THE INSTITUTE FOR CONNECTED COMMUNITIES

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Prevention and Promotion for Better Mental Health Fund: Evaluation of projects to support a borough-wide trauma-informed initiative in Tower Hamlets

Learning from a rapid evaluation

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RESEARCHTHATMATTERS

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We acknowledge Aidan Phillips from the WAVE Trust for his help and support, and each of the delivery partners who helped access each of the research participants.

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1 Executive summary

Background information

This report provides evaluative evidence and insights into the strengths and weaknesses of the London Borough of Tower Hamlets Better Mental Health (BMH) funded programme. In July 2021, the Tower Hamlets Council Public Health Team were awarded funding by the Office for Health Improvement and Disparities to deliver local interventions that aim to promote positive mental health and wellbeing and/or prevent poor mental health and wellbeing. The funding required that the Council takes: a whole system approach; be people and community centred; emphasise collaboration and partnership; tackle inequalities and take a life course approach. The grant was used by the Council to expand and fund existing programmes for the purpose of increasing impact, equity and reach, as well as development of community engagement infrastructure focused on scaling-up knowledge and capabilities in delivering trauma-informed practices. In practice, the Council expanded and funded a borough-wide trauma-informed training programme, and service improvement pilots ran in a maternity service, housing services, and employment and skills service, which involved approximately **900 registered leaners**, **175 direct beneficiaries and a further 5,566 indirect beneficiaries from each of the pilot sites.**

The purpose of the research study

The purpose of the evaluation has been to better understand the implementation and short-term outcomes, and to capture learning of the programme, mainly from the perceptions of service users, trainees and the providers. We used a qualitative approach in the collection and analysis of primary data, which was carried out between May and June 2022 following receiving ethics clearance by the University of East London Research Ethics Committee (ETH2122-0193). The fieldwork consisted of semi-structured interviews, practitioner reflection logs and surveys with a range of **research participants, including residents, programme partners, trainees, commissioners and wider stakeholders (*N*=66).** These primary data were supplemented with the analysis of administrative data captured by the programme partners shared with the Tower Hamlets Council. The approach has been designed to rapidly gather insights into the implementation of the intervention and to build understanding into what worked and what worked less well from the participants' perspectives about the trauma-informed programme. We used a purposeful sampling frame to recruit the research participants. For the analysis, five researchers read through the transcripts independently and identified initial codes. These codes were then compared and refined into several key themes. Disagreements were resolved through discussion and consensus. The themes were then integrated and examined against the aims and objectives of the evaluation of the Better Mental Health Programme. We also used Normalization Process Theory (May and Finch, 2009) to help aid the analysis in explaining what people do to implement a new practice. The evaluation provides evidence and insights into how the programme has the potential to create organisational changes that address in part the interpersonal, process and structural causes of health inequalities in the borough. Borne out in this study, is the necessity for organisational cultural change at the Council leading to a renewed set of values and beliefs that will help to drive forward, unify and sustain established and emerging trauma-informed practices across the borough.

1.1 Meeting Local Needs

Understanding residents' needs is crucial to **reducing health inequalities** and improving the health and **wellbeing** of our residents in Tower Hamlets[1]. Tower Hamlets is a diverse, young, thriving borough in

[1] Tower Hamlets Borough Council (2019) Tower Hamlets Children and Families Strategy 2019-2024, Tower Hamlets Council.
Tower Hamlets Clinical Commissioning Group (2021) Tower Hamlets together: working together to transform people's health and lives in Tower Hamlets, Tower Hamlets Council.
Tower Hamlets Council (2021) Health and Wellbeing Strategy 2021-25, Online: Tower Hamlets Health and Wellbeing Board.
Tower Hamlets Council (2021) London Borough Tower Hamlets: Poverty Review, Online. Action on Aces
Tower Hamlets Council (2021) Mid Pandemic resident's survey 2021: Background, methodology and results, Tower Hamlets Council.
Tower Hamlets Health and Wellbeing Board (2019) Towards a 2019/24 Mental Health Strategy for Tower Hamlets, Tower Hamlets Council.
Tower Hamlets Health and Wellbeing Board (2019) Tower Hamlets Plan: Our borough, our plan (2018-2023), Tower Hamlets Council.
Tower Hamlets Partnership (2021) Annual Report and priorities going forward (2021-2023), Tower Hamlets Council.

the east of London. The borough holds the largest Bangladeshi community in the United Kingdom (32%), as well as the largest Muslim community (38%). Its largest age group is 20 to 39 years old with a slightly larger number of males (52.1%) than females (47.9%) and a high number of single residents (53.3%). Even though the borough has seen improvement in its deprivation index rating, it is still within the 30% most deprived areas in the country. Deprivation within the borough affects especially children and young people. 39% of children in Tower Hamlets live in poverty – the highest rate of poverty in the UK. Nine per cent of the 4,500 babies born each year have a low birth weight. Twenty per cent of mothers in Tower Hamlets are estimated to have a common mental health disorder. There are high rates of diabetes, particularly amongst the Bangladeshi community. Men in Tower Hamlets have the lowest healthy life expectancy in the country, at 53.6 years compared with 63.3 years nationally. Tower Hamlets has the fourth highest incidence of serious mental illness in London and 10% of people registered with a GP are observed as suffering depression. Women in Tower Hamlets are expected to have 57.1 years of good health, compared with the national average of 63.9 years. Life expectancy within Tower Hamlets is below national level, with a higher gap for women. Similarly, infant mortality is higher than national average and preventable mortality is higher than that of London as a whole.

1.2 What do we know about the implementation, short-term outcomes and learning from the programme?

This Better Mental Health Fund (BMHF) programme is the first step by the Council in increasing awareness into trauma-informed ways of working across the borough, with a clear desire to help residents feel safter and more empowered in environments where they live, work and engage services. By the same token, the public and third sector workforce delivering services in the borough should also feel safe, empowered and respected. Thus, the Council ‘s objective is to establish a trauma-informed borough, by working together with anchor institutions such as the East London NHS Foundation Trust to test a co-produced system-wide trauma-informed approach/lens. The delivered programme of work acknowledges that trauma-informed work – even when not labelled as such – had been taking place at a grassroots level led by the VCS and some public services. The Council’s tested trauma-informed programme sought to build upon this work in two distinct ways:

- By providing free training to increase awareness and competencies in trauma-informed ways of working across the public and third sector workforce.
- By funding four pilot enhancement projects (i.e., housing, employment and maternity care) that were co-produced with staff and service users to test different tools and approaches to applying trauma-informed ways of working in services.

Evidenced in this report is how the programme has benefited not only leaners increasing their knowledge and understanding of the central concepts of trauma but also empowered and supported each of the piloted projects to rapidly co-design and implement trauma-informed work-based strategies. The goals of this programme have been to respond to the traumatising and retraumatising effects of the pandemic on at-risk residents, ensuring that public services are responsive to the emerging and complex needs of such residents.

Considered at the outset of the programme was how to best facilitate a structured dialogue between the funded local partners. The projects were implemented with the purpose of increasing awareness and understanding of the concepts and to generate learning on trauma-informed practices, recognising that this was an important foundational step. In practice, the Council co-convened a Community of Practice partnered with NHS East London Health Foundation. The benefits of this space have allowed participating partners to benefit from ‘real-time’ insights into what works allowing them to make adaptions to their pilots. However, the significant challenge for the pilot sites has been the lack of time to genuinely reflect and share learning on the enhancements. This is a twofold problem due to work pressures in combination with trauma-informed practices not being a ‘set technique or intervention’ but rather a change in culture, behaviour and attitude, which requires a substantial period to embed before organisational change is

visible. These dimensions were not fully appreciated at the outset of the programme. Several key learning points and recommendations have therefore arisen in this programme.

Key learning: Training

- The **online delivery format helped significantly to reach over 1,800 learners** during the height of the pandemic, which was unlikely to have been achieved through in-person training.
- The initial **trauma-informed training plan was shortened** on the commissioner's request, resulting in the reduction of the training content. This simultaneously limited the educational journey but enabled more staff to receive foundational trauma knowledge.
- Theory and practice components of the training were valued but unsurprisingly experienced differently by learners from different professions, service responsibility and experience of using trauma-informed approaches. Almost all learners would have valued **guided experiential learning** to support translating the key concepts of trauma into their day-to-day work.
- The simplicity of trauma-informed ways of working sometimes was at risk of being lost in **theoretical models**, but at its core learners have taken away from the training the principles of working in 'empathic' and 'compassionate' ways.
- There was a noticeable **absence of members of the police force and senior managers** attending the training events together with frontline staff to share understanding of trauma-informed ways of working and key priorities for different professions.

Key learning: Pilot sites

- The pilot projects needed to better consider the **trauma in staff before embarking on the pilots** to address low staff morale, which often served to undermine the success of implementing and monitoring the pilot projects.
- The pilot sites experienced **competing internal/external pressures** that undermined the implementation, monitoring and evaluation of the service enhancements.
- The pilot sites would have **benefited from better targeted help** to find solutions to internal and external problems that often hampered the successful implementation of the piloted projects.
- The testing period was too short; the **projects needed more time** for planning, implementation, testing and embedding as well as for monitoring and evaluation.
- The programme exposed the **challenges and opportunities in partnership working** in the borough.
- The **measurement tool** to track progress for the workforce and public was 'not fit for purpose' due to the timescale of the programme and capability of the workforce to apply the tools consistently and robustly on the ground, although a requirement of the grant funding.
- The **pandemic served as both a driver and barrier** in the implementation of the piloted projects, impacting on the levels of engagement and desired co-production between staff and clients.
- The programme has stimulated and **supported multiple approaches** of doing trauma-informed ways of working.
- The diverse piloted projects **set the seeds for a context-specific trauma informed set of practices** for institutions in the borough.
- A significant challenge for the piloted projects is **how to keep trauma-informed ways of working at the forefront of people's minds** and at the core of each organisation once the funding ends.

1.3 Recommendations

Developing and delivering a strategic approach

The Council should:

- Lead anchor institutions to form a task and finish group to co-design and co-produce a **borough-wide trauma-informed strategy**.

- Discuss with anchor institutions how to **co-produce a trauma-informed business plan** for the borough alongside ways to strengthen funding streams and organisational commitment.
- Discuss with anchor institutions how to develop a **joint business case** (and commissioning specifications) for the continuation of a trauma-informed programme for the borough and to **establish a standard set of practices**.
- The Council and anchor institutions should:
- Focus on **culture change** to shape the strategic and business plans, which requires top-down and bottom-up engagement with the VCS and residents.
- Provide the workforce with **step-by-step guidance** on how to apply trauma-informed ways of working and lens in the borough and what success might look like.

