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ORIGINAL ARTICLE

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Exploring the knowledge base of trauma and trauma informed care of staff working in community residential accommodation for adults with an intellectual disability

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Abstract

Background: Taking a trauma informed care approach has demonstrated positive outcomes for services for people in the general population. Given the increased vulnerability to psychological trauma for adults with an intellectual disability, this study explores what residential staff know about trauma and trauma informed care.

Methods: Thirty-two staffs representing three staff groups: direct care staff; managers; and specialist practitioners, were interviewed using semi-structured interviews, which were analysed following a structured framework.

Findings: Each staff group held different perspectives in their knowledge of trauma and trauma informed care. Limitations were noted in staffs' knowledge of trauma, implementation of evidence-based supports, and access to specialist services for adults with an intellectual disability. All participants highlighted their training needs regarding trauma.

Conclusion: Increased training on recognising and responding to trauma is needed among community staff supporting those with a trauma history if organisations are to move towards trauma informed care.

KEYWORDS
intellectual disability, residential, staff, trauma, trauma informed care

1 | INTRODUCTION

The impact of psychological trauma is widely referenced for people in the general population and in recent years there has been a focus on the mental health, the physical health and the social implications of psychological trauma (Kessler et al., 2010; Larkin et al., 2014; Mongan et al., 2017; Shevlin et al., 2015). Whilst there are National Institute for Health and Care Excellence guidelines in place for individualised interventions for traumatic stress disorders, such as eye movement desensitisation and reprocessing (EMDR) and trauma-focussed cognitive behaviour therapy (TF-CBT), there is an increasing move towards organisational interventions for complex trauma in the form of trauma informed care (Keesler, 2014).

Evidence suggests that adults with an intellectual disability may be more vulnerable to traumatic experiences and physical, sexual, emotional abuse (Beadle-Brown et al., 2010; Nixon et al., 2017) and experience more negative life events (Dion et al., 2018) than adults without intellectual disabilities. Additionally, the literature suggests

that they also encounter specific trauma related to the experience of disability itself (Hughes et al., 2019; Schepens et al., 2019) and there are unique differences to how adults with an intellectual disability communicate their experience of trauma, how symptoms of post-traumatic stress are presented, and challenges with diagnostic overshadowing (Daveney et al., 2019). While there is generally a more heightened risk to abuse for adults with an intellectual disability the Division of Clinical Psychology (DCP, 2017) reports that they are more likely to have experiences of multiple placements, sudden changes to their living arrangements, be excluded at times of bereavement, have bullying experiences and lose the right to parent or have relationships. In their systematic review of abuse for adults with an intellectual disability in care settings Colins and Murphy (2021) describe individual, perpetrator and organisational risk factors for abuse of adults with an intellectual disability, noting risks due to severity of intellectual disability, being known to services over time, challenging behaviours and involvement with behaviour management services. A recent scoping review by McNally et al. (2021) highlighted growing evidence for the NICE (2018) recommended interventions but challenges remain for the formal recognition and assessment of trauma for adults with an intellectual disability. Also reported in the review was the need to move towards trauma informed care for people with an intellectual disability who are likely to have been impacted by a trauma history.

Trauma informed care refers to the development of coherent cultures, policies, and practices that recognise and respond to the prevalence and pervasive impact of trauma (De Candia et al., 2014). It is an organisational change framework that promotes the understanding of the widespread impact of childhood adversity and trauma across the life course with the aim to promote potential pathways for recovery while seeking to avoid re-traumatisation (SAMHSA, 2014). Early work by Fallot and Harris (2001) stated the necessity to provide safe, trusting and collaborative relationships within organisations, which is reflected in SAMHSA (2014) description of the principles of choice, collaboration, empowerment, safety and trust as the key aspects of trauma informed care. Although similar principles are applied in person centred care, recommended by the NICE (2018) guidelines for developing services for people with an intellectual disability who have behaviours that challenge and are also recommended in the valuing people (Department of Health, 2001) and valuing people now (Department of Health, 2009) government white papers, SAMHSA emphasises the use of a trauma lens when considering these principles.

Reviews of trauma informed care approaches have established positive outcomes in settings such as looked after children's services (Bunting et al., 2019), inpatient and residential services for young people (Bryson et al., 2017) and adult mental health settings (Muskett, 2014). Purtle (2020) noted that the most significant outcomes related to services that included organisational change as part of their trauma informed care approach. It is the organisational change that holds positive outcomes for staff as well as service users (Hales et al., 2019). To date there are few studies exploring trauma informed care in services that support adults with an intellectual disability who are likely to have been impacted by a trauma history.

