, surveys, expert consultations, and focus groups. Chapter five outlines the discussion, which reflects on the results. A whole-system approach is distilled from both the literature and the results. Chapter five ends with the introduction of the completed Roots framework and a chapter summary. Chapter six concludes the thesis with contributions to knowledge, limitations, implications, and recommendations for future research.

Chapter 2

Review of the Literature

2.1 Introduction

The following chapter includes an examination of the literature. Reviewing organisation culture and culture change, complexity theory, trauma-informed care, and a review of previous implementation frameworks; this can be seen in sections 2.2 - 2.6. The earlier approaches to evaluating trauma-informed care are analysed, and the national trauma summit is briefly introduced. This literature review has the intention to identify a relevant body of knowledge surrounding the research aim. It concludes with an overview of the application of complexity theory on the implementation of trauma-informed care.

2.2 Organisational Culture and Culture Change

The concept of organisational culture was introduced to management and organisation studies in the late 1970s. Although the term itself dates back to the 1950s (Selznick, 1957), scholarly attention towards organisational culture began to generate significance in the early to mid-1980s (Deal and Kennedy, 1982; Smircich, 1983). Organisational culture refers to the expectation of how affairs are usually fulfilled within an organisation; it builds on insights from sociology and anthropology. Ranging from *"the way we do things around here"* (Mannion and Davies, 2018, p 2) to complex definitions such as this one provided by Schein (2010, p 18): *"the pattern of shared*

basic assumption – invented, discovered or developed by a given group as it learns to cope with its problems of external adaption and internal integration – that has worked well enough to be considered valid and therefore to be taught to new members as the correct way to perceive, think and feel in a relationship to those problems".

While there are multiple definitions of organisational culture found in the literature, a consensus can be observed. This consensus was defined by Parmelli et al. (2011, p 1), in which organisational culture *"pertains to the multiple aspects of what is shared among people within the same organisation: e.g. beliefs, values, behavioural norms, routines, traditions, and sense-making"*. Parmelli et al. (2011) identify that many researchers choose to adopt the definition offered by Schein (2010) and agree that it is a widely shared belief that adequately fits the entire multifaceted concept of organisational culture. Although Pizer and Härtel (2005), Parmelli et al. (2011) and many others refer to organisational culture as a system of shared meaning, there are others such as Martin (2001) and Smollan and Sayers (2009) that disagree. The indication is that culture should not be referred to as a system of shared meaning, as it is not the case in many respects and only represents an idealistic view on culture.

Meyerson and Martin (1987) identified three major perspectives that one can choose to adopt towards organisational culture. One such perspective is the *integration* perspective; this refers to the organisation's members' beliefs, values, and attitudes (Schein, 1990; Waterman and Peters, 1982; Deal and Kennedy, 1982). If organisations can pursue a collegial culture, then it is said that this strong culture can enhance organisational performance (Deal and Kennedy, 1982). Another perspective: *differentiation*, does not account for an integrated organisational culture, accepting consensus on beliefs, values, and attitudes as only occurring in subcultures (Frost et al., 1991; Richter and Koch, 2004; Harris and Ogbonna, 1998). The third perspective, known as *fragmentation*, defines organisational culture as being too ambiguous and diverse for all to generate an efficient understanding of culture as a meaningful construct (Alvesson, 2011). Whelan (2016) recommends that the definition of culture must be open to all of these perspectives because the truth concerning the extent to which culture is shared or differentiated can only be uncovered empirically. Whelan (2016) identifies that Schein (2010, p 17) provides flexibility by using the term "group" when discussing culture and therefore decides on the definition *"a social unit that has some kind of shared history"*. In turn, this then can be used as the base to approach organisational

culture. The strength of any particular group's culture is dependent on many factors, such as the length of its history, the stability of its membership, and the types of experiences its members have shared. Schein (2010) refers to beliefs, values, and attitudes as "basic underlying assumptions". By allocating culture with the definition put forward by Schein (2010), Whelan (2016) recommends that the examination of organisational culture will be enhanced.

In the literature, there are two prominent modes of thought when conferring on organisational culture. These two modes of thought spark debate in the literature on adopting the better perspective (Glendon and Stanton, 2000; Mannion and Davies, 2018; Maull et al., 2001; Martin, 2001; Parker and Bradley, 2000; Sinclair, 1993; Watling et al., 2020; Willcoxson and Millett, 2000; Wilson, 2001). One adopts a more anthropological position that chooses to identify culture as being the organisation, proving difficult to determine what is and is not "culture". The other argues against the notion that organisational cultures exist as definite entities. This perspective views culture as something that an organisation has, rather than is, most unlike the former, offering a view of the various strands of culture as variables. Whelan (2016) notes that the dominant view in the literature is identifying culture as a variable in organisations. This view enables the possibility of creating, changing, manipulating, and managing the culture to pursue organisational objectives (Davies et al., 2000). A variable is something that can be identified and analysed. Granting the possibility that it can be used as an organisation's outcome and linked with organisational performance. However, there is an additional alternative mode of thought, one in which that culture can be viewed as an emergent property of the organisation's constituent parts. Davies et al. (2000, p 112) define this perspective as: *"characteristics of that culture may be described and assessed in terms of their functionality regarding the organisation's goals*". No definition in the literature highlights the complexity of organisational culture. It is multifaceted and complicated, tangible and intangible, and influenced by various factors (Wilson, 2001). The following quote from Olins (1991, p 17) is dated but eternally relevant:

"The most important audience for any company is its staff. I cannot understand how people can say that the most important audience they have is the consumer. Because if you cannot train your staff in what you are, in what you think, in how to behave, and in what your moves and precepts are, how the hell can you expect to train your customer?"

Definitions on organisational culture are generally in consensus in the literature, though they can

be ambiguous (Parmelli et al., 2011). However, there is debate on whether culture should be defined as a system of shared meaning in the organisation (Pizer and Härtel, 2005). It is observed that culture is not often shared amongst all members of the organisation (Martin, 2001; Smollan and Sayers, 2009). Many members across organisations have their own interpretation and derivative of the meaning of culture. As an alternative, it might be preferential to refer to organisational culture as a *system of intention, with meaning particular to individuals or groups*. Organisational culture is often idealised, and there is often managerial preference in how organisation are controlled. By examining definitions, it can be observed that organisational culture is often analogous to expectations. An organisation expects to run in a particular way because goals are set, and behaviours must be correlated to meet those goals. However, these expectations are often strict, and organisational culture existing in different interpretations often determines that future goals may not be reached.

One possible perspective to viewing organisational culture would present organisational culture as a balance of beliefs, values, and attitudes shared across members belonging to specific subgroups of the organisations. However, it is impossible to apply any such perspective on organisational culture. Organisations and their components and various factors differ significantly; a bespoke perspective must be applied to all organisations individually. Culture can only be defined appropriately through empiricism (Whelan, 2016). Therefore, based on the literature, we can loosely define organisational culture as: *"a group or a social unit with some shared history, which hold basic underlying assumptions*. Describing organisational culture as containing individuals that share basic underlying assumptions helps identify organisational culture by observing the emergent characteristics portrayed by members in the organisation, allowing them to assess their functionality and fit with organisational goals (Davies et al., 2000).

The pursuit of increasing quality in healthcare has attracted attention towards organisational culture (Smollan and Sayers, 2009). Davies et al. (2000) ask the central question, "How are quality improvements to be wrought in such a complex system as health care?" In pursuance of the culmination for "a culture in which excellence can flourish", Donaldson and Gray (1998) responds with the idea that cultural change needs to be wrought alongside structural reorganisation and system reform. Parmelli et al. (2011) indicate that the repeated identification of the need to change organisational culture alongside structural reforms to pursue effective improvement of healthcare

performance is necessary. However, ineffective change management strategies can produce a sense of change fatigue (Frawley et al., 2018). The following subsections refer to some of the critical elements of organisational culture change.

2.2.1 Subcultures

Schein (2010) suggests that organisations will vary in their cultural conditions. Some may experience an integrated culture, others may experience subset cultures, and some will have a mix of both. It is expected that larger organisations are more likely to experience differentiation in cultures. This happens when an organisation is geographically widespread, or there are many other settings at composition. Typically, the larger the organisation, the more likely it is to experience various subcultures rather than an integrated organisational culture (Schein, 2010).

This identification of subcultures within organisations leads to the belief that the distribution of meaning can be diverse, widespread, and detached. Employee-centred, professional-centred, task-centred, and innovation-centred subcultures are generally defined by hierarchy, department, professional identity, ethnicity, and gender. However, they can also be thought of as separate value systems (Palthe and Ernst Kossek, 2003). Davies et al. (2000) add that subcultures can be associated between groups holding alternative levels of power and influence within the organisations. Subcultures tend to become counter-culture or anti-culture (Elsmore, 2017). In an alternative argument, Armenakis et al. (1993) dispute the existence of subcultures and their polarisation on members' beliefs, attitudes, and intentions, maintaining that subcultures can result in a conflicted response to change. This would result in different groups seeking to differentiate themselves and remain cliquey. In contrast, Davies et al. (2000) make the acute observation of the distinctions between the professional culture, the medical culture, and the organisational culture. The existence of subcultures emphasises the importance of interpretation and the need for the bespoke requirement of change of any kind.

2.2.2 Affect

Smollan and Sayers (2009) identify that emotions are often overlooked in research conducted on change. Undeniably, positive and negative emotions can influence decision-making (Van Kleef

et al., 2011). *"Emotions are direct responses to events, issues, relationships, and objects that are important to people"* (Lazarus, 1991). People's emotions or emotional state are not immune to the process of change, personal or organisational (Beedie et al., 2005). The emotional state or mood is contrasted with emotion. Mood is an emotional state and is less specific, less intense, and much less likely to be provoked by a sudden event. Smollan and Sayers (2009) imply that organisational change can change a person's affective state, emotions and moods. Organisational culture can play an essential role in creating emotions and influencing their expression or repression during times of change (Van Kleef et al., 2011). Individuals may be helped or hindered depending upon how emotion is dealt with at work. According to Smollan and Sayers (2009), organisational culture, organisational change, and emotions are interrelated in four ways. Firstly, organisational change can elicit strong emotions. Secondly, organisational culture is charged with emotion, implying that cultural transformation is particularly emotional. Thirdly, the affective culture of an organisation has an impact on how these emotions are felt and communicated. Fourthly, an individual might have a liking or disliking towards a particular element of the organisation's present culture and therefore possess an attitude, which might influence emotional responses to the types of change. These four relational factors highlight the need for a bottom-up approach where the individual's adjustment to organisational change incorporates emotional and cognitive aspects (Jordan, 2005).

According to Schein (1990), culture is a learning process that a group goes through to overcome external survival and internal integration problems. This learning involves a behavioural, cognitive, and emotional process all at the same time. Furthermore, awareness of the emotional impact of historical events is critical to culture development (Nunn, 2012).

Kunda and Van Maanen (1999, p 46) claim that *"any attempt to manage culture is also an attempt to manage emotions"*. Culture change can be the cause of strong emotional reactions; these reactions can alter experiences, expressions, and the process of regulation (Van Kleef et al., 2011). An organisation must be aware of the importance of the affective culture so that consideration can be given to staff experiencing accentuated emotional responses (Alvesson and Willmott, 2002). Unresponsive organisational cultures can be found to block the emergence of newer and healthier norms; these cultures are found to be employed in obstructing the expression of employee's emotions (Callahan and McCollum, 2002). Individuals with attitudes towards specific elements can result in emotional responses to strategic, cultural, or operational change (Vakola and Nikolaou,

2005). If employees are satisfied with how things are at present, they will express dissatisfaction with change. Conversely, however, this may not always be voiced, and this might cause immediate or delayed friction for the change effort (Bos and Schuurmans, 2002).

Participants in a study by Smollan and Sayers (2009) reported that they hid their own emotions from their staff because they felt it was not professional to express them. An old culturally infused mechanical professional identity requires those to act in approved ways to control inappropriate emotions (O'Connor, 2008). Participants reported adverse emotional reactions when they recognised processes and outcomes of change being unfair, where organisational support was not provided, and feeling unsafe in voicing their dissatisfaction with change. Participants who had support felt comforted. People need their feelings to be validated rather than ignored and do not enjoy being told to harden up (Balanovic et al., 2018). Managers who possess high emotional intelligence skills can leverage understanding and facilitate change (Chrusciel, 2006). Negative cultures are characterised by an absence of support, leading to a host of deleterious consequences (Smollan and Sayers, 2009). Those at the senior managerial level show little concern for people at lower echelons resulting in a lack of trust and instances of injustice (Gardner and Stough, 2002). Clarke (2006) conducted a study on the impact of organisational change and professional identity in healthcare organisations, which encouraged reflection on, discussion of, and support for the emotional aspects of work. A significant finding emerged from the study that identified emotional abilities to appear considerably influenced by the workplace's specific context and the result of performing the job itself. In 1990, Schein (1990) stated that perceptions of a culture influence emotional responses and behaviour. When perceptions of culture are positive, then emotional responses and behaviour are also positive.

Organisations must pay attention to individuals' emotions during organisational change. One particular study, conducted by Turnbull (2002), identified that the participants in his research on change, all of which were managers, experienced both cognitive and affective reactions but often in unintended ways. A culture of trust, openness, innovation and loyalty was the ambition of the organisation's attempts to change. However, situations of difficulty triggered emotions of mistrust, anger, and embarrassment. These emotions were coupled with a need to hide feelings and to pretend to comply with changes. During change, emotions trigger responses that impact behaviours (Kübler-Ross and Kessler, 2005). This complements the need for an awareness of

emotional impacts during change.

2.2.3 Support

Support is essential in the realisation of greater organisational commitment (Jano et al., 2019; O'Driscoll and Randall, 1999; Tumwesigye, 2010). Employees form global beliefs based on how they believe the organisation values their contributions and well-being (Eisenberger et al., 1986). Change is emotionally demanding. However, organisations can assist in managing these demands by offering suitable levels of tangible and psychological support (Smollan and Sayers, 2009). Schein (2010) refers to leadership and culture as being two sides of the same coin. Many variables shape culture; Schein (2010) argues that culture defines leadership in terms of who will be appointed leaders and who will receive attention from followers and that leaders can, under certain conditions, create and change a culture. A fundamental dichotomy in the literature is the difference between leaders and managers (Chiu et al., 2017; Zaleznik, 1977). Schein (2010) highlights this distinction by suggesting that leaders can create and change culture, whereas managers act within a culture. As leaders are often responsible for the support of employees, it is their responsibility to ensure that change is as comfortable as possible for employees (Goleman, 2019). Leaders can create and change culture by caring for their employees by providing appropriate support mechanisms (House et al., 2004).

Leaders who encourage the expression of emotions and place value on the emotional elements of the work promote a healthy organisational culture (Pizer and Härtel, 2005). Affective commitment to change occurs when employees want to remain in the organisation and support its change efforts (Michaelis et al., 2009; Shum et al., 2008).

It is essential to acknowledge the role culture plays in facilitating or impeding organisational change and to reinforce the message that emotions accompany many aspects of change and must be acknowledged. Using appropriate support systems and acting in ways that promote positive emotions during change, negative emotions that may arise in numerous cultural and operational aspects of change can be mitigated (Kusstatscher, 2006). Changing the culture is one method, as announced by Ashkanasy and Daus (2002), in their established guidelines for developing emotionally healthy organisations. Other approaches include choosing staff for emotional sensitivity

training in emotional intelligence and appropriate emotional expression and building a positive and pleasant emotional climate (Hassard and Cox, 2013; Jerabek, 2006; Martins and Terblanche, 2003). Organisations must build appropriate responses to emotions so that they are better equipped to facilitate organisational change (Payne and Cooper, 2003). For organisations to become better equipped to facilitate organisational change, staff require training in emotional intelligence and organisational change (Huy, 1999; McEnrue et al., 2009). Conclusively, managers presenting with high emotional intelligence can identify and respond to emotional reactions to change in employees (Huy, 1999).

2.2.4 Values

According to Schein (1990), values are the crux of organisational culture. Values can emerge and evolve in the organisation, or they are selected (Schwartz, 1997). Values can be attributed to overt guides to behaviour, but the messages and mechanisms may also be used as subtle forms of normative control (Kunda, 2009). The literature suggests that when organisational values are in coalescence with values held by individuals, there are noticeable results in conscientiousness, organisational citizenship behaviours, there is less staff turnover, higher job satisfaction and organisational commitment (Branson, 2008; Klapper et al., 2020; Sullivan et al., 2001). Smollan and Sayers (2009) hypothesise that alignment in values could extend to positive attitudes to change. In the 2008 study by Mannion et al. (2009), a postal questionnaire survey was conducted on 275 English NHS organisations; this study highlighted that one-third of the organisations were currently using a culture assessment instrument to support their clinical governance activity, this was principally one instrument, the Manchester Patient Safety Framework. Parmelli et al. (2011) reviews the literature and identifies various studies examining strategies and tools used for culture assessment. All concede with similar messages articulating that *"there is no ideal instrument for cultural exploration"*, as many are at preliminary stages of development and even at completion, there is little evaluation of the use and the practical application of these tools, or how well they perform with the current culture in operation. Health system reform is seen to require the management of organisational culture. According to Schein (2010), leaders have the ability to reinforce new parts of culture, such as values. The pressing need for new and improved custom culture assessment tools has only been more apparent in recent years (Baker et al., 2016; Bassuk et al.,

2017; Fallot and Harris, 2015; Goodman et al., 2016; Mannion et al., 2009; Mannion and Davies, 2018; Sweeney et al., 2018; Richardson et al., 2012; Van Huy et al., 2020).

2.2.5 A Dynamic Culture

An organisation's culture is rarely static; it is changing, shifting, and undergoing constant transformation (Thomas and Brown, 2011). Organisational norms may change drastically, perhaps due to an organisational crisis or a positive market transformation (Ogbonna, 1992). New members might bring expectations and introduce subtle changes, and current members might transmit culture, either explicitly or implicitly, to new members (Boyd and Richerson, 2005). Both old and new organisational features shape and articulate the organisational culture. Implicit communication might involve mission statements on how services are managed and delivered. External factors of the organisation can also influence change. Strong organisational norms are essential for the healthcare industry and must meet strong professional ethics and the need for a professional identity (Davies et al., 2000).

Organisational culture has been theorised to emerge out of managerial and employee discourse (Davies et al., 2000; Seel, 2003; Snowden and Boone, 2007). This process, known as social constructivism, is a sociological theory of knowledge, which supports the idea that human development is socially situated and knowledge is constructed through the interaction with others (Kiraly, 2006). Employees resist managerial framing of culture, actively and purposefully modify it, or unconsciously influence it via their behaviour, all of which partially contribute to the evolving terrain of organisational culture (Davies et al., 2000).

Davies et al. (2000) adopt a post-modern perspective towards understanding how groups engage in struggles to offer a subjective, authentic, and legitimised view of the world. A diversity of voices are encouraged, and differences are celebrated. This perspective gives all, rather than a few, a voice. It promotes dialogue on the nature and course of change among stakeholders, giving specific attention to those disenfranchised or marginalised from discussions in the past (Alvesson and Deetz, 2006). Moreover, this dialogue challenges existing authorised accounts and balances of power rather than focusing on the refinement of control mechanisms.

Whelan (2016) identifies three alternative viewpoints on the management of culture and the pro-

motion of cultural change. One of them is that senior management can use various interventions to influence the culture of an organisation working under specific conditions. Another perspective acknowledges organisational change as a substantial task, proving more problematic as it depends on the conception of organisational culture adopted. Lastly, there is a perspective that recognises that organisational culture is beyond control and can only exist to interpret an understanding of organisational life. However, culture can shape the way its members behave, both in overt and covert ways. Furthermore, Smollan and Sayers (2009) argue that it alters behaviour even during states of change.

2.2.6 Managing Organisational Culture Change

This research studied the organisational culture literature to seek improvements in service implementation and staff and service user experiences in mental healthcare. There are recommendations to reorganise the organisation's structure and undergo real system reform to coincide with organisational culture change (Donaldson and Gray, 1998). Organisational culture change consists of an alteration to basic underlying assumptions held by a group. Simultaneously, culture can be observed as emergent characteristics or properties of an organisation. Alternatively, these basic underlying assumptions are emergent characteristics of the organisation. Identification of the presentation of emergent characteristics is necessary to monitor an organisational culture change (Davies et al., 2000). Individuals must report their interpretations and meanings of the current organisational culture. Organisational change requires individuals operating within the organisation to also change, as an organisation is embodied entirely in its employees and users. Organisations must engage employees interests to facilitate the implementation of new goals or objectives; these basic underlying assumptions must permeate the organisation.

Subcultures require the consideration of change initiatives. Subcultures that exist in organisations are present with diverse, widespread, and detached meanings. Groups must maintain their own professional culture to complete their tasks. However, if subgroups in the organisation are operating with vastly different basic underlying assumptions, a lack of organisational support or emotional consideration might be apparent. Therefore, communication between subgroups must occur to enable a sense of the current cultural climate. Afterwards, adjustments and interventions can be made to coalesce meaning between subgroups as much as possible without destroying the

necessary basic underlying assumptions that make up their professional cultures.

Organisational change can result in changes to an individual's affective state. Emotions must be considered when conducting organisational change; if an individual is satisfied with the current organisational culture, that individual might present as resistance to change. If people and all of their behaviours, interactions, beliefs, constitute the make-up of organisational culture, then the management of emotions is critical, as emotions are how people respond to events, issues, relationships, and objects (Smollan and Sayers, 2009). Emotions affect moods, which in turn influence attitude and can direct behaviour. Appropriate support mechanisms need to be in place to ensure comfort and safety. Leaders presenting with high emotional intelligence can facilitate change by meeting the emotional needs of individuals in the organisation (Smollan and Sayers, 2009).

Essentially, leaders can manage culture well by managing employees well. People rely on leaders within organisations to provide appropriate support mechanisms when the workplace invokes emotions. Principally, if the workplace is the source of the emotional distress, the organisation is responsible (Schein, 2010). Employees will engage and support change when they feel supported within the organisation (Davies et al., 2000). An organisation that values employees and their emotions is a healthy organisational culture (Jerabek, 2006). Individuals must be invested, interested, inspired, and valued to support an organisation in a change effort. The measuring of employee's perceptions towards generating improvements in the organisation is how organisational change is accurately facilitated (Schein, 1990). If individuals feel positive emotion towards the organisation, they will support improvements. If they feel negative emotion towards the organisation, they will not.

Values in the organisation, either emerging, evolving or being selected by the organisation, become goals that the organisation desires in its operational behaviour. By monitoring adherence to values or principles set within the organisation, these goals act as dynamic destinations. And if alignment is observed with individuals and support is shown, then positive emotion will reinforce the desire to support change. By pursuing these values, the organisation moves towards its goals. Organisational culture is expressed by employees and users who experience the organisation. They construct and display the culture in their many forms of expression. Concisely capturing these expressions can allow decision-makers to manage culture change (Snowden and

Boone, 2007).

2.3 A Complexity Approach

Organisational culture change is undeniably complex; there are many internal and external variables involved (Johnson et al., 2016; Parmelli et al., 2011; Scott et al., 2003). There are difficulties determining whether and to what extent cultural change has occurred (Steward, 1972). As Whelan (2016, p 586) iterates, it is essential first to distinguish the difference between *"managing cultural change by design"* and *"viewing cultural change as an emergent process that happens over time without conscious direction"*. Organisational culture is a multi-faceted concept, and some values and practices may engage certain employees and have oppositive or neutral impacts on others (Schein, 1990).

As organisations become more complicated and reflexive, the machine model becomes extraneous. (Dooley, 1997). Rigorous scientific analysis grew obsolete when the realisation that positive and negative feedback between elements of an organisation disabled the exploration of various phenomena (De Wolf and Holvoet, 2007). As Jennings (2004) defines, *"a system is a set of connected elements that have a defined purpose but which demonstrate properties of the whole rather than the constituent parts"*. The acknowledgement of organisations as systems begins a new perspective. This viewpoint shifts away from linear analysis, which leads to prediction and control, and toward an appreciation of relationship configurations and an understanding of what causes patterns of order and behaviour among a system's components. Kernick (2002, p 124) states: *"The three notable characteristics are connectivity, recursive feedback, and the existence of self-ordering rules that give systems the capacity to emerge as new patterns of order"*. Algorithms in human systems are continuously changing, as agents within the organisation adapt and co-evolve with their environment (Arévalo and Espinosa, 2015). Quantitative approaches to non-linear interactions in human systems, according to Jennings (2004), are restricted, and complexity uses chaos metaphors to provide qualitative insights into organisational behaviour. Jennings (2004) suggests that four metaphors must be considered when acknowledging healthcare organisations: mental models, phase space, attractors, and simple rules.

2.3.1 Mental Models

Individuals act in ways directed by their own internal rules or mental models to respond to the environment (Hill and Levenhagen, 1995). The result of the rich non-linear interactions that occur due to the agent's mental models in response to the local information provided is complexity (Bekebrede et al., 2015). Complex systems learn and adapt over time to adjust to the changing and sharing of the agent's mental models (Cameron and Larsen-Freeman, 2007).

A mental model is a framework that an individual uses to make sense of the world. However, mental models are more complex than just simple beliefs. They are quick, almost unexamined thoughts, that when coupled with repeated experience and feedback, become very sophisticated cognitive structures that operate subconsciously. With experience and feedback, the individual builds a sense of expectancy of the system. These built-in assumptions assist in drawing certain conclusions in different circumstances. During system change, aligning mental models is essential. Allowing individuals to share how they see the world and making sure that people see things the same way can be the difference from an ineffective change effort to a more cooperative one (Page, 2018). Shared mental models are crucial in healthcare to maintain situational awareness, and working together within multi-disciplinary teams improves service user safety.

2.3.2 Phase Space and Attractors

Jennings (2004) likens complex systems to the metaphor of multidimensional phase space. Indicating that each system variable is defined and quantified in one dimension. The prediction of agents moving on their trajectories with time cannot be predicted with certainty. Put simply, it is almost impossible to predict the precise actions of an individual accurately (Silverman, 2001). However, attractors place limits on their room for manoeuvre. Attractors can "nudge" and suggest a direction for these agents, adjusting their pathway slightly (Haynes, 2008). Organisational attractors emerge from the interactions of mental models, usually over a relatively long period (Stacey, 2000). The entire organisation or the whole of phase space can be interwoven with distributed and connected information; this, invariably, would suggest that non-linear, small changes in one area can have significant effects across the whole system (Snowden, 2002). Alternatively, large influences can result in negligible outcomes.

A phase space is a space where all possible states of a system are represented. A point in this phase space specifies the system completely. Phase space maps enable the characterisation of system changes and identify constraints that exist to change in the system (Silverman, 2001). Complex systems present situations where several variables are interacting simultaneously and in interconnected ways. Predicting this precisely is impossible. However, patterns can be observed, and specific interventions can alter the system's trajectory (Jennings, 2004).

2.3.3 Simple Rules

Simple rules or guiding principles applied locally can result in complex, emergent, and novel system behaviour (Eisenhardt and Piezunka, 2011). Systems are purported to organise themselves around a small number of simple rules or guiding principles that may remain at the subconscious level (Sweeney and Griffiths, 2002). Simple rules can translate into the sharing of mental models by individuals of an organisation (Scheutz et al., 2017). Raising the awareness of these rules allows exploration into their implications and offers room to manouvre (Reed et al., 2018). Identifying a system's core rules is critical, and modifying them as needed may allow the system to emerge in a more acceptable pattern of order. Plsek and Greenhalgh (2001) identify three types of simple rules: general direction pointing, system prohibition, i.e. setting boundaries, and resource or permission providing. Using narrative or observation can assist in the discovery of simple rules (Snowden and Boone, 2007). Small-scale experimentation and simple rules will drive the emergent behaviour of a health system to the desired pattern (Plsek and Greenhalgh, 2001).

The use of complexity research in the human domain has been interpreted in various ways, resulting in a plethora of frameworks (Chae, 2012; Dawkins and Barker, 2020; Snowden and Boone, 2007). According to Large et al. (2015), these interpretations are more effective when considered complementary to gain insights into complex contexts like organisational innovation and culture change. Snowden and Boone (2007) suggest that the phenomenal domain of organisational innovation is realised through a network of human-to-human connections. Such networks can spontaneously self-organise through the interactions of local actors, resulting in emergent order. Evolving patterns in behaviours of the network without any prior comprehension create a system-wide blueprint for the evolution of the system (De Wolf and Holvoet, 2007). The interacting agent's immediate local "intentions" are continually emerging in context (Snowden and Boone,

2007). Arthur (2014) focuses on the amplification feedback loops that occur within the network due to actions and action interpretations and the dynamic complexity of intentional and unexpected repercussions over time. The level of complexity is apparent, and understanding this is beneficial. Snowden (2002) views innovation and culture change as a complex adaptive system.

By way of a general definition, it can be said that a complex adaptive system is a system that exhibits a particular kind of behaviour. This particular kind of behaviour is best characterised by the characteristics of emergence, self-organisation, and a sensitivity to initial conditions (Holland, 1992; Miller et al., 2009).

2.3.4 Emergence

Emergence is a key characteristic of complex adaptive systems (King and Horrocks, 2010; Nicolis et al., 1989). Following the advent of complexity theory (Waldrop, 1993), emergence rose to prominence again. Emergence is: *"Simple interactions between simple agents could give rise to surprisingly complex behaviour."* (Quadara and Hunter, 2016). The philosopher Lewes (1875, p 412) coined the term "emergent" in its present interpretation (emergence) in 1875 (Bivona, 2019) when discussing the nature of causality:

"...although each effect is the resultant of its components, we cannot always trace the steps of the process, so as to see in the product the mode of operation of each factor. In the latter case, I propose to call the effect an emergent. It arises from the combined agencies, but in a form, that does not display the agents in action".

Lewes' definition did not arrive at serious consideration until the movement known as Emergent Evolutionism came forth (Hussain et al., 2018). Emergence was initially proposed as supplementary and then, shortly afterwards, a correction to an overly mechanistic and incrementalist view of evolution in Darwin's theory of evolution (Davies et al., 2000).

The literature identifies seven conditions of emergence, isolating the first three conditions and rationalising that they are centred on agent-based simulations.

1. Connectivity

   "Change in an organisation is a change in the patterns of relationships between those who

are members of the organisations (and also new patterns of interaction with the environment)" (Seel, 2003). Current patterns of connectivity in the organisation become stagnant; if they are not continuously introduced as original connectivity, they remain as they are, in a state of perpetual constant (Pathak et al., 2007). Connections that are built with particular importance given to intersecting boundaries are, as Seel (2003) considers, being of the utmost importance in preparing an organisation for change. Before interventions are introduced, entities must exist at the precipice of transformation; they must be vulnerable in the sense that they are cooperative. It may be necessary that interventions are needed for the entity to enter this cooperative vulnerability (Seel, 2003). There must first exist ordered disorder, a willingness to change (Brody et al., 2012).

2. Diversity

   Diversity, in all of its castes: cultural, intellectual, and emotional, are considered crucial for emergent change to occur (Bushe and Marshak, 2016). With diversification, organisations unlock a space of possibility in which experimentation and exploration can flourish. However, if diversity is found to be present without the other conditions, it can result in anarchy and conflict (Seel, 2003). For it to work efficiently, it must remain cohesive with the other conditions.

3. Rate of Information Flow

   Transpiring interactions should be frequent and of high quality; if they do not occur in this manner, they are not cohesive with the first condition. Stacey (2000) suggests that a dissipative system requires a constant flow of energy or information to sustain itself. However, this energy or information flow must be of a vigorous and rich nature to necessitate the system for operation in far-from-equilibrium conditions. If the structure augments, it requires more energy or information to sustain the shift than the more straightforward structure it replaced.

4. Lack of Inhibitors

   Extreme measures in anxiety can contain emergence. Extreme measures in power dynamics can also inhibit emergence. Hierarchical structures can suppress emergent behaviour, as they feel threatened by new possibilities in new organisational forms (Seel, 2003). Change to those in power can be daunting and can be a reason for resistance to change. Results are

uncertain, and shifts in dynamics might leave them vulnerable (Coch and French Jr, 1948). An example of this is an unwillingness to make any kind of self-sacrifice. Recognising that there might be a threat that challenges the core organisational identity to which attachment has taken place and general anxiety about change can kindle resistance (Thakur and Srivastava, 2018).

5. Good Boundaries

   Deadlines, clear goals and intentions, prescriptions about lengths or size, all of these are variants of well-bounded space, within which emergence relies on to occur. Leaders should give clear boundaries to liberate individuals, letting go of control, whilst retaining enough autonomy to referee when required (Seel, 2003).

   Seel (2003) adds that good boundaries are essential to another characteristic of complex adaptive systems: self-organisation. Adding that self-organisation is better formulated when; stringent boundary conditions specifying what is disallowed; the addition of a clear goal; then letting go to allow freedom with experimentation of the parameters. In summary, *"anything not expressly prohibited by the language of this agreement is allowed"* (Snowden and Boone, 2007).

6. Intentionality

   To encourage a particular kind of output, one must arrive at a specific input (positive intentions can lead to positive outcomes). This does not suggest that it is possible to influence total control over emergence, only a general direction. This emergent property is created from interactions within a human system, which then feedback into the system and influence its future development (Seel, 2003).

7. Watchful Anticipation

   Emergence cannot be rushed. Humans systems are often craving for action, and this can distil the effects of emergence. It requires patience and a sensitivity to the unfolding moment. Organisations find it difficult when attempting "real" change because it usually travels in ways that are concurrent with existing patterns. Doing things differently and being different is difficult (Seel, 2003).

Seel (2003) concludes that the emergent inquiry is still early in its implementation to broader organisational change. The command-and-control paradigm remains the prevailing manner in which organisations present themselves. This desire for certainty and belief in the possibility of ”making things happen” still exists in everyday practice. Emergent paradigms are being tested; many are being implemented in organisations. However, Seel (2003) affirms that an overarching framework is missing to justify them. However, frameworks have since been produced that propose to explain the emergent inquiry (Snowden and Boone, 2007). One such paper reviews the dichotomy between planned and emergent change in organisation development research. The conclusions suggest that the most effective approach for such a consideration is to connect planned and emergent change over time (Bartunek and Livne-Tarandach, 2009). This proposes an interesting discussion, as Seel (2003) never confronted planned change in his work.

Goldstein (1999) identifies emergence as an important construct in the study of organisational dynamics, and in particular, leadership. Typically, organisational structures, strategies, practices, leadership and follower roles are through impositions from command-and-control hierarchies. However, the construct of emergence would comprise of an alternative means. In its alternative means, emergence explains varied aspects of organisational dynamics through *“emphasising spontaneous innovations which emerge out of interactions within social networks of persons and between persons and technologies”*. These innovations, Goldstein (1999) implies, are understood as the emergence of collectivities at the macro-level out of connectivities at the micro-level. Many outcomes can present themselves unknowingly. This suggests that observable outcomes are more than merely the sum of the parts (Plsek and Greenhalgh, 2001). Goldstein (1999) provides reasoning for the matter: innovations influenced by “connectivities” at the micro-level are at an increased probability of demonstrating creative solutions, evoking commitment from employees. They are more likely to empower rather than disempower employee contributions.

The application of emergence reports that the self-organising processes operate in a ”bottom-up” manner, allowing occurrence to be frequent when command-and-control mechanisms are relaxed or dismantled (Chesters, 2018). Complexity theory proposes that the parameters of culture and social structure are all social acts of a particular kind (Stacey, 2000). This affirms that the repetitive and enduring values, beliefs, traditions, habits, routines and procedures are continually reproduced in the interactions between people. However, Stacey (2000) asserts there will always be variation

as habits are rarely definitive. Stacey (2000) suggests that organisational change is the same as a change in communicative interaction, prompting the awareness of the conversational life of people in organisations to be of primary importance in the creation of knowledge, or in other words, the facilitation of change.

2.3.5 Self-organisation

Self-organisation is a form of a distributed non-linear process of pattern formation. Organisations tend to "self-organise"; this occurs when some form of order arises from local interactions between the parts of an initially disordered system (Serugendo et al., 2003). A few common examples are flocks of birds, financial networks, social networks, global logistics networks, or the human brain. Without centralised control, global organisation is an emergent feature of the local interactions between the parts (De Wolf and Holvoet, 2004). These local interactions are otherwise known as attractors; attractors create and hold stable patterns within the system (Haynes, 2008). These attractors form a "landscape" that shape and determine patterns of interaction within the system (Stacey, 2000).