Embedding participation across our organisation.

The Council should:

- **Assist anchor institutions** to further embed trauma-informed approaches in their core services by ***embracing the uniqueness*** of all organisations.
- Co-produce a borough wide trauma-informed **toolkit drawing on the unique approaches tested** and ran in the borough
- Ask anchor institutions to **gather and share data on related lived experience of trauma experienced by staff and clients to work on an evaulation framework** that shows formative and summative results to assist evidence-based decision making.
- Better monitor and find new ways to **support staff experiencing trauma** in the workplace and how to better communicate trauma-informed practice values far more widely.
- The implementation of a trauma-informed brought wide strategy (business case) should avoid overloading assigned coordinator(s) and **provide adequate resources and practical support**.

Working with our community sector

The Council should:

- Ask VCS how they can **support the voices of marginalised communities are heard at every stage** of the co-production process of a borough strategy, ensuring that the interpersonal aspect of trauma is not overshadowed by the procedural and structural concerns.
- The VCS should lead on **co-developing a mechanism** in partnership with the Council to ensure marginalised communities are empowered and supported to get involved in the co-production of a system-wide trauma-informed strategy.

Key skills and knowledge needed

The Council should:

- Engage with partners to develop a **shared understanding of what the goals, aims and** Talk **expectations** of a system-wide trauma-informed approach(es) for staff and residents.
- Talk with partners and **map trauma-informed training offerings** with a view of listing courses and/or pooling resources to maximise the reach to potential leaners.
- Lead on **co-developing and jointly commissioning** a statutory training programme and develop trauma identification resources to integrate the multiple approaches used in the borough.
- Work with partners to **provide specialist trauma training for professionals** to enable continuity of care across service systems and along the life course.
- Discuss with anchor partners how to **provide refresher training** that provides the VCS and Public sector workforce and clients with concrete skills, language and knowledge to effectively avoid re-traumatisation.
- Ensure that commissioned trauma-informed training is **interactive, working with small groups sizes, and provides real-world examples** to model best practice.
- Ask that contracted trainers are **culturally reflective** of the community of learners to establish trust and credibility to allow learners to have a safe space to identify and explore context-specific trauma.

- Discuss with strategic leads on how best to **engage senior managers' commitment** to attend training to build trust and confidence in frontline staff implementing trauma-informed approaches.
- Consider the design of the training programme to formulate a hybrid approach providing **foundational and advanced** knowledge.

This evaluation points to the need for a business case that considers the physical, social, emotional and cultural environments in which residents live and work too in order to hard-wire trauma-informed ways of working/lens into the system. In other words, the anchor institutions must go through cultural change as part of a process to establish a mature trauma-informed hypothesis that will help to drive forward, unify and sustain established and emerging trauma-informed practices in the borough. Otherwise, the risk is that the gains made in implementing trauma-informed ways of working are viewed as a fad that can be easily dropped by services who have been exposed to the programme. Future commissioning processes also needs to consider how best to establish early coordination support, a structured and consistent space for collaborators to share learning and problem solve, purposeful targets that are SMART and can be enshrined in a borough business plan. The plan would serve as a roadmap to ensure that trauma-informed ways of working are sustainable across the borough.

2 Introduction

This research project is funded by the Better Mental Health Fund (BMHF) undertaken by Tower Hamlets Public Health. This service improvement evaluation has been commissioned by the London Borough of Tower Hamlets Public Health Team through funds made by The Office for Health Improvement and Disparities in July 2021. The funded programme has delivered large-scale training for Council, NHS and Voluntary sector workers on trauma-informed practices, as well as funding four trauma-informed service enhancement projects (e.g., maternity care, hostels and employment service) in the borough. The aim of the evaluation is to understand the short-term impact of the training and service enhancements to help inform and shape the roll-out of trauma-informed ways of working across the whole system. It is important to stress, that the Tower Hamlets Council programme considers everyone having experienced trauma at some time in their life and does not target individuals presently seeking treatment for trauma. This evaluation is limited to gathering evaluative evidence and insights into how four local services have gone about co-planning and co-delivering trauma-informed service enhancements and how learner's exposure to training has impacted their awareness and understanding of general trauma concepts for their work. The purpose of the evaluation is to understand:

1. Whether the activities that Public Health set out to implement turned out as planned, and whether there are gaps in implementation (e.g., numbers and types of audiences the projects have reached, feedback including on quality of delivery)

2. What the short-term outcomes of the activities were, from a range of perspectives (e.g., residents, staff, managers, senior leaders) and what the key enhancing and influencing factors have been (e.g., constraints, facilitators)

3. Learnings for future action on becoming more trauma-informed in Tower Hamlets (e.g., helpful practices, gaps, areas for improvement, key considerations). This includes advice on what long term measures of effectiveness/implementation to consider for future programmes and interventions.

The programme activities or stages covered in this report involved: the training of the workforce; initial engagement with clients and other staff; and the implementation, monitoring, evaluation and learning gained in the training and pilots. Specifically, the delivery steps in each pilot followed a similar pattern of:

- Understanding the problem.
- Developing a plan and change ideas.
- Testing and using data to understand change.
- Implementation and sustainability.

2.1 Background to the Prevention and Promotion of Better Mental Health Fund (BMHF) Programme

The BMHF was part of the government's Mental Health Recovery Action Plan 2021/22, which allocated £500 million to improve and expand mental health services, out of which approximately £15 million was allocated to the local authorities for community mental health support (Department of Health and Social Care, 2021). One of the long-term focuses of the Mental Health Recovery Action Plan is to implement trauma-informed approaches in public services (Department of Health and Social Care, 2021).

The Tower Hamlets Council Public Health Team trauma-informed programme of work was conceived in consultation with the NHS East London Health Foundation Trust, who share a joint vision to establish a trauma-informed borough. The programme was funded through the Prevention and Promotion for Better Mental Health Fund, which was set up by the Office for Health Improvement and Disparities (OHID) in 2021 with the aim of addressing those mental health difficulties that were aggravated by the COVID-19 pandemic, including loneliness and physical isolation, unemployment and financial difficulties, and racial discrimination and the impact of racial inequalities. The BMHF supported 40 local authorities in delivering community mental health services in the most deprived areas in England that responded to the emerging support needs during the pandemic and recovery (Centre for Mental Health, 2022). It is also important to note that trauma-informed approaches can be applied to policies, strategies, organisations and services that strive to acknowledge and mitigate the impacts of trauma on people's health and wellbeing to effectively get to the root causes of the support needs of residents. The following sections considers some of the context-specific problems faced by residents living and working in Tower Hamlets.

Unemployment in Tower Hamlets

In 2020, the percentage of residents of Tower Hamlets aged 16 to 65 (that is, of working age) was 73.3%, higher than the percentage of residents within this age range in London (67.2%) and the whole of the United Kingdom (62.4%).

Out of all the working age residents of Tower Hamlets, 77.1% were economically active, in comparison to 79.4% of residents being economically active in the whole of London and 78.4% in the whole of the United Kingdom.

72.9% of Tower Hamlets residents were in employment, in comparison to 74.8% of residents in employment in the whole of London and 74.8% in the whole of the United Kingdom; 66.1% of residents of Tower Hamlets were employees, in comparison to 63.4% of residents of London and 65.3% in the whole of the United Kingdom. On the other hand, 6.4% of residents of Tower Hamlets were self-employed, in comparison to 11.2% of residents of London and 9.3% in the whole of the United Kingdom.

Of male residents, 80.2% were in employment in Tower Hamlets, in comparison to 78.6% of male residents in London and 78.2% of male residents in the United Kingdom; 65% of female residents were in employment in Tower Hamlets, in comparison to 70.9% of female residents in London and 71.5% of female residents in the United Kingdom.

Top reasons for economic inactivity in Tower Hamlets were being a student – with 40.8% declaring being a student as a reason for economic inactivity, as opposed to 35.8% of London residents and 28.1% in the whole of the United Kingdom – and looking after family – with 27.3% reporting caring responsibilities as a reason, as opposed to 22.2% of London residents and 19.2% in the whole of the United Kingdom.

Of all inactive residents of the London Borough of Tower Hamlets (LBTH), 88.3% reported not wanting a job, in comparison to 79.4% of inactive residents of London and 81.4% in the whole of the United Kingdom.

Average gross hourly payment for full-time workers in the LB of Tower Hamlets was £23.26 for male residents and £19.94 for female residents, in comparison to the London average of £20.23 for male residents and £18.34 for female residents, and the United Kingdom average of £16.26 for male residents and £14.86 for female residents.

In terms of qualifications, 83% of residents in the LB of Tower Hamlets had a minimum of NVQ1, 76.9% had a minimum of NVQ2, 64.8% had a minimum of NVQ3 and 52% had a minimum of NVQ4; 6.4% of residents had no qualifications, higher than the London average (5.5%) but lower than the national average (6.6%).

The job density in Tower Hamlets was 1.32, higher than the London average (0.99) and the national average (0.84).

The economic activity in the LB of Tower Hamlets was overwhelmingly dominated by micro business, both in enterprises (90.9%) and local units (87.5%). A micro business is described as a business that employs less than 9 persons.

The section below explains more about why this is a needs-led evaluation linked to testing out a borough-wide trauma-informed approach.

Homelessness in Tower Hamlets

According to the 2021 CHAIN report elaborated by the Greater London Authority, 33.5% of new rough sleepers in Tower Hamlets, a total of 54 persons, had been asked to leave their previous settlement prior to being seen rough sleeping for the first time, either by eviction or otherwise. Of rough sleepers, 23%, a total of 37 persons, declared financial or job-related reasons, out of which 13%, representing 21 persons, declared loss of job as a reason to leave prior settlement.

Overall, a total of 218 new rough sleepers were identified in Tower Hamlets in the year 2021. The overwhelming majority of people seen rough sleeping in Tower Hamlets in 2021 hold a British nationality (60%, representing 233 persons), followed by Central and Eastern Europe nationalities (20%, representing 70 persons), EEA nationalities (7%, representing 28 persons), African nationalities (9%, representing 34 persons) and Asian nationalities (4%, representing 16 persons).