In the limited number of studies reporting on the implementation of trauma informed care (Keesler, 2014, 2016; Rich et al., 2020), the authors found a lack of understanding of trauma informed care at an organisational level for direct care staff, gaps in managers' understanding of trauma experiences for adults with an intellectual disability and gaps in the implementation of trauma informed care principles. Keesler (2020) also highlighted the impact of the lack of trauma informed organisational culture for direct care workers across a number of different service provisions for adults with an intellectual disability and found that staff in residential settings were associated with, and contribute to, lower levels of compassion satisfaction and increased likelihood of burnout.

These studies have begun to explore direct care staff and service managers' experiences and understanding of trauma informed care across a variety of services for adults with an intellectual disability. As with the general population, attention needs to be given to the introduction and evaluation of trauma informed care approaches specifically for residential and supported living services for adults with and intellectual disability.

1.1 | Study rationale

Whilst there has been some recent exploration of staff understanding of trauma informed care in services for adults with an intellectual disability, there are currently no studies specifically exploring staff knowledge regarding trauma and trauma informed care in community residential services. Furthermore, there are no studies examining the knowledge and understanding of specialist practitioners, such as behaviour practitioners and psychologists, who provide supports into residential and supported living services.

1.2 | Aim/objectives

The aim of this study is to explore the understanding of trauma, trauma interventions and trauma informed care among direct care workers, managers and specialist practitioners working into community residential services for adults with an intellectual disability.

In order to achieve this aim, we set the following research objectives:

1. Assess staffs' understanding of trauma or complex trauma for adults with an intellectual disability.
2. Determine staffs' knowledge or experience of how adults with an intellectual disability and trauma history either internalise or externalise their experience.
3. Establish staffs' knowledge or experience on how to treat or support adults with an intellectual disability who have a trauma history.
4. Ascertain staffs' thoughts on what needs to happen for trauma informed care to be implemented in residential care or supported living for adults with an intellectual disability.

2 | METHODS

2.1 | Design

A qualitative method was employed using a series of 1–1 semi-structured interviews (Table 1), conducted remotely, with three groups of participants to reflect different service roles. The format of the semi-structured interviews allows for rich and detailed data to be collected regarding the individual's experiences and perspectives on potentially sensitive topics (Braun & Clarke, 2013).

2.2 | Participants, recruitment, and context

Specialist practitioners (behaviour practitioners, psychologists, specialist allied health professionals), direct care staff (community residential staff currently working in a direct care role) and managers (managers, assistant managers, operational managers etc) who work in community residential or supported living accommodation for adults with an intellectual disability were recruited from three statutory service providers and from two large voluntary providers for people with an intellectual disability in Northern Ireland (NI). The research team identified a senior stakeholder from each service provider as a project collaborator, who shared details of the study and invited participation from all staff currently working in residential and supported living services within their organisation. It is important to note, that although it was not part of the inclusion criteria, participants who chose to take part in the study all identified that they worked with individuals who had an intellectual disability and a trauma history.

Table 2 shows that a total of 32 staff participated in the study. It notes if the staff had any specialist training in trauma and the range of years' experience they had working with people with an intellectual disability. It was not expected that staff beyond specialist practitioners would have any specialist training in trauma.

TABLE 1 Key questions in the semi-structured interview

1. What is your understanding of trauma or complex trauma for people with an [intellectual disability]?
2. What is your knowledge or experience of how adults with an [intellectual disability] and trauma history externalise or internalise their experience?
3. What is your knowledge or experience on how to treat or support people with an [intellectual disability] who have a trauma history?
4. What needs to happen for trauma informed care to be implemented in residential care or supported living schemes?

2.3 | Interview format

The interview enquiry was based on Substance Abuse and Mental Health Administration (SAMHSA) (2014) 4Rs key assumptions for a trauma informed care approach:

- *Realisation* of ubiquity and impact of trauma.
- *Recognition* of how people respond to their trauma experience.
- *Response* from an organisation to trauma.
- *Resist re-traumatisation* of service users and staff.

The open-ended interview questions and subsidiary prompts were piloted by the research team. The interview questions were then further piloted and agreed with an advisory group of professional stakeholders for the project. Due to COVID-19 restrictions the interviews were offered using remote platforms (Zoom, Skype or MS Teams) or telephone. Interviews were audio-recorded and transcribed verbatim. Participants were provided with information sheets and consent forms and invited to take part in the study. Interviews took place from October 2020 to February 2021 and on average the interviews lasted 29 min, with a range of 14–53 min per interview.