The notion of self-organisation is related to the interplay of feedback loops (Nicolis et al., 1989). When feedback systems are pushed far from equilibrium conditions, they can spontaneously produce complex forms of behaviour. This is a form of self-organisation where behaviour emerges from processes at the micro-level (Nicolis et al., 1989). Centralised, top-down regulation and control is only possible in linear systems; these systems are generally present in smaller organisations. Larger organisations with distributed connectivity, larger staff populations, and the capacity for autonomous decision-making become more difficult to coordinate from a centralised location. The high level of distributed interactions enables the formation of patterns to occur. There is a theoretical point of more non-linear distributed interactions than centrally routed connections, and this space allows self-organisation to take hold. These non-linear interactions contribute to the presentation of self-organisation.

Self-organisation often occurs out at the fringes where leadership is weak, and there are many local interactions. Self-organisation is often known as the study of patterns. In social systems, these are patterns of correlation, correlations between the choices of agents. Self-organisation changes

the correlation between agent states within the system; it coordinates them by using feedback loops (Dawkins and Barker, 2020). A positive feedback loop is self-reinforcing. Good examples of positive feedback loops are the contagiousness of positive emotions or motivational leaders. In all cases, more begets more. An attractor is a default set of states within the system; it is the pattern of organisation. Therefore, positive feedback loops can amplify small events into significant systemic phenomena, creating local attractors that have to cooperate or compete to achieve global coordination (Chesters, 2018).

2.3.6 Sensitive Dependence to Initial Conditions

The system is considered sensitive when tiny perturbations or variations in conditions lead to observable outcomes that are inherently unpredictable; it is impossible to add up all the small steps required to predict long-term development (Thomas, 2016). Systems are inclined to naturally evolve to a critical state in their lifecycle, in which they develop an extreme sensitivity to minor variations in conditions. One crucial point is that complex systems regularly operate in non-linearity (Simon, 1977). Here, Plsek and Greenhalgh (2001) remark on a property appearing in complex systems: *"a small difference in the initial variables leads to huge differences in outcomes."* The only way to know what a complex system will do is to observe it, stating that no further understanding of the agents, of better models, or more analysis will assist in this understanding (Plsek and Greenhalgh, 2001; Simon, 1977).

2.3.7 A Complexity Ontology

Bateson (1972) asserts that it is impossible to exercise power over an interactive system in which one is a participant. His point of view is congruent with the insights gained through the study of complexity. According to the concept of complexity in its different interpretations, the nature of the multiple interacting, continuously changing interactions and limits of the system hinders precise prediction over extended periods, making the scientific technique of verification difficult (Sice et al., 2018; Stacey, 2000). This has substantial managerial ramifications; the emphasis must shift from obtaining the desired state to maintaining attention on how organisational members interact in the present and what characteristics of these interactions enable learning and innovation.

The pattern and character of the actor's relationships determine the system's dynamics, and the dynamics of the system govern the reaction to any perturbation (Sice et al., 2008; Thirkle et al., 2018).

Imposing order in a complex environment will fail, but setting the stage, taking a step back, allowing patterns to emerge, and determining which patterns are desirable will succeed (Snowden and Boone, 2007). Then, by devolving power downwards, leaders may empower employees and create a culture that encourages individuals to be proud of themselves and their work. As a result, establishing a path to "wellbeing" increases employee satisfaction and engagement (Beggs, 2014).

A complexity ontology implies that controlling culture change would necessitate the following steps:

- The act of establishing boundaries. Barriers can restrict or define a person's actions and behaviour. The system can self-regulate within specified boundaries (Snowden and Boone, 2007). In the context of trauma-informed care, the boundaries would be based on fundamental principles broadly defining trauma-informed care, allowing for new interpretations and flexibility in practice to accommodate the wide range of trauma conditions, histories, and responses.

- Participating in the process of making sense of current reality while leaving assumptions and preconceptions open to study, challenging, and managing boundaries by engaging in dialogue; as a result, strategies such as deep listening (Bohm et al., 1996; Stowell, 2013) and quiet listening can be used to assist everyone in understanding the significance of empathetic listening, open communication, and not taking criticism personally (Snowden and Boone, 2007).

- The promotion of a variety of viewpoints. Accommodating a range of viewpoints and mental models while also recognising and regulating *weak signals*, which are the unforeseen or intended repercussions of perturbations that may escalate and cause a change in system behaviour (Snowden and Boone, 2007).

- Stimulation of attractors. Attractors occur when small stimuli and probes resonate with people (Stacey, 2000). As attractors gain momentum, they provide structure and coherence

(Haynes, 2008). Attractors provide shape and coherence as they develop momentum. In the context of trauma-informed care, these stimuli and probes would take the shape of safe-to-fail parallel interventions consistent with core trauma-informed care principles.

- Monitor for emergence. In practice, this will necessitate a trusted human sensor network that continuously provides mini-narratives of experiences and the ability to self-interpret them, resulting in an organisation-wide evidence system that tracks the direction of change and aids real-time decision-making.

- Concentrate on describing and reflecting on current interactions and how they help or hinder innovation and change (Thirkle et al., 2018).

In a complex context, outcomes are unpredictable; instead of attempting to achieve predefined outcomes and potentially missing possibilities that arise unexpectedly, the focus should be on establishing an atmosphere from which good things can emerge. Koya et al. (2015, 2016, 2017) research leadership qualities in the health care industry and recommend embracing uncertainty as it is a crucial trait of influential leaders. These findings align with contemporary discussions about leadership development in the NHS (Woods, 2014).

According to enactive cognitive science and findings from interpersonal neurobiology, awareness, knowledge, and abilities are embodied (Maturana and Varela, 1980; Varela, 1979; Siegel, 2011). The integration and stabilisation of attention in monitoring physical sensations, mental activity, and relationships is required for the intentionality of ”seeing reality” more clearly and continuously improving the capabilities of awareness and reflection. A heightened level of awareness is commonly referred to as ”mindfulness” in a western translation. This word is extensively used in the west, where ”mindfulness” is described as the opposite of ”mindlessness,” which is characterised as operating on autopilot or just downloading mental models, assumptions, and prejudices rather than seeing present reality as it occurs. Kabat-Zinn (2003, p 143) gives the following operational definition of mindfulness: *”The awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience, moment by moment”*. It is important to note that this understanding of mindfulness, defined as paying attention to experience as it unfolds, is not only linked to present-moment sensations but also to accepting and witnessing the present-moment experience, which can include any or all aspects of

experience, such as sensations or mental activity; thoughts, feelings, memory, intentions, beliefs, attitudes (Siegel, 2011).

According to studies in neurobiology (Varela, 1979), awareness development techniques are linked to the development of the pre-frontal cortex of the brain. The vertical (gut, heart and cortex) and horizontal (left and right brain hemisphere) integration of the brain and the development of qualities like emotional balance and modulation of fear; response flexibility – pause before you act; insight – linking past with present experience and future possibility; empathy and compassion for ourselves and others; morality – what is appropriate from the perspective of the common good; intuition - non-rational way of wisdom and knowledge, and thus with well-being (Siegel, 2011; Vyas et al., 2012). Mindfulness, mindful compassion, and Mindsight (Siegel, 2001) are critical for maintaining awareness and spotting "weak signals," attunement in dialogue with staff and service users, and promoting resilience and well-being in the context of trauma-informed care. According to recent research in the health industry, organisations that provide work environments that promote physical and mental well-being and compassionate communication have higher employee engagement (Koya et al., 2017, 2016).

Complexity insights can be utilised in practical frameworks, and these frameworks are seen to be favourable (Jennings, 2004). The complexity insights are contested in their application to healthcare organisations. However, Jennings (2004) suggests using the metaphors of complexity as a pragmatic toolkit in research.

2.4 The Complexity of Culture Change

Changing an organisation's culture is a complex process. The definition of organisational culture is questioned, and its existence is questionable. Its presence must be accepted, and significance must be given to meaning. There are numerous approaches to culture change. However, complexity theory would determine that it is only possible to change the culture by observing it first. This review of the literature would, so far, give sufficient evidence to support the claim that culture change exists in the complex domain and that organisational culture, for the most part, is intangible. Concluding, the only way that organisational culture can be observed in the present moment is through intangible culture (Snowden and Boone, 2007). These are displays of language or other

practices, representations or expressions.

Viewing mental health services as a hierarchy of interrelated systems that interact in non-linear ways grants an appreciation of the configuration of relationships and an understanding of what creates patterns of order and behaviour among a system's components. Deconstructing this statement, systems include the people of the organisation, among other sub-systems. This view permits the understanding of the patterns of order and behaviour between people and other systems. However, emphasis is applied to people, as people are the active components of culture, and they are as interpreted: *"human systems"*. They create it, and they consume it. Therefore, people present an understanding of culture and a glimpse of how culture change might occur (Jennings, 2004).

The use of quantitative approaches is not suited to gain insights into organisational behaviour. Complexity instead relies on qualitative methods, as it draws upon the metaphors of chaos to collect insights (Jennings, 2004). An organisation's culture is directed by guiding principles. Mental models held by individuals in the organisation determine the direction of the organisation (Seel, 2003). Mental models can be observed through interactions between people, and organisational attractors can emerge from the interaction of mental models (Haynes, 2008). An organisational attractor is a suggestion that can offset the direction of agents (Stacey, 2000). Agents being the organisation or the organisation's constituent parts. By appointing simple rules, it is possible to allow the system to emerge in a more desirable pattern of order (Plsek and Greenhalgh, 2001). A narrative-based approach, or observation, can assist in detecting simple rules already in existence (Seel, 2003).

Introducing probes and safe-to-fail experiments can provide the observations of patterns, and if a pattern emerges, it is called an attractor. If it is beneficial, an attraction will form. If it is positive, further resources are given to support this attractor. If it is negative, an appropriate response is needed to divert resources away from this attractor (Snowden and Boone, 2007). A similar governance structure is required organisation-wide, but different approaches will work on separate occasions; thus, a bespoke approach is often necessary for various subgroups or subcultures. However, change occurs on an individual level. Interactions are vulnerable to change, and individuals divert control in their preferred direction. People evolve as a community-based intelligence.

Complexity theory is a beneficial approach to research when treated as a pragmatic toolkit (Jen-

nings, 2004). Factoring in characteristics of emergence, self-organisation, and the sensitivity to initial conditions can assist with the understanding of human systems and their constituent parts. Snowden and Boone (2007) sum it up neatly: *"We manage the emergence of beneficial coherence within attractors, within boundaries, allowing locally valid solutions to emerge"*.

2.5 Trauma-informed Care: A Perspective from the Literature

The trauma-informed care approach is founded on the assumption that most people who contact human services have been through some trauma, struggle, or loss (Anda et al., 2006). This knowledge must be shared by all parties involved in order for it to pervade service relationships and delivery (Fallot and Harris, 2001). To address toxic stress in organisations, sustained long-term system leadership and governance, and a culture of open learning are needed (Bloom and Sreedhar, 2008). Paterson (2014) defines trauma-informed care as: *"a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development"* (Thirkle et al., 2018).

Yatchmenoff et al. (2017), based on a systematic review of trauma-informed care literature, argues that trauma-informed care principles fall into three domains: safety, empowerment, and self-worth. Trauma-informed care is a system-wide endeavour; it aspires to change the organisation and its aspects to be sensitive to the potential existence of trauma. However, this does not necessarily require the organisation or the people within it to provide the treatment or interventions that work on the trauma symptoms (Quadara and Hunter, 2016; Thirkle et al., 2018). There are several published sets of trauma-informed principles to guide implementation efforts (Baker et al., 2016; Bassuk et al., 2017; Elliott et al., 2005; Fallot and Harris, 2015; Goodman et al., 2016; Jennings, 2004; Richardson et al., 2012; SAMHSA, 2014*b*). The frameworks provided by Jennings (2004) and Elliott et al. (2005) both include access to trauma-specific therapies as a critical component. These desensitisation and behavioural therapies include grounding techniques, which assist trauma survivors in managing dissociative symptoms. These guiding principles act as simple rules for all those in the organisation to follow.

Harris and Fallot (2001) initially presented five core values of trauma-informed care: Safety; Trustworthiness; Choice; Collaboration; and Empowerment. These principles have been expanded upon and further developed by other researchers (Baker et al., 2016; Bassuk et al., 2017; Elliott et al., 2005; Goodman et al., 2016; Jennings, 2004; Quadara and Hunter, 2016; SAMHSA, 2014*b*; Sweeney et al., 2016; Richardson et al., 2012; Yatchmenoff et al., 2017). There are many principles to be found in the literature, and their similarities are easy to identify. Moreover, Quadara and Hunter (2016) note a congruence on the principles in the literature and define a summary:

- Having a solid explanation for the incidence and character of interpersonal violence-related trauma, as well as its effects on other aspects of life and functioning;
- Ensure that organisational, operational, and direct service provider methods and procedures do not jeopardise, but rather enhance, consumer and survivor physical, psychological, and emotional safety.;
- Adopting service cultures and practices that emphasise autonomy, collaboration, and strength-based approaches that empower consumers in their recovery.;
- Recognising and responding to consumers' personal, social, and cultural settings, which affect both their demands and recovery and healing pathways;
- Recognising the interconnectedness between trauma and healing (Quadara and Hunter, 2016).

Efforts to define trauma-informed care, determine its principles, and build engagement require a focus on implementation (Miller and Najavits, 2012). Service providers want specific examples of what it means in practice and the most effective techniques for implementing the necessary changes. However, Yatchmenoff et al. (2017) point to a plethora of national centres, web-based resources, conferences, training opportunities, and experts who can provide technical assistance or consultation, concluding that much of the implementation discussion is still academic, based on principles and general guidelines. However, most of this work does prove useful (Thirkle et al., 2018). Such as the five initial principles provided by Harris and Fallot (2001), and subsequently, the development of other principles by other authors (Baker et al., 2016; Bassuk et al., 2017; Elliott et al., 2005; Goodman et al., 2016; Jennings, 2004; Quadara and Hunter, 2016; Richardson et al., 2012; SAMHSA, 2014*b*; Sweeney et al., 2016; Yatchmenoff et al., 2017). SAMHSA (2014*b*) identified ten implementation domains derived from organisational change management

literature and other models for the implementation of Trauma-informed Care: Governance and Leadership; Policy; Physical Environment; Engagement and Involvement; Cross-Sector Collaboration; Screening, Assessment, and Treatment services; Training and Workforce Development; Progress Monitoring and Quality Assurance; Financing; and Evaluation.

Each of these domains are important to consider. However, effective self-assessment, tracking, monitoring of trauma-informed principles, and effective use of evidence-based trauma-specific screenings, assessments, and treatments must occur regularly for successful implementation. Conducting trauma-informed organisational assessments or having measures and indicators in place to show their level of trauma-informed application is paramount. This involves considering people who have experienced trauma, enabling the collection of feedback from people who use services whilst retaining anonymity and confidentiality and monitoring the organisational progress in becoming wholly trauma-informed. More importantly, is that these principles are put into action (Sweeney et al., 2018).

2.5.1 The Rationale for Trauma-informed Practices

People who come into contact with mental health services and have experienced sexual or physical abuse as a child are more likely to require prolonged psychiatric treatment, more likely to self-harm, are admitted to hospitals more frequently, prescribed more medication, and are more likely to die by suicide than those who have not (Read et al., 2009). Because of the operational principles of coercion and control, survivors are frequently re-traumatised when they come into contact with mental health systems (Bloom and Farragher, 2011). Many trauma-informed service frameworks recognise that people who use services may have experienced trauma. This trauma may have impacted them in ways that affect their interactions with that service, making it difficult to form trusting relationships and results in feeling insecure in services (Sweeney et al., 2018). Instead, trauma-informed services are delivered in ways that promote safety and trust while avoiding re-traumatisation. Training, supervision, and employee assistance are critical to achieving this goal, and they can help avoid burnout and reduce staff turnover (Sweeney et al., 2016). Staff and service users are both affected by mental health services. Service users may feel threatened and act aggressively towards workers. As a result, employees may become suspicious and angry. Organisations may use punitive and risk-averse tactics in response (Fallot and Harris, 2001). The impact

of trauma on a person's ability to survive in the present moment is understood by all staff participating in trauma-informed mental health care. The most crucial shift consists of shifting from the thinking *"what is wrong with you"* to *"what happened to you"* (Fallot and Harris, 2001).

Current services and supports that fail to recognise the significance of trauma in people's lives and fail to recognise the need for safety, mutuality, collaboration, and empowerment should expect to witness re-traumatisation, leading survivors to seek other ways to cope (Sweeney et al., 2016). The notion that the services where people can seek help might traumatise people more is discussed by Jennings (2004) and Sweeney et al. (2016). Staff working in mental health services may face conflicts between their personal and ethical standards of conduct due to the policies, procedures, and practices they are compelled to follow (Haddad and Geiger, 2018). An example is given by Sweeney et al. (2016): *"The use of seclusion and restraint as an institutional practice erodes the very meaning of compassion and care, the primary reasons why most staff enter their chosen field."* Staff members are under constant stress due to conflicts between their employment responsibilities and their moral code, and they must learn and adapt (Haddad and Geiger, 2018). Coping mechanisms can include losing the ability to empathise, perceiving individuals as *"others"*, and disregarding their humanity and fundamental human rights (Sweeney et al., 2016). These situations have the potential to create corrupted cultures. It is expected that in corrupted cultures, the organisation's core principles are no longer sought. Staff needs are prioritised over those of service users; when less restrictive solutions are available, coercion and control may be used (Sweeney et al., 2018). Many working practices and routines (professional hierarchies and lack of supervision for staff) that are in place dehumanise both staff and service users and lead to human rights violations (Sweeney et al., 2016). Preventing further harm is a core challenge for any system wishing to move towards trauma-informed practice. The Hippocratic Oath is commonly known for one of its main principles of non-maleficence; this simple practice of "do no harm" can be strongly correlated to trauma-informed practice. The trauma-informed approach applies to the delivery of all human services because of the focus on minimising further harm and the attention it pays to the impact of the work on staff. This is particularly relevant in mental health services as vicarious trauma can take its toll on staff (Bober and Regehr, 2006).

2.5.2 The Implementation of Trauma-informed Care

Yatchmenoff et al. (2017) detail trauma-informed care initiatives as usually subscribing to the Plan-Do-Study-Act (PDSA) model of iterative change. Yatchmenoff et al. (2017) expand on this by detailing the typical process: the early stages of the trauma-informed care initiative involve acquiring foundational knowledge, generating buy-in, and ensuring other elements of readiness. They begin with foundational training and establishing a workgroup that is charged with leading the implementation effort (Fallot and Harris, 2015). All staff in the organisation are expected to receive training in the core knowledge areas (Thirkle et al., 2018). Shortly after training, the trauma-informed care workgroups monitor results, propose additions, identify strengths and challenges. However, Taylor et al. (2014) report that the application and use of the PDSA method is often unproductive, insisting that a consistent reporting mechanism is needed when following cycles like the PDSA method - stating that this would allow for meta-evaluation and systematic reviews to adapt and improve the cycle to increase chances of success. Leis and Shojania (2017) also support this by concluding that teams must perform self-assessment around the authenticity of PDSA application to ensure that the PDSA cycle is successfully harnessed. If trauma-informed care initiatives follow the PDSA cycle closely, they too should perform self-assessment and conduct systematic reviews for continuous improvement.

It is critical to develop a workgroup to keep the momentum going throughout the organisation and serve as a role model for trauma-informed practice. Effective communication can help the group and its methods become more institutionalised while also ensuring that no single person is completely responsible for the endeavour (Fallot and Harris, 2015). If trauma-informed care is a response to address the growing awareness around the role of trauma in mental health, looking to models of organisational compassion might be fruitful. Frost et al. (2006) describe how a compassionate organisational response can focus on the interpersonal skills of the staff (particularly frontline staff), the systems that enable those staff to do their jobs effectively, and finally, the organisational narratives surrounding the nature of the tasks and how they are integrated into policies and strategies. Pathways are one way of describing the task; members of the trauma-informed workgroup can walk through a client's experience from the moment the service need arises, including referral or self-referral, initial contact, appointment scheduling, entry and intake, the waiting room, location of bathrooms, signage, all the way to exiting services (Sweeney et al.,

2018). These pathways explore each step for situations that could trigger a trauma reaction, fail to trigger a trauma reaction, or even welcome one. This method appeals to direct service staff because it is concrete rather than abstract and includes the experiences that service users might have shared. Utilising a narrative-based approach allows for ease and effectiveness for direct involvement from individuals with lived experience of trauma and the service system in question (Snowden and Boone, 2007). The narrative-based approach helps gather information from consumer advisory groups or listening sessions with service users (Thirkle et al., 2018; Yatchmenoff et al., 2017).

Commissioned services need to show that the changes they make align with the trauma-informed vision (SAMHSA, 2014*b*). However, most of the current understanding of trauma-informed care rests on principles and values rather than specific recommendations for action (Yatchmenoff et al., 2017). The literature is now growing in information regarding what commonly happens in the implementation process, the barriers encountered, factors that can facilitate the process, and how organisations are effectively moving forward despite significant challenges (Yatchmenoff et al., 2017). However, there is still work to be done. Building the planning process around the principles seems to be a common approach in facilitating trauma-informed care. Although some frameworks and instruments propose to measure: what changes, how many changes, what type of changes would influence these or other outcomes, and how long it should take for outcomes to be realised, promising results are yet to be reported (Thirkle et al., 2018).

Trauma-informed care requires all agents operating within the environment to be engaging in trauma-informed practice. Trauma-informed care can be objectified under three essential domains, of which all other definitions fall under: safety, empowerment, and self-worth (Yatchmenoff et al., 2017). By effectively assessing, tracking, and monitoring these principles, organisations can determine adherence to trauma-informed practice (SAMHSA, 2014*b*). By setting simple rules and establishing boundaries, it is possible, in combination with a narrative-based approach, to observe individuals' mental models and witness the implementation of trauma-informed care.

2.5.3 Evaluating the Implementation of Trauma-informed Care

SAMHSA (2014*c*) recommend conducting an organisational self-assessment of trauma-informed

services. This self-assessment should evaluate the current effectiveness of trauma-informed practices across each service and level of the organisation. It is intended to provide feedback to allow for learning and development. It can also serve as a *"blueprint for change, and as a benchmark of compliance and progress in implementing trauma-informed care practices across time"* (SAMHSA, 2014*a*). Advising that any self-assessment should obtain feedback from key stakeholders, particularly consumers, family members, referral sources, community organisations, and all levels of the organisation's staff (SAMHSA, 2014*c*). The assessment should not be undertaken on a one-time basis. It should be repeated frequently to assist in quality improvement. Using self-assessments and evaluating ongoing processes can assist in ensuring the stability of a programme (SAMHSA, 2014*b*).

There are many self-assessment models available in the literature; however, models with a conceptual domain similar to the organisation's area of interest should be used (Ford and Evans, 2002). This is difficult in certain areas of interest like trauma-informed care, as models are scarcely available. However, this provides the opportunity for development. Regardless, Cross (1989, p 7) suggests that an organisation must be culturally competent to enable effective self-assessment. Cultural competence refers to *"a set of congruent behaviours, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in multicultural environments"*. Organisations change continuously, and maintenance through periodic reassessments and adjustments is needed to keep up with this ever-changing dynamic. Suggesting the need for self-assessment reassembly as often as necessary. To build an instrument that would allow for effective self-assessment, achieving organisational cultural competence is vital. Ford and Evans (2002) suggest that the conceptual domain, concreteness, diagnostic guidance, affiliation, and validity are factors that can separate a good model from a less effective one. Chiarenza et al. (2019) indicate that the self-assessment tool should show the main areas that should be addressed and Cross (1989) contributes to this by suggesting three principal components to building a practical self-assessment tool:

- The organisation needs a defined set of values and principles, along with demonstrated behaviours, attitudes, policies, and structures that enable effective work across cultures;
- The organisation must value diversity, manage the dynamics of difference, acquire and institutionalise cultural knowledge, and adapt to diversity and the cultural contexts of the

communities it serves;

- The organisation must incorporate the above in all aspects of policymaking, administration, and service delivery and systematically involve consumers and families.

A self-assessment tool meeting the first component would define a set of values and principles (Cross, 1989) or main areas that should be addressed (Chiarenza et al., 2019). All members of the organisation should experience these core values. This is to behave in ways that reflect the organisation, to possess an appropriate attitude, to agree with policies, and to work alongside structures that are fit for individuals. These simple rules help steer the organisation towards its goals. The second component requests the organisation to be flexible, adaptable, and responsive to change. The self-assessment must acknowledge the dynamics of the system. The third component requires the permeation of all the above components in the organisation. If the organisation does not adopt these fully, it cannot say that it is culturally competent. Similarly, if an organisation does not assume the values, principles, behaviours, attitudes, policies and structures accompanying trauma-informed care, it cannot claim to be trauma-informed (Fallot and Harris, 2001). According to Ford and Evans (2002), self-assessment tools that are broad in their impact typically examine organisational performance, while narrow tools examine quality assurance. Trauma-informed care sees individuals and their needs as the highest priority. It certainly lends itself towards quality assurance rather than organisational performance, which would indicate that the scope of trauma-informed care self-assessments is narrow. This is not to suggest that trauma-informed care is ignorant of organisational performance, as that is also a serious consideration.

The awareness of cultural competence is not unfamiliar to the implementation literature of trauma-informed care. SAMHSA (2014*a*) provides a manual for organisations to develop their organisation's cultural competence. It insists that to create a culturally competent organisation, the organisation must be equipped with the tools to gather and collect information from all levels of the organisation. Collecting information allows monitoring and feedback from all perspectives on a project; it highlights areas in need of improvement and determines the effectiveness of implementation. Organisations must be aware of how they function, and evaluation needs to occur on operational aspects of the organisation. Organisations using self-assessments improve their level of awareness by measuring compliance, effectiveness, or quality improvement procedures. These self-assessments allow organisations to gauge the effectiveness of an organisation's services, struc-

ture, and practices. Organisations obtain considerable information from collecting feedback from many internal and external sources; this information can include data on current performance, areas requiring improvement, and developmental needs (Saunders and Mann, 2005).

SAMHSA (2014*a*) also provide an eight-step plan for organisations to move towards cultural competence. This cultural competence plan can be followed to adopt any other culture-change or paradigm shift, such as trauma-informed care. There are eight suggested steps to guide and support this plan. The eighth step is an important consideration to this study. This step alone indicates that the development of ongoing monitoring and performance improvement strategies is crucial, stating that it is only worthwhile if these provide guidance, determine direction and priorities, and facilitate action. Monitoring should be continued throughout, not only to evaluate progress and performance but also to acknowledge changes; these might exist in the form of new service needs. A system that allows perpetual monitoring will enable an organisation to formulate strategies to meet new demands and continuously improve the quality of services. Therefore, a self-assessment tool must consider previously published documentation; otherwise, an unnecessarily elongated instrument development process may be needed. Self-assessments specific to trauma-informed care are to be developed with consideration to the information generated previously. By providing guidance, determining actions and priorities, facilitating those actions, prescribing self-assessment on a recurrent basis, and undergoing frequent ”maintenance” through a reassembly process, it is possible to effectively self-assess the climate of trauma-informed care (Cross, 1989; Fallot and Harris, 2001; Ford and Evans, 2002; SAMHSA, 2014*a*).

Hummer et al. (2010) undertook a case study approach to address whether and how organisations supported trauma-informed practice in addition to the clinical practice elements that specifically address trauma. Conducting a total of 75 interviews, 33 clinical record reviews, 12 treatment team observations and reviews of policy and procedure manuals at eight sites nominated by peers as using trauma-informed care practices. The findings from the site visits were analysed using an adaptation of the original self-assessment scale developed by Fallot and Harris in 2006 (Fallot and Harris, 2006). This measure was initially designed to operate within adult service-system organisations. This measure identifies six domains of trauma-informed care; these domains were constructed with the support from research with female survivors of trauma, reflecting on programme procedures and settings. Hummer et al. (2010) adjusted this measure for use with organisations

providing residential treatment services to children and youth with the permissions of the original authors. Following data collection, a scale of high, moderate, or low trauma-informed care implementation was assigned to organisational-level policies and practices. Results demonstrated the importance of including an organisational self-assessment and process in the trauma-informed care curriculum. Findings suggest that organisations are not fully embracing trauma-informed care. This led to the realisation that trauma-specific interventions are not the only aspect of fostering the culture change necessary for success. Thereafter, Hummer et al. (2010) developed a curriculum consisting of three modules utilising the collaborative learning model. The first module, *Understanding Trauma and Trauma-informed Care*, attends to learning principles of trauma-informed care. Paying attention to safety, trustworthiness, choice, collaboration, empowerment, skills acquisition, empathy, and the role relationships play in healing trauma. This module stands as an introduction to trauma-informed care; it allows participants to develop their philosophy and commitment. The second module, *Application of the Learning Collaborative Model to Florida Residential Treatment Settings for Youth*, concentrates on developing an understanding of why the collaborative learning model was selected to implement trauma-informed care practices. Hummer et al. (2010) elaborated on this selection, stating that it was chosen for its focus on adopting best practices in diverse service settings and emphasised adult learning principles, interactive training methods, and skills-focused learning; capitalising on shared learning and collaboration. Module three, *Getting Started: Metrics and Organisational Assessment Tools*, raises awareness on feedback to organisational change. In this module, the importance of self-assessments are highlighted, emphasising their assistance with positive change and transparent culture. This module is arguably the most critical module for sustaining trauma-informed care as: *"changes in outcomes and practice, however small, need to be observed, recorded, and given as feedback to all levels of the organisation (leadership, clinical, milieu) as frequently as possible"* (Hummer et al., 2010). This is also congruent with complexity theory; this is similar to the "butterfly effect", which is the sensitive dependence to initial conditions, implying that a slight change in one state of a deterministic non-linear system can result in significant differences in a later state. By constantly observing the ever-changing positions that differ moment-to-moment, it is possible to peek into the future or observe a possible trajectory temporarily.

2.6 Monitoring the Implementation of Trauma-informed Care

SAMHSA (2014*c*) proposes that various strategies can be used for collecting data and communicating findings to stakeholders. It is attempted here to identify such strategies for collecting data. Many frameworks and instruments propose to assist in the evaluation of trauma-informed care. Few are easily found in the literature, and there are fewer that are reported. There may be more frameworks or instruments hidden in the depths of literature. It was found that many organisations have developed their tools and have decided to keep them hidden or kept at bay by cost. Table 1 demonstrates 15 of these instruments in the literature (Thirkle et al., 2021).

Table 1: Instrument Comparison

Instrument Name	Main Features	Timeline	Scope of Use
Agency Self-Assessment	Self-report questionnaire. Can be implemented online	NR	Used to assess the organisation's readiness to implement a trauma-informed approach
Attitudes related to Trauma-informed Care	A psychometrically valid measure of trauma-informed care. In-depth development process Can be implemented online	2012	Assess service providers' attitudes relevant to Trauma-informed care
Creating Cultures of Trauma-informed Care	Acts as a set of guidelines or framework for adopting trauma-informed care	2001	To be used in the development, implementation, evaluation, and ongoing monitoring of trauma-informed care
TICOMETER	A psychometrically valid measure of trauma-informed care. In-depth development process	NR	To measure staff's perceptions of trauma-informed care adoption. It does not directly measure the perceptions of service users

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TIP Scales	In-depth development process. Free to access TIP guide	NR	An exploration into whether and to what degree programmes are succeeding in their efforts to adopt a trauma-informed approach
National Council for Behavioural Health: TIC organisational Self-Assessment	Self-report questionnaire	NR	Designed to increase awareness and readiness to adopt the key components of a trauma-informed care organisation and to identify what is required to keep doing and reinforcing, stop doing, or start doing the right thing
PRoQOL	Not a measure of trauma-informed care adoption, but a measure of the aspects of caring	2009	To measure the positive and negative aspects of caring
TIC-OSAT	Strengths-based organisational tool	NR	Provides organisations with a point in time snapshot
TIAA	Validated tool. Self-report questionnaire	2012	Pinpoint areas where organisations are doing well and pinpoint areas for improvement
Trauma-informed Organisational Self-Assessment	Built with feedback from trauma and research experts, consumers, and community providers	NR	Organisations can use this assessment to examine their current practices and take steps to become trauma-informed

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TISCI	Uses a systems perspective. The wording has universal meanings. In-depth development process	2010	Provides a snapshot of the extent to which the current community child welfare system is trauma-informed
TreSIA	A self-report questionnaire using score mapping	NR	Assess readiness for implementation of trauma-informed care
Trauma System Readiness Tool	A self-report measure designed for child welfare systems to use	2012	Part of an extensive practice toolkit that includes several resources to be used by child welfare systems in their goals to become trauma-informed
TIC in Youth Service Settings: OSA	Self-report questionnaire	NR	Implementation of elements inclusive in the instrument, representing an ideal to strive for
TICPOT	Comprehensive questionnaire	2015	TICPOT is designed to support staff and services to continue to develop their practices of becoming aware of people engaging with their service, which may be impacted by past and current trauma.

End of table

2.6.1 Attitudes Related to Trauma-informed Care Scale

The Attitudes Related to Trauma-informed Care Scale (ARTIC) is tailored towards human services focusing on the education sector. This tool is a psychometrically valid measure of trauma-informed care. It has a credible history and an established development process. The development of the ARTIC involved an extensive literature review and then used a mixed-methods approach

to developing the domains and items within. The founders of the ARTIC used community-based participatory research methods. Three versions of the ARTIC exist for human service settings: a 45 item scale, a 35 item scale, and a 10 item short form. There is also a parallel version for educational settings. The ARTIC assesses the readiness for and barriers to trauma-informed care implementation; it purports to obtain a baseline measure to assess change over time as a result of trauma-informed care interventions. It can determine which staff might need additional training and supervision related to trauma-informed care. The ARTIC is accompanied by a published article which documents a psychometric assessment of the tool. This tool measures attitudes and not behaviours. It consists of seven domains that represent: *"much of the current thinking about important elements of trauma-informed care"*, five of which are labelled as primary subscales, and two labelled as supplementary subscales. The five main subscales are 1) Underlying Causes of Problem Behaviour and Symptoms, 2) Responses to Problem Behaviour and Symptoms, 3) On-the-job Behaviour, 4) Self-efficacy at Work, and 5) Reactions to the Work. The supplementary subscales are 6) Personal Support of Trauma-informed Care and 7) System-wide Support for Trauma-informed Care. These subscales were developed using multiple sources, utilising theoretical and empirical literature on trauma-informed care, the internal expert knowledge related to psychological trauma, and trauma-informed care implementation. It includes 75 items in total with a subtracted amount for the shorter forms.

Baker et al. (2016) used a partnership-based approach to develop a direct, efficient, and cost-effective measure of trauma-informed care focused on evaluating the trauma-informed attitudes of staff directed at settings serving individuals with histories of trauma. During development, the ARTIC was deployed to 760 staff employed in education, human services, and health care. Using the ARTIC is a *"relatively brief, flexible, efficient, and cost-effective measure that can be easily administered and used by organisations"* (Baker et al., 2016, p 72). There are three versions of the ARTIC, the ARTIC-45 being the most comprehensive scale, ARTIC-35 can be used when the organisation has not yet introduced the idea of trauma-informed care, and the ARTIC-10 can be administered if the organisation has limited resources. The ARTIC is a quantitative analysis tool focused on evaluating the attitudes of service providers. Baker et al. (2016) recommend that service providers embody trauma-informed care in their everyday interactions with students and clients.

The 45-item ARTIC scale is argued by Baker et al. (2016) to be both valid and reliable. It proved to be factor structure consistent with research and theory, alongside finding evidence for internal reliability and temporal consistency over six months of ARTIC use. As the ARTIC is a measure of attitudes and not of behaviours, it was necessary to conduct preliminary data collection of bespoke metrics exclusive to individual organisations. Using the ARTIC might assist in providing easy-to-use benchmarks relevant to trauma-informed care adoption and implementation; however, as individuals differ in their subjective perspectives on trauma-informed care, this might prove difficult to transfer from organisation to organisation, especially across multi-disciplinary sectors. Instead, it would be advisable to suggest that a bespoke use of the ARTIC to provide periodic updates to benchmarks is used. For example, if the ARTIC were conducted monthly as a "culture-scan", it would be necessary to perform preliminary data collection on metrics that staff might perceive as objective to trauma-informed care. By doing this, it is possible to align individual goals with organisational ones. However, this would be temporary and would require the organisation to be flexible with its goals. As the organisation grows, so must its goals. A constant adaptation process must exist in the form of feedback loops. It is heavily advised by Baker et al. (2016) that research into trauma-informed care implementation and evaluation must ensure that all stakeholders are represented. Trauma-informed care requires both system change and personal change.