Specific nationalities apart from the United Kingdom are Romania (12.8%, representing 50 persons), Poland (2.8%, representing 11 persons), Italy (1.8%, representing 7 persons), Somalia and the Republic of Ireland (Both with 1.3%, each representing 5 persons).

Gender is overwhelmingly male (83%, representing 331 persons) over female (17%, representing 67 persons). Ethnicity is overwhelmingly white (36.5% identifying as white British; 21% identifying as white other) followed by black African (8.8%) and Asian Bangladeshi (8%). Of rough sleepers, 40% (160) were between the ages of 36 and 45; 27%, representing 107 persons, were between the ages of 26 and 35 and 19%, representing 74 persons, were between the ages of 46 and 55.

Of rough sleepers, 58% identified drugs as support needs, 50% identified mental health as support needs and 33% identified alcohol as support needs; 47% identified more than one of the previous as support needs, and 20% identified none of the previous as support needs. Of rough sleepers, 50% reported experience in prison.

The number of services of accommodation offered by the Council went from 253 to 339 events, of which COVID-19 Emergency Accommodation went from 16 events in 2020 (6%) to 154 events in 2021 (45%). A total of 5 persons departed temporary accommodations. The reasons for leaving temporary accommodation were eviction because of behaviour (40%, representing two persons) and planned departure (60%, representing 3 individuals).

Maternal and child health in Tower Hamlets

According to data provided by the NHS to the Tower Hamlets Council (data from 2011), the two ethnic groups with highest percentage of births are Asian – Bangladeshi, with 48.86% of births within the LB of Tower Hamlets, representing 2,030 new-borns, and white British, with 13.8% of births within the LB of Tower Hamlets, representing 578 new-borns.

Asian – Bangladeshi women have the highest percentage of maternity at the 26 to 29 age range, with 54.91% of births occurring within this age range, while white British women have the highest percentage of births under 18 years old, with 30.43% of births occurring within this age range.

In 2009, 66% (87) of conceptions under the age of 18 led to an abortion. This is higher than the average for England (49%) and for London (61%). Although the number and rate of 15–17 year olds conceiving decreased from the 2003–05 period to the 2006–08 period, the percentage of under 18 conceptions leading to abortion has increased slightly.

Between the years 2011 and 2012, the midwifery Gateway Team at the Royal London Hospital has seen an increase of referrals from domestic violence of 23.8%. Female Genital Mutilation (FGM) has been observed to be prevalent within the Somali community, with 13 out of 29 women of Somali origin delivering in this period documented as victims of FGM. No evidence of FGM was found in other BAME background women delivering during the period (out of a total of 34 patients).

An audit was extended to retrieve information about the effects of FGM in pregnancy and to establish the adequate procedures to ensure good practice and quality delivering: 74 maternity notes were retrieved, with 47 of these notes being for Somali women; 44 of these women had experienced FGM, 15 had previous repair (reversal), 10 had FGM recorded in the birth register and 19 had FGM recorded in their maternity notes. No women were documented as having Type 3 FGM which was unexpected, as according to WHO figures, Type 3 was most prevalent type of FGM amongst Somali women.

Smoking during pregnancy was relatively low in Tower Hamlets, with improvements during the 2010–11 period. The prevalence of smoking at time of delivery was particularly low in pregnant women from the Bangladeshi community: 0.84% of all maternities, compared to 2.2% of white women. Within the group of women smoking at the time of delivery, 61.2% were white and 23.0% were Bangladeshi.

Of pregnant women in Tower Hamlets, 12.3% were found to have a BMI > 30 at booking between 2012 and 2013. Statistics on the prevalence of maternal obesity are not collected routinely in the UK. Trend data from the Health Survey for England (HSE) for the period 1993 to 2010 show an increase in the prevalence of obesity (BMI at least 30 kg/m2) amongst women of childbearing age between 16 and 44 years.

Data from Public Health England/United Kingdom Health Services Agency lists Tower Hamlets infant mortality rate as 3.3, lower than the rate for England (3.9) in the period between 2018 and 2020. However, child mortality is slightly superior, with a rate of 11.1 in Tower Hamlets and a rate of 10.3 for the whole of England.

For this period, child vaccination rates have worsened in Tower Hamlets, with values below English average.

School readiness, or percentage of children achieving a good level of development at the end of reception, has improved, and is above national average, with a percentage of 69.9% for Tower Hamlets in comparison to the English average (63.2%).

While below English average, the number of children in low-income families has increased in Tower Hamlets, in both relative (28%) and absolute (22.1%) terms.

Violence against women

The Violence Against Women and Girls Strategy 2016–19 the LB of Tower Hamlets envisioned acknowledges that violence against women and girls is a significant problem in the borough. In this document, Tower Hamlets is listed as being the local authority with the sixth highest number of recorded sexual offences in England. Furthermore, between 2014 and 2015, Tower Hamlets had the ninth highest prevalence in London for rape, and sixteenth for sexual offences.

Tower Hamlets consistently has one of the highest rates of reported domestic abuse across London. Between November 2014 and November 2015, there were 2,773 domestic crimes reported, which is a 13.3% increase on the previous year and means that Tower Hamlets had the third highest rates of reporting in London after Croydon and Greenwich.

Moreover, the document expresses concern about a significant number of conditions that make women within the borough particularly vulnerable, such as mental health, substance issues, language barriers or disabilities. Such support needs are known to make women affected by violence less likely to seek help or assistance from authorities and health providers.

According to this document, similar levels of violence affect LGBT individuals, and acknowledge that both men and women can be victims and perpetrators. However, approximately 97% of all known victims of interpersonal violence in Tower Hamlets were female.

Furthermore, recent reports from PHE/UKHSA reiterates risk factors identified in the 2012 report by Tower Hamlets, specifically an association existing between domestic violence and antenatal depression, postnatal depression, post-traumatic depression, anxiety and PTSD. However, the report states that it is unclear whether domestic violence increases the risk of mental health decline or whether, conversely, mental health problems might result in vulnerability to domestic violence. In any case, the relationship between all the conditions is solid, even if a causal relationship has not been established. The report also reiterates substance abuse, homelessness and teenage pregnancy as risk factors that might impact negatively mental health during pregnancy.

The first phase of this programme of work has been the training of the workforce, followed by establishing and testing pilots, wrapped by stakeholder conversation. The work of organisations embarking on trauma-informed ways of working is to prevent trauma and re-traumatisation. This includes engaging residents living in high-rise blocks five years following the Grenfell fire, recognising the lack of safe public spaces for families to exercise and enjoy each other without fear of crime, and tackling the root causes of homelessness at a population level. The awareness raising elements of the programme goal were to excite and energise the workforce to reflect on their service both for the individual and teams. A small number of attendees then went on to test trauma-informed ways of working in their workplace in collaboration with patients, residents and the public. These pilots had mixed success in terms of what they were able to co-design and implement to make a difference in the service users and workforce. At its most basic, it forced a new type of conversation between the provider and recipient and/or placed a greater importance on building trusting relationship.

2.2 Pilot project descriptions

The project consisted of a training and a pilot delivery arm. LBTH commissioned Kate Cairns Associates Ltd (KCA) and WAVE Trust to deliver trauma-informed approaches training for service providers within the borough, and the LBTH Employment and Skills team, Providence Row Housing Association (PRHA), The Salvation Army (TSA), Barts Health NHS Trust (Barts Health) and Royal London Hospital, East London NHS Foundation Trust (ELFT) Psychology in Hostels team and Bromley by Bow Centre (BBBC) to facilitate and support evaluation of the pilots (e.g. Employment and Skills, ELFT and Providence House) deliver and evaluate the trauma-informed service pilots.

Training providers

WAVE trust and KCA was commissioned to deliver the training element of the project. Both providers were required to: (1) develop and deliver a learning and development programme to increase awareness of trauma-informed approaches (TIA), an adoption of their respective models (e.g., KCA – Five to Thrive); (2) generate insight and learning about whether and how the delivery of trauma-informed approaches training across the public, voluntary and community sector influences the adoption of trauma-informed approaches and how it can inform future actions in Tower Hamlets; and (3) evaluate the training process through trainee feedback and its impact on service provision and change of practices.

Kate Cairns Associates Ltd (KCA)

KCA was commissioned £9,800 to deliver two virtual interactive sessions to managerial staff, a webinar for practitioners, and two virtual interactive sessions delivered to three cohorts of 20 Champions, and to create e-learning resources including customised e-learning, printable resources, video clips and the recording of the webinar, articles, a book list, and relevant web links. Furthermore, KCA was expected to attend 4–6 meetings to present about the programme and to gather input from a range of stakeholders (senior managers, staff, parents) and reflect upon these in the delivery and evaluation.

The monitoring and reporting requirements for the organisation were the following:

- Stakeholder engagement analysis (summary of learnings that KCA will adopt in delivery of learning and development activities in Tower Hamlets).
- For each learning and development activity listed in the Delivery Requirements, the numbers of people who have participated by role, organisation type and demographic figures. .
- Learning outcomes for managers' tutorials, practitioners' webinar, Champions' tutorials and online resources.
- Overall project evaluation (process and outcomes) including delivery, feedback analysis, lessons learnt, focus groups and interviews.

WAVE Trust

WAVE Trust was commissioned £78,015 to deliver phases of training and complete a detailed process and outcome evaluation. They were expected to achieve a target of 1,800 people trained by 30 June 2022.

The engagement phase consisted of stakeholder meetings to inform the development of a plan for training programme delivery, supported by LBTH by connecting with local stakeholders. The training development was also informed by feedback from residents with lived experience of trauma.

The delivery phase was expected to involve the following stages:

- Two introductory presentations made available to each practitioner, tailored to local needs, priorities and previous training experience based on feedback received.
- Full-day Champion sessions, exclusively for staff aiming to be 'Trauma Champions'. These people would commit themselves towards driving a transformation within their organisations (they do not need to be senior).
- Discussions: trainees' opportunity to engage in reflection and follow-up discussions via monthly virtual Q&A sessions.
- Facebook group: Trainees' access to a private, multi-sector Facebook group overseen by WAVE where they can share feedback and discuss with one another.
- Resource Pack: including explanations of key concepts (e.g., trauma), tools to support practice implementation and a summary of key training slides. Trauma Champions to also receive further learning materials and tools that relate to project implementation on a structural level and supporting organisational change.