2.4 | Data analysis

The data gathered from the interviews were analysed using a framework analysis, developed by Ritchie and Spencer (1994) for data analyses in the field of applied social policy, but now used more widely. The framework analysis follows five stages: (1) data analysis, (2) developing the theoretical framework, (3) indexing, (4) charting, and (5) synthesising the data (Furber, 2010). One of the key benefits of conducting a framework analysis is that, in addition to the qualitative categories and sub-categories generated, the matrix format allows for responses across the three staff groups to be quantified for the indexes generated within the framework of the questions posed. This allows for comparisons to be made across the sample and also within individual interviews, meaning that while comprehensive analyses of key categories arising across the entire data set are possible, individual participants' views remain (Gale et al., 2013).

The framework analysis also places emphasis on *priori* issues and emergent data driven categories which guide the development of the analytic framework (Parkinson et al., 2015), allowing for both an inductive and deductive process of analyses. This structured approach to the analysis was also required given the relatively large number of interviews which were conducted. Once the interviews were

TABLE 2 Participant demographics

Role	Number of participants	Specialist training in trauma	Years of experience (mean)
Specialist practitioner[a]	13	2[b]	1–22 years (9.8 years)
Direct care worker	8	0	3 montsths to 15 years (4.7 years)
Manager	11	0	6–42 years (21.7 years)

[a]10 Behaviour practitioners, 1 Speech therapist, 1 Psychologist, 1 mental health practitioner.
[b]EMDR and Dialectical Behaviour Therapy. Total sample size ($N = 32$).

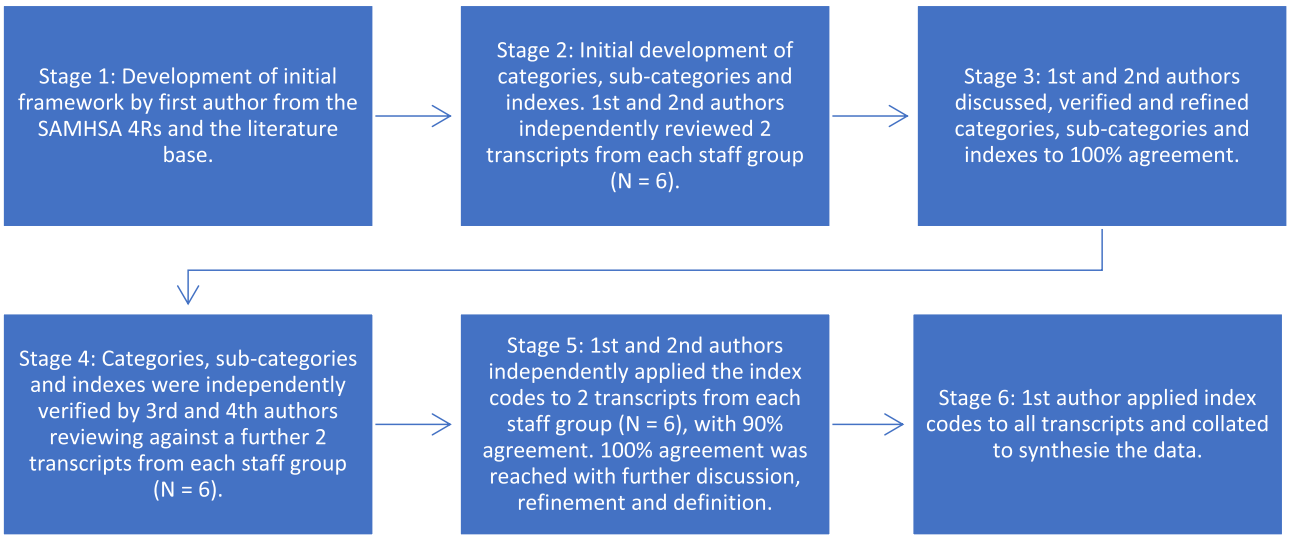

FIGURE 1 Process of refinement and analysis

transcribed, an initial theoretical framework, closely related to the questions posed, was developed. The initial framework was further refined, and data analysed by the research team (Figure 1).

2.5 | Ethics approval

The project received ethical approval from the Office for Research Ethics Committee Northern Ireland (ORECNI).

2.6 | Findings

Within the analytic framework of the 4Rs four major categories were developed: (1) Understanding of psychological trauma for adults with an intellectual disability; (2) Recognition of how adults with an intellectual disability respond to trauma experiences; (3) Response or support for adults who have an intellectual disability and trauma history; and (4) Trauma informed care in residential services for adults with an intellectual disability. The categories, sub-categories and frequency of index response for each participant staff group, generated from the analysis of the interview data, are detailed in Table 3. A qualitative description of the categories, sub-categories and indexes are outlined as:

2.6.1 | Category 1: Understanding of psychological trauma for adults with an intellectual disability (REALISATION)

Category 1 was divided into the two subcategories relating to (1) what participants understood about trauma in general; and (2) what they understood about the specific vulnerabilities of adults with an intellectual disability.