The ARTIC intends to fill the gaps in trauma-informed care implementation literature. There is still no objective way to determine the extent to which an individual or system is trauma-informed. The ARTIC does indeed begin to fill this critical gap by taking, arguably, the first well-derived and strongly supported step into measuring trauma-informed care, albeit assessing only one central component: service providers' attitudes around trauma-informed care. Although the ARTIC is promising, it does omit a larger role in the organisation. The adoption of trauma-informed care is a culture change - which by nature is inherently complex. Therefore, any culture change must factor in the complexities of the situation. It is not clear that the ARTIC does this. However, there is slight acknowledgement with a previous statement from Baker et al. (2016): *"Who through their everyday interactions with students and clients, embody trauma-informed care within an organisation"*. This statement is the embodiment of a complex culture change. However, the ARTIC does not examine these interactions in-depth, choosing only to focus on quantitative methods rather

than the opposite, examining these interactions in detail. The ARTIC offers a partial picture of trauma-informed care evaluation.

Baker et al. (2016) forward the notion that trauma-informed care is a paradigm shift away from traditional practices, agreeing that organisations must be ready to adopt this change. Being change-ready is crucial for successful adoption. Sustaining a culture change is difficult, especially when wider system pressures act against the change and operate as a functioning norm, even when this state is self-deprecating. The ARTIC has a wide range of uses, from assessing if the organisation is change ready to test out the efficacy of interventions. The ARTIC is valuable to a certain extent but does miss out on crucial qualitative data collection. It is stories, not numbers, that enable a fuller understanding of the mechanisms of human attitudes and behaviours (Snowden and Boone, 2007).

2.6.2 TICOMETER

The TICOMETER is also a psychometrically valid measure of trauma-informed care. It is designed for use in health and human services. It has an established development process fostered by an expert panel comprising researchers, clinicians, trauma experts, and people with lived experience of recovery from trauma. The TICOMETER is a valuable contribution. However, it was only developed to determine the staff's perceptions of the degree to which trauma-informed care has been implemented. A published article accompanies the TICOMETER. It works by assessing five essential trauma-informed domains: 1) Building Trauma-informed Knowledge and Skills, 2) Establishing Trusting Relationships, 3) Respective Service users, 4) Fostering Trauma-informed Service Delivery and 5) Promoting Trauma-informed Policies and Procedures. It has a total of 35 items, making it a concise tool. The TICOMETER measures 35 trauma-informed care indicators in less than 15 minutes. It works based on individual staff responses and utilises the entire organisation to gather data. It works on assessing the level of trauma-informed care, staff training needs, and implementation priorities. The TICOMETER is the first psychometrically validated instrument that measures the levels of trauma-informed care in health and human service organisations. On the assessment of trauma-informed care, an acute definition is provided by Bassuk et al. (2017, p 151), *"Organisations, with the input of service users, must modify their values, principles, and culture to ensure that services, practices, and policies are trauma-informed"*.

The development of the tool was conducted with an expert panel that selected relevant items and domains. This expert panel comprises researchers, clinicians, trauma experts, and people with lived experience of recovery from trauma. The expert panel, alongside existing literature and assessment tools, were used to generate these *"pertinent organising domains"*. Rating scale models, confirmatory factor analytic (CFA) models, internal consistency and test-retest reliability statistics, and receiver-operating curves were used to assess the item fit, reliability, and face and construct validity of the TICOMETER. Each domain reflects a critical dimension of trauma-informed care defined by panel members, service users, the literature, and previous trauma-informed organisational self-assessment tools. The domains reflect the widely accepted principles of trauma-informed care and parallel the domains identified in other organisational assessment tools. Reportedly, the TICOMETER domains presented high reliability along with good item and CFA fit. There were notable associations between domain scores and a priori rankings, which demonstrated the validity of the domains. The authors and the expert panel generated items for each domain, ending with a refined 35 items. The guiding principles in this development process are that each item should be understandable without a priori understanding of trauma-informed care. A forced-choice response format was chosen to enable respondents to signal their agreement or disagreement.

An initial refinement survey was launched as there were 189 items developed initially. This was hosted via Survey Monkey and was completed by 667 service providers. Recruitment was conducted through e-mail and telephone outreach. A broad range of staff were recruited, as is aligned with trauma-informed care principles; all practices and policies should be clear to all levels of staff. During analysis, expert panel members designated the organisation's level of trauma-informed care. This process resulted in a final set of 25 items across the five domains. By developing a scoring system, it was identifiable to monitor if an organisation had excellent, good, fair, or insufficient levels of trauma-informed care; for organisations to be considered highly trauma-informed, most of the items need to have a firm agreement (Bassuk et al., 2017).

Bassuk et al. (2017) also identify that there are no brief measures with strong psychometric properties that systematically assess trauma-informed care at the organisational level. Commenting on the few tools that exist merely act as guides for creating a trauma-informed programme through a lengthy process. The TICOMETER measures the perceptions of all staff, including administrative, clinical, and executive members. The TICOMETER, however, fails to measure the service user's

perceptions, which could be considered the most important, as they are on the receiving end of trauma-informed care culture. Bassuk et al. (2017) affirm that high-quality measures must be developed, as they are a necessary component for building trauma-informed human service delivery systems.

2.6.3 Trauma-informed Practice Scales

The Trauma-informed Practice (TIP) Scales followed an extensive and established development process. It began with a comprehensive literature review. Interviews with trauma-informed care experts were conducted, and focus groups were followed and held with survivors and advocates of trauma-informed care. It was designed for non-specific use. A published article also accompanies it (Goodman et al., 2016). The domains are: 1) The Environment of Agency & Mutual Respect, 2) Access to Information to Trauma, 3) Opportunities for Connection, 4) Emphasis on Strengths, 5) Cultural Responsiveness & Inclusivity, and 6) Support for Parenting. The assessment included a total of 33 items.

Trauma-informed care is symbolic of general expectations for competent practice, possessing characteristics such as showing respect, holism and of being a strengths-based approach. However, trauma-informed care is also indicative of specific practices, such as staff training on the nature and effects of lifetime trauma, universal screening for trauma history, and service user education on "trauma triggers" and potential coping responses (Goodman et al., 2016). Goodman et al. (2016) recognise a notable absence of a measuring system that can establish, refine, and promote trauma-informed approaches to working with survivors. Goodman et al. (2016) also conducted a qualitative content analysis of accessible publications describing trauma-informed approaches for domestic violence programmes. Results demonstrated that six principles were dominant: a) establishing emotional safety; b) restoring choice and control; c) facilitating connections; d) supporting coping responses; e) responding to identity and context; and f) building strengths. These principles, argued by Goodman et al. (2016), are emblematic of trauma-informed principles. However, noting that practices defined are specific to domestic violence programmes.

Items were generated by following a four-step process utilising four data sources. Firstly, a qualitative analysis of relevant publications was conducted; this produced overarching principles and

specific practices that became the basis for survey items. Afterwards, interviews with 15 national experts on trauma-informed practices in the domestic violence context were held, expanding the item pool. Thirdly, focus groups were conducted with survivors and advocates, resulting in participants adding several additional items related to cultural sensitivity. It was also found that participants disagreed that the word "trauma" confidently reflected its gravity, nor did they feel it resonated with other participants. Finally, a pilot test was delivered to 15 participants to validate the measure. Once a final set of items were developed, the TIP scales were examined for their psychometric properties by administering the tool to 370 domestic violence survivors. Participants were recruited through staff at each programme. Flyers, a study description, consent forms, surveys, gift cards for participants, and stamped self-addressed envelopes were provided for all programmes.

Goodman et al. (2016) recognise that the trauma-informed care paradigm is important, but at present, is merely a buzzword. They were inferring that the translation of trauma-informed principles in everyday practice is unclear and without evidence. The TIP scales aim to represent the perspectives of service users, the extent to which they are experiencing fully that of which the organisation aspires to offer. These scales are put forward with the intention to a) identify strengths and weaknesses; b) improve the organisation's practices; c) demonstrate to stakeholders that trauma-informed care is effectively employed; d) generate an understanding of how trauma-informed practice is related to survivor outcomes.

Though the self-assessment tool was developed empirically, it only focuses on a partial view of the possible. Referring to module 2, Hummer et al. (2010) acknowledged that it must be understood that *"organisations are dynamic communities that need to change and grow to be successful; that good ideas are created both from the top-down and bottom-up; that there is a benefit to ideas being tested quickly, with immediate change and feedback for purposes of improvement; that implementing change requires commitment, resources, and incentives; that youth and their families are a valuable part of the organisational team; and that individuals learn best from sharing experiences with each other"*. Objective self-assessments do not allow for the understanding of organisations as dynamic communities that need to be able to change and grow to be a success. This self-assessment tool can and should be a part of the integration of trauma-informed care; however, it neglects to attend to the actualisation of the tool's attributes. It is one thing for an

organisation to believe it is engaging in these attributes but another in its doing. Therefore, these attributes should function as fuzzy-boundaries, and only through self-assessment maintenance can trauma-informed care be accurately captured in the present.

2.6.4 Fallot and Harris CCTIC

The Creating Cultures of Trauma-informed Care (CCTIC) framework was developed early in the conceptualisation of trauma-informed care (Fallot and Harris, 2001, 2006, 2015). It was designed as reference material in the development, implementation, evaluation, and ongoing evaluation of trauma-informed programmes. It was tailored towards child/adult serving agencies/programmes. It provides established guidance, and the domains address both service-level, administrative, and system-level changes. It has served as foundational work for other organisational assessments to use and build upon. It consists of six domains. These are 1) Safety, 2) Trustworthiness, 3) Choice, 4) Collaboration, 5) Empowerment, and 6) Trauma Screening Process.

According to Fallot and Harris (2001), if a programme can effectively demonstrate that its culture reflects each of the five core values of trauma-informed care, these being: safety, trustworthiness, choice, collaboration, and empowerment, in every contact, physical setting, relationship, and activity, and it is evident in every experience and interaction, then the programme's culture is trauma-informed. However, it could be argued differently. If these five core values are used to evaluate trauma-informed care and monitor feedback from all levels display congruence, which would require constant monitoring. And in this continuous monitoring, these values are met in most instances; then, the organisation may be deemed trauma-informed. Therefore, this must be evidenced, and it must be evidenced frequently to account for the change. The self-assessment tool developed by Fallot and Harris (2001) is similar to a "fidelity scale", existing as a simple checklist. This does possess value, but the results from this self-assessment are not reliable in a consistent manner. What is proposed and what is real is different, and on checklists, this can be unclear. Unless deployed in a novel approach, checklists cannot be used to view a genuine picture of current and ongoing adoption. However, the CCTIC was created as a benchmark and has been singularly helpful for learning and development.

2.6.5 Agency Self-assessment

The Agency Self-assessment was created with feedback from trauma and research experts, consumers and community providers. It was designed for application in residential programmes serving homeless populations, and organisations including direct care staff, case managers, supervisors, clinicians and administration teams. This assessment tool can be used to examine current practices and take steps to become trauma-informed. The domains are 1) Supporting Staff Development, 2) Creating a Safe and Supportive Environment, 3) Assessing and Planning Services, 4) Involving Consumers, and 5) Adapting Policies. It consists of 151 items that are considerable compared to other tools and requires 40 minutes for completion. The Agency Self-assessment is non-specific in its application; it is designed to identify programme and environmental change opportunities and inform organisational policy. It is an adaptable framework comprising a self-report questionnaire that has the potential to be completed online. Staff members are asked to use a scale ranging from "strongly disagree" to "strongly agree" to rate their agreement, based on their opinion towards the organisation's adoption of each domain. They are asked to answer based on their experience in the past twelve months. This will be difficult for staff to respond to, as most recent events are more likely to impact this scale. Suppose a staff member has recently experienced an overwhelmingly negative or positive situation in the past week. In that case, this will override any long-term feelings that they have experienced in the past 12 months. Emotional bias must be considered. This is a lengthy tool that might induce participant fatigue.

In the guide for the Agency Self-assessment, the purpose is written briefly and descriptively. Describing the tool as assistance towards assessing an organisation's readiness to implementing a trauma-informed approach. It is stated that *"honest and candid staff responses can benefit organisations by helping to identify opportunities for programme and environmental change, assist in professional development planning, and can be used to inform organisational policy change."* This statement appeals to a very particular question: *"How can it be assured that the answers we are receiving are honest and candid?"* This question is repeated among many of these instruments.

The tool is distributed anonymously, in either Word or Excel format, or on Survey Monkey to assist with data collection and analysis. It is also recommended that a designated point person

collect the completed assessments and compile the results. Therefore, an analysis of the data is required before the team can visualise it. This costs time, money, and effort, producing a lag concerning content communication. Responses marked as "strongly disagree" and "disagree" are practices that could be strengthened. Responses marked as "do not know" need attention, as this might indicate further clarification. If there are varied consistencies, it is stated that an overall understanding might be askew and that perspectives might be distinctive.

2.6.6 Professional Quality of Life Scale

The Professional Quality of Life Scale (PROQOL) was not designed to measure the adoption of trauma-informed care. However, it was deemed appropriate to include because it is the most frequently used metric for determining the positive and negative outcomes of assisting people suffering or traumatised.

Since 1995, the PROQOL has been used regularly. Since its inception, it has been revised multiple times, and the latest version is PROQOL 5. The PROQOL is a simple-to-use instrument that allows for quick interpretation of the negative and positive consequences of assisting those suffering or traumatised. This tool places value on employee well-being. It examines compassion satisfaction, compassion fatigue, burnout, and vicarious trauma. The PROQOL catalyses transformation. PROQOL results inspire introspection and brainstorming about what is correct, what may be improved, and what is incorrect and cannot be improved. It highlights the importance of what is going well and what is not. The PROQOL is coupled with a manual, which offers instruction on its use. The PROQOL tool is flexible and adaptable. It can be used once or many times. It can be used as a self-checking mechanism. It is recommended in the manual that *"one potentially important use of the information is to re-evaluate and adjust one's self-care plan or even a group's or organisation's plan"*. It suggests that using the tool can assist in a continuous collection of data that will act as a scan to enable constant feedback, possibly resulting in feedback loops. One thousand thirty-five references support the PROQOL manual and presumably the tool itself.

2.6.7 Sanctuary Model S.E.L.F Implementation Tool

The Sanctuary Model S.E.L.F Implementation Tool follows a series of steps to align an organisation's practices, attitudes, and philosophies toward a trauma-informed perspective. There are four components to delivering the service of the Sanctuary Institute. The Diagnostic Assessment involves a two-day on-site observation and interprocess, which is used to generate a report to highlight the organisation's strengths and weaknesses alongside 11 domains. Secondly, The Five-Day Sanctuary Institute: An Intensive Educational Experience is launched. This is a five-day training course for people who are charged with leading a "steering committee". This committee is provided with components, tools, and materials to lead the creation of a trauma-sensitive culture. Following this, the next step is to develop a Core Team. The steering committee is tasked with assigning a larger team of people to assist and expand trauma-informed care into the entire organisation. The fourth component is On-site Consultation and Technical Assistance; this component exists as an assigned faculty member from the institute to assist (Bloom and Sreedhar, 2008).

2.6.8 Trauma-informed System Change Instrument

The Trauma-informed System Change Instrument (TISCI) was designed for child welfare systems and specific application in a children's trauma assessment centre. It uses a systems perspective, and the wording is purposefully universal so that it has broader application. Its goal is to give a cross-agency snapshot of how trauma-informed the current community child welfare systems are. The domains are: 1) Policy, 2) Agency Practice, 3), Connections, 4) Integration, 5) Openness, and 6) Tradition. It consists of 26 items. This instrument allows for tracking change at the organisational level and identifies perceptions of change needed in certain key areas. The TISCI was designed and developed to measure how a complex community system has changed because of a community initiative. A team of experts were utilised for their input on its development.

Richardson et al. (2012) identify the need for a trauma-informed child welfare system. Using a systems perspective, individuals are viewed as an agent interacting with many other, overlapping agents. This illuminates the complexity of the system, with each entity of the system being surrounded by systems of interaction. Richardson et al. (2012) delve into the ideas of complexity

theory and describe the impact of change like a ripple effect, *"when a catalyst of change enters a system, a ripple effect can occur, so that this catalyst creates further change"*. This further elaborates how the role of system theory enacts change. *"other system forces within the organisation, from other organisations, from individuals in the system, will be in play to keep the change from happening to maintain equilibrium. If the forces for change are strong enough and come from enough entities within the system, especially entities with strength (power to change systems), the point of equilibrium can shift further in the direction of change to the new paradigm shift"* (Richardson et al., 2012). Additionally, the need for entities to be in harmony is indicative of positive change.

Richardson et al. (2012) identify two issues relevant to the development of an instrument designed to measure trauma-informed care, stating that these issues not only focus on child welfare but are also applicable to the system at large. The first issue is recognising that measurement must occur at a system level with the system as a unit of change. Secondly, no elements have been operationalised satisfactorily at any level for purposes of valid and reliable measurement. Richardson et al. (2012, p 171) raise the awareness of establishing the validity of measurement for tracking the change in a complex system, stating that it a) "relies on the definition of a system", and b) "how the system functions". Afterwards, Richardson et al. (2012, p 171) provide questions for each point. The first point is: "What is the content area of the specific system, and to what extent does this content exist within the system?" The second point; "Understanding how systems change can inform the understanding of a health system change to become more trauma-informed". As highlighted by Richardson et al. (2012), one theory of change is a theory provided by Coffman et al. (2009) within complex systems. It suggests that change occurs in varying degrees in five major domains – context, components, infrastructure, connections and scale. Richardson et al. (2012) used context, components, and connections to indicate relevance in child welfare systems. Calling to the challenges arriving in determining to what extent change needs to occur in each domain.

As expressed by Richardson et al. (2012), a generalised model may be derived from the change in a complex system. The essential elements of change may be operationalised so that they hold meaning across contexts and are valid constructs of a paradigm shift in a complex system. Richardson et al. (2012) agree with the notion that a social movement is necessary. It is vital to engage a com-

munity in supporting a paradigm shift. This emphasises that an instrument measuring the impact of trauma-informed care should stem from a grassroots level.

Three hundred forty-two people in four Michigan communities between 2008 and 2009 undertook the TISCI. The instrument consists of 19 Likert-type items scaled from 1 to 5. These are anchored at 1 = not at all true, 3 = somewhat true, and 5 = completely true. These 19 items are fit into four latent factors: 1) Policy, 2) Agency Practice, 3) Integration, and 4) Openness. The instrument was developed with a systems perspective, using three areas of systems to define the measurement of change: policy, agency practice, and connections. Richardson et al. (2012) agree that emotions are elemental in change, arguing that controlling for individual attitudes regarding the change in practice is vital in determining the extent to which communities are changing.

2.6.9 The Trauma-informed Agency Assessment

The Trauma-informed Agency Assessment (TIAA) was designed for child-serving organisations, youth and family. This tool has undergone validation and is intended to identify areas where organisations are doing well and pinpoint areas for improving trauma-informed performance. Its development process included key stakeholders, including youth and family members, and this was essential for developing the conceptual framework for the TIAA. The domains are: 1) Physical and Emotional Safety, 2) Youth and Family Empowerment, 3) Trustworthiness, 4) Trauma Competence, 5) Cultural Competence, and 6) Commitment to Trauma-informed Philosophy. It included 25 items.

2.6.10 The National Council for Behavioural Health: Trauma-informed Care Organisational Self-assessment

The National Council for Behavioural Health: Trauma-informed Care Organisational Self-assessment was developed with child and adult serving agencies in mind. It was designed to increase the awareness and readiness to adopt the key components of a trauma-informed care organisation and identify what is required to maintain, reinforce, and stop doing the wrong thing or start doing the right thing. The domains are: 1) Early Screening and Assessment, 2) Consumer-driven care and Services, 3) Trauma-informed and Responsive Workforce, 4) Provision of Trauma-informed

evidence-based and Emerging Best Practices, 5) Creating Safe and Secure Environments, 6) Engage in Community Outreach and Partnership Building, and 7) Ongoing Performance Improvement and Evaluation. The tool comprised 34 items.

2.6.11 Trauma-informed Care Organisational Self-assessment Tool

The Trauma-informed Care Organisational Self-assessment Tool (TIC-OSAT) was designed for human service organisations, mental health services, and community-based organisations. It can provide organisations with a snapshot of where they are in their journey towards becoming trauma-informed. It consists of ten domains: 1) Governance and Leadership, 2) Policy, 3) Physical Environment, 4) Engagement and Involvement, 5) Cross-sector Collaboration, 6) Screening, Assessment, Treatment Services 7) Training and Workforce Development, 8) Progress Monitoring and Quality Assurance, 9) Financing, and 10) Evaluation.

2.6.12 The Trauma Responsive Systems Implementation Advisor

The Trauma Responsive Systems Implementation Advisor (TRESIA) is non-specific in its application. It was designed to be completed as a group or as a team-based activity. This tool details the location of an organisation and where it might be plotted adjacent to key characteristics in environments operating in trauma-informed care. It was intended to give the organisation a view in terms of its readiness to implement trauma-informed care. It has five domains: 1) Leadership and Culture, 2) Trauma-informed Care Response Structure, 3) Policies and Processes, 4) Employee Skills, and 5) Tools and Resources. In these areas, there are ten statements to score for each. There have been no tests for reliability or validity, and it is based on industry-standard assessment concepts. This is the opposite of advice offered by Richardson et al. (2012), as validity is imperative to supporting the programme theory. The assessment tool takes approximately 45 minutes to complete and can be completed individually or as a group, but must be undertaken on behalf of the whole organisation. It follows a four-step process: 1) Self-assessment; 2) Mapping scores; 3) Reviewing recommendations; and 4) The development of an action plan. It has a total of 50 items.

2.6.13 Trauma System Readiness Tool

The Trauma System Readiness Tool was designed for child welfare systems to use to assess the trauma-informed nature of their own system. Results provide cross-informant data to each system detailing how front-line caseworkers' responses from the survey are similar or different from supervisors' and administrators'. It consists of five domains: 1) Child Welfare Agency's Understanding of the Impact of Childhood Traumatic Stress on Children Being Served (30 items), 2) Child Welfare Agency's Understanding of Parent/Adult Trauma History and Its Impact on Parenting and Parents' Response to Services (20 items), 3) Trauma and the Child Welfare System (26 items), 4) Vicarious Trauma (also known as Secondary Traumatic Stress) in Professionals Working in Child Welfare Systems (6 items), and 5) System Integration/Service Coordination with Other Child-Serving Entities (5 items). It comprised 87 items in total.

2.6.14 Trauma-informed care in Youth Service Settings: Organisational Self-assessment

The Trauma-informed Care in Youth Service Settings: Organisational Self-assessment was developed for youth-serving settings. Sections of this assessment were adapted from the CCTIC. The domains are: 1) Administrative Support for Programme-Wide Trauma-informed Services, 2) Organizational Structure, 3) Trauma Screening and Assessment, 4) Milieu Treatment Practices and Behavior Management (for congregate care settings), 5) Physical Environment and Layout of Agency, 6) Clinical Treatment Practices, 7) Restraint and Seclusion Reduction, 8) Workforce Development, 9) Staff Trauma Training and 10) Monitoring Trauma-informed Initiatives.

2.6.15 Trauma-informed Care and Practice Organisational Toolkit

The Trauma-informed Care and Practice Organisational Toolkit (TICPOT) was designed for organisations to build on existing trauma-informed policies and practices and for those beginning a journey to becoming trauma-informed. It was designed to support staff and services to continue developing their practices of becoming aware of people engaging with their service, which may be impacted by past and current trauma. The domains are: 1) Governance, Management and Leadership, 2) Organisational Policies and Structure, 3) Consumer and Carer/Family Participation, 4) Direct services to Consumers, 5) Healthy and Effective Workforce, and 6) Outcomes and

Evaluation. It is a very comprehensive tool and consists of 216 items.

Many of these assessment tools were built internally and were stand-alone projects that did not seem to develop afterwards. A few still see updates to the time of writing and propose to be in use. However, there is a payment barrier to many, meaning full access to some of these assessment tools was impossible.

2.7 Previous Approaches

As the systems are very much context-dependent, a bespoke approach is required. The responsibilities and barriers for every organisation are unique and complex. As stated by Richardson et al. (2012), establishing measurements of change is vital as *"once a construct becomes measured, it becomes real in the sense that it has been operationalised and is visible"*. Furthering this, *"instruments evaluated for their validity in measuring change is key to supporting the programme theory"*. Richardson et al. (2012) explain that this has utility in three ways. Firstly, it can provide a snapshot of the current state of an organisation being trauma-informed. Secondly, it can target areas of need that can push development towards being trauma-informed. And thirdly, it can be used, over time, to display the extent to which progress has been made on adopting trauma-informed care. It is possible to use this work as a foundation to operationalise trauma-informed care within a systems framework.

Richardson et al. (2012) offer suggestions on the development of instruments and regards gaining opinions and feedback from experts that are relevant to all types of communities as imperative. Richardson et al. (2012) concludes that an assessment tool must be continuously developed in the field alongside better interventions to improve trauma-informed system practice. The tool must be flexible, adaptable, fluid, and responsive to change. Therefore, ongoing feedback collection on the measurement itself must be acquired. This coincides with Strategy 14 found in SAMHSA (2014b), which argues that obtaining feedback and evaluations of organisational performance regularly is essential in improving the quality of services. This self-assessment maintenance has been echoed throughout self-assessment literature.

For an organisation to ensure it is acting according to trauma-informed principles, SAMHSA (2014*c*) recommends that organisations obtain feedback on evaluations of organisational perfor-

mance regularly. A transparent system must be provided to leave feedback, and feedback should be able to be collected at any time. Evaluations should be made to report on the organisation's progress towards becoming trauma-informed. Monitoring regularly allows organisations to combat new obstacles and threats, and understand what works. It equips organisations with the ability to formulate different strategies, meet objectives and respond to the changing needs of the population.

Following the review of these instruments, approaches can be categorised into two domains. One domain is the approach that most of these instruments have adopted, which is to follow along with a linear self-assessment style reminiscent of a standard checklist. However, a culture change is significantly challenging; it is complex. Using an approach to capture, measure, monitor, and regulate the state of affairs is and does belong in the complexity domain. The ever-changing dynamic of organisational culture means that measuring these changes is complex. Complex problems, such as tracking change in an organisation, require complex solutions. The following instruments satisfy this criteria: a) The ARTIC, b) The TICOMETER, c) The TIP Scales, and d) The TISCI. These self-assessments provide firm foundations for the development of an additional trauma-informed care self-assessment. Each of these assessments follows a similar approach in their development, which embody trauma-informed care principles. Firstly, current literature is utilised to form a base view of specific trauma-informed care metrics. They expand on the reviewed literature by following up with interviews with trauma-informed care experts and use focus groups with service users and champions. Secondly, surveys or focus groups are administered to refine the survey instrument in development. Once satisfactory refinement has been made, a third step involves evaluating the reliability and validity of the instruments. The final product must correspond well with existing literature on trauma-informed care, particularly the specific sector in which the bespoke tool should be operational. The argument would be to work against a checklist. Checklists work in highly ritualised environments. However, they fail outside these contexts as often they are ticked off without fulfilment leading to a deconstructed social process. Therefore, identification of complex contexts and the use of appropriate instrumentation is necessary.

2.8 National Trauma Summit

In March 2019, a National Trauma Summit was held in the United Kingdom by the Academic Health Science Network and the Northern England Clinical Network. The community was utilised in drawing out themes that could be useful in designing and organising trauma-informed services. It brought together individuals, organisations, and healthcare stakeholders from around the UK committed to improving service users' experiences and implementing trauma-informed care into their practice. 85 Participants were involved at the national trauma summit (Kennedy, 2020). Using a narrative-based approach, key themes and principles were derived from positive and negative experiences whilst understanding the complexities of large-scale change. The key themes can be seen in the table below:

1. Safety
2. Human Experience Language
3. Empowerment
4. Healing Interventions
5. Responsive System Design
6. Compassionate and Transformational Leadership
7. Relational Reparation

2.9 The Application of Complexity Theory on the Implementation of Trauma-informed Care

Trauma-informed care requires a whole system approach where desired outcomes are unique to the individual and the service. Change and innovation are achieved through the ripple effects of individual actions, feedback on progress, and the shared vision of people (Thirkle et al., 2018). Human change is complex because there is rarely one right way of doing something. The service must adapt to meet each individual's needs and remain responsive over time. There are challenges to facilitating a trauma-informed care culture change in practice:

- Awareness, knowledge, skills and motivation;
- Emotional and physical well-being, resilience in dealing with difficult situations daily;
- The quality of communicative interactions within the organisation and with service users, i.e. compassion, empathy;
- System artefacts, such as organisational structures and procedures, NICE and other sector-specific regulations;
- Measurement, decision-making and acting with innovation in a large scale organisation (Thirkle et al., 2018).

The challenges of measurement, monitoring and acting are best addressed through trusted human sensor networks functioning as ethnographers within their organisations. Diversification and discussion are critical components of detecting ”weak signal” difficulties and possibilities. Boundary management is critical for ensuring “stable” flexibility in trauma-informed care delivery (Thirkle et al., 2018). These ideas of complexity can assist in guiding the self-assessment process toward transformation and evaluation:

- Change in individuals or organisations is rarely linear. A reflexive approach can accommodate these non-linear changes.
- There is also not a *one size fits all* interpretation of trauma-informed implementation. Different settings need to reach their definitions through co-production to identify what is required for them.
- Different teams within an organisation, different individuals within teams and different service users may all display or perceive different strengths in relation to the implementation of trauma-informed care. Different narratives must be brought together for a better picture of the whole.
- The process of reflection is essential. Reflection enables the assimilation of trauma-informed values and goals.

The complexity facing the facilitators of trauma-informed care requires a *whole system approach*. Success is measured solely to enhance service quality and where intended goals emerge naturally from day-to-day activities. Traditional *plan-do-act* approaches lack the variety required to absorb

and address the multiplicity of interrelated challenges (Beer, 1981). There is a need for an integrative comprehension of the *human system* to develop awareness, monitor, and act effectively in this complex context. Here, it is possible to outline certain ontological and epistemological perspectives from the latest developments in the natural sciences, i.e. interpersonal neurobiology and complexity science are considered most relevant to addressing the challenges in trauma-informed care culture change programmes (Siegel, 2011; Thirkle et al., 2018; Varela, 1979).

A new conceptual framework that is immeasurably different from the "reduce and resolve" approach that clinical care and service organisations are using today is needed; a framework that practices a perspective encompassing dynamic, emergent, creative, and intuitive rationale (Plsek and Greenhalgh, 2001). To cope with escalating complexity in health care: linear models must be abandoned, unpredictability accepted, autonomy and creativity utilised and respected, and the ability to respond flexibly to emerging patterns and opportunities obtained. Facilitating change in the context of trauma-informed care requires attention to both communicative interactions and the cultivation of individual awareness and well-being. Leadership is profoundly personal and inherently collective and may be defined as shaping *life-enhancing* conditions and promoting organisational wellness through a sensitive organisational culture (Thirkle et al., 2018; Quadara and Hunter, 2016).

Trauma-informed care is not a fixed and universal endpoint. It is a multi-layered concept that needs to reflect complexity. The standards and evaluations must adapt to the complexity of different settings in which relevant principles are applicable (Kennedy, 2020). The framework for trauma-informed care implementation must be flexible; it must be regularly maintained to keep the standards up to date. The process must be inclusive. Safe spaces where experiences are welcome, and interpretations can be shared are necessary. This is where individuals can feel listened to and so that the concept of trauma-informed care can evolve naturally.

Chapter 3

Methodology

3.1 Introduction

Problems require solutions. The journey to finding these solutions is achieved through a precise accumulation of a carefully selected mixture of methods, materials, tools and techniques. Through experimentation and application, a unique combination can be identified that is appropriate and applicable. Studying the infinite available research methods offers insight and training, valuable towards understanding and application. In this chapter, the identified combination is highlighted, and an explanation is provided on why they were selected. This research aims to address a practical research problem. This problem arose as The Tees, Esk and Wear Valleys NHS Foundation Trust invested in a programme to introduce a trauma-informed approach to implementing services. This programme developed an interest in researching how to effectively implement, facilitate, evaluate, measure and monitor a trauma-informed care approach in practice. This research was conducted to identify and overcome potential barriers to implementations and develop a framework to monitor trauma-informed care implementation. The nature of the research questions required a pragmatic and mixed-methods approach. This approach, comprising of a uniquely selected combination of quantitative and qualitative methods, is used when a single method is not sufficient for an in-depth exploration or numerical measurement is too objective.

The operational context of the questions are inherently complex, so an approach that considers this complexity was essential. Acknowledging the complexity of large organisations, culture, culture

change, and trauma-informed care was necessary to address the research questions. Therefore, the theory of complexity was applied as a pragmatic toolkit. When used as a toolkit, complexity theory can assist in the understanding of organisational culture and organisational culture change (Jennings, 2004).

The encouragement of trauma-informed care permeates all areas surrounding its application; this inspires research to be executed in trauma-informed ways. After examining other approaches, this became more apparent (Baker et al., 2016; Bassuk et al., 2017; Goodman et al., 2016; Richardson et al., 2012). These approaches all opted for a community-based participatory method that empowered people in all areas of the organisation to get involved. This research, in alignment with trauma-informed care, echoes the trauma-informed methods that other approaches have utilised. However, the approach developed for this study was subject to stringent ethical considerations due to the sensitivity of the study. Nevertheless, this did not impact the research considerations of trauma-informed care, as precise and acceptable criteria were required to be met (SAMHSA, 2014*b*; Sweeney et al., 2018).

The research began with the identification of the distinct lack of evidence of trauma-informed care implementation within the trauma-informed care programme. This introduced questions around determining if and to what extent trauma-informed care practices were being implemented. A literature review was undertaken to begin an investigation into the trauma-informed care literature and to search specifically for approaches that were conducted in the past. Existing frameworks and instruments were reviewed, and their methods were examined. The Roots framework then underwent a similar development process to those discovered in the literature. Firstly, domains from the literature were compared with domains from a national trauma summit at a trauma leads meeting. Items were also generated at the same leads meeting. The items were then translated by experts and then underwent a process of articulation in a Delphi survey. Once a consensus was reached, through a delicate balance of decision-making and considering the opinions of service users, the framework was assembled, which led to the production of a user manual. The framework was pilot tested with staff from various services, service users and then finalised. Shortly after, the Roots framework was released open access for public use.

Further detail is given on the research philosophy, and the research process is explored in the following sections. The framework development process is then presented, and a small section is

provided on how the data was analysed from both the surveys and the focus groups.

3.2 Positionality Statement

As this is primarily a qualitative study, the researcher was often fully immersed in the data. At times, the researcher would be actively involved in the implementation of the trauma-informed care programme. This direct presence might have influenced the research. The researcher was often situated between the NHS trust and Northumbria University. The researcher became involved with staff and service users at the NHS trust and built relationships with participants of the study. Being a core member of the trauma-informed programme team, the researcher was also involved in other projects. The researcher was unable to adopt a fully external perspective for the research as the researcher experienced connections to the trust and relationships with staff and service users. While some may have identified the researcher as being external others may have identified the researcher as being internal. These disparate perspectives might have influenced how participants interacted with the research. The researcher acknowledges that full awareness of how they and others have constructed their identifies might not be possible. The research will also have been necessarily influenced by the researcher and by the research context (Holmes, 2020).

3.3 Research Philosophy

Subjectivity is ubiquitous in this world of infinite beliefs. The individual is shaped by the world, by the environment, by the minutia of interactions, and this presents near-infinite possibilities on how that individual observes the world. Not only is the individual shaped by the world, but these once infantile observations mature and then proceed to shape the world further. No two individuals can be entirely the same; people are products of their contexts. The individual acts according to their environment. These infinitely differing perspectives are what ignites research with its practical nature. However, for the reader to gain insight into the author's philosophical stance and understand the author's contextual observations, some specific philosophical underpinnings and paradigms must be explained. The author influences the research, and the author is influenced by the fore-going and ensuing consumption of life. Whilst there are infinite subjective beliefs, which

are applied daily by all, in research, there are categorisations that are objectively known as research paradigms. Abdul Rehman and Alharthi (2016, p 51) would describe that a paradigm is: *"a basic belief system and theoretical framework with assumptions about 1) ontology, 2) epistemology, 3) methodology and 4) methods. A paradigm is how we understand the reality of the world and how we study it"*. Kuhn (1962) first used the word paradigm to explain a philosophical way of thinking. The word paradigm translates to pattern, model, or precedent in the Greek language. In other words, a paradigm is an individual's lucid model of the world, an individually alternating view of the world. As defined by Kivunja and Kuyini (2017), the worldview in research *is the perspective, or thinking, or school of thought, or set of shared beliefs*. This worldview must be made clear for the interpretation of research data.

3.3.1 Epistemology

Epistemology is how things are known and what is regarded as acceptable knowledge (Bryman, 2016). The study of social sciences includes a choice between two different means of acquiring knowledge. One being empiricism and the other being rationalism. The former is knowledge gained by sensory experience by using inductive reasoning, and the latter is knowledge gained by reasoning using deductive reasoning (Walliman, 2015).