The monitoring, evaluation and reporting phase was expected to include quantitative and qualitative data collection with trainees focusing on: (1) their understanding and knowledge about trauma and trauma-informed approaches; (2) knowledge about and confidence in how the training could be applied to their ways of working; (3) experiences with the training (feedback, lessons learnt); and (4) demographic figures and organisational details of each attendee.

Similarly, to KCA, WAVE Trust was expected to report on stakeholder engagement analysis demographic figures and organisational details of attendees and overall project evaluation (process and outcomes).

2.3 Pilot delivery teams

Out of the five delivery partners, four of them were commissioned to deliver the pilot projects (Employment and Skills, Maternity Services – Barts Health, PRHA, TSA) and one (BBBC) was to support the co-production and evaluation process.

All four main providers were expected to deliver:

- Engagement activities to understand residents' and staff's perspectives about how well the services are using trauma-informed approaches.
- Use of quality improvement techniques to identify, test and evaluate change ideas that incorporate trauma-informed ways of working.
- Evaluation of the project's outputs and outcomes and communication of learnings to inform future planning and action in Tower Hamlets.

There were four distinct delivery steps outlined in each service specification that were linked to training, initial engagement with clients and staff, implementation, monitoring, evaluation, learning and communication. The stages involved: (1) Understanding the problem; (2) Developing a plan and change ideas; (3) Testing and using data to understand change; and (4) Implementation of change ideas and ensuring sustainability.

Delivery partners were to involve service users in a co-production process to understand what changes service users wanted to experience in terms of wellbeing and safety (e.g., desired outcomes), and what practical changes could be implemented to the service to try out together. The main goal of these discussions was to establish how services can become more trauma informed to: (a) prevent traumatic

experiences, re-traumatisation, and to mitigate the impact of trauma in the setting; (b) be and feel safer; (c) be more transparent and trustworthy; (d) work together more; (e) help the people the service is for lead in supporting peers and decision making; and (f) respond to cultural, gender and historical issues (e.g., racism, sexism, homophobia, Islamophobia).

Following the process of identifying change ideas through co-production, providers were to work with staff and service users to implement changes and review them on a regular basis. During this work, it was expected that the engagement activities were facilitated in a way that was empowering and collaborative and enable residents to gain the skills to take a full part in the project and implement change ideas.

The desired outcomes of the service pilots included that service users and staff perceive that the service is being delivered in ways that are more inclusive, accessible and relevant for people who have experienced trauma, that there is an improved wellbeing amongst service users, and that they generate shared learning about how trauma-informed approaches can be adopted in the ways that Tower Hamlets Council operates.

Service pilot teams were also expected to carry out their own evaluation using a mix of quantitative and qualitative approaches. All providers were to use the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) with residents at baseline, midpoint and end of the project. They were to collect quotations and/or themes from individual service user descriptions of their wellbeing, and feedback from service users, staff or other relevant people about the quality of the service environment prior to, during and after the project (in relation to trauma-informed principles), additionally to materials that convey narrative or descriptive feedback from service users or staff.

In their evaluation reports, they were required to report on the number of residents involved in the project in total and their demographic characteristics (reflective of target groups identified by LBTH), the number of staff involved in the project and the breakdown of staff roles, and project documents used to deliver the activities that demonstrate the outputs (e.g., discussion plans, resident/staff feedback, change ideas, meeting notes, etc). The following section summarises the differences between the service specifications for each service pilot.

Employment and Skills

The Employment and Skills Team was awarded £27,000 to deliver the pilot within the: (1) Kickstart programme; and (2) the Information, Advice and Guidance (IAG) service (Discretionary Housing Payments and the mainstream service) between 25 October 2021 and 30 June 2022. Activities were to be delivered with support from the BBBC. BBBC involvement were to last until the implementation stage and include half-a-day workshops in different areas (initial engagement event, first co-production event, micro-commissioning voting session, coaching session for staff leaders, support session for clients, celebration event, final session with reflections). BBBC was also to support the evaluation of the pilot with primary data collection and analysis, document review, and sharing learning and recommendations.

Providence Row Housing Association

PRHA was commissioned £21,052 to deliver the pilot within their hostels between 1 November 2021 and 30 June 2022. Their training was to be organised and delivered by East London Foundation Trust ELFT, who also offer methodology and skill development training, an organisation with which they have had a working relationship for a long time. ELFT was also involved in the co-production process with staff and service users and facilitated the production of change ideas.

The Salvation Army

TSA was awarded £22,000 to deliver the pilot within Founders House between 1 November 2021 and 30 June 2022. TSA was to be supported by BBBC in several steps of the process. The BBBC was expected to provide professional advice on the project plans and activities including: (1) review of engagement plans, feedback meeting to provide suggestions on co-production; (2) coaching session for staff leaders supporting pilot projects; and (3) co-production and engagement contingency. Similarly, to the Employment and Skills Service, BBBC was required to support the pilot evaluation, collect and analyse primary data and grey literature, and share learning.

Maternity Service – Barts Health

Barts Health was awarded £22,000 to deliver the TIA pilot at the Royal London Hospital between 7 February 2022 and 30 June 2022. Barts Health was to invite women to participate in the project based on previous feedback they had provided about their experience (whether they were left alone by midwives or doctors at a time that worried them; whether they felt like their concerns were taken seriously). The team's initial aim was to recruit 30 women to be involved in the project.

The following section details the evaluation approach to collect and analyse the primary and secondary data.

3 Data collection

Semi-structured interviews and practitioner reflection logs were used with programme staff and leads and commissioning team, and online surveys with service users and wider stakeholders.

The project team undertook a series of individual semi-structured interviews (*N*=19) to examine the strengths and weaknesses of the programme and key lessons learned. In total, 19 research participants were interviewed, including three with the commissioning team, (*N*=18) practitioner reflection logs were completed by frontline workers, and online surveys were completed with stakeholders (*N*=15), and (*N*=14) survey users.

Table 1.1 – Number of interviewed participants

Participant group	Number of participants
Project leads and staff	24
TH and stakeholders involved in the BMH programme	18
Residents/patients/service users	14

Overall, we recruited **66 research participants**. Using a purposeful sampling frame, the programme coordinators were contacted to help with the recruitment. All interviews were conducted remotely, either online using Microsoft Teams or by phone, at a time convenient to the participants between May and June 2022.

Screening started in the first week of May. A research team coordinator made contacts with all the nominated participants to book an interview appointment. Total flexibility for participants to choose any day or time in the week was offered. Participants had the option to have the interview over the phone or on Teams. Participants were requested to read and sign a consent form and email back the completed consent form to the coordinator before the interview, and verbal consent was obtained at the start of the interview. All interviews were recorded.

A semi-structured approach was followed, with the evaluators utilising an interview schedule and exploring concepts and responses in more depth through follow-up questions. The development of the interview schedule was informed by Normalization Process Theory, a conceptual framework for explaining what people do to implement a new practice (May and Finch, 2009). The interviews lasted between 40 and 60 minutes and were on average 50 minutes long. All the interviews were audio recorded with the consent of the interviewee, transcribed and anonymised. This project has been reviewed by, and received ethics clearance through, the University of East London Research Ethics Committee (ETH2122-0193).

The anonymised interview transcripts were analysed using Thematic Analysis (Braun and Clarke, 2006). For the analysis, two researchers read through the transcripts independently and identified initial codes. These codes were then compared and refined into several key themes. Disagreements were resolved through discussion and consensus. Descriptive and inferential statistics were also analysed using the supplied administrative data. Analysis to assess changes in outcomes is likely to be limited at this point due to small numbers of cases and timescale of the programme. The key themes (e.g., implementation, learning and outcomes) and the sub-themes (trustworthiness, cultural, historical and gender issues, collaboration & mutuality, service users & staff, and finally, place, process and people) presented in this report came out of primary and secondary data, which the research team interrogated, synthesised and examined against the aims and objectives of the evaluation.

4 Findings

4.1 Training: Attendees

A total of 14 participants from the WAVE training were interviewed for a qualitative evaluation. Amongst those, participants of mixed race (10%), Asian Pakistani (5%) or any other Asian (6%) or ethnic (5%) background were found to be overrepresented within the sample of interviewed participants. On the other hand, Bangladeshi (-11%), black African (-7%) and black Caribbean (-5%) were ethnicities underrepresented in comparison to all project participants.

In terms of age groups, those between 26 and 64 years old (6%) and those over 65 years old (6%) were overrepresented within the sample of interviewed participants. On the other hand, participants between 18 and 25 years old (-6%) were underrepresented in comparison to all project participants.

Male participants (10%), participants who identified as a gender other than male or female (7%) and participants who declined to state their gender (5%) were overrepresented within the sample of interviewed participants, whereas female participants (-16%) were underrepresented in comparison to all project participants. Those working in the Children and Family Services (7%), Education (6%) and especially Health Services (13%) were found to be overrepresented, while those working in the Adult Social Care and Safeguarding (-6%) as well as those working in Housing (-5%) were found to be underrepresented in comparison to all project participants.

In terms of seniority, senior workers (17%) as well as workers outside the standard seniority ranks (27%) were found to be overrepresented, while frontline workers (-32%) were underrepresented in comparison to all project participants. Those who had received previous training (21%) were overrepresented, whereas those who did not have previous training (-15%) were underrepresented. Amongst those participants who reported that WAVE training did not result in changes, the most common reasons were practice not changing as a result of training (9) and not wanting or needing any change (8).

Amongst those participants who reported intention to implement change, desired changes include expanding or pursuing more training (4), offering or reintroducing more organisational activities or amendments to activities that reinforce staff wellbeing (3) and empowering service users with more control over decision making (2). Out of those participants who reported that WAVE training did result in changes, the most common changes reported were an increase in awareness of potential root causes of behaviour – including trauma – (3) and an increase of awareness of the importance of self-care both for staff and service users (2).

Issues most commonly reported by interviewees were a hierarchical organisation where relationships are marked by power dynamics (2), organisations having a traumatising, punitive and/or unequal structure (2) and inadequate funding to support and/or build relationships in service users (2).

Vignette 1: Learner experience of back-office staff

A participant who works as a monitoring officer for the council does not often have direct contact with service users, and whenever has it, a trauma-informed approach takes place. Instead, they receive reports of incidents and accidents, as well as complaints, which are all analysed and discussed with managers and staff; staff are encouraged to reflect on whether a trauma-informed approach was in place when the event took occurred. Moreover, this participant suggested that it is important to review accident and incident reports and do qualitative analysis on these to reflect on what approaches are being used and how effective those are. Also, the incidents and accidents should all be followed up and analysed regarding how different responses from staff lead to different responses from service users.