General understanding of trauma

This sub-category demonstrates what participants understood about trauma in general, and their description of trauma as either a single event or complex and enduring experience. Some participants demonstrated an academic understanding of trauma in the general population ('it's that distressing event that causes an emotional reaction'), while others described their understanding from a position of experience ('I have come across a few people that I work with who have had difficult relationships which has impacted on their trust in building relationships with other people').

The results showed that while all participant groups had some general understanding of trauma, specialist practitioners more frequently gave an 'academic description' description of trauma as both a single event or complex and enduring experience, than the other two staff groups. Managers and direct care staff more frequently described their understanding of trauma from a position of experience, with managers demonstrating a more frequent understanding of trauma as a complex and enduring experience.

Understanding of trauma vulnerabilities for people with an intellectual disability

This sub-category reflects what participants highlighted as vulnerabilities to trauma experiences specific to people with an intellectual disability. All direct care staff, and a high number of staff in all three staff groups, described personal vulnerabilities for people with an intellectual disability, such as reduced coping mechanisms ('might not have the tools to cope') and less able to identify what is a traumatic or typical experience ('not understanding that the experience in itself was wrong and it's not acceptable'). Similarly, all three staff groups gave examples of environmental vulnerabilities, such as being in institutional care ('going into hospital or being detained') or reliance on others ('rely on other people for a

TABLE 3 Number of participants mentioning categories, sub-categories and indexes by staff role

Category	Subcategory	Index	Direct carer ($n = 8$)	Practitioner ($n = 13$)	Manager ($n = 11$)	All ($n = 32$)
1. Understanding of psychological trauma for adults with an intellectual disability	General understanding of trauma	Trauma experiences of the general population	5	10	5	20
		Description of single event trauma	4	9	4	17
		Description of complex trauma	4	10	9	23
		Academic understanding	4	7	2	13
		Understanding through experience	5	6	11	21
	Understanding for people with an intellectual disability	Personal vulnerability	8	10	9	27
		Environmental vulnerability	7	12	9	28
		Societal vulnerability	4	7	7	18
		Challenges to identifying trauma experiences	3	8	5	16
2. Recognition of how adults with an intellectual disability respond to trauma experiences	Mental health	Mental health diagnosis	4	8	9	21
		PTSD recognition	2	6	0	8
		Descriptions of the emotional impact	8	11	10	29
		Emotional dysregulation	4	7	4	15
	Physical health	Impact on physical health	0	1	1	2
	Behavioural	Generic description of challenging behaviour	6	12	11	29
		Challenging behaviour linked specifically to trauma	3	6	5	14
		Behavioural change	0	4	0	4
		Other coping behaviours	4	7	11	22
	Relational experience	Avoidant of connection	2	10	1	13
		Increased demands for connection	3	7	2	12
		Impact on staff	3	5	7	15
3. Response or support for adults who have an intellectual disability and trauma history	Assessment	Formal assessment	0	3	0	3
		Absence of assessment tools	1	2	0	3
		Informal assessment	4	10	6	20
		Barriers to assessment	2	8	4	14
	Interventions	General support	8	10	10	28
		Safe relationships	6	7	9	22
		Low intensity support	5	6	4	15
		High intensity/specialist support at an individual level	5	9	6	20
		Challenges to accessing specialist support	1	5	9	15
		Medication	1	3	4	8
		Systemic intervention	3	6	8	17
		Fear of causing harm/re-traumatising	4	3	4	11
	Safe environments	Environmental safety	5	7	10	22
		Safeguarding policies	1	4	1	6
		Safety from others	2	3	5	10
		Positive risk taking	0	1	2	3
	Outcomes	Reduced distress behaviours	3	7	3	13
		Access to supportive relationships	0	2	2	4
		Avoiding cycles of re-traumatising	3	6	3	14
		Resilience/therapeutic growth	0	3	2	5

(Continues)

TABLE 3 (Continued)