This research adopts an interpretive and pragmatic approach. The interpretive approach differs entirely from the traditional hypothesis testing model. The interpretive perspective focuses on the individual and their relative perspective; it directly contrasts positivism, which requires scientific verification. It scopes in on the individual to understand and explain human and social reality (Antwi and Hamza, 2015). Interpretivist studies assume that people create and accept their subjective meanings; therefore, it attempts to access the participants and their particular meanings (Bryman, 2016). Reality is seen as complex, multiple, and unpredictable, so any prior insight into the field is considered insufficient (Hudson and Ozanne, 1988). This leads to the research remaining exploratory and open so that new knowledge can permeate the study and develop with the contribution of participants, stakeholders, or the research itself. This emergent and collaborative approach is a critical characteristic of the interpretive belief that humans are inherently adaptable. So no individual can gain prior knowledge of time and context-bound social realities (Hudson and Ozanne, 1988).

Weber (2012), one of the founders of interpretivism, suggested that the primary goal of the human sciences is to understand. To fully understand a particular topic, a specific approach must be applied that will allow for the use of multiple methods and methodologies. This research undertaken in a pragmatic manner that adopts the position to do whatever it can to understand the depth of the topic. There are three historical streams that the interpretive approach derives from: symbolic interactionism, hermeneutics, and phenomenology (Bonner, 1994). Symbolic interactionism is the theory that the social world is constructed through everyday interactions (Blumer, 1986). Phenomenology demands that the research let go of prevailing understandings of phenomena and only visit direct experiences of the particular phenomenon; this allows for new meaning to emerge as an authentic and enhanced version. The phenomenological principle is to put oneself in the place of another; this empathic principle could be said to be trauma-informed. Hermeneutics is the critical inquiry into resources into which the many parts are related to the whole for revealing deeper meaning (Hooker, 2015). Interpretivism can then be defined as a method of interpreting human action; it holds itself to understand human behaviour further rather than simply explaining it (Karen et al., 2008). As Weber (2012) stated: *"the time has now come for us to understand human dynamics and not simply measure it"*.

Pragmatism is the branch of philosophy in which the truth is assessed regarding effect, outcome, and practicality (James and Burkhardt, 1975). This research, which refers to the understanding of the interpretive perspective to be the truth, is assessed regarding effect, outcome, and practicality. Pragmatism is natural and innate, which allows the formation of decisions that lead to thriving outcomes. These characteristics are closely related to the principles of trauma-informed care. Pragmatism is an active and social nature of inquiry; it is a problem-solving approach to inquiry and an action-based one (Kelly and Cordeiro, 2020). The emergent consequences of pragmatism align with the holistic view of complexity theory. As Long et al. (2018) affirm, pragmatism provides the momentum for change, whilst complexity theory provides a way to operationalise the study of emergent consequences. At the centre of trauma-informed care is the individual; it is the individual's story that matters. Therefore, providing the freedom for the individual to interpret their own story is essential.

While it is important to define the world view that the research adopts, it is equally important to explain what the research considers reality. Walliman (2015) states that all philosophical positions

and accompanying methodologies hold a view of social reality. This view determines what can be regarded as legitimate knowledge.

3.3.2 Ontology

Ontology is the study of what is real or what exists, in general. Onto meaning existence, or being real in the Greek language, and logia meaning science or study (Simons, 1987). The use of ontology in research revolves around the ability to discuss challenging questions to build theories and models and develop and better understand the ontological status of the world (Al-Saadi, 2014). The ontological commitment of this research is the existence that the many and multiple systems of all derivations are inherently complex. The ontology of this complexity is the existence of there being something that is missing as the whole system is reduced down to its individual parts. Thus, the system needs to be examined in its entirety. An understanding is to be held on the principle that when a separate part of the system is examined, other factors cannot be understood unless they are constructed as a whole. The research uses the theory of complexity to understand the reality of existence. This perceived reality permeates the entire research process whereby the shared meaning of language is implicitly and explicitly explored and shared.

3.4 Research Process

An extensive literature review informed the research process on the subject matter. Various approaches were considered, but as the outcome was not yet imagined, similar literature informed the research process significantly, and the research took the direction towards constructing a framework. To build this framework, the study employed expert meetings, and online surveys to collect data using the software SurveyMonkey. The Delphi method was explored and identified as being aligned with trauma-informed care and was modified for use in survey application. Trauma-informed care is insistent on all individuals being heard equally and fairly. The Delphi method, which focuses on individuals' ideas rather than the individuals themselves, permits all stakeholders to offer their opinions in a safe context. It does this through anonymity, and ultimately, only ending when a consensus has been reached. This consensus requires all stakeholders involved to agree on the outcomes of their input. The research also utilises trauma-informed care leads meet-

ings to present and feedback information. These meetings were were held consistently throughout the research project. The framework was co-developed with staff and service users at the Tees, Esk and Wear Valleys Foundation NHS Trust and other experts using secondary data obtained from a national trauma summit. The methodology can be seen in Figure 2.

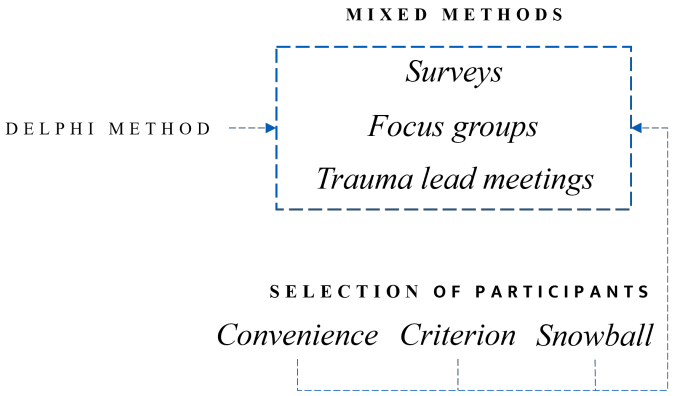

Figure 2: Methodology

3.4.1 Delphi Method

Delphi was an ancient Greek religious sanctuary sacred to the god Apollo. The Oracle of Delphi was chosen to serve as the bridge between the current world and the next one. The Greek empire would not pass judgement unless the Oracle delivered consult (Linstone et al., 1975). The Delphi method, or less known as Estimate-Talk-Estimate, was developed in the 1950s by Olaf Helmer, Norman Dalkey, and Nicholas Rescher of the Rand Corporation. A forecasting method was needed to forecast the impact of technology on warfare, and the Delphi method was produced as a result. An expert group was assembled and asked to provide opinions on the probability, frequency, and intensity of possible enemy attacks. The Delphi method requires consensus, and so this process was repeated until one was attained (Gordon, 1994). Thus far, the Delphi method is used as an interactive forecasting method relying on a panel of experts. The method involves a group of experts who anonymously reply to a questionnaire and subsequently receive feedback in statistical representation. If the participants disagree with the comments, the process repeats itself until the disagreements are curtailed, and the conclusion has arrived at an expert consensus (Skulmoski et al., 2007).

The method agrees on the key assumption that *"forecasts generated from a group are generally*

more accurate than those from individuals". Rowe and Wright (1999) suggest that only studies that follow the classical Delphi method can be classified as Delphi studies. Four key features characterise this classical Delphi:

1. Delphi participants are anonymous by default. This allows participants to be candid with their opinions without social pressures to conform; allowing for merit-based decisions;
2. It is permissible for a participant to edit their views regardless of the progress of the group's work;
3. Feedback is provided so that participants are aware of other participant's perspectives. This also provides further opportunity for clarifying or changing their views;
4. The responses from the group are statistically aggregated. Opening up the data to quantitative analysis and interpretation of data (Rowe and Wright, 1999).

These four characteristics are anonymity, iterated control feedback, statistical group response, and expert input.

The Delphi Method can be effectively modified to meet the needs of a particular study. However, these are not strictly "classical Delphi studies". Assigning the term *classical* Delphi to studies that adhere to the characteristics of the original Delphi provided by Rowe and Wright (1999) is proposed by Skulmoski et al. (2007). The Delphi method is used so that a group consciousness can be accessed and utilised in a decision-making process. It usually adopts the form of a questionnaire or survey, allowing for anonymous and independent opinions to be given. This purposefully avoids the social and practical drawbacks of direct confrontations (Gordon, 1994). Primarily, the Delphi method is used when inclusivity and consensus are valued in the area of work (Linstone et al., 1975).

The technique is advantageous in ambiguous situations. Situations without an objective answer; decision-making, policy, or future planning are examples of a few of these (Forsyth and Burnette, 2010). A more comprehensive range of opinions is included, which is helpful to avoid the bias that a single expert would impose. It is recommended as the method of choice when a subjective statement is required from a group; large sample sizes make it difficult for face-to-face interaction, when anonymity is preferred, and to avoid individual domination over the discussion (Rowe and Wright, 1999). Yang et al. (2012) note suitability for studies that exhibited the following prop-

erties: varied expertise and judgemental inputs; complex, large, multidisciplinary problems with considerable uncertainties; the possibility of unexpected breakthroughs; causal models cannot be built or validated; particularly long time frames; and when opinions are required from a large group, anonymity is deemed beneficial.

Using the Delphi method is most advantageous when seeking consensus in areas of uncertainty or situations lacking in causation. Studies focusing on topics where multiple stakeholder groups are potentially involved are especially relevant here (Avella, 2016). Designing a Delphi study can be done without significant training or effort. Its application is straightforward, and its ability to be modified to meet contexts is enticing (Linstone et al., 1975). Although, Avella (2016) accentuates the importance of maintaining rigour. Delphi requires experts in particular fields, experts will likely arrive from different disciplines, which offers a more diverse knowledge base (Williams and Webb, 1994). This diversity can pave the way for the emergence of new ideas. The anonymity afforded by Delphi studies empowers participants with considerable latitude, allowing participants to present their individual opinions without fear of judgement or criticism. The number of participants does not have to remain consistent in a Delphi study; members can drop out or skip rounds at their discretion (Avella, 2016).

There are certain disadvantages to holding a Delphi study (Fink-Hafner et al., 2019). It can be open to researcher bias as the researcher has a significant amount of authority and influence in the process. The formulation of questions and who is invited can be at the disposal of the researcher. An outside expert should review the formulation of questions so that this bias can be avoided. The researcher should also be cautious in appointing experts as it should be the discipline involved that should determine expertise. It is essential to not constrain panel members from adding to the alternatives generated; the researcher should not impose their preconceptions on respondents. The nature of anonymity could offset the participant's rigour or by the claimant of a pose (Skulmoski et al., 2007).

Delphi method characteristics are in alignment with those proposed by trauma-informed care. A trauma-informed research method would ensure participants can offer their ideas and opinions and ensure that they are taken into account. The research also is not concluded unless a consensus is agreed upon, meaning that the results must be signed off and approved by participants in the study.

3.4.2 Selection of Participants

Survey

This study applied multiple sampling methods in the recruitment of participants. An amalgamation of convenience, criterion and snowball sampling methods was required for the recruitment process. Convenience sampling was required as service user groups were already formed and available to be contacted through staff members at the NHS trust; the study itself was non-commital and required the goodwill of participants. However, as the study only required that the participants were either working in the service or using the service, all opinions of those involved were valued. As the only requirement of participants was to be involved in the service, either as a staff member or as a service user, a criterion sampling method was consolidated. As the researcher did not have full access to potential participants, the snowball sampling method was also utilised. The trauma leads were asked to identify other people within their respective services who might be applicable participants for this study. This was required, as a diverse spectrum of participants was essential. Two sample groups were selected, one comprising staff and the other comprising service users. The inclusion criteria were as follows: staff are identified as being available, engaged in the NHS trust, and chosen or recommended by those aware of the study. Service users are identified as being available, involved in the NHS trust, and selected by staff. The exclusion criteria applied if the potential participant had no affiliation with the NHS TEWV Foundation Trust. They were under the age of 18 or over the age of 65, or they were at imminent risk of harming themselves or others.

There are similar studies in the literature that have used similar sample sizes to conduct research (Goodman et al., 2016; Baker et al., 2016; Bassuk et al., 2017; Richardson et al., 2012). The study set out to recruit 50 staff members and 50 service users to participate in the Delphi survey. The study only managed to recruit 27 staff members and 13 service users to participate in their respective surveys. As the survey was held during the Covid-19 pandemic, access to particular survey promotions were limited.

Focus groups

The focus groups used the sample identified previously for the surveys. The service user focus group used a volunteering service user group put forward by one of the trauma leads, this was a

group accessing services at the recovery college in Durham. The staff focus group samples consisted of trauma leads and their respective service staff. The focus groups were trauma leads from CAMHS (Child and Adolescent Mental Health Services), prison services, ward and community services.

3.5 Framework Development

Rather than using one of the existing frameworks available in trauma-informed care, this research project had the explicit aim to create a framework bespoke to the United Kingdom. Firstly, an extensive literature review was undertaken to investigate trauma-informed care and previous evaluation efforts. Secondly, after the identification of previous self-assessments, comparison and analysis took place. This informed the development process. Thirdly, discussions were held with a combination of experts (trauma leads and other key contributors) on the development of the framework, and a Delphi study was issued to staff and service users for articulation. Thirdly, the outcomes were used to develop domains, descriptions, and items for the framework. This was then transcribed for a better fit by staff and an experts-by-experience group. This concluded with pilot testing through virtual focus groups. The framework development process can be seen in Figure 3.

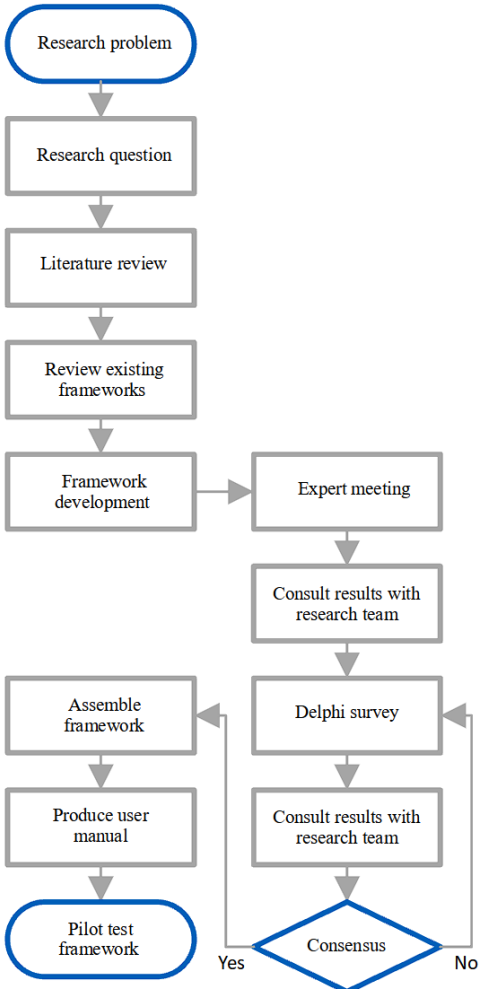

Figure 3: Framework Development

Reliability and Validity

The focus groups used to pilot test the framework were used to obtain feedback for improvement and further development. The reliability and validity of any framework to be used for research purposes is critical. Validity is the most important characteristic of an instrument, and reliability is necessary to achieve validity. Unfortunately, no formal methods were used to test the validity or reliability of the Roots instrument as no resource was dedicated to this purpose. However, the literature review and methods used were chosen to be as reliable and valid as possible. The reliability of the literature review is high - objective sources have been used as much as possible. Google scholar was used as the primary database. Therefore, internet searching using the Google scholar database was undertaken to investigate results emerging from the keywords ”organisational culture change”, ”complexity theory”, ”behaviour change”, ”human behaviour”, ”trauma informed

care" and "trauma-informed care instrument". The keyword "instrument" was subject to various alterations such as "measurement", "evaluation", "assessment", while an addition of the keyword "tools" assisted in the identification process. The results proved effective in uncovering various instruments, other sources were obtained through direct connections. Surveys and focus groups were used to involve staff and service users and are designed to be as reproducible as possible - instructions have been drafted on the process for future healthcare professionals or researchers. The number of participants were set at a maximum of 50 so that data analysis could be done in a timely manner and so this could be repeated in future at ease. Trauma lead meetings were used to maintain research integrity with trauma-informed care principles. Respondents were selected using connections at the NHS trust and no personal information was requested. The questions of the survey were drafted using a co-production approach involving staff, service users, and trauma leads, and these questions were used as the items of the Roots instrument. Microsoft Excel was used to analyse the results of the surveys and Nvivo was used to transcribe the focus groups.

All of the methods employed in this research project are relevant and appropriate for use within trauma-informed services. Using a mixed-methods methodology ensures that data is statistical and opinionated. The Delphi method ensures that all participants agree with the outcome. The focus groups were used to assess the applicability, ease of use and for further articulation of the framework contents.

3.5.1 Research Methods

A variety of ideas and opportunities to gathering data were explored, with most being unfruitful. At the beginning of the project, the Sensemaker software founded by Dave Snowdon, founder of Cognitive Edge, was initially targeted as being a valuable instrument to deploy in the context of trauma-informed care. With the added acknowledgement of complexity, the Sensemaker software was ideal in investigating the research question thoroughly (Van der Merwe et al., 2019). However, stakeholders involved were not as enthusiastic or engaged as the research team, and communications subsequently dropped. The original idea was to deploy the Sensemaker instrument in the field, conduct a series of experiments, analyse the results, and then evaluate the culture by identifying the narrative. The complete loss of communication meant that another idea had to be found. This required a significant literature search to investigate previous frameworks and instruments for

use in trauma-informed care evaluation.

Other avenues were attempted, such as a software known as Crowdsourcing, a platform provided by an organisation known as Clever Together, an entirely focus group based approach which was stunted by a rejected Integrated Research Application System (IRAS) application, which is required by all health and social or community care research in the UK and assists in meeting regulatory and governance requirements, and an innovative system design approach that would have required the development of a user-interface. Ultimately, due to ethical, time, and monetary restrictions, a feasible strategy that met these restrictions was necessary. The literature search proved practical and initial ideas for developing a framework to monitor progress towards trauma-informed care was revived as an alternative.

The decision to hold surveys to construct the framework with staff and service users in the NHS trust was agreed upon between the research team and an amendment to the original ethics form was submitted to Northumbria University to cover the change from initial ideas. An IRAS application was completed with the assistance of the research and development (R&D) teams at both Northumbria University and the NHS Trust. This involved communication between the R&D team at the university and the R&D team at the NHS trust. Completing an IRAS requires in-depth knowledge of the topic undergoing research and of any potential ethical implications. Research applicants are able to submit research applications to the Health Research Authority (HRA) through IRAS including those for HRA Approval and applications for Research Ethics Committee (REC) review. IRAS enables applicants to enter the information about their project once instead of duplicating information in separate application forms and uses filters to ensure that the data collected and collated is appropriate to the type of study and the permissions and approvals required. After a series of amendments to the IRAS application, the IRAS applications was accepted, and the research was granted the ethical approval required to proceed.

A platform that would allow for all conditions of a Delphi survey was needed. A premium account for SurveyMonkey was sought to construct surveys appropriate to the context. The platform needed to be intuitive, online, accessible, user-friendly, allowing for anonymity and data export. These surveys were designed to be undertaken at interval periods. It was necessary to collect and utilise secondary data from a trauma summit (Kennedy, 2020). This data contained seven domains, various items, and definitions and was generated by a multi-disciplinary cohort. The seven

domains and their descriptions are:

1. Safety
    - An organisation that promotes that the individual feels of worth, validates their experiences and opinions, and is safe from physical harm from others and feels a sense of belonging.
2. Language
    - The description of services and mental health, the language used within services and wider communities and language that includes everyday language to promote a more equal and inclusive discussion.
3. Social
    - Awareness of the way that people, when under stress, may be triggered in their current relationships with others based on their previous relationships (attachment patterns) - the delivery of support by ”peers”/people with lived experience of trauma and mental health difficulties.
4. Trauma-specific Interventions
    - Interventions that are trauma-informed and any support delivered to be done so in a way that appreciates the impact of trauma and minimises further harm.
5. Empowerment
    - The confidence gained by owning efforts towards change and feeling the outcomes is of value to you and your own choices. Staff are motivated towards service change and feel positive about their work.
6. Whole System
    - Processes and programmes meant to bring about positive change within the organisation and encourage ways of working that are trauma-informed. People in the whole system can easily access a range of therapies specially designed to treat trauma for the length of time that is right for them.
7. Compassionate Leadership
    - A leadership style that facilitates trust, transparency, empowerment, and respect (and devolved innovation and collective decision-making). People with lived experience using mental health services can develop their leadership skills and take on leadership

roles (Kennedy, 2020).

A leads meeting was held to determine and identify any similarity between domains used in the frameworks found in the literature. This process was necessary because domains generated at the summit are reflected within trauma-informed care practice. These seven domains were used in the framework. Working with a Delphi panel (Linstone et al., 1975), questions were created using the items generated at the leads meeting.

Pilot tests were held in the form of informal focus groups. As the staff version of the framework was considered complete, pilot tests were arranged with NHS staff. The service user version was deemed incomplete, and a focus group was held to determine articulation and clear the confusion generated by the survey. The service user version was then re-worded by clinical psychologists.

3.5.2 Data Analysis

Regardless of the methods employed, the results of any study are of little use in their raw form. The reader should only be expected to study the conclusions and not be responsible for analysing the data. It is the researcher's responsibility to provide these conclusions using the data collected (Walliman, 2015). This study employed a qualitative and quantitative methodology, so both data collection and data analysis reflected that (Bryman, 2016). The surveys and focus groups used in the project produced data that required analysis.

Surveys

The Delphi survey was analysed using Microsoft Excel. The process was the same for both staff and service user surveys. The data was downloaded and exported from the SurveyMonkey website into an xls format. This was then unzipped and the file was opened in Microsoft Excel. The data was then cleaned by removing unnecessary rows of information. The columns respondent ID, collector ID, start date, end date, IP address, email address, first name, last name, custom data and the question "do you wish to participate in this survey?" were all removed. As the questions were answered using the image selection feature of SurveyMonkey, the fields were either image 1, image 2, image 3, or a comment box. Image 1 signifying the red traffic light which means disagree, image 2 being the amber traffic light meaning uncertain, and image 3 being green which

signals agreement. The questions in their raw data format were not already separated into their respective domains as the domains were only headers on SurveyMonkey and not questions. The find and replace feature was used to rename image 1, image 2, and image 3 into red, amber, and green. The questions were organised into their domains (safety, language, social, ect) and placed into a new worksheet. The countif formula was inserted in the row below each column containing the item (=countif(“”). This formula was calculated and the total number of red, amber, and green answers were displayed in the cells underneath. A report was produced that explains the level of agreement amongst respondents. Clustered column bar charts were created to identify participants perceptions on item applicability. The report was distributed among the trauma leads and comments were evaluated at a trauma leads meetings.

Focus Groups

The Roots framework was piloted with the participants in the staff focus groups. The service user focus group focused on further articulation. Both focus groups were audio recorded using OBS studio. Notes were taken at both staff and service user focus groups. The service user focus group differed in that it was for articulation purposes. At the session, participants were asked to assign either essential or desirable to each item in the framework. Participants were also asked if there should be any changes or additions made to any of the items. At the end of each domain, it was asked if there were any items missing from the domain. The staff focus groups were used to pilot test the framework and no further analysis was required. The data collected from both focus groups were cleaned using the recordings.

3.6 A Trauma-informed Methodology

The trauma-informed care paradigm informed the methodology used in this research. The research attempted to manifest trauma-informed principles within every aspect. Methods were only considered if they were found to apply to the trauma-informed care context and on the agreement of the trauma-informed care programme team. Both staff and service user involvement are significant when conducting research on trauma-informed care. Being involved in system change is empowering, especially when involved in the system as a staff member or a system user.

Chapter 4

Results

4.1 Background

The trauma-informed care programme was leading the introduction of trauma-informed care with the ambition of permeating service. The goal was to further implement trauma-informed care by monitoring its application in service or its misapplication. This study arose out of the need to investigate the implementation of trauma-informed care and observe its position in the organisation, as an organisation can only claim to be trauma-informed if it behaves in trauma-informed ways (Fallot and Harris, 2015). The following chapter documents the results collected from the various means of data collection employed in this experimental social research.

4.2 Arriving at the Domains and Items

At the trauma leads meeting, the domains from the four prominent frameworks were compared with those in the summit to determine coverage. This is presented in Tables 2 through 5. In the left column, the domains from the four literature frameworks are presented. In the right column, the summit domains that the leads believed to capture the opposing literature domain are shown.

The ARTIC comparison can be seen in Table 2:

Table 2: ARTIC Domain Comparison

ARTIC	Trauma Summit
Underlying causes of problem behaviour and symptoms	Social context, language
Responses to problem behaviour and symptoms	Safety, social context, trauma-specific interventions
On-the-job behaviour	All
Self-efficacy at work	Safety, whole system, transformational leadership, empowerment
Reactions to the work	Trauma-specific interventions
Personal support of TIC	Safety, whole system
System-wide support for TIC	Whole system, transformational leadership, safety, social context

End of table

The CCTIC comparison can be seen in Table 3:

Table 3: CCTIC Domain Comparison

CCTIC	Trauma Summit
Safety	All
Trustworthiness	Safety, language, empowerment, whole system, social context
Choice	Empowerment, safety, social context
Collaboration	Empowerment, whole system, social context, safety
Empowerment	Empowerment, language, whole system

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Trauma screening process	Safety, language, empowerment, trauma-specific interventions, whole system

End of table

The TICOMETER comparison can be seen in Table 4:

Table 4: TICOMETER Domain Comparison

TICOMETER	**Trauma Summit**
Building trauma-informed knowledge and skills	All
Establishing trusting relationships	All
Respecting service users	Whole System, safety, language
Fostering trauma-informed service delivery	All
Promoting trauma-informed policies and procedures	Whole System, language

End of table

The TIP Scales comparison can be seen in Table 5:

Table 5: TIP Scales Domain Comparison

TIP Scales	**Trauma Summit**
The environment of Agency & Mutual Respect	Social context, safety, empowerment, language
Access to Information to Trauma	Trauma-specific interventions, safety, empowerment, language

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Opportunities for Connection	Empowerment, trauma-specific interventions, social context
Emphasis on Strengths	Social Context, trauma-specific interventions, language, safety
Cultural responsiveness & inclusivity	All
Support for Parenting	Trauma-specific interventions, social context, safety

End of table

4.2.1 Initial Framework Items

It was concluded that all of the literature domains were covered by the summit domains. General feedback from the group identified that transformational leadership should be termed collective leadership. There was also a query raised whether staff well-being should be added as a key domain. At the same meeting, the trauma leads were asked to generate items for each individual domain for the seven summit domains; this process was not initially well-received by the participants. After some time, participants became familiar with the process. The items generated can be seen in Table 6. To assist in the item development process, a small definition for each domain was presented on a slideshow (Kennedy, 2020).

Table 6: Items generated at Leads Meeting

No	*Item*
Domain One - Safety	
1.	I feel safe to share my experience?
2.	Have you built trustworthy relationships?
3.	Do you feel safe to raise concerns?
4.	Did the location make you feel comfortable?

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No	*Item*
5.	Did the person who assessed you acknowledge how difficult this can be?
6.	Did you ever feel judged by staff?
7.	Do staff listen to you?
Domain Two - Language	
1.	Is the language used respectful of your experience and distress?
2.	Were things explained to you in a way in which you understood?
3.	Have you been spoken to in a way that made you feel uncomfortable?
4.	Did you feel like you were heard?
5.	Do you feel like you had to repeat your story?
6.	Were words used that made you upset or distressed?
Domain Three - Social	
1.	Did the person understand you?
2.	Do you have individuals with lived experience as a part of your service?
3.	Do you have access to shared reflective learning?
4.	Is your shared reflective learning practice meaningful?
5.	Are staff compassionate and caring towards you?
Domain Four - Trauma-specific Interventions	
1.	Did you have access to any trauma-specific interventions?
2.	Did you get what you wanted?
3.	Did you have a choice?
4.	Were your needs met?
5.	Do you feel as though you were treated with respect?
6.	Do you feel that you have been passed around services in order to get what you need?
7.	Were the ranges of possible options explained to you?
8.	Were you asked about your experience of trauma?

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No	*Item*
9.	Did you feel staff understand about the impact of trauma and abuse on you?
10.	Did you feel that staff or interventions caused you further harm?
Domain Five - Empowerment	
1.	Did anyone ask about your story?
2.	Did you feel able to share your story?
3.	Did you feel listened to?
4.	Did you feel validated?
5.	Did you make a choice about your treatment?
6.	Did you feel as if you were able to say no?
7.	Did you feel as if you were in control?
8.	Did you feel progress was made at your required speed?
9.	Was there somebody there to help your work?
10.	Do you as a parent/carer feel as you contributed/listened to?
11.	Do you feel comfortable to tell staff where they may have misunderstood?
Domain Six - Whole System	
1.	Did you feel able to get the type of therapy you wanted?
2.	Were your needs met in a timely manner?
3.	Do you feel the service was designed to meet your needs?
4.	Is the service person-centred rather than service centred?
5.	Did you come across any barriers?
6.	Was it difficult to find the help you wanted?
7.	Did you find what you needed elsewhere?
Domain Seven - Compassionate Leadership	
1.	Does the service work well with other services to make sure your needs are met?
2.	Do you feel you are able to deliver Trauma-informed Care?

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No	*Item*
3.	Did the service work well with other people or services you are involved with?
4.	If a mistake was made, were you heard/acknowledged?
5.	Did you feel this was handled well?
6.	Have you ever made a complaint about your care / treatment?
7.	Was this complaint handled sensitively?
8.	Do you feel confident in the person dealing with you?
Domain Eight - Staff Well-being	
1.	I feel safe at work
2.	I have meaningful relationship with colleagues at work
3.	I have opportunities to express myself at work
4.	I can manage my workload

End of table

4.2.2 Staff Version - Trauma-informed Care Team Translation

Following the consensus of items, the articulation of the domains and items was discussed with the trauma-informed care programme team. A staff and service user form were needed for accessibility. The staff form was translated by trauma experts. This can be seen in Table 7.

Table 7: Staff Version - Translation by Trauma-informed Care Team

No	*Item*
Safety	
1.	Service users are safe from physical harm
2.	Staff are safe from physical harm
3.	My team/service sees everyone as of worth with valid experience and opinion

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No	*Item*
4.	Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues
5.	The underlying psychosocial causes of risks are actively addressed
6.	There is an opportunity to reflect on safety plans so we understand what has contributed to a positive outcome to each service user
7.	It feels safe enough to openly learn what could have been done differently, and when things go wrong for service users
8.	We take an approach to risk management that emphasises the service user perspective and minimises any inadvertent long-term harm to healing
9.	There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other
10.	My team proactively plans around safety rather than being reactive to crises
11.	I feel I have enough skills and autonomy to manage safety issues in a patient-centred way
Language	
1.	Presentations/symptoms are considered as potentially meaningful reactions to current or historical circumstances
2.	All potential causes of current presenting presentations are assessed including physical health issues
3.	The survival value of many 'problems' and someone's strengths as a result of their adversity are adequately acknowledged
4.	We allow for multiple narratives around someone's distress and seek to understand rather than seek to impose one model of understanding
5.	Our service adapts to the broader needs of those with complex trauma histories
6.	Understanding the trauma narrative needs to evolve over time at a safe pace

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No	*Item*
7.	Our model of understanding of trauma includes cognitions, sense of self, relationships and physiological impact
8.	Acknowledgement that staff may have their own personal/professional trauma journeys that influence their motivation and understanding
Social	
1.	There are good working collaborative alliances between people, teams and agencies around trauma-based needs
2.	People collaborate towards a personalised healing journey that prevents further harm
3.	There is an emphasis in my service that healing from trauma occurs within safe and trusting relationships
4.	Attention is paid to all aspect of communication of compassion through written, verbal, non-verbal and behaviours
5.	Reflective practice and the capacity to think non-critically about the motivations behind the action of others are paramount
6.	People actively seek to contribute towards a functioning open relationship even when things are difficult
7.	Policies and performance targets include a focus on patient and staff experience
Trauma-specific Interventions	
1.	Sensitive routine inquiry of adversity and trauma forms the basis of our assessments and planning
2.	Our interventions are delivered in an explicitly trauma-informed way, matched to need and available long enough to make a difference
3.	We support people to create conditions where healing from trauma can begin, e.g. housing, income, physical safety etc.
4.	A range of specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR

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No	*Item*
5.	Any new interventions are evaluated for clinical outcomes, impact on functioning and service user experience
6.	Trauma interventions are offered proactively to prevent crises
7.	Any trauma interventions are delivered as part of a wider coherent plan across agencies
Empowerment	
1.	Services explicitly mitigate against the role of power differences in relationships with service users and carers
2.	Creative innovation by all stakeholders is promoted to enable influence to be distributed fairly
3.	trauma-informed transformation is co-produced and co-designed with service users who have a range of views
4.	Direct peer support is available, which minimises stigma
5.	Personalised care and support plans are devised through shared decision making
6.	We consider how different people view power dynamics in different ways and how this can be balanced
7.	People with lived experience of trauma are openly in positions of leadership and influence
8.	Research and business planning are co-produced with people with lived experience
Domain Six - Whole System	
1.	Funding for trauma-informed approaches forms part of core business over time
2.	We monitor trauma-related outcomes
3.	Staff at all levels have adequate trauma-informed skills and are supported to work in a trauma-informed way
4.	A Trauma-informed approach is explicit in the commissioning framework for our service
5.	We have access to peer support with lived experience of trauma

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No	*Item*
6.	People who need help can get help early without being passed around (pathways are clear and comprehensive to cover a variety of needs)
Domain Seven - Compassionate Leadership	
1.	Services have the capacity to manage demand in a way that promotes helpful outcomes
2.	Staff are supported to be motivated to address trauma-related issues
3.	Lived experienced voices are valid in supervision and learning
4.	There is a culture where it is safe to speak up about concerns
5.	Leaders address issues of stigma and acknowledge that adversity can limit all of us at various times
6.	Leaders at all levels are responsible for supporting trauma-informed developments and for integrating them into their own areas of influences
7.	Leaders are open about their own experiences of adversity
8.	Promotion is based on trauma-informed values and experience

End of table

4.2.3 Service user Version - Experts-by-experience Translation

The service user form was co-produced with experts-by-experience at the Recovery College in Durham. This is presented in Table 8.

Table 8: Service user Version - Translation by an Experts-by-Experience Group

No	*Item*
Safety	
1.	I feel safe from physical harm
2.	I feel staff are safe from physical harm

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No	*Item*
3.	I believe that staff see everyone as of worth with valid experience and opinion
4.	I believe staff understand my personal risk in terms of past trauma issues
5.	I feel my personal risk is understood in terms of wider issues such as housing, finance, relationships, etc.
6.	I feel I have the chance to reflect, with staff, on times when things have gone well
7.	When things go wrong, I get the chance to reflect, with staff, so things can be done differently in the future
8.	I feel staff take into account my view when looking at risk in a way which promotes my long-term healing
9.	I believe staff trust one another and are able to respect each other's opinions
10.	I feel my team makes plans around my personal safety in advance rather than after a crisis
11.	I feel the staff have enough skills and ability to deal with safety in a way which is personal to me
Language	
1.	My symptoms, or the way I appear and behave are considered as meaningful reactions to my current or past experiences
2.	I believe all causes of my symptoms, or the way I appear and behave, are considered, including my physical health
3.	I feel staff recognise the survival value of my ways of coping as well as my personal strengths
4.	I believe staff enable me to communicate my distress in a variety of different ways and do not stride to a single model of understanding
5.	I feel mental health services are able to adapt to the broader needs of individuals who have experienced complex trauma

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No	*Item*
6.	I feel staff recognise that a person's trauma takes time and a sense of safety to understand properly
7.	I feel staff's understanding of trauma takes into account my relationships, physical impact, thoughts and sense of self
8.	I understand that staff may have their own trauma histories which impacts on their way of being and understanding of my way
Social	
1.	I believe there are good working relationships between, staff, teams and other agencies
2.	I feel people work together to create a personal healing journey which tries to reduce further harm
3.	I believe there is an understanding within my service/team that healing from trauma happens within safe and trusting relationships
4.	I feel efforts are made to communicate compassion through all types of interaction and communicate methods
5.	I believe staff should be able to reflect, non-judgementally, about their own actions and those of others
6.	I feel that even during difficult times, people seek to promote positive, open relationships
7.	I believe policies and staff targets should include a focus on service user and staff experiences
Trauma-specific Interventions	
1.	I believe sensitive questions about adversity and trauma from the basis of staff assessment & plans
2.	I believe interventions are delivered in an openly trauma-informed way & suit the individuals needs for long enough to make a difference
3.	I believe staff support service users in creating conditions where healing from trauma can begin

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No	*Item*
4.	I believe a range of specialist trauma therapies are available including for more with complex trauma and dissociation e.g. EMDR
5.	I think new interventions should be evaluated for clinical outcomes, impact on well-being & service user experience
6.	I believe trauma interventions are used in advance to prevent crisis
7.	I believe trauma interventions are used as part of a wider plan that involves other agencies
Empowerment	
1.	I believe services actively reduce power differences in relationships with service users & carers
2.	I believe new ideas should be welcomed by everyone involved to promote fairness & equality
3.	I believe trauma-informed changes to the service are co-produces & co-designed with service users
4.	I believe direct peer support should be available
5.	I am involved in decisions about my care & support plans
6.	Services know that people react differently to power imbalances and try to balance them
7.	I think people with lived experiences of trauma should be openly in positions of leadership & influence
8.	I think research & business planning should be co-produced with people both lived experiences
Domain Six - Whole System	
1.	I believe funding for trauma-informed approaches should form part of business as usual
2.	I believe trauma-related outcomes should be monitored
3.	I think all staff have adequate training & support to work in a trauma-informed way
4.	I believe services should have a trauma-informed approach built into the way services are paid for

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No	*Item*
5.	I have access to peer support from people with lived experience of trauma
6.	I think people who need help can get help early without being passed around
Domain Seven - Compassionate Leadership	
1.	I think services deal with demand in a way that encourages helpful outcomes
2.	I think staff are supported to want to address trauma-related issues
3.	I believe it is important to have lived experience officers in supervision & learning
4.	I believe staff feel it is safe to speak up about concerns
5.	I believe staff at all levels are aware of issues of stigma
6.	I believe leaders at all levels should be responsible for supporting trauma-informed developments & providing them in their own areas
7.	I believe staff leaders are open about their own experiences of adversity
8.	I believe trauma-informed values & experience is being promoted

End of table

4.2.4 Identification of Meaning Between Versions

As both staff and service user versions had seen substantial external input, a quality assurance process was necessary. Both versions were examined together to ensure meaning was captured. These changes were made in the service user version. This is demonstrated in Table 9.