Therefore, this participant has a wider overview, as they say that service users should not be seen as the ones causing problems, but instead, the approach should be consistent, look at the causes of their behaviours, and see them as vulnerable individuals who might struggle at accepting support and have some behavioural challenges. For instance, through analysis, they found after twenty incidents involving the same individual, staff did not respond using a trauma-informed approach. Accordingly, this participant, as part of their role, encourages members of staff to take part in the training and provides them with information about it. Besides, the participant perceives the training as an eye-opener, as this approach can be used not only with service users, but also with everyone involved in the organisation, including staff. The training has helped this individual to adopt strategies for their own wellbeing, as their role implies a lot of pressure and demands from different domains; thus, they need to be flexible and negotiable, and would find it beneficial that all staff members take the training, so they become more aware and start adopting similar strategies towards not only service users, but also colleagues, including this participant.

Changes trainees made following the training itself

Perhaps the most distinct area where the training has positively impacted learners has been their change in awareness, understanding and attitudes towards their own practice and organisational culture. Learners recognised that changes were needed in their own organisation and by partners (e.g., health, education, social care and local government etc.) to become more trauma informed. Almost all the learners found WAVE training to be a very good starting point. Distinct from an increase in awareness, understanding and attitudes is the reported knowledge obtained by learners from the WAVE training. Learners commented:

> *"I came back to realise what can we implement to ensure it's inclusive, representative of diverse needs of BME community; and targets are better sorted, leading to better outcomes"*
>
> *"Getting a little bit more granular about people and where they come from. … get a fuller sense of the person…"*
>
> *"…this idea of who is a vulnerable person. Everyone has a degree of vulnerability that they're either willing or unwilling to show"*
>
> *"Yes, more aware of not retriggering past trauma with people ... I teach suicide prevention training; I've changed my approach to how I deliver that. Made me conscious that staff don't leave trauma at their door"*
>
> *"I became more sensitive … I work with teachers and parents, and directly with young people … Sometimes we forget about the human qualities of this work, emotional intelligence, problem-solving…"*
>
> *"One thing I remember from the training is without relationship, we can't do anything. I've become more relational, less prescriptive. More humanistic … And more humble. We don't know more than them, there is no client and therapist, only two human beings"*
>
> *"Tend to think of here and now, and last few months. So, it's made me think about what happened to people when younger. Which I feel has been key in conversations."*
>
> *"it's always been a similar sort of approach, but I think we've now made it more of a formal way of working with our young people … what it is that's causing them to behave and respond in the way they are…"*
>
> *"I really got from the training that if we want to make change, we can't just moan, we need input too. And not just one person, need a few people to move with it"*
>
> *"But quite a few of us been on WAVE training have come together a bit more, so we feel we might be more able to push it going forwards. So, I feel helped by the training"*
>
> *"What I've done differently is anticipated that more, that with normal working procedures, people might need more reassurance, we may need to be slower, clearer, more considered about how we go about things"*
>
> *"So, I had an understanding, but it wasn't a TI understanding. I knew something had happened in their lives but hadn't connected that with trauma. So, it was eye-opening. It was fantastic. So happy after the session. It explains everything in a completely new way"*

Some participants reflected about their own wellbeing and how their roles, workload and work routines might influence it. Thus, some participants learned skills and knowledge and started to adopt some strategies for their own benefit, both in their personal lives and within their roles, which then can also be applied in the workplace or would enhance their practice. A couple of participants also mentioned the importance of staff caring and supporting each other to promote that wellbeing.

Vignette 2: Learner experience researcher training

A relevant interview was conducted with a CBT therapist as, although the training was just a refresher and was not the focus of the answers of this participant, they talked about human qualities, made critiques of the NHS system, and mentioned strategies they consider would be beneficial for staff – most of which other participants did not talk about. The participant talked about humanistic approaches, sensitivity, humility, inclusion, empathy, problem-solving skills, emotional intelligence and compassion, factors that are sometimes forgotten and not put into practice by different practitioners within their roles. They also mentioned how culture (Western and Eastern societies), racism, and the way language is used (linguistics) need to be considered in interventions, because sometimes these factors are linked to the stigmatisation of diagnosis, shame, and misunderstandings between service users and practitioners. They suggested that this all happens because of the rigidity in the structures of the service, including targets they need to meet and annual reports, which all result in systemic oppression. It is noted that this participant finds NHS ways of working traumatising due to factors such as discrimination in terms of bands, even though professionals might have the same knowledge, which is "extremely unequal", as well as poor and oppressive management skills that can affect practitioners in both their personal (self-esteem and confidence) and professional lives (performance).

Therefore, the participant suggests that the NHS system needs to be reshaped, and management structures need to be softer. Accordingly, they mention that movements are promoting change in the NHS culture. Besides, this participant finds it difficult to balance their management role with implementing a trauma-informed approach, as they do not want to become a 'soldier' of the NHS system, but at the same time, they feel guilty that by being more human they might not be fulfilling NHS expectations related to their role. They also suggested that the NHS should provide practitioners with opportunities such as having longer lunch breaks, extracurricular activities once a week, debriefing, or time and spaces that allow staff to take part in yoga in order to promote practitioners' wellbeing, which will be associated to their performance. Moreover, they also would like to have training with broader content in which they can be taught to be reflective and more human in their practice. To conclude, the participant noted that despite the fact that organisations are improving in trauma-informed approaches, the NHS still has a lot to do, and schools and Ofsted even more.

Training as a refresher (not much knowledge increase):

> *"But WAVE training updated that, as it was a few years ago. Training always gives you confidence. Refreshing training can increase confidence re doing the right thing, or at least not wrong thing"*
>
> *"Training reminds you that the behaviours are a symptom of something else"*
>
> *"I suppose to be fair I don't think it's to do with the training as we were doing it anyway, but training reinforced that it takes time"*
>
> *"I'd probably say no. I work as a social prescriber; we do rapid response … I've found I'm picking up other things from them [parents in workshops delivered by the participant] now"*
>
> *"Not necessarily. Nature of our work is lots of young vulnerable people at high risk of violence or relapse of drugs. So always had to be a bit trauma-informed … Mostly recapping."*
>
> *"No, because in our work relationships are paramount, it's the most important part of the therapy. We're very relational in our approach. So didn't change anything. But nice to know the benefits in such ways of working are being followed up"*
>
> *"We've always tried to work in a Ti way with developing programmes, approaches, consulting for other organisations. So not that I didn't learn from it, but I was familiar with a lot of the stuff said."*
>
> *"But can't say I did WAVE's training and that really impacted a particular approach."*
>
> *"We'd already done stuff around this anyway. But having these conversations and attending the training highlights and brings it back to the forefront"*
>
> *"Not sure about change. I went into the training already knowing a fair bit about trauma and Ti responses. It's really reinforced that perspective, and how the longevity of trauma can impact on services users"*
>
> *"I don't remember WAVE's training giving me anything specific about this." [talking specifically about de-escalating challenging situations]*

For some participants, the training was more a refresher/reminder, and their knowledge was just a little bit expanded. This is because they already got either some knowledge or experience (or both) because as they work with people in different practices and roles within the mental health field, they consciously or unconsciously use trauma-informed approaches, thus they just became a bit more aware about the benefits of working in such a way. Some think that the training would be more useful for those with less experience and knowledge about TI. Accordingly, there is not much change in their practice after the training.

Very confident at applying knowledge:

> *"Has it changed anything? Not really. I haven't had much escalation from young people to me, currently. So haven't felt the need to change it"*
>
> *"I don't know. Don't think specifically I have. I think we always try to give a lot of time, make sure we're in the right setting for discussions."*
>
> *"No, because these situations haven't arose, thankfully"*
>
> *"When I did WAVE training, I thought this is what we're trying to do all the time. So not necessarily done this new since training. So, trying to establish continuity of care where possible"*
>
> *"Because our approach has always been quite open and we're different from a school or college, staff come from background of perhaps lived experience, so have a level of empathy and understanding from the start"*

Some participants feel very confident in their practice as they have been using a trauma-informed approach as part of their role and feel that either there is not much that needs to be changed from what they are already doing, or that they do not often face situations that imply making changes in their current approach.

Confident at applying knowledge:

> *"What's changed is we're making sure we're providing that listening ear. Identifying the issues that relate to culture and faith, and any other issues. Making sure those competencies are there. Tackling problem from root cause perspective"*
>
> *"…I've been able to find out more about individual people … (Inquiring into root causes a little bit more) Yeah."*
>
> *"So, when you have 1-to-1 relationship, providing that listening ear in confidence, making sure the information stays within us, giving them that comfort…"*
>
> *"Awareness has helped us to remodel and restructure as to where our direction should be, and how specific it needs to be"*
>
> *"Being calm, respectful to the person. Making sure your body language and tone is at a moderate level … made me realise I need to change my working attitudes and behaviours"*
>
> *"…what can we look to change from the training, inspired us to create different working pattern. Also, trying to work on basis of how can we get community to engage better. Especially re where mental health is concerned, hidden issues about shame, dignity, what would society say, will I fit in"*
>
> *"Additional thing we've introduced is a learner support plan, which has a section to identify triggers based on early childhood traumas"*
>
> *"…refreshed and reminded myself that best way to deescalate is to let the young person vent what it is that's worrying them. Or go for a walk first round playground, then we'll talk about what happened. give them an opportunity to release anger or whatever they're feeling so they can verbalise what's going on"*
>
> *"Making sure I close the communications loop, going back to people, saying this is what's going to happen with the information. Taking the time to be clear with people about why Im asking for the information. Why it will help me and them. Say I'll let you know the outcome of where the information goes, and I'll do that, don't leave them hanging. If I don't have an answer, I let them know … If say you're going to do something and do it, that builds trust"*
>
> *"Really working hard to build those bridges with people who've just met you. Some students I've only just met them on Zoom. Making them feel safe enough to ask for help early on. WAVE training emphasised that, that anyone you meet has had some trauma in their life"*
>
> *"I adapt my communications with them and don't presume because I'm part of CAMHS and NHS that I can teach them anything or should fix a problem … I learned how to follow people, rather than just protecting myself behind policies and institutional power of the NHS."*
>
> *"We introduced rag rating, green, amber red. Red as high risk, green settled, amber having some issues. So, after training, we're reintroducing that"*
>
> *"Definitely developed my understanding of importance of giving people autonomy over their choices and decisions. I've been trying to put that through to other team, what do you need, want, for this area, lets co-design together"*
>
> *"I guess it changes the approach in terms of not taking someone's words so personal, taking a step back, see how to respond to them."*

Participants did not explicitly say how confident they feel, but considering the context of the interview, it seems that some of them feel confident at applying some knowledge as they talked about specific/detailed skills and strategies that they were either already using and that were reinforced or started to use after the training in scenarios such as supporting vulnerable individuals, de-escalating challenging situations, building trustable relationships with service users, and supporting their own and others' mental wellbeing. Those skills and strategies include ways of listening and communicating, attitudes and confidentiality, as well as redirecting and making changes in their programmes/projects/services. Also, a few participants coincided in the importance of acknowledging and investigating the roots of the problems, which, as some suggested, are related childhood and traumas associated to this life period.