Category	Subcategory	Index	Direct carer ($n = 8$)	Practitioner ($n = 13$)	Manager ($n = 11$)	All ($n = 32$)
4. Trauma informed care in residential services for adults with an intellectual disability	Training	General training provision	8	13	11	32
		Models of training	1	10	8	19
		Training to staff at all levels	1	5	5	11
		Training as a process	2	4	2	8
		Integrated with other training/models of care	1	2	5	8
	Organisation level change	Trauma informed leadership	0	6	1	7
		Trauma informed policies and procedures	2	4	5	11
		Enabling access to specialist services	3	9	1	13
		Good communication within the system	2	3	2	7
		Involving service users	0	2	5	7
	Staff Support	Supervision/team meetings/training/ structures	3	7	3	13
		Reflective practice/Debriefing	0	6	6	12
		Appropriate conditions of work	0	7	1	8
		Trauma resources materials	1	2	0	3
	Individual level	Placement matching support needs	0	3	2	5
		Trauma informed care plans	2	1	3	6
		Regular reviews employing a trauma lens	1	1	1	3
		Access to specialist intervention	0	1	0	1
	Barriers	Resources	2	8	9	19
		Difficulties in recruiting staff/staff turnover	0	6	4	10
		Competing models of care/access to training/uptake of new ways of working	2	4	6	12
		Support of people with increasing complex	1	3	2	6

Abbreviation: PTSD, post-traumatic stress disorder.

lot of things that gives them a lot of power over their lives'). Fewer participants gave examples of societal vulnerabilities experienced, though these experiences were reported slightly more often by managers ('[society] mindset that they should be kept out of the way').

Challenges to identifying past trauma for people with an intellectual disability were reported more by specialist practitioners than the other two staff groups, with issues such as lack of historical information ('speculate about a person's past because you won't always get all the information'), diagnostic overshadowing ('more likely to be attributed to their [intellectual disability] without anyone looking further into it]') or judgements made about what is traumatic ('You could overthink situations and be too quick to jump in there and say that is related to trauma').

2.6.2 | Category 2: Recognition of how adults with an intellectual disability respond to trauma experiences (RECOGNITION)

This category is divided into four sub-categories, which relate to (1) mental health presentation; (2) physical health presentation; (3) behavioural presentation; and (4) the impact from a relational context.

Mental health

In this sub-category participants described symptoms of mental health presentations, such as post-traumatic stress disorder (PTSD), anxiety, depression and general descriptions of emotional dysregulation ('have a melt-down') and the emotional impact of trauma ('low self-esteem, low self-worth, don't feel valued'). Descriptions of the emotional

impact of trauma was provided by most participants across all three staff groups. General mental health presentations were described mostly by managers and the more specific recognition of symptoms of PTSD was more often reported by specialist practitioners, but not mentioned by managers at all. Although not as frequently described in general by all participants, specialist practitioners and direct care staff were marginally more likely to note emotional dysregulation in relation to trauma.

Physical health

This sub-category was not strongly represented in the interviews, with only one specialist practitioner and one manager mentioning physical manifestations of distress ('headaches, tremors, upset stomachs'). None of the participants across the three groups linked trauma to long-term physical health conditions for adults with an intellectual disability.

Behavioural

This sub-category suggests that behavioural presentations could be connected to expressions of distress associated with trauma. While the majority of participants made generic comments in relation to behaviour ('I guess her behaviours spiralled out of control', 'consider negative behaviours and maybe lashing out, if things get built up'), less than half of the participants across all three staff groups were able to make explicit observations linking behavioural presentations to past trauma ('he can be very aggressive and that's all around trauma, and about triggers of trauma in the past'). Half of the direct care staff and just over half of specialist practitioners identified other coping behaviours ('alcohol use', 'self-harm'), however, these behaviours were reported by all managers. Notably, only specialist practitioners identified behaviour change as an indicator of trauma ('say [person] goes into town every day, guaranteed, but suddenly it starts to drop in those daily activities').

Relational experiences

This sub-category describes relational experiences of adults with an intellectual disability following traumatic experiences. Compared with managers and direct care staff, specialist practitioners most often reported incidents of avoidance ('cautious of new staff, very wary of what these new people will bring') and increased demands for connection ('they'll be described as manipulative', 'she would play on having a lot of attention') among adults with an intellectual disability. In contrast, managers most often recognised the significant impact of residents' relational dynamics on staff ('staff find them very challenging and emotionally draining').

2.6.3 | Category 3: Responses or support for adults who have an intellectual disability and trauma history (RESPONSE)

This category identifies what staff know about responses or supports that are available for adults who have an intellectual disability and a trauma history. The category is divided into four sub-categories relating to (1) assessment of trauma; (2) potential interventions; (3) creating safe environments; and (4) potential outcomes for individuals.