Table 9: Identification of Meaning

No	*Item*
Safety	
1.	Meaning captured
2.	Meaning captured
3.	Meaning captured

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No	*Item*
4.	Meaning captured
5.	Meaning captured
6.	Meaning captured
7.	Meaning captured
8.	Meaning captured
9.	Potential loss of meaning. Service user item changed to ”I believe people trust one another and are able to respect each other’s opinions”
10.	Meaning captured
11.	Meaning captured
Language	
1.	Meaning captured
2.	Meaning captured
3.	Meaning captured
4.	Meaning captured
5.	Meaning captured
6.	Meaning captured
7.	Meaning captured
8.	Meaning captured
Social	
1.	Meaning captured
2.	Meaning captured
3.	Meaning captured
4.	Meaning captured
5.	Potential loss of meaning. Service user item changed to ”I believe people should be able to reflect, non-judgementally, about their own actions and those of others”
6.	Meaning captured

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No	*Item*
7.	Meaning captured
Trauma-specific Interventions	
1.	Meaning captured
2.	Meaning captured
3.	Meaning captured
4.	Potential loss of meaning. Service user item changed to ”I believe a range of specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR”
5.	Potential loss of meaning. Service user item changed to ”I think new interventions are evaluated for clinical outcomes, impact on well-being & service user experience”
6.	Meaning captured
7.	Meaning captured
Empowerment	
1.	Meaning captured
2.	Meaning captured
3.	Meaning captured
4.	Potential loss of meaning. Service user item changed to ”I believe direct peer support which minimises stigma should be available”
5.	Meaning captured
6.	Meaning captured
7.	Potential loss of meaning. Service user item changed to ”I believe people with lived experiences of trauma are openly in positions of leadership & influence”
8.	Potential loss of meaning- Service user item changed to ”I believe research & business planning are co-produced with people who have lived experience”
Domain Six - Whole System	

Continued on the next page

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No	*Item*
1.	Potential loss of meaning. Service user item changed to ”I believe funding for trauma-informed approaches form part of business as usual”
2.	Potential loss of meaning. Service user item changed to ”I believe trauma-related outcomes are monitored”
3.	Meaning captured
4.	Potential loss of meaning. Service user item changed to ”I believe services have a trauma-informed approach built into the way services are paid for”
5.	Meaning captured
6.	Meaning captured
Domain Seven - Compassionate Leadership	
1.	Meaning captured
2.	Meaning captured
3.	Meaning captured
4.	Potential loss of meaning. Service user item changed to ”I believe it is safe for staff to speak up about concerns”
5.	Meaning captured
6.	Potential loss of meaning. Service user item changed to ”I believe leaders at all levels are responsible for supporting trauma-informed developments & providing them in their own areas”
7.	Meaning captured
8.	Potential loss of meaning. Service user item changed to ”I believe trauma-informed values & experience forms the basis for promotion”

End of table

4.3 Surveys

The clustered column bar charts were created in Microsoft Excel. The title of each chart is the domain that it represents. The X-axis defines the items of measurement and is labelled in alphabetical characters. The Y-axis defines the number of responses, with the maximum number being the total number of responses received in the survey. The number of responses to each answer was added above the columns to serve as data labels. The columns and their colours were designed to represent the red, amber, green traffic light system that the survey used for collecting data. The HEX codes for each colour were taken from the survey and were then inputted into the relevant columns to demonstrate consistency. For greyscale print, a pattern was added to each column so distinction could be made easily. The key is seen underneath the figure with their respective items. This key is displayed in a grid format to improve the presentation and allow the key to fit in text with the chart. This format allows for enhanced readability. Both staff and service user clustered column bar charts use the same design principles in their presentations.

4.3.1 Staff Survey

Safety (See Figure 4)

The domain Safety had a total number of 296 responses. 166 were green, 105 were amber, and 25 were red. Green responses equated to 56.08%, amber responses equated to 35.47%, and red responses equated to 8.45%. The item ”Service users are safe from physical harm” received 17 green, 9 amber, and 1 red. With percentages of 62.96% green, 33.33% amber, and 3.70 red. The item ”Staff are safe from physical harm” received 16 green, 9 amber, and 2 red. With percentages of 59.26% green, 33.33% amber, and 7.41% red. The item ”My team/service sees everyone as of worth with valid experience and opinion” received 20 green, 6 amber, and 1 red. With percentages of 74.07% green, 22.22% amber, and 3.70% red. The item ”Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues” received 13 green, 12 amber, and 2 red. With percentages of 48.15% green, 44.33% amber, and 7.41% red. The item ”The underlying psychosocial causes of risks are actively addressed” received 10 green, 5 amber, and 2 red. With percentages of 37.04% green, 56.56% amber, and 7.41% red. The item ”There is an opportunity to reflect on safety plans so we understand what has contributed to a

positive outcome to each service user" received 14 green, 7 amber, and 5 red. With percentages of 51.85% green, 25.93% amber, and 18.52% red. The item "It feels safe enough to openly learn what we could have been done differently when things go wrong for service users" received 15 green, 9 amber, and 3 red. With percentages of 55.56% green, 33.33% amber, and 11.11% red. The item "We take an approach to risk management that emphasises the service user perspective and minimises any inadvertent long-term harm to healing" received 12 green, 12 amber, and 3 red. With percentages of 44.44% green, 44.44% amber, and 11.11% red. The item "There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other" received 14 green, 10 amber, and 3 red. With percentages of 51.85% green, 37.04% amber, and 11.11% red. The item "My team proactively plans around safety rather than being reactive to crises" received 14 green, 10 amber, and 3 red. With percentages of 51.85% green, 37.04% amber, and 11.11% red. The item "Service users are safe from physical harm" received 17 green, 9 amber, and 1 red. With percentages of 63% green, 33% amber, and 4% red. The item "I feel I have enough skills and autonomy to manage safety issues in a patient-centred way" received 21 green, 6 amber, and 0 red. With percentages of 77.78% green, 22.22% amber, and 0.00% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Safety?" A total of 19 comments were left. 13 of those comments were "no". P2 left the comment "hard to say". P10 left the comment "Adequate supervision following clinical sessions and reflective space". P16 left the comment "not that I can think of". P22 left the comment "Staffing levels often prevent the ability to safely manage risk, when caseloads are too high the focus becomes on surviving crisis rather than planning for them". P23 left the comment "Are we psychologically harming our clients". P26 left the comment "Crisis and contingency plan that is developed collaboratively with the service user".

Language (See Figure 5)

The domain Language had a total number of 214 responses. 114 were green, 93 were amber, and 7 were red. Green responses equated to 53.27%, amber responses equated to 43.46%, and red responses equated to 3.27%. The item "Presentations/symptoms are considered as potentially meaningful reactions to current or historical circumstances" received 19 green, 8 amber, and 0 red. With percentages of 70.37% green, 29.63% amber, and 0.00% red. The item "All potential

causes of current presenting presentations are assessed including physical health issues" received 15 green, 12 amber, and 0 red. With percentages of 55.56% green, 44.44% amber, and 0.00% red. The item "The survival value of many 'problems' and someone's strengths as a result of their adversity are adequately acknowledged" received 11 green, 14 amber, and 1 red. With percentages of 40.74% green, 51.85% amber, and 3.70% red. The item "We allow for multiple narratives around someone's distress and seek to understand rather than seek to impose one model of understanding" received 14 green, 11 amber, and 2 red. With percentages of 51.85% green, 40.74% amber, and 7.41% red. The item "Our service adapts to the broader needs of those with complex trauma histories" received 10 green, 16 amber, and 1 red. With percentages of 37.04% green, 59.26% amber, and 3.70% red. The item "Understanding that the trauma narrative is allowed to evolve over time at a safe pace" received 13 green, 12 amber, and 1 red. With percentages of 48.15% green, 44.44% amber, and 3.70% red. The item "Our model of understanding of trauma includes cognitions, sense of self, relationships and physiological impact" received 17 green, 10 amber, and 0 red. With percentages of 62.96% green, 37.04% amber, and 0.00% red. The item "Acknowledgment that staff may have their own personal/professional trauma journeys that influence their motivation and understanding" received 15 green, 10 amber, and 2 red. With percentages of 55.56% green, 37.04% amber, and 7.41% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Language?" A total of 18 comments were left. 14 of those comments were "no". P4 left the comment "I feel that all staff in the care sector need to have training on trauma-informed care as this would help people have an understanding when and if a patient has behaviours that challenge" P8 left the comment "Consider the language abilities of the person". P10 left the comment "Language should include visual guides as part of language". P23 left the comment "Stigmatising language or dehumanising language".

Social (See Figure 6)

The domain Social had a total number of 189 responses. 102 were green, 76 were amber, and 11 were red. Green responses equated to 53.97%, amber responses equated to 40.21%, and red responses equated to 5.82%. The item "There are good working collaborative alliances between people, teams and agencies around trauma-based needs" received 11 green, 15 amber, and 1 red. With percentages of 40.74% green, 55.56% amber, and 3.70% red. The item "People collaborate

towards a personalised healing journey that prevents further harm" received 11 green, 14 amber, and 2 red. With percentages of 40.74% green, 51.85% amber, and 7.41% red. The item "There is an emphasis in my service that healing from trauma occurs within safe and trusting relationships" received 18 green, 8 amber, and 1 red. With percentages of 66.67% green, 29.63% amber, and 3.70% red. The item "Attention is paid to all aspect of communication of compassion through written, verbal, non-verbal and behaviours" received 17 green, 10 amber, and 0 red. With percentages of 62.96% green, 37.04% amber, and 0.00% red. The item "Reflective practice and the capacity to think non-critically about the motivations behind the action of others are paramount" received 20 green, 5 amber, and 2 red. With percentages of 74.07% green, 18.52% amber, and 7.41% red. The item "People actively seek to contribute towards functioning positive relationships even when things are difficult" received 14 green, 12 amber, and 1 red. With percentages of 51.85% green, 44.44% amber, and 3.70% red. The item "Policies and performance targets include a focus on patient and staff experience" received 11 green, 12 amber, and 4 red. With percentages of 40.74% green, 44.44% amber, and 14.81% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Social?" A total of 13 comments were left. Three of those comments were "no", seven of those comments were "none", one of those comments were "N/A", and another commented "none that I can think of". P10 left the comment "Family or relevant other involvement where appropriate".

Trauma-specific Interventions (See Figure 7

The domain Trauma-specific Interventions had a total number of 189 responses. 78 were green, 81 were amber, and 30 were red. Green responses equated to 41.27%, amber responses equated to 42.86%, and red responses equated to 15.87%. The item "Sensitive routine inquiry of adversity and trauma forms the basis of our assessments and planning" received 18 green, 9 amber, and 0 red. With percentages of 66.67% green, 33.33% amber, and 0.00% red. The item "Our interventions are delivered in an explicitly trauma-informed way, matched to need and available long enough to make a difference" received 8 green, 15 amber, and 4 red. With percentages of 29.63% green, 55.56% amber, and 14.81% red. The item "We support people to create conditions where healing from trauma can begin, e.g. housing, income, physical safety etc." received 13 green, 12 amber, and 2 red. With percentages of 48.15% green, 44.44% amber, and 7.41% red. The item "A range of

specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR" received 10 green, 10 amber, and 7 red. With percentages of 37.04% green, 37.04% amber, and 25.93% red. The item "Any new interventions are evaluated for clinical outcomes, impact on functioning and service user experience" received 10 green, 10 amber, and 7 red. With percentages of 37.04% green, 37.04% amber, and 25.93% red. The item "Trauma interventions are offered proactively to prevent crises" received 10 green, 12 amber, and 5 red. With percentages of 37.04% green, 44.44% amber, and 18.52% red. The item "Any trauma interventions are delivered as part of a wider coherent plan across agencies" received 9 green, 13 amber, and 5 red. With percentages of 33.33% green, 48.15% amber, and 18.52% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Trauma-specific Interventions?" A total of 18 comments were left. One of those comments were "no", 10 of those comments were "none", one comment was "N/A", one being "not sure", one comment was "cannot think of any" and another commented "none that I can think of". P4 left the comment "I still believe there needs to be more training in this area for all staff". P5 left the comment "we are a trauma-informed service who do not offer work for Trauma!". P22 left the comment "We do not have the capacity to deliver trauma interventions in a timely way".

Empowerment (See Figure 8

The domain Empowerment had a total number of 216 responses. 80 were green, 87 were amber, and 49 were red. Green responses equated to 37.04%, amber responses equated to 40.28%, and red responses equated to 22.69%. The item "Services explicitly mitigate against the role of power differences in relationships with service users and carers" received 12 green, 10 amber, and 5 red. With percentages of 44.44% green, 37.04% amber, and 18.52% red. The item "Creative innovation by all stakeholders is promoted to enable influence to be distributed fairly" received 5 green, 15 amber, and 7 red. With percentages of 18.52% green, 55.56% amber, and 25.93% red. The item "Trauma-informed transformation is co-produced and co-designed with service users who have a range of views" received 12 green, 11 amber, and 4 red. With percentages of 44.44% green, 40.74% amber, and 14.81% red. The item "Direct peer support is available, which minimises stigma" received 10 green, 9 amber, and 8 red. With percentages of 37.04% green, 33.33% amber, and 29.63% red. The item "Personalised care and support plans are devised

through shared decision making" received 16 green, 9 amber, and 2 red. With percentages of 59.26% green, 33.33% amber, and 7.41% red. The item "We consider how different people view power dynamics in different ways and how this can be balanced" received 7 green, 13 amber, and 7 red. With percentages of 25.93% green, 48.15% amber, and 25.93% red. The item "People with lived experience of trauma are openly in positions of leadership and influence" received 7 green, 9 amber, and 11 red. With percentages of 25.93% green, 33.33% amber, and 40.74% red. The item "Creative innovation by all stakeholders is promoted to enable influence to be distributed fairly" received 11 green, 11 amber, and 5 red. With percentages of 40.74% green, 40.74% amber, and 18.52% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Empowerment". A total of 15 comments were left. 13 of those comments were "none". One comment was "N/A", and another was "not sure".

Whole System (See Figure 9)

The domain Whole System had a total number of 154 responses. 51 were green, 69 were amber, and 34 were red. Green responses equated to 33.12%, amber responses equated to 44.81%, and red responses equated to 22.08%. The item "Funding for trauma-informed approaches forms part of core business over time" received 7 green, 15 amber, and 3 red. With percentages of 25.93% green, 55.56% amber, and 11.11% red. The item "We monitor trauma-related outcomes" received 11 green, 10 amber, and 5 red. With percentages of 40.74% green, 37.04% amber, and 18.52% red. The item "Staff at all levels have adequate trauma-informed skills and are supported to work in a trauma-informed way" received 6 green, 15 amber, and 5 red. With percentages of 22.22% green, 55.56% amber, and 18.52% red. The item "A trauma-informed approach is explicit in the commissioning framework for our service" received 11 green, 8 amber, and 7 red. With percentages of 40.74% green, 29.63% amber, and 25.93% red. The item "We have access to peer support with lived experience of trauma" received 8 green, 11 amber, and 6 red. With percentages of 29.63% green, 40.74% amber, and 22.22% red. The item "People who need help can get help early without being passed around (pathways are clear and comprehensive to cover a variety of needs)" received 8 green, 10 amber, and 8 red. With percentages of 29.63% green, 37.04% amber, and 29.63% red.

Participants were able to leave an open-ended response under the question: ”Do you think that any items are missing from the domain Whole System?” A total of 16 comments were left. 11 of those comments were ”none”. One comment was ”no, another was ”N/A”, and another comment was ”n”. P4 left the comment ”I have marked yellow on quite a lot of the answers as I am unsure to the answers and did not want to tick a red in case I was wrong”. P18 left the comment ”Staff members trauma experiences are embraced as useful experiences contributing to the capacity to offer the best possible care”.

Compassionate Leadership (See Figure 10)

The domain Compassionate Leadership had a total number of 207 responses. 81 were green, 94 were amber, and 32 were red. Green responses equated to 39.13%, amber responses equated to 45.41%, and red responses equated to 15.46%. The item ”Services have the capacity to manage demand in a way that promotes helpful outcomes” received 12 green, 8 amber, and 6 red. With percentages of 44.44% green, 29.63% amber, and 22.22% red. The item ”Staff are supported to be motivated to address trauma-related issues” received 13 green, 12 amber, and 1 red. With percentages of 48.15% green, 44.44% amber, and 3.70% red. The item ”Lived experienced voices are valid in supervision and learning” received 10 green, 14 amber, and 2 red. With percentages of 37.04% green, 51.85% amber, and 7.41% red. The item ”There is a culture where it is safe to speak up about concerns” received 13 green, 8 amber, and 5 red. With percentages of 48.15% green, 29.63% amber, and 18.52% red. The item ”Leaders address issues of stigma and acknowledge that adversity can limit all of us at various times” received 8 green, 15 amber, and 3 red. With percentages of 29.63% green, 55.56% amber, and 11.11% red. The item ”Leaders at all levels are responsible for supporting trauma-informed developments and for integrating them into their own areas of influences” received 11 green, 14 amber, and 1 red. With percentages of 40.74% green, 51.85% amber, and 3.70% red. The item ”Leaders are open about their own experiences of adversity” received 7 green, 13 amber, and 6 red. With percentages of 25.93% green, 48.15% amber, and 22.22% red. The item ”Promotion is based on trauma-informed values and experience” received 7 green, 10 amber, and 8 red. With percentages of 25.93% green, 37.04% amber, and 29.63% red.

Participants were able to leave an open-ended response under the question: ”Do you think that any items are missing from the domain Compassionate Leadership?” A total of 14 comments were

left. 11 of those comments were ”none”. One comment was ”N/A”, another was ”not sure”. P22 left the comment ”Leadership can sometimes be very blaming and do not consider the impact of their feedback from SUIs (serious untoward incidents) on staff, which can be traumatising in itself!”.

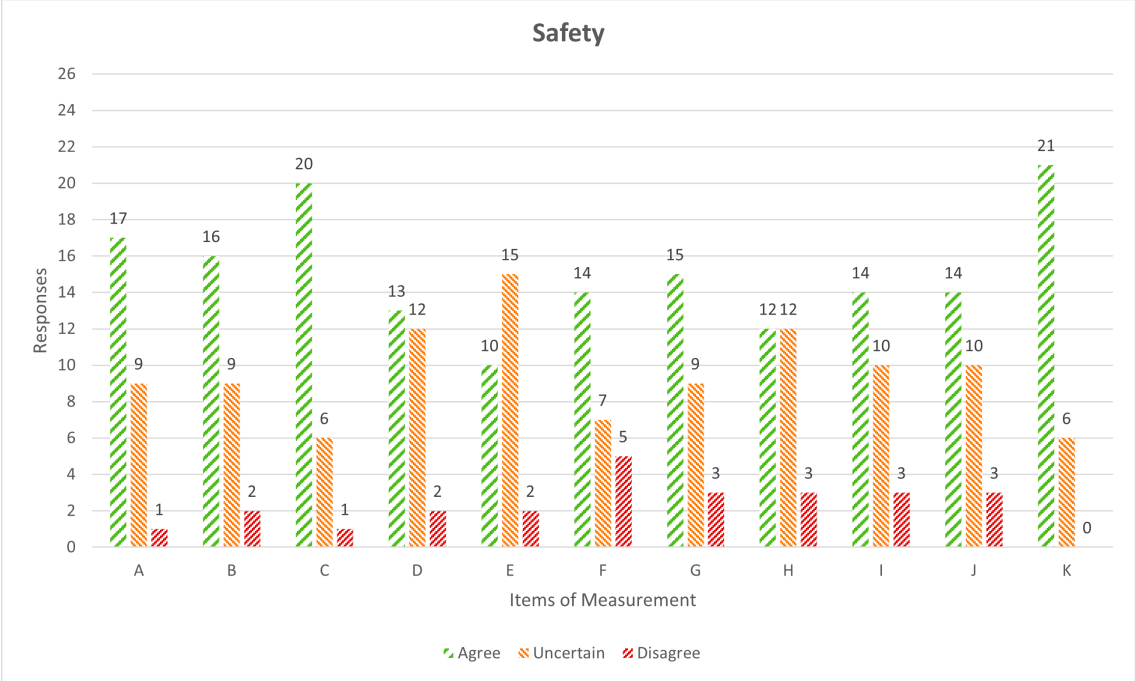

Figure 4: Staff - Safety

Items A-K

(A) Service users are safe from physical harm

(B) Staff are safe from physical harm

(C) My team/service see's everyone as of worth with valid experience and opinion

(D) Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues

(E) The underlying psychosocial causes of risks are actively addressed

(F) There is an opportunity to reflect on safety plans, so we understand what has contributed to a positive outcome to each service user

(G) It feels safe enough to openly learn what we could have been done differently when things go wrong for service users

(H) We take an approach to risk management that emphasises the service user perspective and minimizes any inadvertent long-term harm to healing

(I) There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other

(J) My team proactively plans around safety rather than being reactive to crises

(K) I feel I have enough skills and autonomy to manage safety issues in a patient-centred way

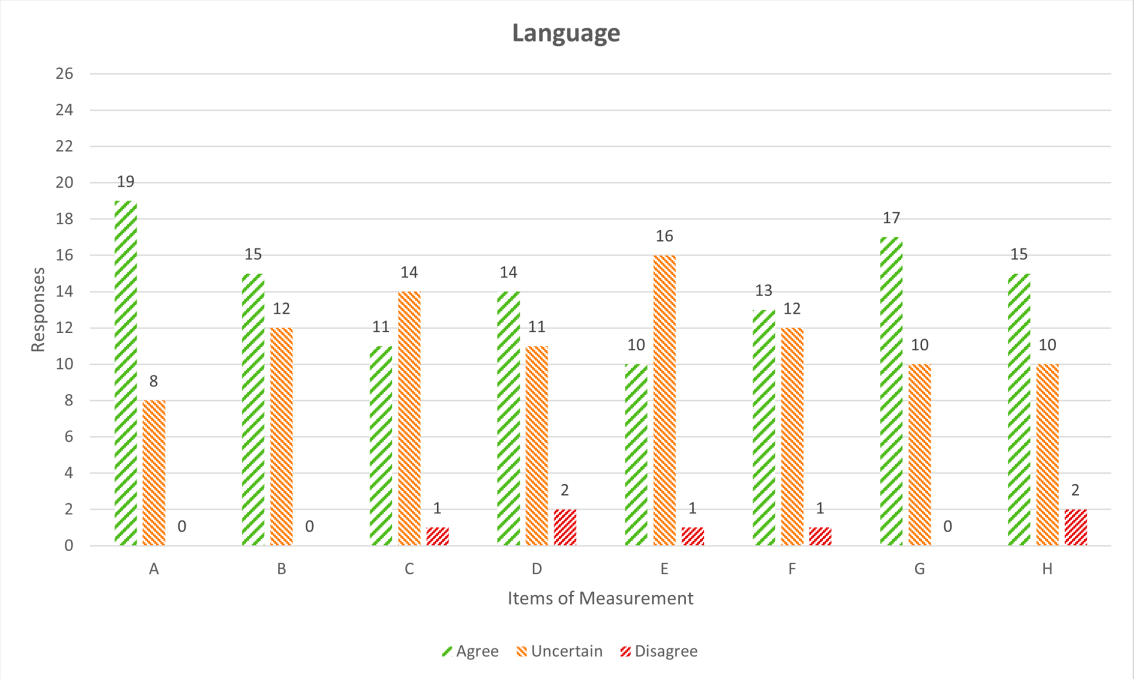

Figure 5: Staff - Language

Items A-H

(A) Presentations/ symptoms are considered as potentially meaningful reactions to current or historical circumstances

(B) All potential causes of current presenting presentations are assessed including physical health issues

(C) The survival value of many 'problems' and someone's strengths as a result of their adversity are adequately acknowledged

(D) We allow for multiple narratives around someone's distress and seek to understand rather than seek to impose one model of understanding

(E) Our service adapts to the broader needs of those with complex trauma histories

(F) Understanding that the trauma narrative is allowed to evolve over time at a safe pace

(G) Our model of understanding of trauma includes cognitions, sense of self, relationships and physiological impact

(H) Acknowledgment that staff may have their own personal/professional trauma journeys that influence their motivation and understanding

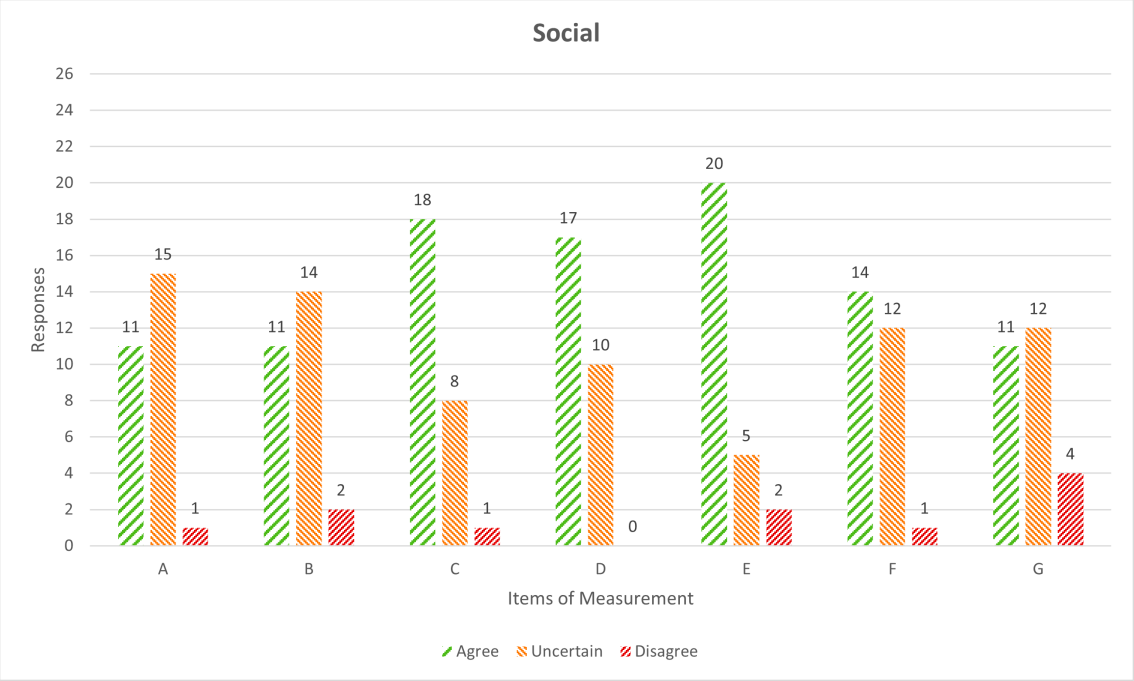

Figure 6: Staff - Social

Items A-G

(A) There are good working collaborative alliances between people, teams and agencies around trauma-based needs

(B) People collaborate towards a personalised healing journey that prevents further harm

(C) There is an emphasis in my service that healing from trauma occurs within safe and trusting relationships

(D) Attention is paid to all aspect of communication of compassion through written, verbal, non-verbal and behaviours

(E) I believe people should be able to reflect, non-judgementally, about their own actions and those of others

(F) People actively seek to contribute towards functioning positive relationships even when things are difficult

(G) Policies and performance targets include a focus on patient and staff experience

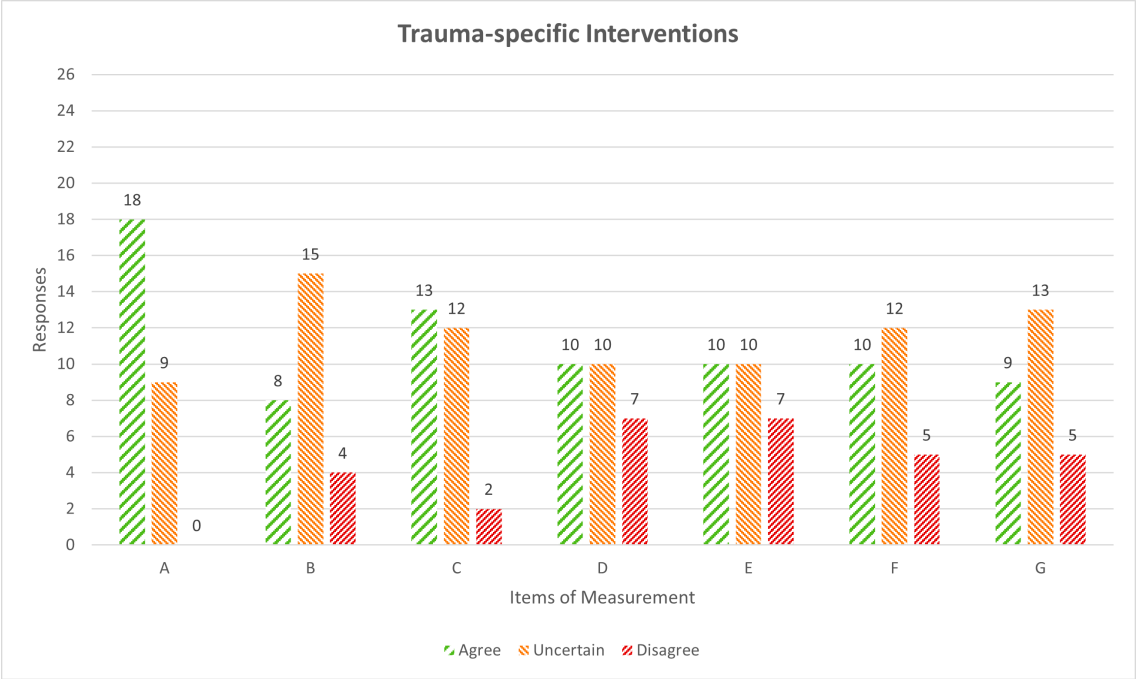

Figure 7: Staff - Trauma-specific Interventions

Items A-G

(A) Sensitive routine inquiry of adversity and trauma forms the basis of our assessments and planning

(B) Our interventions are delivered in an explicitly trauma-informed way, matched to need and available long enough to make a difference

(C) We support people to create conditions where healing from trauma can begin, e.g. housing, income, physical safety etc.