Vignette 3: Learning experience outcomes

Another participant, who is a General Practitioner and a Clinical Lead, talked about some relevant aspects of the training, what they got from it, and how their practice changed since the training; this has been included in the interview analysis table. The relevant aspect of this interview is that this participant suggested that, despite the benefits they found in the training, there is not "much time for training", and that the two hours that this training took, were too long, and that they have a lot to know about. This participant said that it would be easier to find time from lunch breaks or just an extra hour of the shift to attend small refreshers, rather than proper training that might imply working on a day off or cancelling clinics.

The participant appreciates the importance of the subject; however, they say that regardless of how important the subject of the training is, it is still a small part of their workload and of all they have to learn about as they are General Practitioners. This participant is also aware that some colleagues have attended the training and says that they have not discussed it, so twenty minutes can be invested to put ideas together and reflect on whether the approach in their practice is trauma-informed or not. They also suggested that other staff within the setting such as receptionists should receive the trauma-informed approach training as they have direct contact with service users. Perhaps the positions of this participant might be a bit contradictory.

Less confident at applying knowledge:

> *"I definitely need to deescalate myself more. There's also a number of things where I have to sit myself down. Maybe write something down in another room, my only way of being able to do that…"*
>
> *"Don't just take the education from training, but the contacts and experience. Can be really useful. That's how we keep learning."*
>
> *"Just making the management structure softer. It's very rough around the edges … But I struggle between being a good manager and a TI, responsive person. Don't want to become a soldier of the system."*
>
> *"I would say there are lots of Ti individuals in our organisation who really champion it, but we could do better. There's room for growth."*
>
> *"We've had lots of discussions. Don't think we've done anything specifically."*
>
> *"I think we're getting much better at it, always been a lot of talk in public health about equity, but I think we're still looking at it from sense of equity as racial, religious, gender. All important, but maybe that Ti perspective on those things is slightly missing."*

Despite participants not explicitly saying how confident they feel, it seems that some still need to grow in confidence at using trauma-informed approaches learned from the training. Some participants talked about the emotional work that they need to do on themselves to able to apply a more appropriate and effective trauma-informed approach. Also, some feel that a trauma-informed approach is an ongoing learning process in which they have had little training, thus there is a lot more that they or staff within the organisation need to learn about this approach through both training and experience. Moreover, a particular participant struggles at finding a balance in between using trauma-informed approaches and his role as manager, this is very much related to his criticism of the NHS system. Thus, he might not be very confident at delivering trauma-informed approaches. Some participants have had discussions, but nothing has been changed or put into practice yet.

Training:

> *"…If there is any support, help, guidance out there that can tailor to the needs of the BME community … Perhaps looking to get into some training re listening … so good to identify what free training particularly, especially in relation to listening, and responding"*
>
> *"Would a refresher be necessary for me? Yes, 100%. There will be things I've missed out that I might need to re-inform myself, or be more present about having a workshop around that"*
>
> *"But the packages given afterwards, haven't looked at in depth, but I think they will be really useful and helpful for me"*
>
> *"More training I guess would bring consistency. More joined up working within the organisation. Managers to know what to say and what not to say to staff below them, more managerial training for them."*
>
> *"I would like to have more training … Interested in training to do with process, not just content. I don't just want to learn techniques, I want to learn how to be a human being, reflective … Something broader"*
>
> *"Training helps you get your head around that, looking at symptoms and reaction to something. To support each individual best"*

"About training, getting the practitioners to understand the people we're working with. How they see things. Don't take things personally. So more training for those not as good at deescalating."

"Manager and I pushing to get better training rolled out to increase awareness."

"I think maybe might be helpful to have a refresher on how they're managed"

"Yeah, I want to do a workshop with all the staff on de-escalation … but I feel we need to do an internal session on techniques and approaches again to reinforce that way of working, and why we need to do it"

Participants suggested that they would like more in-depth training, guidance, workshops and materials (information) about trauma-informed approaches in which they can develop skills and knowledge related to reflection on practice, observing service users' symptoms and understand these, and listening and responding to service users to enable organisations to have consistency in approaches across staff within organisations. Regular refreshers would be useful.

Research participants comment about the physical space and time to apply learning do trauma-informed work:

"Go back to more face-to-face meetings. When you're physically in a room with someone. What I miss in Zoom are the tea breaks where you chit chat over a cookie and tea, looks of relationships is built there … And can pick up emotional temperature in the room better face-to-face"

"At the current moment in time, all working from home, all referrals managed through Zoom, casework all on phone, don't have an office, though looking to organise one"

"If only checking in a couple of minutes per day, not sure if its really effective. So good to relinquish some of more strategic aspects of roles, bureaucratic side, paperwork, and spend more 1-to-1 time with young people"

"GPs, nurses, etc exposed to a huge amount of trauma, and don't have space to process it."

"I think it's important to have reflective spaces … even if it's 30 mins yoga during the day, extended lunch break, de-briefing at end of Friday, arriving at 10 on Monday…"

Research participants suggested that they need more appropriate spaces (offices) to be able to deliver their services as due to the pandemic they have been working remotely, which is not the best way to implement trauma-informed approaches; thus, they consider that spaces that allow in-person interactions would be beneficial to the trauma-informed approach. Also, some suggested that more time is needed to be spent with services users as the time allocated is limited and many times are not enough.

Research participants comment on desired approaches and activities:

"Could be easier to get mental health support. Not clear for staff to know who mental health first aiders are at the moment. Not a lot of activities, e.g. previous schools had free yoga lessons, things I don't see here"

"Working with people in TI way have to look at how it affects us as practitioners. What is in place to support us? Do we have clinical supervision? ... since the training, having that time to think I may need to take more time out, work proper hours, take lunch break properly"

"I think the NHS could be more sensitive, and it's not"

"Make these areas a bit nicer. Seclusion room is like a prison cell. There could be sensory things in there, music, as opposed to it being a blank space with a door someone's looking at you through"

"I would like to look at some movement around our unit. The highest emotive, difficult wards, there should be more rotation, staff should get time off my ward particularly … Need some work, maybe a work holiday, go to other services, others come to support us for a few weeks or months"

"Yeah, I'd really like to be able to have something to follow on to. So, they're not building dependence on myself, or someone in my position"

"I think people lost a little bit of trust with GP services. It's about building that connection again for the health professional"

"Be nice to have hubs in GP surgeries, people coming for community connection, and we can pick out themes, issues coming up locally and can target them, rather than on individual basis"

"… trying to get intergenerational staff network off the ground, but haven't, because conflict between older and younger members … I think the WAVE training can help with that, as you need teams to work well together to help others"

"More the spaces in which services operate. Environmentally safer, ppl feel more control over how they access the service"

Research participants talked about more specific approaches and activities that they consider might be beneficial to implement with the service users with whom they work, as those approaches would enhance practice, thus a trauma-informed approach can be more positively and effectively implemented. These approaches or strategies include yoga, layout and decoration of settings, and connecting with and between service users to bring community closer and work less individually.

Regarding strategies related to staff, participants mentioned mental health support for practitioners/professionals, more sensitivity from organisations towards staff, extra or extended breaks, leisure opportunities, rotation between staff duties and between settings and opportunities to find common ground and build a network between intergenerational members of staff. Participants suggested that those strategies might have an impact on their own wellbeing, which might be associated to a more effective trauma-informed approach.

Research participants highlight the need for changes in policies to confidently undertake a trauma-informed approach:

"School policies aren't generally Trauma-informed, but something we all want to work on."

"…making the behaviour policy more Trauma-informed"

"Lots of restrictions, things you can't do … So needs to be a relaxation of rules and regulations. Need them, some can be high risk to others, but we need to work around it and make exceptions, cant just have blanket rules"

"Consciously made an effort to provide feedback … e.g. policy on bullying between colleagues, or discrimination from either side, either workplace to patients or patients to people in workplace. And looking at how we engage with each other, how we manage that"

"Our organisation has a really long way to go. (Anything in particular?) HR policies to begin with. Hierarchy another thing. (What re HR policies?) Links to thinking about vulnerability of members of staff"

Some research participants mentioned the need for updating/adjusting policies/rules/legislation as they influence practice, which includes trauma-informed approaches.

Research participants emphasise the importance of funding:

"I feel funding isn't always in line with what's best"

"Due to funding, makes it more difficult generally if you have a very small timeframe, as relationship can take the time to be properly developed and nurtured to be built."

"Elements of. Good at having the conversation, talking about Ti care and how they want to become Ti. But I don't really get that there's the resources or availability to become fully Ti."

"I guess there are aspects of my working life where I have inadequate funding, and funders not recognising the time involved in being able to support people adequately who have experienced significant trauma"

Some participants talked about funding and how it affects aspects such as time, which they associate with an effective trauma-informed approach. Others feel that there Is not enough availability and resources for organisations to fully implement trauma-informed approaches.

4.2 Non-Attendees report

The section above reported on attendees who had registered and attended the training and provided their post-training reflections; however, there was a cohort of potential learners who had registered and completed a pre-training evaluation form but did not eventually attend any of the timetabled sessions. We now turn to look at this gap in the targeted Tower Hamlets workforce to gain insights about what is needed to help bridge this gap. The composition of **the non-attending participants was overwhelmingly female, where white was the most represented group, followed by Asian and black.** Amongst males, white is still the most represented ethnicity, followed by black and Asian (Figure 1.1). White represented a majority in both male and female non-attending participants, with **white men representing 54% of all male**

participants and white female representing 45% of all female participants. White British represented 46% of all white men and 35% of all white women.