Assessment

This sub-category highlights awareness of an informal assessment process across all three staff groups ('interview family, staff, looking through files and then talking to the person as well'). Specialist practitioners demonstrated a greater awareness of informal assessment and also barriers to assessment ('not knowing information from the past', 'just because someone has been through a trauma doesn't mean they want to talk about it') when compared to the other two staff groups. Specialist practitioners showed a limited awareness of formal assessment tools ('I know there is a tool to screen for ACEs which can indicate trauma') and the other two staff groups acknowledged no awareness at all ('I don't know of any formal assessment tools'). This is also reflected in the small number of participants from the direct care staff and the specialist practitioner staff groups who acknowledged an absence of appropriate assessment tools for adults with an intellectual disability.

Interventions

This sub-category identifies interventions at a number of different levels ranging from general support ('we had a cup of tea and sat down and had a chat') and safe relationships ('try to build trust with the staff') to low intensity interventions ('encouraging breathing exercises') and high intensity specialist interventions ('I use EMDR and DBT'). The sub-category also identifies the use of medication as an intervention ('PRN medication would also be used to help ease his anxieties'), the fear of re-traumatising by intervening ('indirectly do harm possibly by getting too involved') and challenges adults with an intellectual disability have to accessing specialist supports ('psychological supports available to me, if I feel traumatised, are more difficult to access if you have an [intellectual disability]'). The supports already in place that map onto the core principles of trauma informed care applied through systemic intervention ('we work in partnership with their support plans, they get input and their voices heard') are also captured in this sub-category.

The results showed that a high number of participants across all roles mentioned general support for adults with an intellectual disability as a response to them being distressed, however, managers and direct care staff reported more on general support and safe relationships, while specialist practitioners more often described more low intensity interventions. Both direct care staff and specialist practitioners were marginally more aware of high intensity specialists supports than managers. Managers reported more than the other two staff groups on the challenges to accessing specialist support, the use of medication, and systemic interventions. Half of the direct care staff indicated that they were afraid of re-traumatising or causing harm by intervening.

Safe environments

This sub-category indicated that all three staff groups reported on the environmental safety of adults with an intellectual disability ('we

would have all the lights on so that when she is going to sleep that makes her feel safe'), though comments were made more often by managers for this index. There was a much lower frequency of comments made regarding safeguarding policies ('it's important to have all staff checks and vetting done', 'follow safeguarding policies'), safety from others ('we would never have someone that's aggressive live with someone that's not') and only a very limited reporting of positive risk taking ('we have to get better at taking risks') by managers and specialist practitioners.

Outcomes

This sub-category is not as strongly represented across the three staff groups and it highlights staff knowledge of positive outcomes for adults with an intellectual disability who have been helped to regulate their distress ('that makes her feel safe and she definitely calms down'), have access to supportive relationships ('always having someone you can talk to'), who staff can support to avoid cycles of re-traumatising ('don't restrict him too much, he's going to get upset and going to be re-traumatised') and where they can show resilience or therapeutic growth through the care and support they receive ('trying to encourage that kind of independence, in a sense resilience, building the skills'). Specialist practitioners mentioned more positive outcomes in general than the other staff groups, particularly with regards to reduced distress behaviours and avoiding cycles of re-traumatising.

2.6.4 | Category 4: Trauma informed care in residential services for adults with an intellectual disability (RESIST RE-TRAUMATISING)

Based solely on staff experience of working with trauma to date, there were five distinct sub-categories highlighting the need for (1) training in trauma; (2) staff support; (3) trauma informed care at an individual level; (4) trauma informed care at an organisational level and; (5) potential barriers to its implementation.

Training

This sub-category highlights the universally recognised need for training from all three staff groups. It is important to also note that the recognition of training needs was reported in all four categories in the interviews. The sub-category of training covers training content ('supporting our direct care staff to understand what trauma is and how we can help people'), discussed in varying degrees by all staff groups; models of training ('develop shared learning with different schemes'), discussed mostly by managers and specialist practitioners; a reported need to train staff at all levels in the organisation ('I think this would be really beneficial throughout our organisation to roll out with staff, and managers, and even some of the people we support'), noted by smaller numbers across the three staff groups; training as a process including review ('I think it could be ongoing, as things do change and evolve'), also noted by smaller numbers across the staff groups; and the need to integrate training within current models of care ('We're a PBS [Positive Behaviour Support] service, so it's about bringing that concept [trauma] into our training sessions'), reported more by managers compared to the other two staff groups.

Organisational level requirements

This sub-category reports on trauma informed leadership ('a good manager can create a culture where staff feel safe', 'empowering staff teams'), trauma informed policies and procedures ('we need to look at how we speak about it and categorise behaviour and the actions of services users, even though it's just paperwork'), pathways to specialist services ('need to build on that networking and collaboration with other services'), the need for good communication within the system ('need to speak with others in the organisation so that we can understand and put context to what we are seeing now'), and service user involvement in developing trauma informed services at an organisational level ('maybe it's about involving service users in partnership and getting them to come in to talk about what trauma is to them'). Comments reported for this sub-category are not strongly represented across the three staff groups in general, however, managers reported more than the other two staff groups on trauma informed policies and procedures and the need to involve service users in service development. Specialist practitioners demonstrated more responses that identified a need for enabling access to specialist services than the other two staff groups.