(D) A range of specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR

(E) Any new interventions are evaluated for clinical outcomes, impact on functioning and service user experience

(F) Trauma interventions are offered proactively to prevent crises

(G) Any trauma interventions are delivered as part of a wider coherent plan across agencies

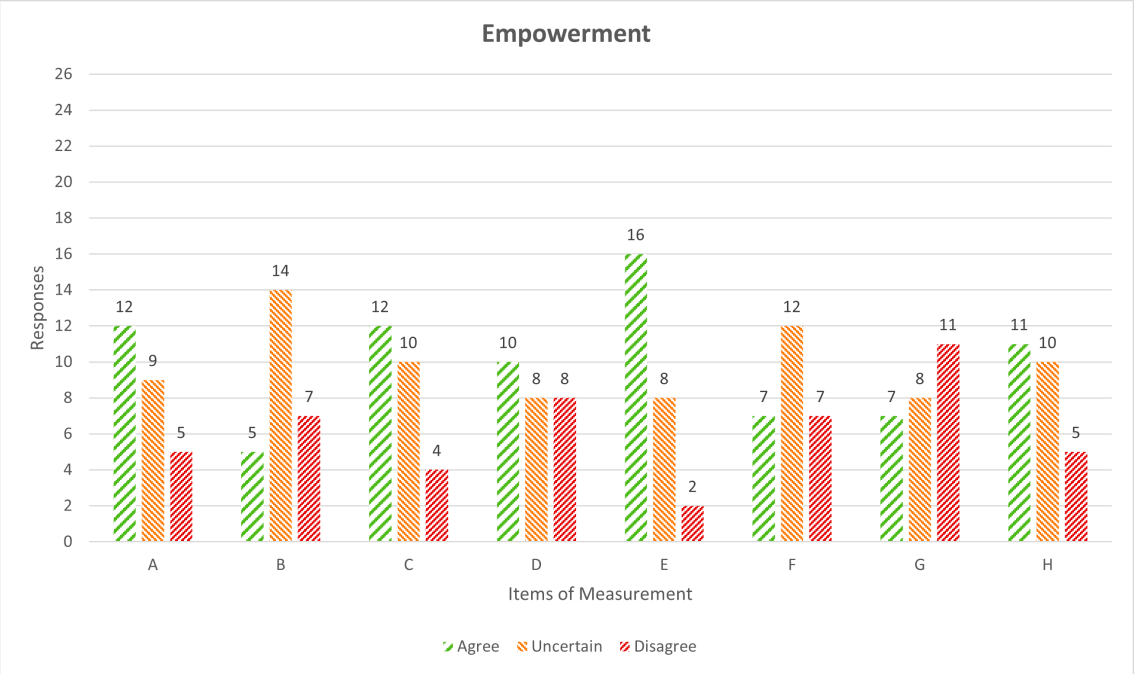

Figure 8: Staff - Empowerment

Items A-H

(A) Services explicitly mitigate against the role of power differences in relationships with service users and carers

(B) Creative innovation by all stakeholders is promoted to enable influence to be distributed fairly

(C) Trauma-informed transformation is co-produced and co-designed with servicer users who have a range of views

(D) Direct peer support is available, which minimises stigma

(E) Personalised care and support plans are devised through shared decision making

(F) We consider how different people view power dynamics in different ways and how this can be balanced

(G) People with lived experience of trauma are openly in positions of leadership and influence

(H) Research and business planning are co-produced with people with lived experience

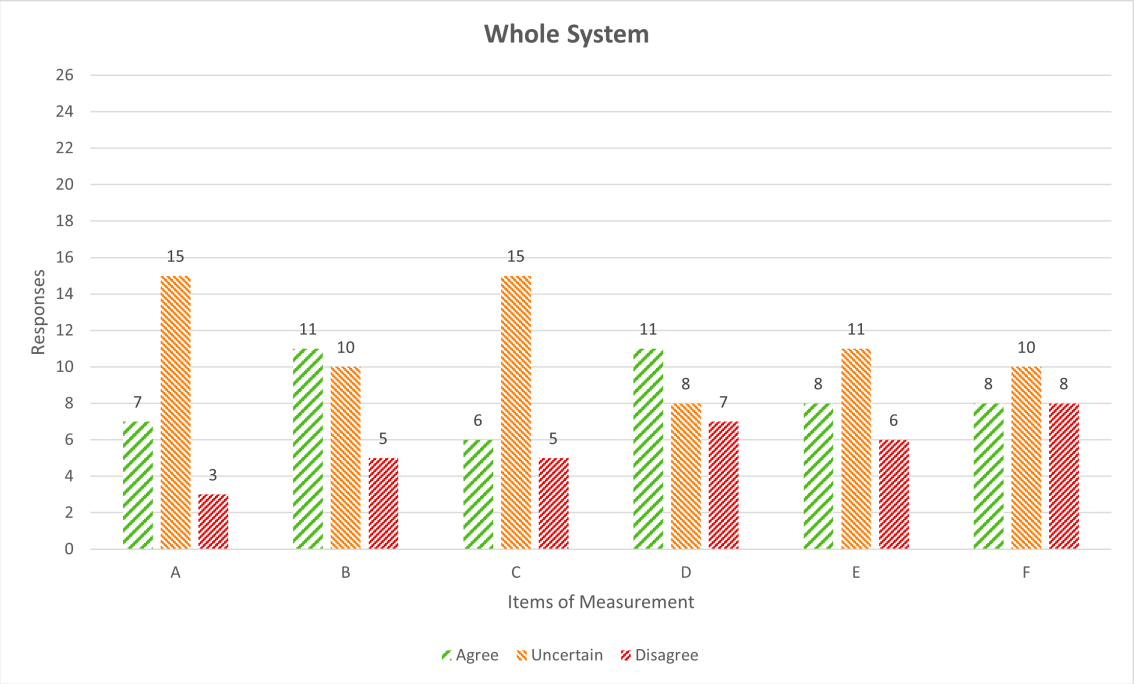

Figure 9: Staff - Whole System

Items A-F

(A) Funding for trauma-informed approaches forms part of core business over time

(B) We monitor trauma-related outcomes

(C) Staff at all levels have adequate trauma-informed skills and are supported to work in a trauma-informed way

(D) A trauma-informed approach is explicit in the commissioning framework for our service

(E) We have access to peer support with lived experience of trauma

(F) People who need help can get help early without being passed around (pathways are clear and comprehensive to cover a variety of needs)

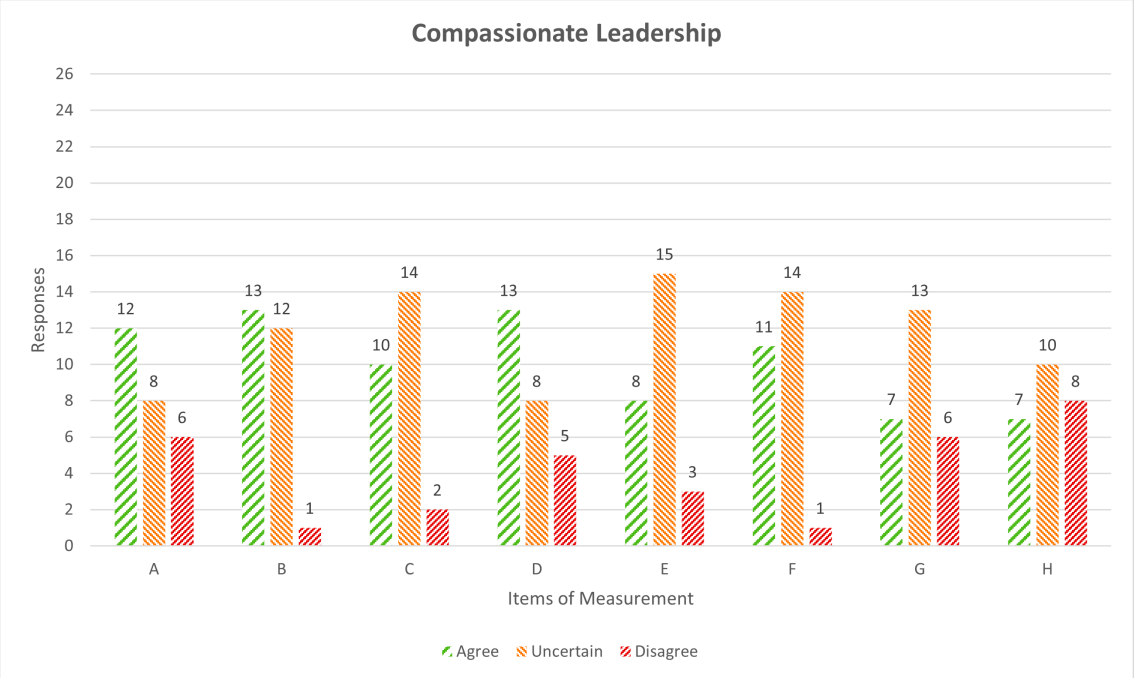

Figure 10: Staff - Compassionate Leadership

Items A-H

(A) Services have the capacity to manage demand in a way that promotes helpful outcomes

(B) Staff are supported to be motivated to address trauma-related issues

(C) Lived experienced voices are valid in supervision and learning

(D) There is a culture where it is safe to speak up about concerns

(E) Leaders address issues of stigma and acknowledge that adversity can limit all of us at various times

(F) Leaders at all levels are responsible for supporting trauma-informed developments and for integrating them into their own areas of influences

(G) Leaders are open about their own experiences of adversity

(H) Promotion is based on trauma-informed values and experience

A total of 51 participants agreed to take part in the staff survey. However, only 27 of those fully completed the survey. Among all 51 participants, participants spent an average time of 02:17:01 on the survey. However, it is suspected that some participants opened the survey and completed it at a later time. If times above 01:00:00 are removed, the average time to completion for all participants is 00:08:02. The 24 participants that did not complete the survey spent an average time of 00:03:55. The 27 participants that did complete the survey spent an average time of 04:15:20 on the survey. However, as previously stated, it is suspected that participants may have left the survey open for a longer period of time until completion. If times above 01:00:00 are removed, the average time to completion is 00:15:38.

4.3.2 Service user Survey

Safety (See Figure 11)

The domain safety had a total number of 143 responses. 83 were green, 40 were amber, and 20 were red. Green responses equated to 58.04%, amber responses equated to 27.97%, and red responses equated to 13.99%. The item ”I feel safe from physical harm” received 9 green, 3 amber, and 1 red. With percentages of 69.23% green, 23.08% amber, and 7.69% red. The item ”I feel staff are safe from physical harm” received 10 green, 3 amber, and 0 red. With percentages of 76.92% green, 23.08% amber, and 0.00% red. The item ”I believe that staff see everyone as of worth with valid experience and opinion” received 7 green, 4 amber, and 2 red. With percentages of 53.85% green, 30.77% amber, and 15.38% red. The item ”I believe staff understand my personal risk in terms of past trauma issues” received 8 green, 0 amber, and 5 red. With percentages of 61.54% green, 0.00% amber, and 38.46% red. The item ”I feel my personal risk is understood in terms of wider issues such as housing, finance, relationships, etc.” received 6 green, 4 amber, and 3 red. With percentages of 46.15% green, 30.77% amber, and 23.08% red. The item ”I feel I have the chance to reflect, with staff, on times when things have gone well” received 4 green, 7 amber, and 2 red. With percentages of 30.77% green, 53.85% amber, and 15.38% red. The item ”When things go wrong, I get the chance to reflect, with staff, so things can be done differently in the future” received 9 green, 1 amber, and 3 red. With percentages of 69.23% green, 7.69% amber, and 23.08% red. The item ”I feel staff take into account my view when looking at risk in a way which promotes my long-term healing” received 7 green, 5 amber, and 1 red. With percentages of

53.85% green, 38.46% amber, and 7.69% red. The item ”I believe people trust one another and are able to respect each other’s opinions” received 7 green, 6 amber, and 0 red. With percentages of 53.85% green, 46.15% amber, and 0.00% red. The item ”I feel my team makes plans around my personal safety in advance rather than after a crisis” received 9 green, 2 amber, and 2 red. With percentages of 69.23% green, 15.38% amber, and 15.38% red. The item ”I feel the staff have enough skills and ability to deal with safety in a way which is personal to me” received 7 green, 5 amber, and 1 red. With percentages of 53.85% green, 38.46% amber, and 7.69% red.

Participants were able to leave an open-ended response under the question: ”Do you think that any items are missing from the domain Safety?” A total of 6 comments were left. One of those comments were ”yes”. One comment was ”no”. P2 left the comment ”Do you feel staff have a good understanding of Trauma in ASD (autism spectrum disorder), to enable them to keep ASD patients and themselves safe?” P4 left the comment ”Development of personal responsibility in relationship to my and others safety”. P9 left the comment ”Crisis teams are the worst at planning regarding safety in a crisis. This is where I see the most examples of ‘positive risk taking’. No proper assessments each time in crisis and often told I have capacity to suicide and to have a cup of tea etc. Perhaps you could separate the crisis team from the generic category of mental health team”. P13 left the comment ”I would also like to feel that I can step out at any point either temporarily or for a longer time if I get overwhelmed”.

Language (See Figure 12)

The domain language had a total number of 104 responses. 63 were green, 19 were amber, and 22 were red. Green responses equated to 60.58%, amber responses equated to 18.27%, and red responses equated to 21.15%. The item ”My symptoms, or the way I appear and behave are considered as meaningful reactions to my current or past experiences” received 9 green, 1 amber, and 3 red. With percentages of 69.23% green, 7.69% amber, and 23.08% red. The item ”I believe all causes of my symptoms, or the way I appear and behave, are considered, including my physical health” received 7 green, 2 amber, and 4 red. With percentages of 53.85% green, 15.38% amber, and 30.77% red. The item ”I feel staff recognise the survival value of my ways of coping as well as my personal strengths” received 8 green, 3 amber, and 2 red. With percentages of 61.54% green, 23.08% amber, and 15.38% red. The item ”I believe staff enable me to communicate my distress in a variety of different ways and do not stride to a single model of understanding” received 7

green, 4 amber, and 2 red. With percentages of 53.85% green, 30.77% amber, and 15.38% red. The item ”I feel mental health services are able to adapt to the broader needs of individuals who have experienced complex trauma” received 6 green, 3 amber, and 4 red. With percentages of 46.15% green, 23.08% amber, and 30.77% red. The item ”I feel staff recognise that a person’s trauma takes time and a sense of safety to understand properly” received 8 green, 2 amber, and 3 red. With percentages of 61.54% green, 15.38% amber, and 23.08% red. The item ”I feel staff’s understanding of trauma takes into account my relationships, physical impact, thoughts and sense of self” received 8 green, 2 amber, and 3 red. With percentages of 61.54% green, 15.38% amber, and 23.08% red. The item ”I understand that staff may have their own trauma histories which impacts on their way of being and understanding of my way” received 10 green, 2 amber, and 1 red. With percentages of 76.92% green, 15.38% amber, and 7.69% red.

Participants were able to leave an open-ended response under the question: ”Do you think that any items are missing from the domain Language?” A total of 5 comments were left. Two of those comments were ”no”. P4 left the comment” That people with mental health issues are not stupid and can understand complex ideas and motivations. That things should be explained clearly and that understanding should be checked for”. P9 left the comment ”I think the domain should also include the word adversity as not all patients will relate to trauma or in fact have suffered trauma in the sense it is often meant”. P13 left the comment ”We all have prejudices and we all make assumptions, no matter how hard we try to avoid it. I would like to feel I can challenge what I might consider to be inaccurate perceptions”.

Social (See Figure 13)

The domain social had a total number of 91 responses. 50 were green, 27 were amber, and 14 were red. Green responses equated to 54.95%, amber responses equated to 29.67%, and red responses equated to 15.38%. The item ”I believe there are good working relationships between, staff, teams and other agencies” received 5 green, 6 amber, and 2 red. With percentages of 38.46% green, 46.15% amber, and 15.38% red. The item ”I feel people work together to create a personal healing journey which tries to reduce further harm” received 5 green, 5 amber, and 3 red. With percentages of 38.46% green, 38.46% amber, and 23.08% red. The item ”I feel staff recognise the survival value of my ways of coping as well as my personal strengths” received 8 green, 3 amber, and 2 red. With percentages of 61.54% green, 23.08% amber, and 15.38% red. The item ”I

believe staff enable me to communicate my distress in a variety of different ways and do not stride to a single model of understanding" received 8 green, 4 amber, and 1 red. With percentages of 61.54% green, 30.77% amber, and 7.69% red. The item "I believe people should be able to reflect, non-judgementally, about their own actions and those of others" received 11 green, 1 amber, and 1 red. With percentages of 84.62% green, 7.69% amber, and 7.69% red. The item "I feel that even during difficult times, people seek to promote positive, open relationships" received 4 green, 6 amber, and 3 red. With percentages of 30.77% green, 46.15% amber, and 23.08% red. The item "I believe policies and staff targets should include a focus on service user and staff experiences" received 9 green, 2 amber, and 2 red. With percentages of 69.23% green, 15.38% amber, and 15.38% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Social?" A total of five comments were left. P2 left the comment "I believe it staff need to be aware of cultural differences in order to be able to effectively work with patients". P4 left the comment "That no person is an island, and that they need to have their family and friend understand what they have been through and the treatment that they have received". P9 left the comment "Just wanted to say that I'm not sure I'm pressing on the correct traffic light colours. I'm doing so as if I'm filling the survey in regards to my experiences in services. Is that right? Or should I have been prioritising which of the questions I think is important? Bit confusing".

Trauma-specific Interventions (See Figure 14)

The domain trauma-specific interventions had a total number of 91 responses. 49 were green, 17 were amber, and 25 were red. Green responses equated to 53.85%, amber responses equated to 18.68%, and red responses equated to 27.47%. The item "I believe sensitive questions about adversity and trauma from the basis of staff assessment & plans" received 7 green, 3 amber, and 3 red. With percentages of 53.85% green, 23.08% amber, and 23.08% red. The item "I believe interventions are delivered in an openly trauma-informed way & suit the individuals needs for long enough to make a difference" received 8 green, 1 amber, and 4 red. With percentages of 61.54% green, 7.69% amber, and 30.77% red. The item "I believe staff support service users in creating conditions where healing from trauma can begin" received 6 green, 4 amber, and 3 red. With percentages of 46.15% green, 30.77% amber, and 23.08% red. The item "I believe a

range of specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR" received 7 green, 1 amber, and 5 red. With percentages of 53.85% green, 7.69% amber, and 38.46% red. The item "I think new interventions are evaluated for clinical outcomes, impact on well-being & service user experience" received 10 green, 2 amber, and 1 red. With percentages of 76.92% green, 15.38% amber, and 7.69% red. The item "I believe trauma interventions are used in advance to prevent crisis" received 8 green, 1 amber, and 4 red. With percentages of 61.54% green, 7.69% amber, and 30.77% red. The item "I believe trauma interventions are used as part of a wider plan that involves other agencies" received 3 green, 5 amber, and 5 red. With percentages of 23.08% green, 38.46% amber, and 38.46% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Trauma-specific Interventions?" A total of six comments were left. One comment was "N/A". P2 commented "When someone with ASD is in distress, do not pounce and restrain but rather go in calmly and calmly talk to them, this is much more effective and much safer than trying to restrain them. Do not ignore a patient when they are trying to report a problem on the ward as they my land up getting murdered as I nearly did". P3 commented "IFS has worked for after 30 years of trauma. Trauma therapy is good but not enough on NHS in the current climate. I have low cost therapy now". P4 commented "Wider use of therapies, using aspects of MBT, DBT and CBT". P9 commented "What are trauma-specific interventions? Do you also mean trauma-specific therapies? Those with complied trauma are excluded because of a 'PD' label". P13 commented "I think it would helpful if I could be confident that practitioners understand that recovery from complex trauma can take a long time and may need a sequence of different interventions. P.S - I think there might be typo in Q. 31 where it says 'from', should it be 'form'?"

Empowerment (See Figure 15)

The domain empowerment had a total number of 104 responses. 73 were green, 20 were amber, and 11 were red. Green responses equated to 70.19%, amber responses equated to 19.23%, and red responses equated to 10.58%. The item "I believe services actively reduce power differences in relationships with service users & carers" received 7 green, 3 amber, and 3 red. With percentages of 53.85% green, 23.08% amber, and 23.08% red. The item "I believe new ideas should be welcomed by everyone involved to promote fairness & equality" received 11 green, 2 amber, and 0 red. With

percentages of 84.62% green, 15.38% amber, and 0.00% red. The item ”I believe trauma-informed changes to the service are co-produces & co-designed with service users” received 7 green, 3 amber, and 3 red. With percentages of 53.85% green, 23.08% amber, and 23.08% red. The item ”I believe direct peer support which minimises stigma should be available” received 10 green, 3 amber, and 0 red. With percentages of 76.92% green, 23.08% amber, and 0.00% red. The item ”I am involved in decisions about my care & support plans” received 9 green, 3 amber, and 1 red. With percentages of 69.23% green, 23.08% amber, and 7.69% red. The item ”Services know that people react differently to power imbalances and try to balance them” received 7 green, 3 amber, and 3 red. With percentages of 53.85% green, 23.08% amber, and 23.08% red. The item ”I believe people with lived experiences of trauma are openly in positions of leadership & influence” received 11 green, 1 amber, and 1 red. With percentages of 84.62% green, 7.69% amber, and 7.69% red. The item ”I believe research & business planning are co-produced with people who have lived experience” received 11 green, 2 amber, and 0 red. With percentages of 84.62% green, 15.38% amber, and 0.00% red.

Participants were able to leave an open-ended response under the question: ”Do you think that any items are missing from the domain Empowerment?” A total of four comments were left. One comment was ”N/A”. P2 commented ”I believe people need to be encouraged to discuss their issues and what needs to change and how they are going to go about making those changes”. P4 commented ”The chance to partake in service user forums with those with decision making power within the NHS”. P9 commented ”I think too often patients are expected to empower themselves with little meaningful help from services and that often extreme distress is treated as behavioural. Also think that co-production is poor and often simply involvement and not valued. I think diversity in terms of race, gender, sexuality etc should be included in all aspects of co-production”.

Whole System (See Figure 16)

The domain whole system had a total number of 78 responses. 51 were green, 7 were amber, and 20 were red. Green responses equated to 65.38%, amber responses equated to 8.97%, and red responses equated to 25.64%. The item ”I believe funding for trauma-informed approaches forms part of business as usual” received 10 green, 2 amber, and 1 red. With percentages of 76.92% green, 15.38% amber, and 7.69% red. The item ”I believe trauma-related outcomes are

monitored" received 11 green, 1 amber, and 1 red. With percentages of 84.62% green, 7.69% amber, and 7.69% red. The item "I think all staff have adequate training & support to work in a trauma-informed way" received 6 green, 2 amber, and 5 red. With percentages of 46.15% green, 15.38% amber, and 38.46% red. The item "I believe services have a trauma-informed approach built into the way services are paid for" received 12 green, 0 amber, and 1 red. With percentages of 92.31% green, 0.00% amber, and 7.69% red. The item "I have access to peer support from people with lived experience of trauma" received 6 green, 1 amber, and 6 red. With percentages of 46.15% green, 7.69% amber, and 46.15% red. The item "I think people who need help can get help early without being passed around" received 6 green, 1 amber, and 6 red. With percentages of 46.15% green, 7.69% amber, and 46.15% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Whole System?" A total of five comments were left. One comment was "N/A". P2 commented "Police should be better trained to deal with potential suicides. I feel that there needs to be more understanding and acceptance of how people react to different kinds of support and support must be adapted to the individuals needs". P4 commented "That personality disorder should not be stigmatised and that everyone is treated as an individual not based on their diagnosis". P8 commented "The system is broken. It will only handle you if you are doped up on prescription meds. God help anyone who tries to stand up for the way they are treated by the mental health system, you are immediately punished by withdrawal of support if you are outspoken about anything. I'm sure lots of people have committed suicide this year under the watch of the CMHTs, people are better off without them". P10 commented "trauma-informed is becoming a buzzword and could become a tick box exercise. I think in this domain missing is trauma-specific and trauma-informed staff and services for those who have or are suffering from iatrogenic trauma".

Compassionate Leadership (See Figure 17)

The domain Compassionate Leadership had a total number of 104 responses. 60 were green, 17 were amber, and 27 were red. Green responses equated to 57.69%, amber responses equated to 16.35%, and red responses equated to 25.96%. The item "I think services deal with demand in a way that encourages helpful outcomes" received 6 green, 2 amber, and 5 red. With percentages of 46.15% green, 15.38% amber, and 38.46% red. The item "I think staff are supported to want to

address trauma-related issues" received 5 green, 3 amber, and 5 red. With percentages of 38.46% green, 23.08% amber, and 38.46% red. The item "I believe it is important to have lived experience officers in supervision & learning" received 11 green, 0 amber, and 2 red. With percentages of 84.62% green, 0.00% amber, and 15.38% red. The item "I believe it is safe for staff to speak up about concerns" received 6 green, 4 amber, and 3 red. With percentages of 46.15% green, 30.77% amber, and 23.08% red. The item "I believe staff at all levels are aware of issues of stigma" received 8 green, 2 amber, and 3 red. With percentages of 61.54% green, 15.38% amber, and 23.08% red. The item "I believe leaders at all levels are responsible for supporting trauma-informed developments & providing them in their own areas" received 11 green, 0 amber, and 2 red. With percentages of 84.62% green, 0.00% amber, and 15.38% red. The item "I believe staff leaders are open about their own experiences of adversity" received 7 green, 2 amber, and 4 red. With percentages of 53.85% green, 15.38% amber, and 30.77% red. The item "I believe trauma-informed values & experience forms the basis for promotion" received 6 green, 4 amber, and 3 red. With percentages of 46.15% green, 30.77% amber, and 23.08% red.

Participants were able to leave an open-ended response under the question: "Do you think that any items are missing from the domain Compassionate Leadership?" A total of four comments were left. One comment was "N/A", and another was "none". P2 left the comment "Always take the individuals experiences and what they are going through into consideration when making ANY decision however big or small that decision may seem to be". P13 left the comment "I would like to feel that leaders are able and willing to spread the word to other bodies and agencies about the effectiveness of trauma-informed approaches". The clustered column chart can be seen in Figure 16.

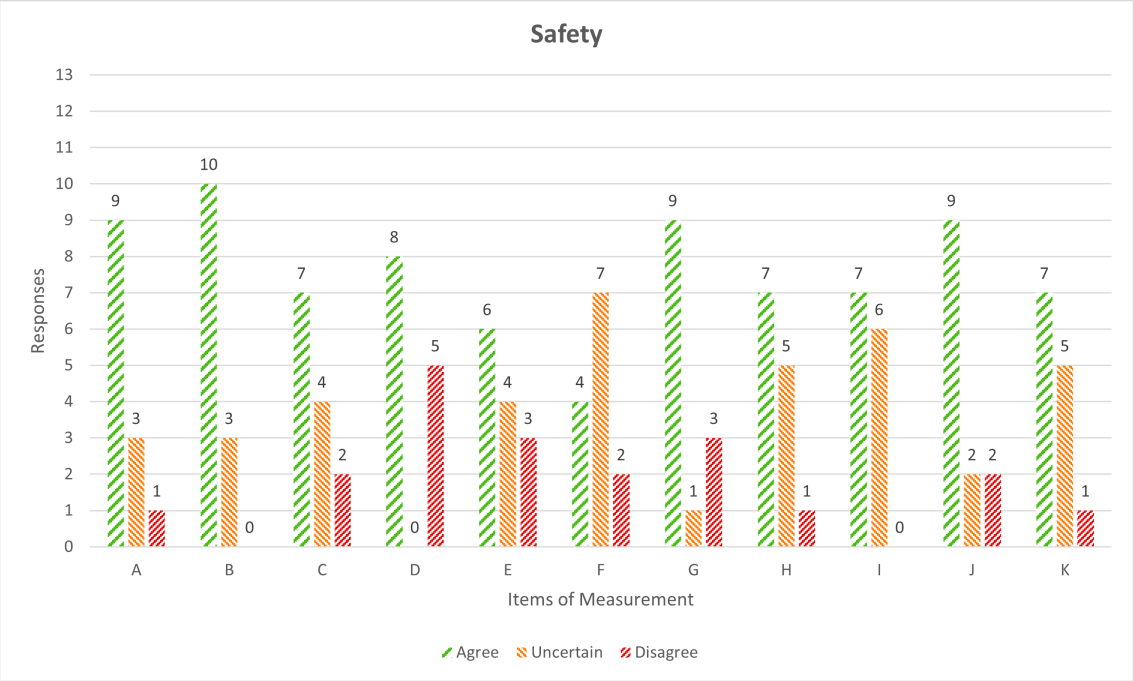

Figure 11: Service user - Safety

Items A-K

(A) I feel safe from physical harm

(B) I feel staff are safe from physical harm

(C) I believe that staff see everyone as of worth with valid experience and opinion

(D) I believe staff understand my personal risk in terms of past trauma issues

(E) I feel my personal risk is understood in terms of wider issues such as housing, finance, relationships, etc.

(F) I feel I have the chance to reflect, with staff, on times when things have gone well

(G) When things go wrong, I get the chance to reflect, with staff, so things can be done differently in the future

(H) I feel staff take into account my view when looking at risk in a way which promotes my long-term healing

(I) I believe people trust one another and are able to respect each other's opinions

(J) I feel my team makes plans around my personal safety in advance rather than after a crisis

(K) I feel the staff have enough skills and ability to deal with safety in a way which is personal to me

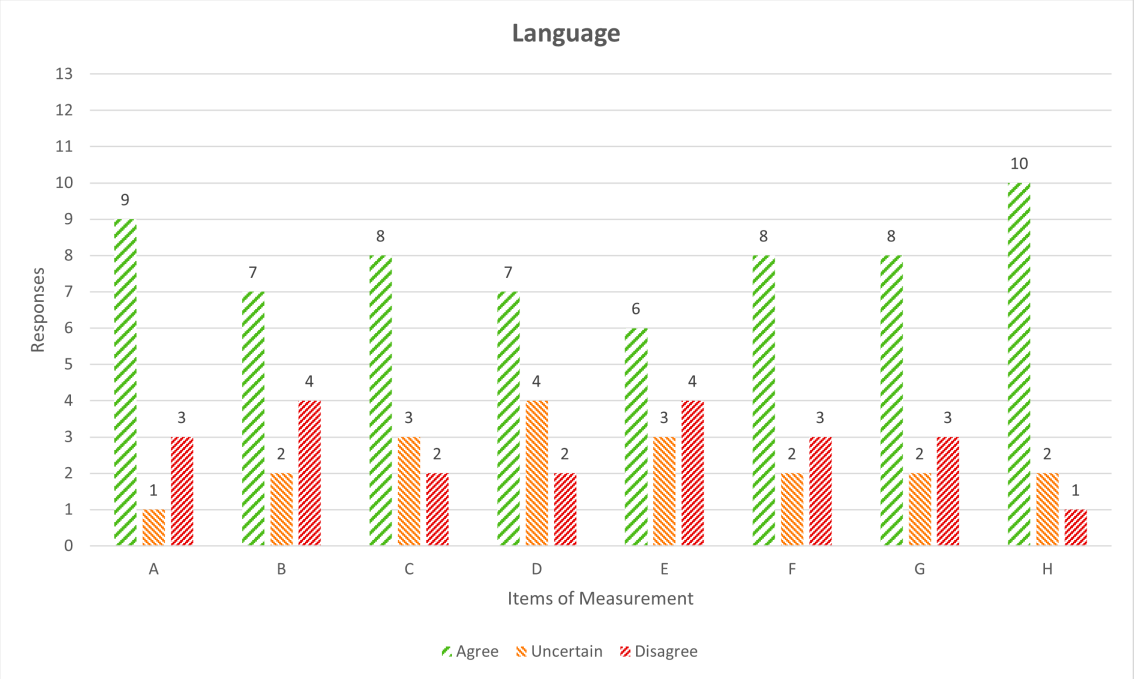

Figure 12: Service user - Language

Items A-H

(A) My symptoms, or the way I appear and behave are considered as meaningful reactions to my current or past experiences

(B) I believe all causes of my symptoms, or the way I appear and behave, are considered, including my physical health

(C) I feel staff recognise the survival value of my ways of coping as well as my personal strengths

(D) I believe staff enable me to communicate my distress in a variety of different ways and do not stride to a single model of understanding

(E) I feel mental health services are able to adapt to the broader needs of individuals who have experienced complex trauma

(F) I feel staff recognise that a person's trauma takes time and a sense of safety to understand properly

(G) I feel staff's understanding of trauma takes into account my relationships, physical impact, thoughts and sense of self

(H) I understand that staff may have their own trauma histories which impacts on their way of being and understanding of my way

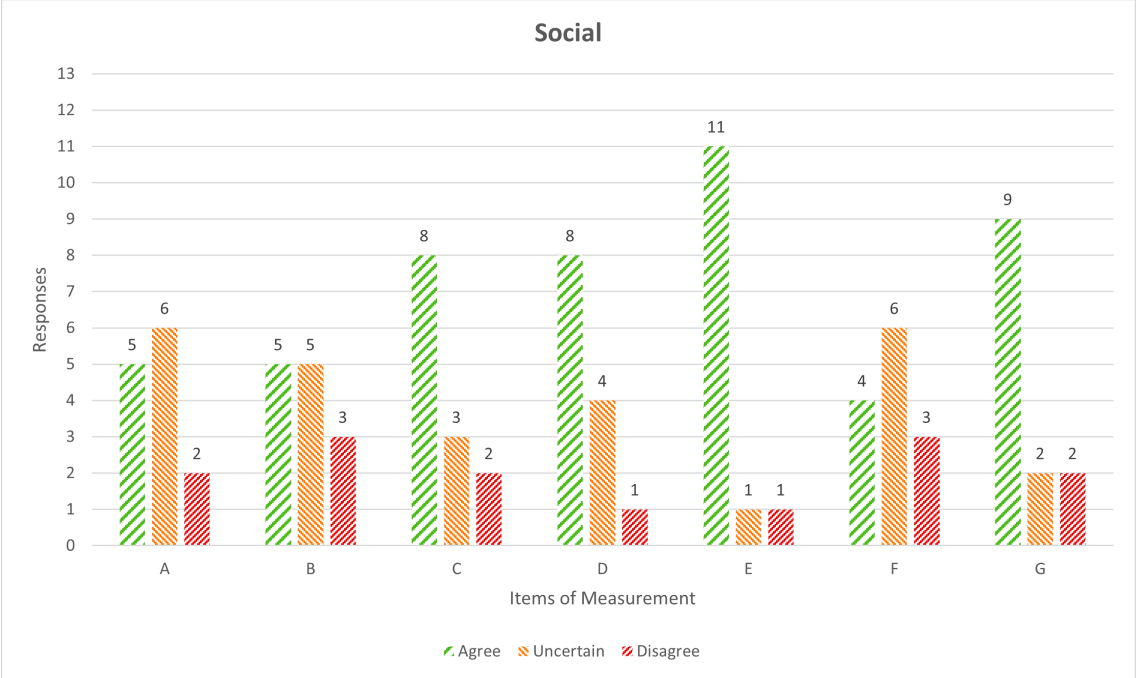

Figure 13: Service user - Social

Items A-G

(A) I believe there are good working relationships between, staff, teams and other agencies

(B) I feel people work together to create a personal healing journey which tries to reduce further harm

(C) I believe there is an understanding within my service/team that healing from trauma happens within safe and trusting relationships

(D) I feel efforts are made to communicate compassion through all types of interaction and communicate methods

(E) I believe staff should be able to reflect, non-judgementally, about their own actions and those of others

(F) I feel that even during difficult times, people seek to promote positive, open relationships

(G) I believe policies and staff targets should include a focus on service user and staff experiences

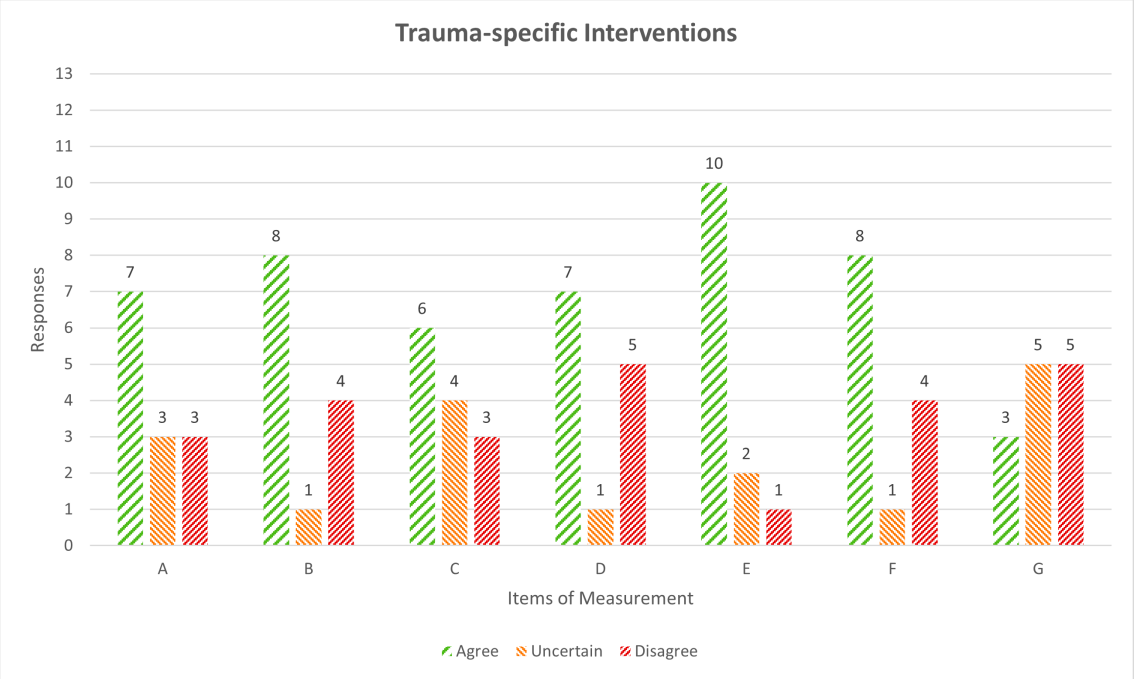

Figure 14: Service user - Trauma-specific Interventions

Items A-G

(A) I believe sensitive questions about adversity and trauma from the basis of staff assessment & plans

(B) I believe interventions are delivered in an openly trauma-informed way & suit the individuals needs for long enough to make a difference

(C) I believe staff support service users in creating conditions where healing from trauma can begin

(D) I believe a range of specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR

(E) I think new interventions are evaluated for clinical outcomes, impact on well-being & service user experience

(F) I believe trauma interventions are used in advance to prevent crisis

(G) I believe trauma interventions are used as part of a wider plan that involves other agencies

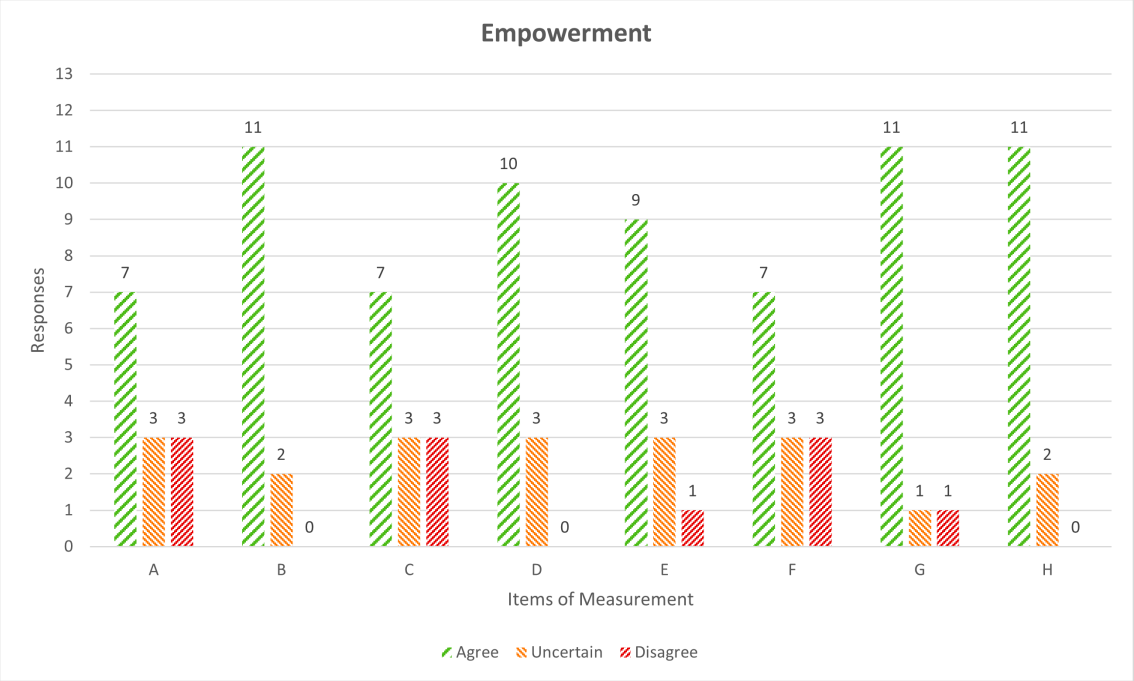

Figure 15: Service user - Empowerment

Items A-H

(A) I believe services actively reduce power differences in relationships with service users & carers

(B) I believe new ideas should be welcomed by everyone involved to promote fairness & equality

(C) I believe trauma-informed changes to the service are co-produced & co-designed with service users