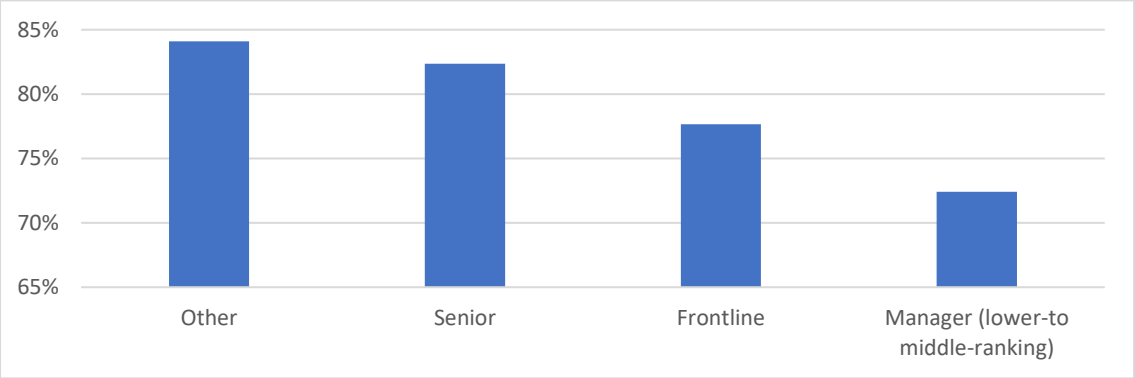
Asian represented the second largest ethnicity in females but the third in males, with Asian men representing 16% of all male participants and Asian women representing 29% of all female participants. Bangladeshi was the largest Asian group, representing 11% of all male and 13% of all females. Black represented the second largest ethnicity in males but the third in females, with black men representing 19% of all male and black women representing 22% of all females. Black Caribbean is the largest black group for males, with 14% of all males, while black African is the largest black group for females, with 13% of all females (Table 2.1).

Table 2.1 – Gender and ethnicity of participants who decided to stop attending by percentage

		Male		Female		Total
		N	%	N	%	N
White		20	54%	73	45%	93
	White British & Irish	17	46%	58	35%	75
	Other white	3	8%	15	9%	18
Asian		6	16%	48	29%	54
	Bangladeshi	4	11%	22	13%	26
	Indian	1	3%	18	11%	19
	Other Asian	1	3%	7	4%	8
	Pakistani	0	0%	1	1%	1
Black		7	19%	36	22%	43
	Black African	2	5%	22	13%	24
	Black Caribbean	5	14%	12	7%	17
	Other black	0	0%	2	1%	2
Mixed		3	8%	2	1%	5
Other		1	3%	5	3%	6
Prefer not to say		0	0%	7	4%	7
		37	18%	164	82%	201

Amongst participants who decided not to attend according to seniority, the proportion of non-attendees that did not have previous training in trauma-informed approaches was **82% of participants at the senior level,** 78% of participants at the frontline and 72% of participants at the manager level. The single person that was a senior at the frontline did not have previous training in trauma-informed approaches (Figure 1.1).

Figure 1.1 – Percentage of non-attendees that did not receive previous training by seniority

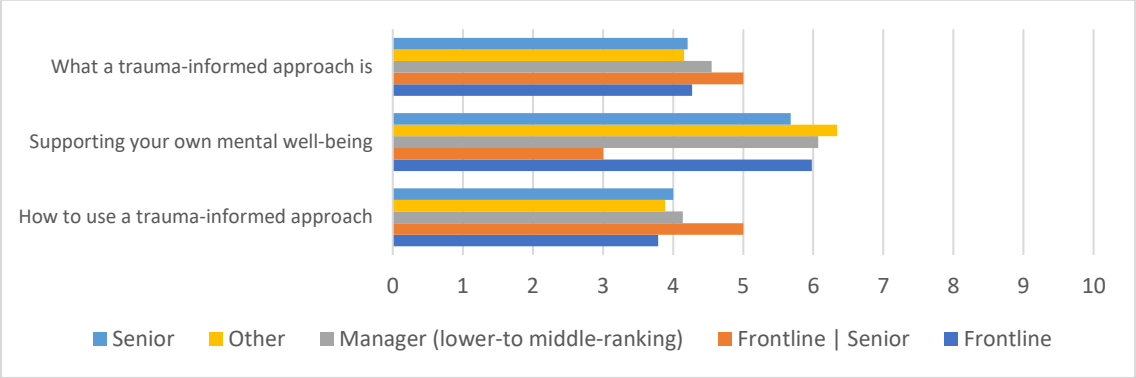


Source: WAVE Pre-training evaluation form

Figure 1.2 illustrates trauma-informed skills that presented lower scores between different levels of seniority of participants who had not previously received trauma-informed approach training.

Overall, results suggest that participants who had stopped attending might not fully comprehend the definition of a trauma-informed approach and how to implement it. Moreover, coping with own mental wellbeing also received scores lower than average.

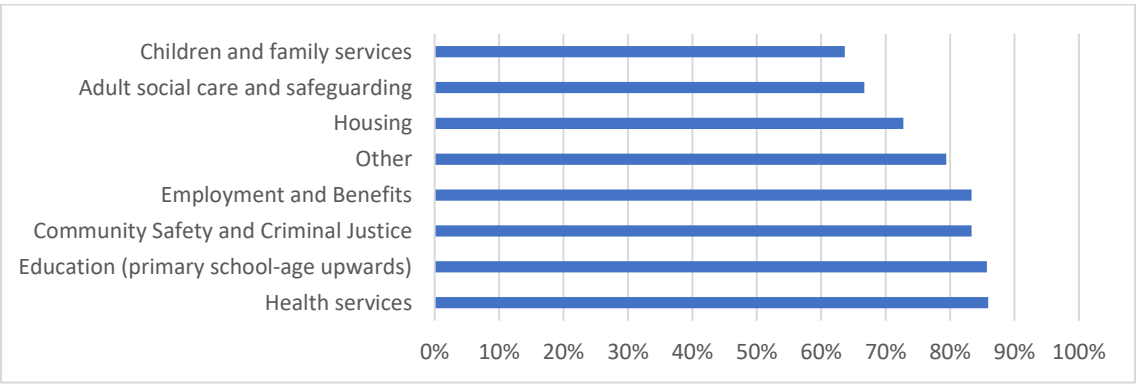
Figure 1.2 – Scores in trauma-informed approach skills by seniority



Source: WAVE Pre-training evaluation form

Figure 1.3 compares, out of all participants who had not received previous training regarding trauma-informed approaches, their proportion according to profession. The largest professions represented are Health Services and Education (86%), followed by Community Safety and Criminal Justice and Employment and Benefits (83%), Other professional environments (79%), Housing (73%), Adult social care and safeguarding (67%) and Children and Family Services (64%).

Figure 1.3 – Percentage of non-attendees that did not receive previous training by profession

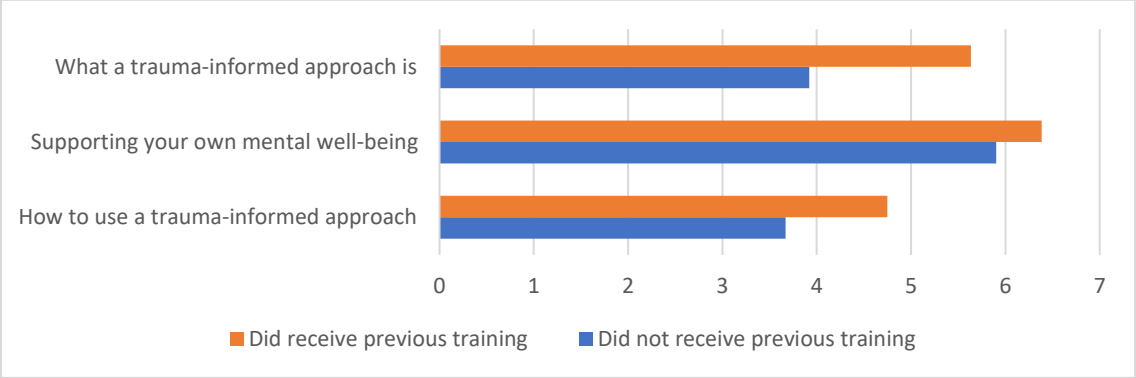


Source: WAVE Pre-training evaluation form

Figure 1.4 illustrates trauma-informed skills that presented lowest scores comparing participants who had previously received training on trauma-informed approaches to participants who had not.

Participants who had previously received training on trauma-informed approaches showed higher scores overall than participants who had not received previous training on trauma-informed approaches. However, participants might still struggle with the definition of trauma-informed approaches and how to implement them.

Figure 1.4 – Differences in trauma-informed approach skills scores between non-attendees who had received previous training and non-attendees who had not

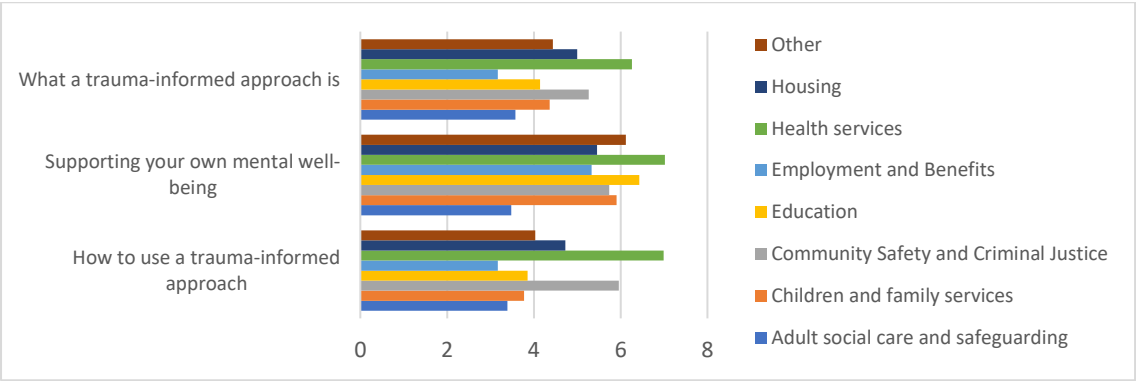


Source: WAVE Pre-training evaluation form

Figure 1.5 illustrates scores variations on the trauma-informed skills that presented lowest scores on both participants who had previously received training on trauma-informed approaches and participants who had not according to profession.

Participants working in health services had the highest scores, whereas participants working in adult social had the lowest. Overall, the rest of professions generally have higher scores in regard to supporting own mental health and lower in the other two.