Staff support

This sub-category identifies staff requirement for supervision ('supervision and team meetings should be encouraged as a place to think about trauma, rather than just a thing that we do'); debriefing/reflective practice ('reflective practice and allowing staff to be able to process what gets transferred and counter-transferred'); appropriate conditions of work ('I think it's an incredibly complex job [direct care staff] and I think it should be recognised as a professional job', 'just throw people in there and some people are paid very little as well'); and appropriate resources ('I think having the right resources in their houses would go a long way, for example in CAMHS we had resources for talking about bereavement') to feel supported in the implementation of a trauma informed care approach. This sub-category was also not well represented across all three staff groups, however, specialist practitioners appeared to recognise the general needs of staff support more than direct care staff and managers.

Individual level requirements

This sub-category emphasises on trauma informed care from the position of the individual with an intellectual disability and the requirements for placements matching their support needs ('services do need to be bespoke and to the person's individual needs'); care plans that have been developed with a consideration of trauma ('that it [trauma] is actually in their care an support plan'); reviews with a trauma lens ('needs to be monitoring recording how these approaches are being used, if they're effective and someone regularly reviewing'); and access to specialist services ('people should have access to individual therapy'). Indexes in this sub-category were the least reported of all categories across all three staff groups.

Barriers

This sub-category highlights what staff view as potential barriers to the implementation of trauma informed care and suggests concern regarding costs ('time and resources'); challenges to staff recruitment and retention ('having the staff, getting the staff and keeping the staff');competing models of care ('I think for the ready established services it will be more difficult because it's something new coming in'); and changing roles of service delivery ('the job is no longer helping people make their tea, do their shopping and going out. It's traumatic times for staff as well because of the complex people we now expect them to care for'). The results show that managers have most concern about the availability of resources and their belief around competing models of care, while specialist practitioners and managers acknowledge some difficulty in recruiting staff. There is limited recognition of the changing support needs of people living in residential and supported living across all three staff groups.

3 | DISCUSSION

This is the first study to explore staffs' understanding of trauma among adults with an intellectual disability, who live in community residential or supported housing. The study investigates understanding across three staff groupings, who hold different positions of care within their organisations. Their understanding is framed using SAMHSA (2014) 4Rs of trauma informed care: Realisation, Recognition, Response and Resisting re-traumatisation. When considering the limited knowledge demonstrated overall in the results of this study for the three staff groups, across the four main categories, they each demonstrated relatively more knowledge in the areas of 'Realisation' and 'Recognition' than 'Responsiveness' and 'Resisting re-traumatisation'. This level of understanding is not surprising given that the majority of participants had no training in trauma, and this position would be in keeping with Treisman's (2018) description of being trauma aware, a precursor to being trauma informed and trauma responsive.

3.1 | Realisation

From the findings, it was clear that staff had a general understanding of trauma both from experience of working with traumatised individuals and academically, related to their role in their organisation. There was also an understanding of the specific vulnerabilities to trauma experiences for people with an intellectual disability.

3.2 | Recognition

Staff demonstrated more specific gaps in their knowledge in respect of recognition of trauma. It is of note that all staff groups described challenging behaviour as possibly being linked to trauma for the people they support, though only half from each group explicitly linked it to their trauma experiences, and therefore missing the potential trauma related mediating factors reported by Clark et al. (2016). Positive Behaviour Support is the dominant framework for the participating services, and it is significant that 10 of the 13 specialist practitioners who contributed were behaviour practitioners. It is perhaps critical to consider the trauma mediating factors for some challenging behaviours in that it necessitates a different response from service providers, as all too often direct care staff rely on a behaviour support plan and expect to change behaviour through modification. Behaviours rooted in trauma will require a more relational understanding and intervention.

Interestingly, only two staff members out of the 32 interviewed described physical responses to upsetting experiences, and the impact on physical health related to trauma was not represented in the participants' responses at all. This is contrary to the well-established acknowledgement that trauma has long-term outcomes on physical health for the general population, such as cardiovascular and pulmonary diseases (Spitzer et al., 2009) and the evidence linking abuse to chronic health conditions for people with an intellectual disability (Santoro et al., 2018). Given the existing health inequalities for people with an intellectual disability (Emerson et al., 2016; Krahn & Fox, 2014), this study highlights that the link to trauma and physical health needs to be addressed in an overall trauma informed care response.