(D) I believe direct peer support which minimises stigma should be available

(E) I am involved in decisions about my care & support plans

(F) Services know that people react differently to power imbalances and try to balance them

(G) I believe people with lived experiences of trauma are openly in positions of leadership & influence

(H) I believe research & business planning are co-produced with people who have lived experience

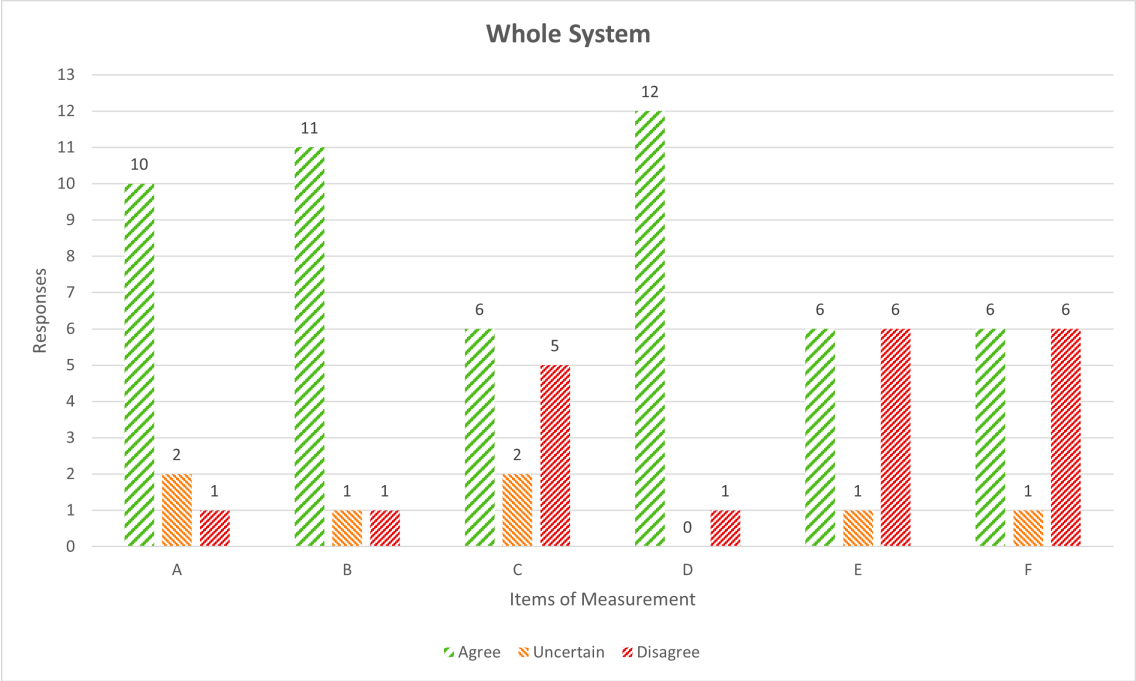

Figure 16: Service user - Whole System

Items A-F

(A) I believe funding for trauma-informed approaches forms part of business as usual

(B) I believe trauma-related outcomes are monitored

(C) I think all staff have adequate training & support to work in a trauma-informed way

(D) I believe services have a trauma-informed approach built into the way services are paid for

(E) I have access to peer support from people with lived experience of trauma

(F) I think people who need help can get help early without being passed around

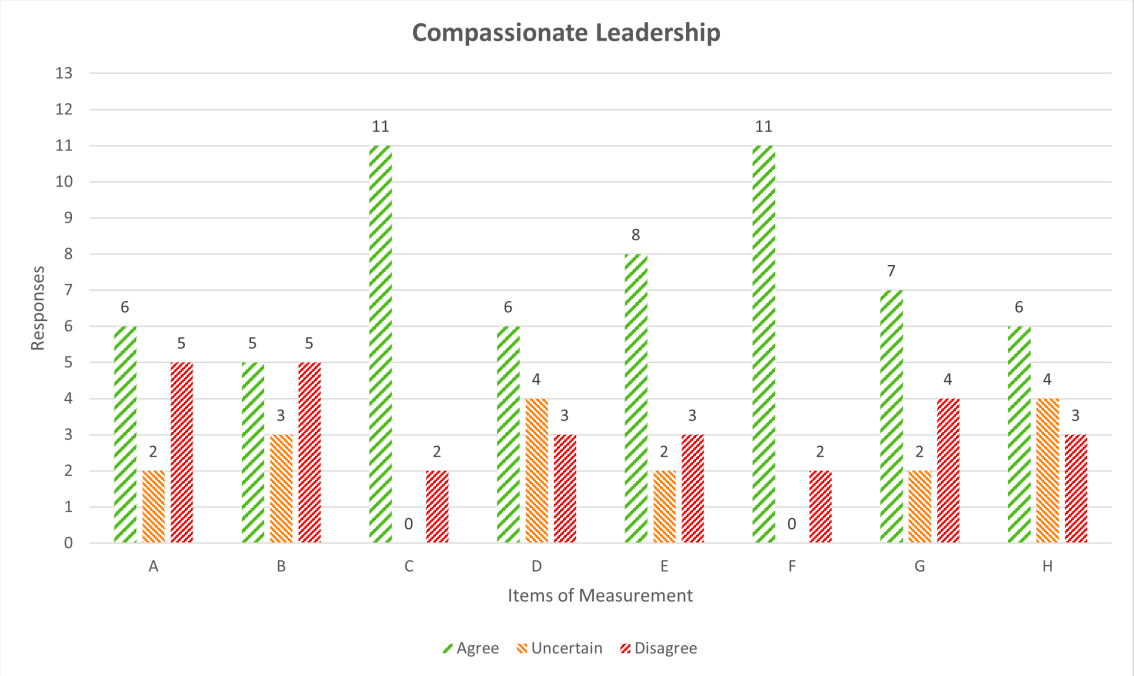

Figure 17: Service user - Compassionate Leadership

Items A-H

(A) I think services deal with demand in a way that encourages helpful outcomes

(B) I think staff are supported to want to address trauma-related issues

(C) I believe it is important to have lived experience officers in supervision & learning

(D) I believe it is safe for staff to speak up about concerns

(E) I believe staff at all levels are aware of issues of stigma

(F) I believe leaders at all levels are responsible for supporting trauma-informed developments & providing them in their own areas

(G) I believe staff leaders are open about their own experiences of adversity

(H) I believe trauma-informed values & experience forms the basis for promotion

A total of 46 participants agreed to take part in the service user survey. However, only 13 of those fully completed the survey. Among all 46 participants, participants spent an average time of 00:08:57 on the survey. The 33 participants that did not complete the survey spent an average time of 00:01:12. The 13 participants that did complete the survey spent an average time of 00:26:42 on the survey.

4.4 Focus Groups

Focus groups were held with staff and service users for two different purposes. Pilot testing with staff and re-assessing articulation with service users.

4.4.1 Staff Focus Groups

The staff focus groups differed significantly from the service user focus groups. The staff focus groups were considered satisfactory at a leads meeting, and it was decided to pilot test the framework as it was and identify feedback for future implementation. These were arranged with the assistance of the trauma leads. Trauma leads were asked to identify potential participants from their respective services. The focus groups were audio-recorded as they consisted of mostly qualitative data. The RAG rating quantitative scaling is shown for all focus groups below. The rating shown in the tables below is not an exact copy of the answer. Answers were sometimes ”warm green” or ”soft amber”. It has been allocated significance by the researcher and is shown using an asterisk.

The focus groups were 2.5 hours in length. It was initially planned to get through the entire framework within 2.5 hours. When the first focus group was held, it became apparent that this was unrealistic. It was decided that future focus groups would aim to examine two domains. It was also decided that a volunteer chair be appointed so that the researcher could document findings as the focus group progressed. Tables 10 - 20 present the staff focus groups.

Staff Focus Group - One

Table 10: Staff Focus Group One Safety

No	Item	RAG Rating
1.	Service users are safe from physical harm	Green*
2.	Staff are safe from physical harm	Green
3.	My team/service sees everyone as of worth with valid experience and opinion	Amber*
4.	Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues	Amber
5.	The underlying psychosocial causes of risks are actively addressed	Amber*
6.	There is an opportunity to reflect on safety plans so we understand what has contributed to a positive outcome to each service user	Amber
7.	It feels safe enough to openly learn what we could have been done differently when things go wrong for service users	Amber
8.	We take an approach to risk management that emphasises the service user perspective and minimizes any inadvertent long-term harm to healing	Amber
9.	There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other	Amber
10.	My team proactively plans around safety rather than being reactive to crises	Amber*
11.	I feel I have enough skills and autonomy to manage safety issues in a patient-centred way	Amber*

End of table

Staff Focus Group Two

Table 11: Staff Focus Group Two - Safety

No	Item	RAG Rating
1.	Service users are safe from physical harm	Amber*
2.	Staff are safe from physical harm	Amber*
3.	My team/service sees everyone as of worth with valid experience and opinion	Green*
4.	Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues	Green*
5.	The underlying psychosocial causes of risks are actively addressed	Amber*
6.	There is an opportunity to reflect on safety plans so we understand what has contributed to a positive outcome to each service user	Amber
7.	It feels safe enough to openly learn what we could have been done differently when things go wrong for service users	Amber*
8.	We take an approach to risk management that emphasises the service user perspective and minimizes any inadvertent long-term harm to healing	Amber
9.	There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other	Green*
10.	My team proactively plans around safety rather than being reactive to crises	Green
11.	I feel I have enough skills and autonomy to manage safety issues in a patient-centred way	Amber*

End of table

Table 12: Staff Focus Group Two - Empowerment

No	Item	RAG Rating

Continued on the next page

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1.	Services explicitly mitigate against the role of power differences in relationships with service users and carers	Amber*
2.	Creative innovation by all stakeholders is promoted to enable influence to be distributed fairly	Amber*
3.	trauma-informed transformation is co-produced and co-designed with service users who have a range of views	Amber
4.	Direct peer support is available, which minimises stigma	Amber
5.	Personalised care and support plans are devised through shared decision making	Green
6.	We consider how different people view power dynamics in different ways and how this can be balanced	Green
7.	People with lived experience of trauma are openly in positions of leadership and influence	Amber*
8.	Research and business planning are co-produced with people with lived experience	N/A

End of table

Focus Group Three

Table 13: Staff Focus Group Three - Safety

No	Safety	RAG Rating
1.	Service users are safe from physical harm	Amber
2.	Staff are safe from physical harm	Amber
3.	My team/service sees everyone as of worth with valid experience and opinion	Amber
4.	Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues	Amber

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5.	The underlying psychosocial causes of risks are actively addressed	Amber
6.	There is an opportunity to reflect on safety plans so we understand what has contributed to a positive outcome to each service user	Green
7.	It feels safe enough to openly learn what we could have been done differently when things go wrong for service users	Amber
8.	We take an approach to risk management that emphasises the service user perspective and minimizes any inadvertent long-term harm to healing	Amber
9.	There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other	Amber
10.	My team proactively plans around safety rather than being reactive to crises	Amber
11.	I feel I have enough skills and autonomy to manage safety issues in a patient-centred way	Amber

End of table

Table 14: Staff Focus Group Three - Language

No	Item	RAG Rating
1.	Presentations/symptoms are considered as potentially meaningful reactions to current or historical circumstances	Amber
2.	All potential causes of current presenting presentations are assessed including physical health issues	Green
3.	The survival value of many 'problems' and someone's strengths as a result of their adversity are adequately acknowledged	Amber
4.	We allow for multiple narratives around someone's distress and seek to understand rather than seek to impose one model of understanding	Green

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5.	Our service adapts to the broader needs of those with complex trauma histories	Green
6.	Understanding the trauma narrative needs to evolve over time at a safe pace	Green
7.	Our model of understanding of trauma includes cognitions, sense of self, relationships and physiological impact	Green
8.	Acknowledgment that staff may have their own personal/professional trauma journeys that influence their motivation and understanding	Green

End of table

Table 15: Staff Focus Group Three - Social

No	Item	RAG Rating
1.	There are good working collaborative alliances between people, teams and agencies around trauma-based needs	Green
2.	People collaborate towards a personalised healing journey that prevents further harm	Green
3.	There is an emphasis in my service that healing from trauma occurs within safe and trusting relationships	Green
4.	Attention is paid to all aspect of communication of compassion through written, verbal, non-verbal and behaviours	Amber
5.	Reflective practice and the capacity to think non-critically about the motivations behind the action of others are paramount	Green
6.	People actively seek to contribute towards a functioning open relationship even when things are difficult	Green
7.	Policies and performance targets include a focus on patient and staff experience	Amber

End of table

Table 16: Staff Focus Group Three - Trauma-specific Interventions

No	Item	RAG Rating
1.	Sensitive routine inquiry of adversity and trauma forms the basis of our assessments and planning	Green
2.	Our interventions are delivered in an explicitly trauma-informed way, matched to need and available long enough to make a difference	Amber
3.	We support people to create conditions where healing from trauma can begin, e.g. housing, income, physical safety etc.	Green
4.	A range of specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR	Green
5.	Any new interventions are evaluated for clinical outcomes, impact on functioning and service user experience	Green
6.	Trauma interventions are offered proactively to prevent crises	Amber
7.	Any trauma interventions are delivered as part of a wider coherent plan across agencies	Amber

End of table

Focus Group Four

Table 17: Staff Focus Group Four - Safety

No	Item	RAG Rating
1.	Service users are safe from physical harm	Amber*
2.	Staff are safe from physical harm	Amber*
3.	My team/service sees everyone as of worth with valid experience and opinion	Amber

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4.	Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues	Amber*
5.	The underlying psychosocial causes of risks are actively addressed	Amber
6.	There is an opportunity to reflect on safety plans so we understand what has contributed to a positive outcome to each service user	Amber*
7.	It feels safe enough to openly learn what we could have been done differently when things go wrong for service users	Amber*
8.	We take an approach to risk management that emphasises the service user perspective and minimizes any inadvertent long-term harm to healing	Amber*
9.	There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other	Amber*
10.	My team proactively plans around safety rather than being reactive to crises	Amber*
11.	I feel I have enough skills and autonomy to manage safety issues in a patient-centred way	Green*

End of table

Table 18: Staff Focus Group Four - Whole System

No	**Item**	**RAG Rating**
1.	Funding for trauma-informed approaches forms part of core business over time	Red
2.	We monitor trauma-related outcomes	Amber*
3.	Staff at all levels have adequate trauma-informed skills and are supported to work in a trauma-informed way	Amber*
4.	A trauma-informed approach is explicit in the commissioning framework for our service	N/A

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5.	We have access to peer support with lived experience of trauma	Red
6.	People who need help can get help early without being passed around (pathways are clear and comprehensive to cover a variety of needs)	Red

End of table

Focus Group Five

Table 19: Staff Focus Group Five - Safety

No	Item	RAG Rating
1.	Service users are safe from physical harm	Green
2.	Staff are safe from physical harm	Green
3.	My team/service sees everyone as of worth with valid experience and opinion	Green
4.	Risks are understood in the context of life experience and formulated as an emergence from underlying trauma issues	Amber*
5.	The underlying psychosocial causes of risks are actively addressed	Amber
6.	There is an opportunity to reflect on safety plans so we understand what has contributed to a positive outcome to each service user	Green*
7.	It feels safe enough to openly learn what we could have been done differently when things go wrong for service users	Green
8.	We take an approach to risk management that emphasises the service user perspective and minimizes any inadvertent long-term harm to healing	Green
9.	There is a culture where people trust each other to voice opinions whilst maintaining respect and value for each other	Green
10.	My team proactively plans around safety rather than being reactive to crises	Amber*

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11.	I feel I have enough skills and autonomy to manage safety issues in a patient-centred way	Green

End of table

Table 20: Staff Focus Group Five - Compassionate Leadership

No	Item	RAG Rating
1.	Services have the capacity to manage demand in a way that promotes helpful outcomes	Amber
2.	Staff are supported to be motivated to address trauma-related issues	Amber*
3.	Lived experienced voices are valid in supervision and learning	Amber*
4.	There is a culture where it is safe to speak up about concerns	Green
5.	Leaders address issues of stigma and acknowledge that adversity can limit all of us at various times	Green
6.	Leaders at all levels are responsible for supporting trauma-informed developments and for integrating them into their own areas of influences	Amber*
7.	Leaders are open about their own experiences of adversity	Green
8.	Promotion is based on trauma-informed values and experience	Amber

End of table

4.4.2 Service user Focus Group

The service user focus group was held because it was previously identified in the surveys that there were some inconsistencies. The wording of the items themselves were questioned, and complaints were raised around the confusion of the survey presentation.

The domains Safety, Language, Social, Trauma-specific Interventions, Empowerment, Whole System, and Compassionate Leadership and their respective items were presented at an informal focus

group consisting of 5 service users. The service users were given the evaluation form to examine a few days before the session. During the session, the facilitator went through each domain and asked the participants to assign either essential or desirable to each item. The facilitator also asked if there should be any changes or additions made to any of the items. At the end of each domain, it was asked if there any items were missing from the domain. Tables 21 - 27 present the staff focus groups.

Table 21: Service user Focus Group - Safety

No	Safety	Essential or Desirable
1.	I feel safe from physical harm	Essential
2.	I feel staff are safe from physical harm	Essential
3.	I believe that staff see everyone as of worth with valid experience and opinion	Essential
4.	I believe staff understand my personal risk in terms of past trauma issues	Essential
5.	I feel my personal risk is understood in terms of wider issues such as housing, finance, relationships, etc.	Essential
6.	I feel I have the chance to reflect, with staff, on times when things have gone well	Desirable
7.	When things go wrong, I get the chance to reflect, with staff, so things can be done differently in the future	Essential
8.	I feel staff take into account my view when looking at risk in a way which promotes my long-term healing	Essential
9.	I believe people trust one another and are able to respect each other's opinions	Essential
10.	I feel my team makes plans around my personal safety in advance rather than after a crisis	Essential
11.	I feel the staff have enough skills and ability to deal with safety in a way which is personal to me	Essential

End of table

It was expressed that items 1 & 2 would be better combined to read: “Staff and service users feel mutually safe from physical harm”. It was felt that items 4 and 5 were ambiguous, and the words “personal risk” might be better off explored with specifics. Item 7 was the cause for a large debate as it was seen as essential but only after the item was addressed with context. Item 9 was seen to missing text around “challenging each other” and “having a psychologically safe environment”. Item 9 might be better worded as “I believe staff trust one another, feel safe to challenge each other, and are able to respect each other’s opinions in a psychologically safe environment”. Item 10 was seen as missing context and might be better worded as “I feel my team makes collaborative plans with me around my personal safety in advance rather than after a crisis”. Item 11 might be better worded as “I feel the staff have enough skills and ability to deal with safety in a way which is personal to me in a risk-averse manner”. The domain safety was observed as missing items around staff being more sensitive to potentially distressing service users and a risk-averse culture.

Table 22: Service user Focus Group - Language

No	Language	Essential or Desirable
1.	My symptoms, or the way I appear and behave are considered as meaningful reactions to my current or past experiences	Essential
2.	I believe all causes of my symptoms, or the way I appear and behave, are considered, including my physical health	Essential
3.	I feel staff recognise the survival value of my ways of coping as well as my personal strengths	Essential
4.	I believe staff enable me to communicate my distress in a variety of different ways and do not stride to a single model of understanding	Essential
5.	I feel mental health services are able to adapt to the broader needs of individuals who have experienced complex trauma	Essential
6.	I feel staff recognise that a person’s trauma takes time and a sense of safety to understand properly	Essential

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7.	I feel staff's understanding of trauma takes into account my relationships, physical impact, thoughts and sense of self	Essential
8.	I understand that staff may have their own trauma histories which impacts on their way of being and understanding of my way	Essential

End of table

Item 7 triggered further questions and insight. The removal of relationships from the item and perhaps creating a few more questions around attachment might be suited here.

Table 23: Service user Focus Group - Social

No	**Social**	**Essential or Desirable**
1.	I believe these are good working relationships between, staff, teams and other agencies	Essential
2.	I feel people work together to create a personal healing journey which tries to reduce further harm	Essential
3.	I believe there is an understanding within my service/team that healing from trauma happens within safe and trusting relationships	Essential
4.	I feel efforts are made to communicate compassion through all types of interaction and communicate methods	Essential
5.	I believe staff should be able to reflect, non-judgementally, about their own actions and those of others	Essential
6.	I feel that even during difficult times, people seek to promote positive, open relationships	Confusing
7.	I believe policies and staff targets should include a focus on service user and staff experiences	Confusing

End of table

Item 1 sparked interesting discussions around good relationships in practice and their meaningfulness. It was suggested that the item could be explored further. Perhaps other items could be added here around uninformed staff, teams, agencies, and warm handovers. Item 6 was too confusing: "difficult times" and "positive, open relationships" was not clear. Item 7 enabled a discussion around targets being unwelcome in a trauma-informed organisation. However, there was seen to be value in this item. A valuable comment was suggested around perhaps targets being qualitative and not quantitative. Item 7 would need further work for an application. The domain Social was observed to be missing items around the recognition that social oppressions (poverty, racism) can be traumatic and powerful. More specifically, staff awareness of power and abuse dynamics and how patient dynamics can replicate or move away from that (holding the power to the story).

Table 24: Service user Focus Group - Trauma-specific Interventions

No	Trauma-specific Interventions	Essential or Desirable
1.	I believe sensitive questions about adversity and trauma from the basis of staff assessment & plans	Essential
2.	I believe interventions are delivered in an openly trauma-informed way & suit the individuals needs for long enough to make a difference	Essential
3.	I believe staff support service users in creating conditions where healing from trauma can begin	Essential
4.	I believe a range of specialist trauma therapies are available including for those with complex trauma and dissociation e.g. EMDR	Essential
5.	I think new interventions are evaluated for clinical outcomes, impact on well-being & service user experience	Essential
6.	I believe trauma interventions are used in advance to prevent crisis	Essential

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7.	I believe trauma interventions are used as part of a wider plan that involves other agencies	Essential

End of table

Item 4 provoked the idea that examples should not be provided within the item as it will set expectation. EMDR should therefore be removed. Item 5 made way for discussion around measuring as "some things can't be explained in "a way that works". Item 6 motivated another item around "different therapies and treatments need to be delivered at a high standard across the trust". Item 7 triggered a comment "healing and justice go hand in hand". The domain Trauma-specific Interventions was observed to be missing items around peer-led funding.

Table 25: Service user Focus Group - Empowerment

No	Empowerment	Essential or Desirable
1.	I believe services actively reduce power differences in relationships with service users & carers	Essential
2.	I believe new ideas should be welcomed by everyone involved to promote fairness & equality	Uncertain
3.	I believe trauma-informed changes to the service are co-produced & co-designed with service users	Essential
4.	I believe direct peer support which minimises stigma should be available	Essential
5.	I am involved in decisions about my care & support plans	Essential
6.	Services know that people react differently to power imbalances and try to balance them	Essential
7.	I believe people with lived experiences of trauma are openly in positions of leadership & influence	Essential

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8.	I believe research & business planning are co-produced with people who have lived experience	Essential

End of table

Item 2 startled many of the service users who thought that new ideas should be carefully assessed. Item 4 could be changed to "I believe direct peer support should be available after a risk assessment". It was decided that some people are not safe to have peer support yet. Item 7 should be reworded to "I think people with lived experiences of trauma should be welcomed and accepted in positions of leadership & influence. The domain Empowerment was observed to be missing items around choice.

Table 26: Service user Focus Group - Whole System

No	Whole System	Essential or Desirable
1.	I believe funding for trauma-informed approaches forms part of business as usual	Essential
2.	I believe trauma-related outcomes are monitored	Essential
3.	I think all staff have adequate training & support to work in a trauma-informed way	Essential
4.	I believe services have a trauma-informed approach built into the way services are paid for	Essential
5.	I have access to peer support from people with lived experience of trauma	Essential
6.	I think people who need help can get help early without being passed around	Essential

End of table

Item 1 triggered a new item around trauma-informed approaches being funded enough. Item 3 encouraged a new item around training requiring frequent updating and needing to be sustained

at all levels. Item 6 could be reworded to "I think people who need trauma-informed help can get trauma-informed help without being passed around. The domain Whole System was observed to be missing items around training and information on understanding care and rights, and tools to increase vocabulary on care and rights.

Table 27: Service user Focus Group - Compassionate Leadership

No	Compassionate Leadership	Essential or Desirable
1.	I think services deal with demand in a way that encourages helpful outcomes	Essential
2.	I think staff are supported to want to address trauma-related issues	Essential
3.	I believe it is important to have lived experience officers in supervision	Desirable
4.	I believe it is safe for staff to speak up about concerns	Essential
5.	I believe staff at all levels are aware of issues of stigma	Essential
6.	I believe leaders at all levels are responsible for supporting trauma-informed developments & providing them in their own areas	Essential
7.	I believe staff leaders are open about their own experiences of adversity	Remove
8.	I believe trauma-informed values & experience forms the basis for promotion	Essential

End of table

Item 4 could be reworded to "I believe staff feel there is a psychologically safe space to speak up about concerns". Item 7 was strongly disagreed upon. Item 7 was seen as a very "personal thing" and "should be a choice". The domain Compassionate Leadership was observed to be missing items around leaders being compassionate towards self, staff, service users, and carers.

The service users reported feeling empowered whilst discussing the contents of the framework,

and they seemed to enjoy taking part in the exercise.

4.5 Chapter Summary

This chapter documented the results that were obtained using different methods of data collection. A review of the literature was necessary to determine an appropriate research approach. Using the domains that were created at the trauma summit and the discovery of existing frameworks and instruments, a trauma leads meeting was arranged to ascertain the similarity of the domains found in the four prominent tools, the ARTIC, the CCTIC, the TICOMETER, and the TIP Scales, against the domains generated at the trauma summit. The trauma leads were also asked to create items and did so after initially experiencing confusion. These items were then given to an expert team to make the items practicable. This revised version was then co-designed with experts by experience at a recovery college in Durham.

Both versions of the framework were then distributed via a survey to reach a consensus on the content of the framework. A red, amber, green traffic light system was incorporated to enable quantitative analysis. It was also possible for participants to leave comments at the end of each domain to give feedback on missing items or correct existing items' wording. A trauma leads meeting was held to discuss the results of the surveys. It was decided that the survey results should be used for articulation; all items are essential in consideration of trauma-informed care. At the same meeting, it was decided to pilot test the framework in its current form using a series of focus groups. One focus group was held with service users, and five were held with members of staff. The service user framework needed additional work, so the service user focus group was designed to allow service users to decide if items were essential or desirable; this was one hour. Staff focus groups were held to pilot test the framework and were asked to complete the framework. It was only possible to complete two domains for most groups since the focus groups had to take place via Microsoft Teams, and these were held for two and a half hours. The quantitative data is the essential or desirable table for the service user framework and the RAG rating for the staff focus group. The qualitative insights are the comments and discussions that emerged from the surveys and focus groups.

Chapter 5

Discussion

5.1 Introduction

This study emerged from the need to evaluate mental health services in their efforts of becoming trauma-informed. The identification of bespoke requirements fueled the development of the Roots framework to fulfil this need. A team at the Tees, Esk and Wear Valleys Foundation NHS Trust founded the trauma-informed care programme to take necessary steps to integrate and sustain trauma-informed service changes. This research set out to investigate the barriers behind implementing and maintaining a trauma-informed service in the UK. Research into the evaluation of trauma-informed care is found to be predominantly North American. The UK healthcare system is immeasurably different to its American counterpart. The trauma-informed care programme had no indicators in place to determine effective trauma-informed care application. The research questions **RQ1**: *What barriers restrict the implementation of trauma-informed care into mental health services in the United Kingdom?* and **RQ2**: *How are mental health services in the United Kingdom able to overcome barriers to sustain trauma-informed care implementation?* were answered using various methods. This chapter examines the necessity of the literature review and the study results to answer the research question.

5.2 Surveys

Two surveys were distributed amongst separate participants - one for staff and another for service users. Although surveys were completed, the SurveyMonkey surveys were not as successful as anticipated. The surveys were launched during the Covid-19 pandemic, which may have contributed to the low response rate. Both staff and service users at the Tees, Esk and Wear Valleys Foundation NHS Trust were operating within unprecedented circumstances, and the world was undergoing profound change. Staff were under pressure to manage increased workloads, and could no longer socialise and meet their needs as usual under government restrictions. Service users were presented with very unfamiliar situations and have had their service and method of treatment change drastically. The fulfilment of a survey unrelated to Covid-19 was not a priority for individuals in mental health services. However, the importance of the trauma-informed care model is recognised and is needed now more than ever. The sensitivities of Covid-19 are highlighting the social nature of human beings and why relationships are essential to healing and existing as an entity in a complex system like the world.

The staff and service user survey were both issued and distributed at the same time. Staff groups were already known, and trauma leads were asked to distribute the surveys (convenience sampling). The trauma leads were asked if they knew anyone else that they could ask to distribute the survey for wider spread (snowball sampling). Minimum participation was set at 25 participants (criterion sampling), and the staff survey received 27, only just meeting the requirement. The service user survey followed a similar recruitment process but was challenged in identifying potential groups. It was first decided that a group at the recovery college would be appropriate but proved to not be sufficient in the end.

Other groups were needed, but the engagement was low. The pool of participants was potentially high, but the uptake was low. A snowball sampling process was undertaken, much like the process for the staff survey, in which staff were asked to identify participants and distribute the survey to them. One individual provided feedback alongside a refusal to distributing the survey stating that the ”language is inaccessible” and ”therefore would feel uncomfortable sharing”. This was followed up, and the individual was invited to provide consultation but refused. Another individual suggested that the language ”will probably be too complex for the client group I work with” and

questioned the involvement of anyone with literacy problems/learning disabilities in the design of the service user form. The experts by experience staff group at the Durham Recovery College took the lead on the translation. It is unknown if those involved in the recovery college have literacy problems or learning disabilities. The service user survey received a total of 13 responses indicating issues in not meeting minimum requirements.

In the service user form, all participants spent an average of 08:57 on the survey; this includes those that dropped out. Participants that did not complete the survey spent an average of 01:12 before they decided to leave the form. Participants that completed the survey required an average of 26:42. In the staff form, participants spent an average of 08:02 on the survey; this also includes those that dropped out of the survey early. Participants that did not complete the survey spent an average of 03:55 on the survey before deciding to leave. Participants that completed the survey spent an average of 15:38 on the survey. Ninety-seven participants took part in the surveys. It is unclear why a remarkable total of 57 participants did not complete the survey. This is more than half of the total participants, as only 40 participants completed the surveys. Unfortunately, it was not possible to launch a detailed investigation into the possible causes of the lack of participation due to time constraints. However, insights arose in various meetings afterwards, which offered potential answers. The length of the survey was brought into question - the framework consists of seven domains and 54 items. The survey itself was 61 questions long. The survey was designed on SurveyMonkey to operate in a scrolling format, only permitting participants access to proceed by completing current questions. This might have deterred participants as they could not see the end of the survey without clicking the button *"next"*. It was also reported that both surveys were confusing. The instructional description was deemed too lengthy and overly complex. The wording for many items was reported as being unclear. The service user survey was translated to be mainly in the first person, and this confused service user participants as to how they should respond to the survey. It was found that few participants thought they were answering the items rather than rating the items application in trauma-informed care. To summarise, it was found that the length, wording, design, circumstance, and format of the surveys were hypothesised as being the culprits of the participant's early exit from the survey.

5.2.1 Consensus

It is also necessary to consider the level of consensus that will be used in a Delphi study. There is no universally accepted proportion for the Delphi method because the level of participation varies on the number of participants, the purpose of the research, and the availability of resources. When to cease collecting data and what constitutes ”consensus” in relation to the conclusions of the study are also important considerations for the researcher (Williams and Webb, 1994). McKenna (1994) draws on insights provided by Loughlin and Moore (1979) and suggests that consensus should be equated with 51% agreement amongst respondents. Seventy-five percent is recommended by Sumsion (1998), whereas 80% is recommended by Green et al. (1999). Alternatively, Crisp et al. (1997) questioned the usefulness of employing percentage metrics, arguing that the consistency of responses over a period of rounds is more accurate evidence of consensus.

The survey instructed the participants to rate items according to a RAG rating. These were three choices - to agree (green), to be uncertain (amber), or to disagree (red). This made deciding on a consensus difficult, as percentages were split across three choices. The decision to omit the uncertain choice from the consensus was made as this made it almost impossible to end on consensus.

5.2.2 Staff Survey Consensus

The domain safety had eight domains above 51% green; they were items a, b, c, f, g, i, j and k. Two were above 70%; they were items c and k. None were above 80%. However, by eliminating amber from the consensus calculation, all items were above 51%, 70%, and 80%. The domain language had five items above 51%; they were items a, b, d, g, and h. One item was above 70%, which was item a. None were above 80%. However, with the removal of uncertainty, all items were above 51%, 70%, and 80%. The domain social had four items above 51%. They were items c, d, e, and f. One item was above 70%, which was item e. None were above 80%. However, with the removal of uncertainty, all items were above 51% and 70%, and six items were above 80%; they were items a, b, c, d, e, and f. The domain trauma-specific interventions had one item above 51%, which was item a. No items were above 70% or 80%. However, with the removal of uncertainty, all items were above 51%. Two items were above 70%; they were items a and c. Two

items were above 80%; they were items a and c. The domain empowerment had one item above 51%, which item e. No items were above 70% or 80%. However, with the removal of uncertainty, five items were above 51%. They were items a, c, d, e, and g. Three items were above 70%; they were items a, c, and e. One item was above 80%, which was item e. The domain whole system had no items above 51%, 70%, or 80%. However, with the removal of uncertainty, five items were above 51%. They were items a, b, c, d, and e. One item was above 70%, which was item a. No items were above 80%. The domain compassionate leadership had no items above 51%, 70%, or 80%. However, with the removal of uncertainty, seven items were above 51%. They were items a, b, c, d, e, f, and g. Five items were above 70%; they were items b, c, d, e, and f. Three items were above 80%; they were items b, c, and f. Figure 19 distinguishes the consensus between the normal data set and the clean data set for the staff survey.

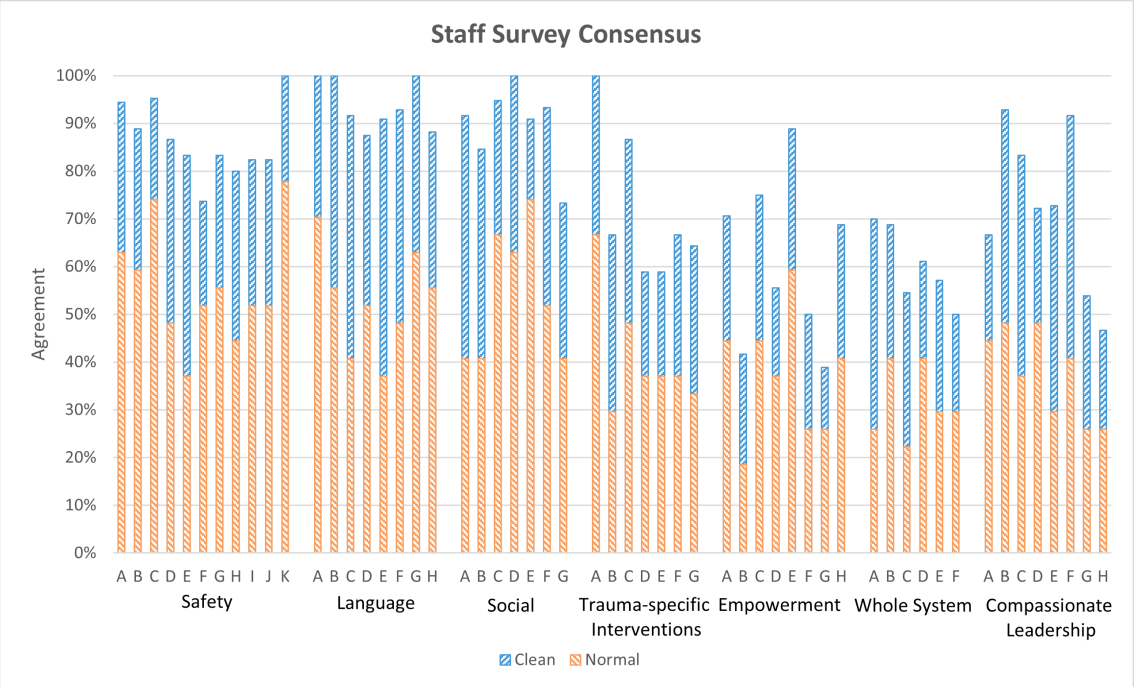

Figure 18: Staff Survey Consensus

5.2.3 Service user Survey Consensus

The domain safety had nine domains above 51%; they were items a, b, c, d, g, h, i, j, and k. One item was above 70%. None were above 80%. However, with the removal of uncertainty, all items were above 51%. Eight items were above 70%; they were items a, b, c, g, h, i, j, and k. Six items

were above 80%; they were items a, b, h, i, j, and k. The domain language had seven items above 51%; they were items a, b, c, d, f, g, and h. One item was above 70%; this was item h. No items were above 80%. However, with the removal of uncertainty, all items were above 51%. Six items were above 70%; they were items a, c, d, f, g, and h. Two items were above 80%; they were items a and h. The domain social had four domains above 51%; they were items c, d, e, and g. One item was above both 70% and 80%, which was item e. However, with the removal of uncertainty, all items are above 51%. Five items were above 70%; they were items a, c, d, e, and g. Four items are above 80%; they were c, d, e, and g. The domain whole system has three items above 51% and 70%; they were items a, b, and d. Two items were above 80%; these were items b and d. However, with the removal of uncertainty, four items are above 51%; these were a, b, c, and d. Three items were above 70% and 80%; these were items a, b, and d. The domain empowerment had all items above 51%. Four items were above 70%; they were b, d, g, and h. Three items were above 80%; they were b, g, and h. However, with the removal of uncertainty, all items were above 51% and 70%. Six items were above 80%; they were items b, d, e, g, and h. The domain trauma-specific interventions had five items above 51%; they were items a, b, d, e, and f. One item was above 70%; this was item e. No items were above 80%. However, with the removal of uncertainty, seven items were above 51%; they were items a, b, c, d, e, and f. Two items were above 70%; they were items a and e. One item was above 80%; this was item e. The domain compassionate leadership had four items above 51%; they were items c, e, f and g. Two items were above both 70% and 80%; they were items c and f. However, with the removal of uncertainty, seven items were above 51%; they were items a, c, d, e, f, g and h. Three items were above 70%; they were items c, e, and f. One item was above 80%; this was item f. Figure 18 distinguishes the consensus between the normal data set and the clean data set for the service user survey.

This data was presented at a trauma-informed care leads meeting to give experts an opinion on removing several items. However, it was strongly felt that all items within the framework were essential to the development of trauma-informed care. It was noted that the wording and the presentation of the framework needed work, especially in the service user version. From this, it was decided that the results of the surveys be used for articulation, and all the items remain in the framework. However, it could still be said that the majority voted for most of the items to remain. The staff survey was evidencing this more. Considering that the items were co-produced initially,

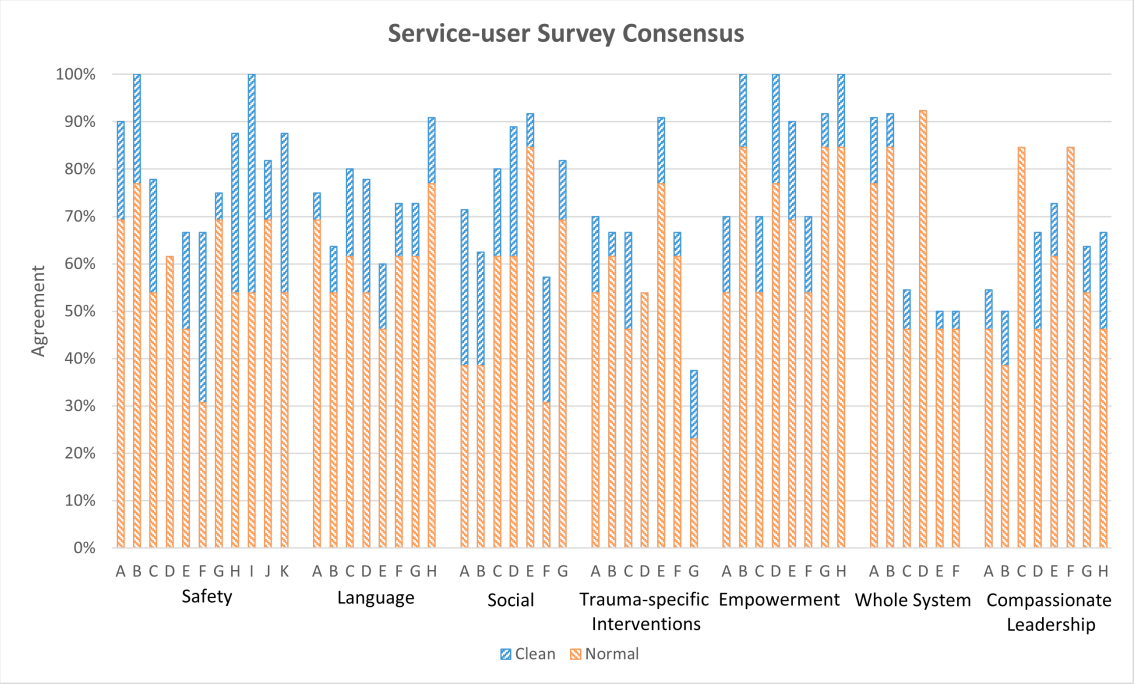

Figure 19: Service user Survey Consensus

it was positive that the survey results also showed that most of these items were essential. Given the complexity of trauma-informed care and the community of practice in producing these items, it was expected that other practitioners see these as essential as well. In the end, the trauma leads took control and decided to keep the items. It was then decided to move forward with pilot testing the framework.

5.3 Focus Groups

A series of focus groups were held with staff and service users. As it was felt that the service user framework needed more work, it was decided to have a concise focus group focusing on the wording and whether service users deemed items to be essential or desirable. The staff focus groups served as pilot tests to evaluate the framework and collect feedback on the exercise.

5.3.1 Service user Focus Group

The service user focus group was one hour in length and was held with participants recruited at the recovery college in Durham. Participants were introduced to the framework and the purpose

of the focus group. Initially, participants were confused with the framework and its future use, but a commitment was obtained after some clarification and assurance. Participants were very responsive to the framework and reported feeling empowered throughout. Forty-eight items were seen as essential, two were seen to be desirable, two were confusing, one was uncertain, and one item was asked to be removed. As an overwhelming majority of items were seen as being essential, it could be said that consensus was achieved for most of the items to remain in the framework.

5.3.2 Staff Focus Groups

Five focus groups were held with staff members in the Tees, Esk and Wear Valleys Foundation NHS Trust. The first focus group was exploratory as it was uncertain what data would emerge from the focus groups at this stage. The intention was to complete the entire framework within the 2.5 hours allocated. However, it became clear immediately as time went by that this would not be possible. This initial focus group informed the process, and other focus groups were undertaken differently. Focus groups are given the abbreviations FG1 through FG5.

FG1 was able to examine the domain Safety thoroughly and the domain Language to an extent. The participants of the group were all psychologists; the participants were mindful of how this might affect the data. It was felt that the length of the framework was questionable and that some questions felt ambiguous. Although the length of the framework has been studied in-depth, it did prompt the participants to raise the concern of completing the exercise and framework in a meaningful way. Some participants found it hard to gather evidence for items and benefited from further clarity and explanation. Participants did find the exercise challenging; however, the demographic of the group might suggest that participants were investigating beyond the item itself. This point was raised by one of the participants when one item was tough to answer. FG2 was more efficient and was able to examine the domains Safety and Empowerment. The intention was now to complete two domains per focus group following FG1. This made for a focus group that felt more at ease. A volunteer was chosen to chair the meeting for familiarity. This method produced better outcomes and prompted meaningful discussions. Participants found the framework helpful as it breaks down trauma-informed care and allows for measurement. It was recognised that the exercise is beneficial for teams but does require commitment. FG3 was incredibly productive and

examined the domains Safety, Language, Social, and Trauma-specific Interventions. This group was very efficient mainly due to team relations and high motivation around trauma-informed care implementation. They reflected upon the framework and its ability to engage thought and how the framework was thorough. FG4 managed to complete the domains Safety and Empowerment. FG4 found the framework very helpful and reflected positively on the framework. It was also found useful to be able to reflect on how trauma-informed the service is. FG5 were able to complete the domains Safety and Compassionate Leadership. The group found it beneficial to reflect and talk with each other and how the framework highlighted strengths and areas of development. Several individuals within the focus groups questioned the integrity of the RAG rating and the limitations that the three-point scale has. A few individuals favoured the RAG rating, and the RAG rating was seen to be effective in practice. It challenged the participants to reflect on practice and on answering items honestly.

5.4 A Whole System Approach

The study results confirm the need for a whole-system approach towards monitoring the implementation of trauma-informed care. The evaluation of trauma-informed care offers individuals the opportunity for reflection, where staff and service users can participate in an ongoing process of making sense of trauma-informed care (Baker et al., 2016; Bassuk et al., 2017; Elliott et al., 2005; Fallot and Harris, 2015; Goodman et al., 2016; Jennings, 2004; Richardson et al., 2012; SAMHSA, 2014*b*). The trauma-informed care model undergoes continuous interpretation by implementation, and by reflection of practitioners and service users alike (Large et al., 2015; Seel, 2003; Snowden and Boone, 2007). Implementation generates shared meaning, and the use of experimentation can help with the discovery of new insights (Plsek and Greenhalgh, 2001). The culture of an organisation undergoes change alongside the introduction of new system models. These models demand individuals to modify their behaviour and change how they interact with the environment (Cameron and Larsen-Freeman, 2007; Page, 2018). Organisational culture is not only *how we do things around here*, it is also what service users should expect. The implementation of trauma-informed care is, in essence, a constant culture change. Trauma-informed care can be seen to be a life-emergent model. People make up the active components of organisational cul-

ture. People present an understanding of organisational culture, and the close examination of these human systems offers insight into successful change efforts (Jennings, 2004). Using narrative-based approaches, introducing attractors, and setting boundaries can allow locally valid solutions to emerge from those at the frontline (Haynes, 2008; Seel, 2003; Silverman, 2001; Snowden and Boone, 2007; Yatchmenoff et al., 2017).

The organisational change management literature is highly applicable to the implementation of trauma-informed care (Cross, 1989; Davies et al., 2000; Ford and Evans, 2002; Smollan and Sayers, 2009; Whelan, 2016). SAMHSA (2014*b*) identify self-assessment as being paramount. Arguably, one of the more critical considerations of trauma-informed care is the freedom to evolve at a suitable pace. Self-assessment allows the organisation to reflect on what is going right and what is going wrong (Fallot and Harris, 2001). The former can be done more, and the latter can be done less through prioritisation. By harmonising mental models, trauma-informed care can permeate the organisation through its members (Cameron and Larsen-Freeman, 2007; Page, 2018; Jennings, 2004). The role of language is crucial as all stakeholders must understand it, or confusion can disable quality feedback (Snowden and Boone, 2007). Involvement, empowerment and encouragement are powerful motivators of collecting feedback. Consensus must be agreed on articulation, and framework maintenance must occur to realise this (Ford and Evans, 2002; Linstone et al., 1975). The model must be allowed to change, which can be seen by observing emergence and self-organisation (Seel, 2003; Snowden and Boone, 2007; Stacey, 2000). This organic life-emergent model changes with time and with individuals.

The findings from the surveys were a strong reminder for the need to co-develop a shared language and use it in practice. Confusion and estimation are dangerous tools when serious reflection and evaluation are required. Complexity theory would ascertain that continuous identification of mutual language is needed to accurately capture culture. However, the use of the RAG rating in the surveys proved successful as participants recognised this familiar approach and so it became an integral part of the Roots instrument. As the project progressed, the language used evolved and expectations were no longer being managed with the items established previously. This reinforces the need for timely maintenance of instruments and their contents. The identification of needs must occur frequently. In the focus groups, it became clear that the purpose of the focus group must be understood by all members of the group otherwise commitment is not sustained. The

findings from the service user focus group emphasised the need for a diverse group of individuals as different opinions strengthened the discussion. The staff focus groups served as pilot tests and were useful to evaluate the Roots instrument in practice. However, staff were able to join if they had the time and resources to do so. This excluded staff who do not have the flexibility with time or the option to claim additional training sessions. According to complexity theory, self organisation occurs at the fringes of the organisation, and so by not collecting the opinions of domestic staff, crucial markers were missed.

It is understood that well-established boundaries liberate individuals and empower them with choice and control. Another method is to set strict boundaries around what is disallowed and empower individuals with a clear goal (Snowden and Boone, 2007). This gives individuals the authority to make prudent decisions and provides a sense of freedom where self-organisation can flourish (Seel, 2003). Trauma-informed care requires a whole system approach where desired outcomes are unique to the individual and the service. Change and innovation are achieved through the ripple effects of individual actions, feedback on progress, and the shared vision of networks of people. Human change is complex because there is rarely one right way of doing something. The service will need to adapt to meet each individual's needs and remain responsive over time (Thirkle et al., 2018). For an organisation to be trauma-informed, it needs to apply trauma-informed principles and culture in practice (Fallot and Harris, 2015). Adopting a system-wide model requires enthusiasm and commitment from all members of the organisation. As organisations and individuals within the organisation change, the service must adapt to meet the needs of staff and service users to ensure they remain trauma-informed (Thirkle et al., 2021). Communication and clarification of these values across teams, departments, buildings or trusts will assist in providing individuals with the self-knowledge that is often missing, i.e. *"how are we adhering to the principles of trauma-informed care that we, as a group, have selected as being essential at present?"*, and *"how are we able to improve in the areas that we are not doing so well in?"*.

5.5 A Reflective Account on the Process of Research

The research undertaken was experimental - the outcome was not envisaged until later on in the project. This often meant that research methods were investigated and negotiated with the team for

extended periods of time. This often delayed primary research taking place, as the team remained undecided on a research approach. Opportunities fell away as stakeholders lost interest and discussions lost momentum. Major changes were made frequently which required further review of literature - this caused significant delay to research as ethics approval required amendments and submitting applications to IRAS is time consuming. The initial idea was to develop a fully automated instrument that would be able to synthesise an evaluation of trauma-informed care by collecting stories from the people that use the organisation. However, this became impossible as resources dwindled. There was significant pressure from stakeholders at Northumbria University and at the NHS trust. As the research team became aware of the time constraints, it was decided to move forward with the creation of an evaluation framework. There was a significant delay with ethics approval. The Northumbria University legal team were six months behind in signing off on the projects ethical clearance. When the project was eventually given ethical clearance, research was suspended as a result of the Covid-19 pandemic halting research unrelated to Covid-19. Research restrictions were lifted earlier than expected and the surveys began recruiting participants. Recruiting staff and service users from mental health services proved difficult. The detrimental effects Covid-19 had on people's mental health may have been a contributing factor. The staff survey reached an acceptable level of input but the service user survey was unable to do so. The results indicated some items could be removed from the framework. However, presenting the survey results to trauma leads resulted in the decision that all items are relevant and should remain in the framework. This contradicted the data from the surveys. As the service user survey provoked confusion, it was decided that further work was needed.

To finalise the framework, focus groups were held to evaluate the delivery process. A service user group emerged from the Recovery College in Durham which assisted in the articulation of the service user items. Staff focus groups emerged from trauma leads volunteering their services. The data influenced the contents of a user-manual developed to assist with the application of the Roots framework.

5.6 A Reflective Framework for Mapping the Implementation Journey of Trauma-informed Care

Roots is the outcome of a collaboration between the Trauma-Informed Care Programme at Tees, Esk, and Wear Valleys NHS Foundation Trust, the Programme's various internal and external stakeholders (including service users and trauma leads), the department of Computer-information Sciences at the University of Northumbria at Newcastle and the product of this doctoral project. It builds on an implementation framework for trauma-informed approaches developed from a national summit held by the Academic Health Science Network and the Northern England Clinical Network (Kennedy, 2020).

Roots is a reflective framework for mapping the implementation journey of trauma-informed care. It is a reflective framework that enables individuals, teams, and services to discuss, reflect, and grow towards being trauma-informed. It exists as a thoroughly developed set of practice items under empirically tested domains. The items themselves work very well in promoting discussion, and preliminary focus groups have already demonstrated positivity. It is a very empowering discussion-based tool, which can set in motion system-wide changes. The actual application of Roots can vary dependent on service contexts. The Roots reflective tool is a practice-based guide to support the transformation of services and settings in becoming trauma-informed, building on the learning in the implementation framework (Kennedy, 2020). Individuals or teams in organisations should review the practice points in Roots. If it is agreed on how trauma-informed care is to be achieved in the organisation, with a shared understanding, they are better able to meet their independent values. Roots is designed to provide an organisation or team with a reflective overview of how well they are adhering or progressing towards trauma-informed care in key identified areas. The framework is designed to be used cyclically, prompting mapping, planning, action and review. The results provide learning value to inform organisations (and individuals) towards self-knowledge and a culture of development. Learning and knowledge sharing can take place with the comparison of results across individuals and settings. In services where outcomes are lacking, a closer examination of trauma-informed practice could identify areas for improvement. In areas working well, the tool can sketch how that is happening and the key factors contributing to successful outcomes that others can learn from. Changes in trauma-informed cultures could be

mapped over time too.

Roots comprises seven domains: Safety, Language, Social (relationships), Trauma-specific Interventions, Empowerment, Whole System and Compassionate Leadership. These domains were obtained from the National Trauma-Informed Care Community of Action's implementation report titled "Creating a Narrative for Trauma-Informed Service Transformation", which emerged from a summit of clinicians, managers, leaders, people with lived experience, researchers and others on Thursday 28th March 2019 (Kennedy, 2020). Each of these domains consists of several potential practical items. There are two parallel forms: one for staff and one for service users. Each form gives a different perspective, but comparatively, they can highlight different perceptions that may need to be addressed. Together they provide a more rounded overview of actual delivery, helping to mitigate against bias. A RAG rating system is proposed for each domain. The ratings add to the qualitative data in the reflections. It takes the form of a word document that the facilitator completes after the discussion of each item. Appendix A is the staff version, and Appendix B is the service user version. These are parallel forms, and both must be completed to ensure a rounded and balanced view.

Each colour represents the extent of delivery for current trauma-informed practices in that service. Fundamentally, red represents a distinct lack of trauma-informed care in a particular domain. Amber means that the service is making good progress towards most of the practice points. Green suggests that the service is effectively implementing trauma-informed care. The RAG rating is based on discussion and consensus decision making. The facilitator is there to ensure a fair rating and to challenge any gaming of the rating. Each domain is contained within a separate table. The table details which domain it is with a reminder of each definition. Within the table, there are four columns: practice point for consideration, applicable to service (reason must be documented), implementation status (RAG rating), and example (justification for rating). The set of practice points for reflection by the group challenges thinking and enables discussion. The applicable to service (reason) column asks why this item needs to be applied in service to create trauma-informed care. Each item is indicative and may not be applicable in every setting. The implementation column is the RAG rating that asks the user how trauma-informed they believe their service is regarding the item in question. The example column (justification) asks for examples of why the service may or may not be delivering a trauma-informed service. Reflecting on each practice point can stim-

ulate positive or negative examples and provide meaningful information. The act of assigning a colour can allow the individual or service to reflect on their current standing with trauma-informed service delivery. This can also prompt and motivate individuals and services to improve delivery. Providing examples can be helpful for clarity and comparison across contexts.

Roots is adaptable and can be used across many contexts. Exercises using Roots can range from being a simple one-day team event to a full-scale organisational effort to determine the level of trauma-informed care. The intent for any service is to achieve the "Green" state for all items, be aware that this might not be possible for particular services or specific circumstances. Roots has the potential to be transferred to online platforms for virtual communities. The suitability of these platforms can vary. For example, it can be challenging to find a platform that allows for the nomination of colour and reporting of examples in the same way that the document allows. However, there are ways around this, and several platforms have solutions to this. It is important to assign a RAG rating, request examples, collate group-based reports and offer participants at least one more round of reflection until a consensus develops. It is through sharing and collaboration that Roots influences culture. The resulting report could reflect the opinions of "communities" that are geographically disparate but brought together to consider practice in particular kinds of settings.

5.7 Chapter Summary

This chapter set out to interpret and evaluate the research findings and how the results relate to the literature review and research questions. A literature review was undertaken at first to begin to understand the current climate around trauma-informed care evaluation. Previous approaches, instruments, and frameworks were discovered and then investigated. This sparked an intensive comparative review between what was done in the past and what is needed in the present. The data collection process is discussed in its various elements. Beginning with the implementation framework developed at the national trauma summit in March 2019, this was introduced as foundational to the Roots framework. A discussion ensued around the decision to use the domains from the summit framework in the Roots framework. Afterwards, the various trauma leads meetings were discussed, and their contributions to the Roots framework were held in regard. The

Delphi survey was discussed, and participant consensus was concluded upon. The pilot study focus groups were then focused on giving attention to the demonstration of the Roots framework in practice and articulating the service user items. A whole-system approach is recommended for a thorough examination into the implementation of trauma-informed care - it is fundamental to engage with the larger system and begin to understand how the parts of the organisation interact and influence one another in the present and future. Roots is offered as one way to start this understanding. This dynamic, flexible, learning-based tool can drive system change in trauma-informed directions.

Chapter 6

Conclusion

6.1 General Summary

The implementation of trauma-informed care is complex. However, trauma-informed transformation can be less complicated through the lens of complexity. As discussed in this thesis, complexity can allow an alternative perspective, which factors in all parts of the system. It is well known that a car's engine would not function correctly without any of its parts, as is the same with individuals, organisations, and also healthcare models. Often, it is the reliability of the small unknown parts that little is known about, but complete trust is placed. Tending to all parts equals a healthy operating system. The principles of trauma-informed care align with complexity theory. Both are ideas that impose immense value upon the well-being of all elements within the system. The importance of this permeated the study and was driven by it. The research itself hopes to be defined as trauma-informed, as that is what it set out to do. This was done by making sure staff and service users had an equal contribution to the outcome. By using a Delphi study, to only end when a consensus was reached. By using focus groups for staff and service user consultation. From making sure service user material was proofread and co-produced with experts-by-experience to recruiting staff from all areas of their respective services. All stages of this research project are imbued with principles of complexity theory and trauma-informed care.

The trauma-informed care programme in the Tees Esk and Wear Valleys NHS Foundation Trust was tasked to integrate a trauma-informed care shift in how the service is delivered. The pro-

gramme was already one year into its deployment when this research project was undertaken. The programme team wanted to investigate the effect and impact of trauma-informed care adoption. This process would allow for learning and evolving to occur so that a move towards total adoption could be actualised. An ability to measure if, how, and to what extent the organisation was adhering to the adoption of trauma-informed care was needed. This was initially idealised as a measuring framework or an instrument used to assess the current organisational climate and its current perspectives on trauma-informed care.

It was necessary for a thorough and critical review of the most recent literature to be undertaken. An investigation into trauma-informed care revealed that trauma-informed care is a system model and that system models can be considered an organisational culture. Trauma-informed care is purposed for all human services; it is not exclusive to healthcare. However, as this research was undertaken in a healthcare domain, this was taken into account. Literature considers healthcare and culture to be complex constructs, and so it is proposed that trauma-informed care also operates in the complex domain. In the interest of being thorough and amplifying the impact of the research, the theory of complexity was employed so that the research was complexity-aware. Therefore, the literature review concentrated on trauma-informed care, organisational culture, and complexity theory, including reviewing all peripherals, including human behaviour, emotions, values, and characteristics.

The literature review revealed the trauma-informed transformation process, which involved the formation of organisational principles, and that systems should operate within the bounds of these principles to be considered trauma-informed. However, it is observed that many instances of these such principles exist. Building the planning and assessment process around the principles was observed to be the main approach in facilitating trauma-informed care. One key issue was identified by Yatchmenoff et al. (2017): the current understanding in the literature was around principles and values rather than practice-based action recommendations. The recommendations for action were identified as being a gap in the trauma-informed literature. Therefore, this project set out to co-produce a framework and publish articles with recommendations for action. Furthermore, it was identified that instruments to evaluate trauma-informed care were already in existence. This identification influenced the research as it was then necessary to study these existing instruments and attempt to incorporate their findings.

A few of these instruments (Bassuk et al., 2017; Baker et al., 2016; Goodman et al., 2016; Richardson et al., 2012) had publications associated with them. These publications offered insight into the trauma-informed care assessment development process. It was concluded that a contextual framework is needed in all circumstances. A participatory action research approach was considered for adoption to allow for a co-production process to take place. It was important for the research process to adhere to the underlying trauma-informed care principles. The ideal framework would be informed by literature and previous instruments, and co-produced with experts, staff and service users.

A paper was published in which several of the known instruments were examined critically. Domains from these instruments were taken and domains that were generated at a national trauma summit. These domains were collected and taken to a meeting between the trauma leads staff. It was decided to use the domains from the implementation framework developed at a national trauma summit (Kennedy, 2020). The team were asked to cluster the domains and identify similarities. Following this process, the team were asked to generate items for the clustered domains. Several items per domains were generated.

These items and domains were then taken to a survey and projected out to staff and service users from the NHS trust. As the Delphi method was employed, a minimum requirement of 25 participants was required, but this was not met in the service user survey. The participants were asked to use a RAG rating to determine item fit. This process allowed the research team to minimise the number of items selected by individuals in the organisation. The results from the survey were then analysed using statistical analysis via Microsoft Excel. The results were then taken back to a meeting with the trauma leads staff, who concluded that all items were essential and should remain within the framework. The experts found that the survey was confusing. Suggestions around word changes were offered. Focus groups were held with staff to pilot test the framework. One focus group was held with service users to confirm articulation of the service user version.

This thesis set out to establish a stronger footing in the domain of trauma-informed care application and evaluation. It took a unique perspective, using complexity theory as a pragmatic toolkit and trauma-informed care principles in all aspects of work undertaken. The work towards a framework that is different to the ”reduce and resolve” approach can be seen to be progressive in the trauma-informed care climate. Complexity informs that the best approach is the person-centred approach.

By utilising trusted human sensor networks, it is possible to identify challenges and opportunities, and through these challenges and opportunities, positive change can be observed.

6.2 Contribution

This PhD project was a collaborative venture between Northumbria University and the Tees, Esk and Wear Valleys Foundation NHS Trust. The study contributed to furthering the implementation of trauma-informed care in the trauma-informed care programme at the TEWV NHS trust and contributed to advancements in the literature. The study followed a twinned trauma-informed care and complexity theory driven approach, which informed all facets of research design. The comparison of previous frameworks and instruments was fundamental to moving forward with development of a new framework. This new framework was co-produced and released open-access, and was accompanied with a user manual for user assistance.

The four main contributions to knowledge are:

1. An extensive literature review that involved the first evaluation of self-assessment tools for use in trauma-informed care;
2. The development of a complex systems perspective on trauma-informed care implementation and evaluation. This is the whole systems approach that was influenced by the literature;
3. The Roots framework and the accompanying user manual was the direct product of this PhD project. The reflective learning tool is the first UK based trauma-informed self-assessment;
4. Pilot testing the Roots framework with staff members from various services.

6.3 Limitations

As with every study, there are limitations. This study has seen many obstacles and possesses many such limitations. Arguably, the most significant impediment encountered during the study was the Covid-19 pandemic that shook the world and halted research and development in many sectors. This research received a suspension from the TEWV NHS trust, and alongside national lockdown measures, the entire process had been upended. Another research plan had to be drafted, and new

ways of working had to be found. The new research directive was significantly more concise than initially planned as time, resource, and certain restraints affected the process.

The small sample sizes used in this study are not representative of a large organisation like the NHS, nor do they honour trauma-informed principles. There are over 7500 staff members at the TEWV NHS and TEWV covers areas from County Durham to North Yorkshire. Both complexity theory and trauma-informed care encourage inclusivity and diversity. Recruitment was difficult, the global pandemic forced recruitment methods online and so a wider pool of participants were missed.

The Roots framework lacks formal psychometric assessment. Its validity and reliability lies mainly in the development process. Future studies must take formal steps to ensuring validity and reliability of evaluation tools.

6.4 Implications

This study contributed towards the development of the Roots framework and the creation of an accompanying user manual. The Roots framework uses the considerations of organisational psychology, human behaviour, organisational culture change, and complexity theory. This PhD project examined previous self-assessments, compared them, and published a paper of comparison.

6.5 Future Research

Several avenues could be explored with regards to this research and in this field in general. A more significant sample size would benefit all aspects of this research - listening to more voices and building a larger ”sensor network”, including recruiting fairly from all services within healthcare to avoid senior-level domination. Building the framework is the first step and possibly one of the smaller steps to monitor the application of trauma-informed care. It could be argued that the framework and its contents should change with the service. Something then must be built to contain this changing framework and collect and present the voices of all those involved. Psychometric testing of reliability and validity in larger demonstrations and developing an intuitive

instrument to automatically collect narratives from users to inform trauma-informed care delivery.

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Appendix A

Roots - Staff Framework

No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
Domain One - Safety				
1.	Service users are safe from physical harm			
2.	Staff are safe from physical harm			
3.	My team/service sees everyone as of worth with valid experience and opinion			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
4.	An individual's risks are understood and formulated in the context of previous experience and trauma			
5.	The underlying psychosocial causes of risks are actively addressed			
6.	There is an opportunity for staff and service users to reflect on safety plans to understand what has contributed to a positive outcome			
7.	It feels safe enough to reflect and be honest when things go wrong for service users			
8.	We take a collaborative risk-management approach with service users to minimise inadvertent long-term harm to healing			
9.	There is a culture where staff and service users trust each other to voice opinions whilst maintaining respect and value for each other			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
10.	My team proactively plans around safety rather than being reactive to crises			
11.	I feel I have enough skills and autonomy to manage safety issues in a patient-centred way			
Domain Two - Language				
1.	Service user presentations and symptoms are considered as strategies to cope with current or historical life experiences			
2.	All potential causes of current presenting issues are assessed including physical health issues			
3.	The survival value of a service user's coping strategies is acknowledged as a result of their adversity or trauma history			
4.	We allow for multiple narratives around someone's distress and seek to understand rather than seek to impose one model of understanding			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
5.	Our services are flexible and will adapt to the broader needs of those with complex trauma histories			
6.	Understanding the trauma narrative needs to evolve over time and at the service user's pace			
7.	Our model of understanding of trauma accounts for cognition, sense of self, relationships, and physiological impact			
8.	It is acknowledged that staff may have their own personal/professional trauma journeys that influence their motivation and understanding			
Domain Three - Social				
1.	There are good working collaborative alliances between staff, service users, teams and agencies around trauma-based needs			
2.	Staff collaborate with service users and each other towards a personalised healing journey that prevents further harm			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
3.	There is an emphasis in my service that healing from trauma occurs within safe and trusting relationships			
4.	Attention is paid to ensure all forms of communication (written, verbal, non-verbal, and behaviours) are compassionate			
5.	Reflective practice and the capacity to think non-critically about the motivations behind the action of others are paramount			
6.	Staff actively seek to contribute towards a functioning open relationship even when things are difficult			
7.	Policies and performance targets include a focus on patient and staff experience			
Domain Four - Trauma-specific Interventions				
1.	Sensitive routine inquiry of adversity and trauma forms the basis of our assessments and planning			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
2.	Our interventions are delivered in an explicit trauma-informed way, matched to needs and available long enough to make a difference			
3.	Staff support service users to create conditions where healing from trauma can begin e.g., housing, income, physical safety etc.			
4.	A range of specialist trauma therapies are available including for those with complex trauma and dissociation			
5.	Any new interventions are evaluated for clinical outcomes, impact on functioning and service user experience			
6.	Trauma interventions are offered proactively to prevent crises			
7.	Any trauma interventions are delivered as part of a wider coherent plan across agencies			
Domain Five - Empowerment				
1.	Services explicitly mitigate the role of the power difference between staff, service users and carers			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
2.	Staff and service users have the freedom to be creative and flexible in planning care together and are supported to be part of service change and innovation			
3.	Trauma-informed transformation is co-produced and co-designed with service users who have a range of views			
4.	Direct peer support is available, which minimises stigma			
5.	Personalised care and support plans are devised through shared decision making			
6.	We consider how different staff and service users view power dynamics in different ways and how this can be balanced			
7.	People with lived experience of trauma are encouraged to be in positions of leadership and influence			
Domain Six - Whole System				
1.	Funding for trauma-informed approaches forms part of core business			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
2.	We monitor trauma-related outcomes			
3.	Staff at all levels have adequate trauma-informed skills and are supported to work in a trauma-informed way			
4.	A Trauma-informed approach is explicit in the commissioning framework for our service			
5.	Staff have access to peer support with lived experience of trauma			
6.	Service users who need help can get help early without being passed around (pathways are clear and comprehensive to cover a variety of needs)			
Domain Seven - Compassionate Leadership				
1.	Services have the capacity to manage demand in a way that promotes helpful outcomes			
2.	Staff are supported to be motivated to address trauma-related issues			
3.	Lived experienced voices are valid in supervision and learning			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
4.	There is a culture where it is safe to speak up about concerns			
5.	Leaders address issues of stigma and acknowledge that adversity can limit all of us at various times			
6.	Leaders at all levels are responsible for supporting trauma-informed developments and integrate them into their own areas of influences			
7.	Leaders are open about their own experiences of adversity			
8.	Staff are promoted into positions based on trauma-informed values and experience			

End of table

Appendix B

Roots - Service user Framework

No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
Domain One - Safety				
1.	I feel safe from physical harm in this service			
2.	Staff are safe from physical harm here			
3.	Staff see everyone as of worth with valid experience and opinion			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
4.	Staff understand my personal risks as arising from the consequences of my past or current adverse experiences e.g., abuse, housing, finance etc.			
5.	The triggers and underlying reasons for my personal risks are addressed			
6.	I have the chance to reflect and learn with staff after my safety has been at risk either from myself or others so things can be done differently in the future			
7.	Staff take into account my view when looking at risk in a way that promotes my long-term healing			
8.	I trust staff and are able to respect each other's opinions			
9.	My team makes plans around my personal safety in advance rather than after a crisis			
10.	The staff have the ability to deal with safety in a way that is personal to me			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
11.	I feel safe from physical harm in this service			
Domain Two - Language				
1.	My symptoms, or the way I appear and behave, are considered as meaningful reactions to my current or past experiences			
2.	All causes of my symptoms, or the way I appear and behave, are considered, including my physical health			
3.	Staff recognise the survival value of my ways of coping as well as my personal strengths			
4.	Staff hold in mind different ways my distress can be understood and do not impose a single model of understanding			
5.	My mental health services are able to adapt to my individual needs			
6.	Staff recognise that a person's understanding changes over time and needs a sense of safety to adapt			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
7.	Staff's understanding of the context of my mental health problems takes into account my relationships, physical impact, thoughts and sense of self			
8.	I understand that staff may have their own stories of adversity which impacts their way of being and understanding of me			
Domain Three - Social				
1.	I notice good working relationships between staff, teams and other agencies			
2.	Staff work together with me to create a personal healing journey that tries to reduce further harm			
3.	There is an understanding within my service/team that they can help best with safe and trusting relationships			
4.	Efforts are made to communicate compassion through all types of interaction and communications			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
5.	Staff can reflect, non-judgementally, on their own actions and those of others			
6.	Even during difficult times, staff seek to promote positive, open relationships			
7.	It seems that policies and staff targets have included a focus on service user and staff experiences			
Domain Four - Trauma-specific Interventions				
1.	Sensitive questions about bad things in people's lives from the basis of assessments			
2.	Interventions are delivered in a way to suit my individual needs for long enough to make a difference			
3.	Staff support me in creating a life where my recovery can begin			
4.	A range of specialist trauma therapies are available if I needed them			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
5.	Interventions are evaluated properly and include me in this evaluation			
6.	I have access to 'interventions' to prevent a crisis in my mental health			
7.	Interventions addressing the bad things in my life are coordinated with the rest of my care			
Domain Five - Empowerment				
1.	Staff actively make me feel as empowered as they are			
2.	New ideas about my care are welcomed			
3.	Changes to the service are made and agreed with people who use this service			
4.	The service has linked me to support from others who have faced similar challenges to myself			
5.	I am involved in decisions about my care			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
6.	Services show they know that people react differently to power imbalances			
7.	People who use services are openly in positions of leadership and influence			
Domain Six - Whole System				
1.	The service is adequately funded to provide what I need to recover from my adversity			
2.	Outcomes related to the impact of the bad things in my life are important to this service			
3.	Staff show they have adequate training and support to work with me on addressing the bad things that have happened to me			
4.	Services have ways to help me recover from any bad experiences I have had			
5.	I have access to peer support from people like me			
6.	I can get help early without being passed around services			

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No	*Item*	*Applicable to Service*	*Implementation*	*Examples*
Domain Seven - Compassionate Leadership				
1.	Services deal with demand in a way that encourages my recovery			
2.	Staff want to address issues related to bad things that have happened to me			
3.	There are people with lived experience of adversity supervising staff			
4.	I believe that staff would speak up about concerns they had about the service			
5.	Staff at all levels are aware of issues of stigma			
6.	Leaders at all levels support developments to address the causes of mental health problems			
7.	Staff leaders are open about their own experiences of adversity			
8.	Values relating to empowerment, choice and not labelling people are being promoted by the service I use			

End of table