3.3 | Response

In the context of response to trauma, informal assessment processes were described by half of all three staff groups, demonstrating a cognisance of the fact that assessment was necessary. Equally this evidences that half the staff had no awareness of how to begin to assess if a person had experienced trauma. As expected, specialist practitioners demonstrated more awareness of the assessment process in general, however it was clear that they were not using assessment tools validated for use with people with an intellectual disability, such as the Bangor Life Events Scale for Intellectual Disability (BLESID: Wigham et al., 2014) or the Lancaster and Northgate Trauma Scales for Intellectual Disabilities (LANTS: Wigham et al., 2011), which have potential for identifying PTSD for this population (Daveney et al., 2019). It is important that staff are made aware of and approach assessment in a formalised multi-modal and individualised manner (Kildahl et al., 2020).

The findings also demonstrated a lack of knowledge regarding evidenced based interventions for trauma, such as those recommended in the NICE (2018) guidelines for the general population, and staff (managers in particular) noted that people with an intellectual disability had limited access to any interventions such as EMDR and trauma focused CBT. It is encouraging though that 'safe relationships' were recognised by at least half of all staff as a form of intervention, as Isobel and Delgado (2018) reported that safe and collaborative relationships were key in creating the safe foundation for trauma healing. While specialist practitioners focussed more on

outcome their responses were very much descriptive and there were no formal processes described to capture outcomes for people with an intellectual disability.

3.4 | Resist re-traumatising

In exploration with staff of what needs to happen for a community residential service to be trauma informed there was understandably a dearth of knowledge regarding what constitutes trauma informed care. Unsurprisingly, the need for training was highlighted by all participants across all aspects of the interview. However, the acknowledgement of a need for change at both an individual and organisational level was minimal and should be addressed alongside training, as taking both a top-down and bottom-up approach, addressing the organisation as a whole, produces the most significant outcomes for services users (Cook & Hole, 2021; Purtle, 2020).

Interestingly, it was noted that some direct care staff approached to be involved in the study declined due to their own experience of trauma. It is not unusual that traumatised staff would be supporting traumatised people (Bloom & Farragher, 2013) and Keesler (2018) demonstrated elevated Adverse Childhood Experience (ACE) scores for direct care staff working in settings for people with intellectual disabilities. Therefore, the need for staff support in managing these 'healing' relationships is an essential aspect of trauma informed care.

Barriers to implementing trauma informed care, similar to previous research by Akin et al. (2017), such as lack of resources, staff turnover and competing agendas/models of care were described predominantly by specialist practitioners and managers. Some of these barriers can be mitigated by the introduction of the trauma informed care approach in itself, such as reduction in staff turnover (Sanders, 2009) and reduction in re-traumatising events, such as seclusion and restraint (Wale et al., 2011). Trauma informed care can also be integrated into existing models of care, such as the Positive Behaviour Support framework, as part of creating capable environments and understanding functions of behaviours from a deeper perspective (Harding, 2021).

3.5 | Limitations and strengths of study

This study is limited to a small, self-selected sample of participants who had experience of, and interest in, working with adults who have an intellectual disability who experience trauma. The study is also limited to a small geographical area of predominantly white ethnicity that has its own cultural experience of trauma related to political conflict. However, the study's strength lies in the rigour of the methodology implemented in the framework analysis.

4 | CONCLUSION

The overall findings of this study highlight that although policy drivers are in place there is a lack of appropriate assessment; limited implementation of evidenced based supports; and limited access to specialist services for adults with an intellectual disability who experience trauma in practice. Additionally, there is a gap between what is offered to people in the general population and to those with an intellectual disability, despite their increased likelihood of experiencing trauma. There is clearly a requirement to address the training needs of staff and organisations in relation to recognition and responding to trauma in a move towards trauma informed care. It is also clear that staff members working in different positions within an organisation will hold different perspectives of what is important for trauma informed care to be implemented. Therefore, it would be essential to include all staff groups in co-creating a realist perspective on the development of a trauma informed care framework, influenced by the current evidence base regarding trauma for adults with an intellectual disability, and which can be integrated with existing models of care. Given the potential impact of COVID 19 on increased fear of infections, loss of peers, staff pressures, isolation from family and social connections (Bradley, 2020) it would be prudent for this to be accounted for in the development of a trauma informed framework for residential and supported living services as we emerge from the pandemic.

Future research will be required to report on the development of the trauma informed care framework, set indicators of change, to evaluate its effectiveness and to explore barriers to implementation.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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