Figure 1.5 – Differences in trauma-informed approach skills scores between non-attendees by professional sector



Source: WAVE Pre-training evaluation form

Learning and development opportunities about trauma-informed approaches in public sector and voluntary and community sector services

Research participants who attended the training consider how trauma-informed approaches (TIAs) can be applied to policies, strategies, organisations and services that strive to acknowledge and mitigate the impacts of trauma on people's health and wellbeing. They state:

> *"Other divisions have not done the course. But there is WAVE training, an online training about TI that is compulsory for the organisation [TH Council] so in part, yes the council is TI."*
>
> *"The training provides skills to reflect on incidences and understand what may have triggered residents prior to incidences. It provides ways of discussions amongst staff."*
>
> *"The pilot has helped guide us through training the team. Some training should be continued. We are looking at how to source continuing the training i.e. in corporate inductions. There are talks to continue this and its resources. It is important to train all staff"*
>
> *"TI would be beneficial for public and third sector partners."*
>
> *"TIA in maternity is definitely needed."*
>
> *"Encourage mandatory TIA training for all midwives"*
>
> *"Everyone needs to access the Wave training within LBTH."*

"All co-production staff participants supposed to have accessed the wave training but not everyone has done so."

"Through training, case studies, idea generation and development, a Dragon's Den and project action meetings, three groups developed and are currently delivering their trauma-informed projects…"

"…there was good-engagement from the people who attended online, with useful conversations. She was impressed by the variety of names/roles attending the training->variety of people from different services across LBTH"

4.3 Service enhancement pilots

In this section, we turn to look at the different experiences in co-designing and co-delivering the test service enhancements with a focus on the weaknesses and strengths in implementation. **Table 3.1 gives the total number (*N*=5,741) of people directly (*N*=175) or indirectly (*N*= 5,566) exposed to the programme.**

Table 3.1 – Number of beneficiaries and staff per project

Type	Providence House	Salvation Army	Maternity Service	Employment & Skills
Direct Beneficence (residents)	28	43	20	14
Direct Beneficence (Staff)	18	20	4,000	1,147
Indirect Beneficence (Resident)	7	80	300	16
Direct Beneficence (Staff/Vol)	0	16	300	16

Tower Hamlets Employment and Skills Services

What are the characteristics of the participants that are engaging in the initiatives? (e.g., gender, ethnicity, age, and English as a second language)

Table 4.1 provides a broad overview of the profile of participants engaging in this service according to their gender, age and ethnicity. It compares the number of participants in each group and subgroup to the percentage of subgroup over group (e.g., within Asian participants, how many are Bangladeshi) and the percentage of group over total (e.g., within total sample, how many are Asians).

Out of a sample of 1,166 participants, most were between 18 and 64 years old (i.e., within working capacity), with **much more concentration of participants between 26 and 64 years old (57%) than participants between 18 and 25 years old (34%)**. The proportion of male and female is even, if slightly more male than female. **Asians made up the biggest ethnic group (62%)**, followed by white (16%) and black (11%). Bangladeshi is the largest ethnicity within the Asian group (93%), black African is the largest ethnicity within the black group (71%) and any other white ethnicities than English, or Irish were the largest within the white group (82%).

Table 4.1 – Demographics of the Employment & Skills project

		N	% of Total	% of Group
Age				
	0-4 years	0	0%	
	5-17 years	1	0%	
	18-25 years	399	34%	
	26-64 years	668	57%	
	65 plus years	7	1%	
	Unknown	14	1%	
Gender				
	Male	572	49%	
	Female	582	50%	
	Other	1	<1%	

	Unknown	11	1%	
Ethnicity				
Asian		723	62%	
	Bangladeshi	671		93%
	Indian	21		3%
	Other Asian	16		2%
	Pakistani	15		2%
White		184	16%	
	White English & Irish	101		55%
	Other White	83		82%
Black		129	11%	
	Black African	91		71%
	Black Caribbean	34		37%
	Other Black	4		12%
Mixed		42	4%	
	Mixed – White & Black Caribbean	18		43%
	White & Black African	11		61%
	Mixed - Other	9		82%
	Mixed – White & Asian	4		44%
Other		39	3%	
	Arab	19		49%
	Any other	20		51%
Unknown / Not Stated		51	4%	
Total		1166		

Source: Database provided by Tower Hamlets

Research participants (i.e., staff and service users) were evaluated following the Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS), a shortened version of the Warwick–Edinburgh Mental Well-being Scale that uses seven of the fourteen positive statements worded with five response categories from ‘none of the time’ to ‘all of the time’ in a Likert scale from 1 to 5. These statements relate more to the functional aspect of mental wellbeing than the rest of the statements that can be found on the full questionnaire. A threshold was established at “3 – Most of the time” as the cut point below which mental wellbeing can be considered to not be good (Table 4.2).

Table 4.2 – The seven statements of the SWEMWBS and its five response categories

Statements	None of the time	Rarely	Some of the time	Often	All of the time
	1	2	3	4	5
I’ve been feeling optimistic about the future					
I’ve been feeling useful					
I’ve been feeling relaxed					
I’ve been dealing with problems well					
I’ve been thinking clearly					
I’ve been feeling close to other people					
I’ve been able to make up my mind about things					

Source: Warwick Medical School

Figure 2.1 provides a comparison of mental wellbeing scores, as measured by the SWEMWBS, between Kickstarter participants and Staff members, as well as between those and the averages in England for the year 2017. This questionnaire was applied to 13 participants, 5 of which were Kickstarters and 8 of which were Staff.

Overall, **Kickstarters scored higher than the national average for both men and women** (27.6 to 23.7 and 23.2 respectively). On the other hand, **Staff only scored slightly above the national average** compared to the same (24.5 to 23.7 and 23.2 respectively).

Figure 2.1 – Comparison between Kickstarter and Staff SWEMWBS score and national scores for the year 2017

Source: Health Survey for England (2017)

Maternity Service (Royal London Hospital)

Table 5.1 provides a broad overview of the profile of participants engaging in this service, according to their gender, age and ethnicity.

Between patients and staff, the **total number of participants was 33**, of which 13 were patients and 10 were Staff. All of them were females and the majority were **over 25 years old**. The largest ethnic group represented amongst service users was white (9), followed by Asian (3) and black (1). The largest ethnicity within the white group was white British & Irish (6), while the largest ethnicity within the Asian group was Bangladeshi (2). The individual within the black group was of any other black background other than African or Caribbean.

Out of the 33 participants, **7 patients and 8 members of Staff undertook the wellbeing questionnaire.**

Table 5.1 – Demographics of the Maternity Project

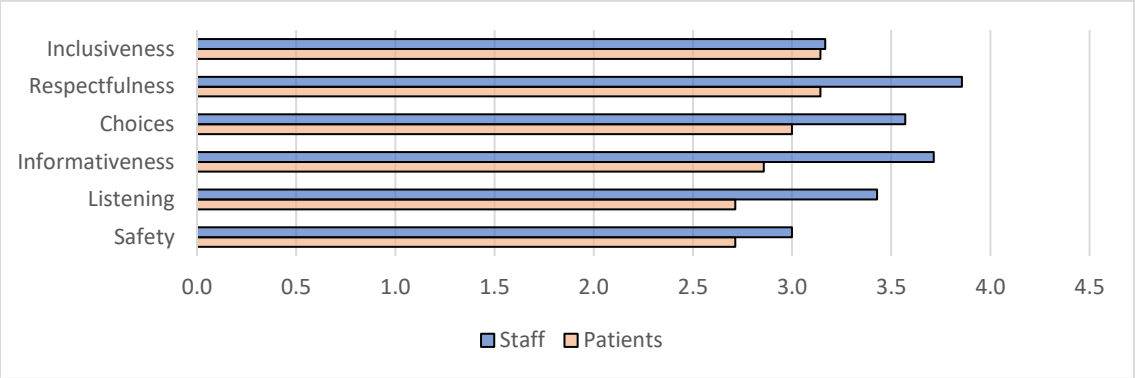
		N	% of Total	% of Group
Age				
18-25		1	3%	
26-64		32	97%	
Gender				
Female		33	100%	
Ethnicity				
Asian		3	23%	
	Indian	1		33%
	Bangladeshi	2		66%
White		9	69%	
	White British & Irish	6		66%
	White Other	3		33%
Black		1	7%	
	Other Black	1		100%
Total		13		

Source: Database provided by Tower Hamlets

Figure 3.1 provides a comparison of satisfaction scores between Staff and Patients, Overall, Staff assessed the service more positively than patients. **Staff scores were consistently higher than Patient scores.**

"Inclusiveness" was the score where patients score and staff scores had less of a difference, while "Informativeness", "Respectfulness" and "Listening" where the scores showed the biggest difference. **Patients rated "Inclusiveness" the highest and "Safety" the lowest, while Staff rated "Safety" the lowest and "Respectfulness" the highest**.

Figure 3.1 – Comparison between Staff and Patients' Service Satisfaction Questionnaire average answers to each individual statement



Source: Database provided by Tower Hamlets

Figure 3.2 provides a comparison of mental wellbeing scores, as measured by the SWEMWBS, between Patients and Staff members, as well as between those and the averages in England for the year 2017.

Overall, Staff scored higher than the national average for both men and women (24 to 23.7 and 23.2 respectively). On the other hand, Patients scored below national average compared to the same (22 to 23.7 and 23.2 respectively).

Figure 3.2 – Comparison between Staff and Patient SWEMWBS scores and national scores for the year 2017

Source: Health Survey for England (2017)

Founders House Hostel

Table 6.1 provides a broad overview of the profile of participants within the Salvation Army project, according to their gender, age and ethnicity. The **total number of beneficiaries was 159**, out of which the largest age group was between 26 and 64 years old (42%), excluding participants who did not provide this information (48%). Most participants were male (77%), excluding participants who did not provide this information (23%).

Major ethnic groups were white British & Irish (18%), Asian of any other Asian background (11%) and black of any other black background (11%). Mixed race participants amounted to 3%, and 93 participants (58%) did not provide information regarding their ethnicity.

Out of all 159 participants, **123 were men, 118 were at risk of homelessness and 50 were unemployed.**

Out of the 33 participants, **11 residents and 10 members of Staff undertook the wellbeing questionnaire**, with some changes in the number of residents in between the pre and post questionnaires.

Table 6.1 – Demographic distribution of participants on the Salvation Army's project

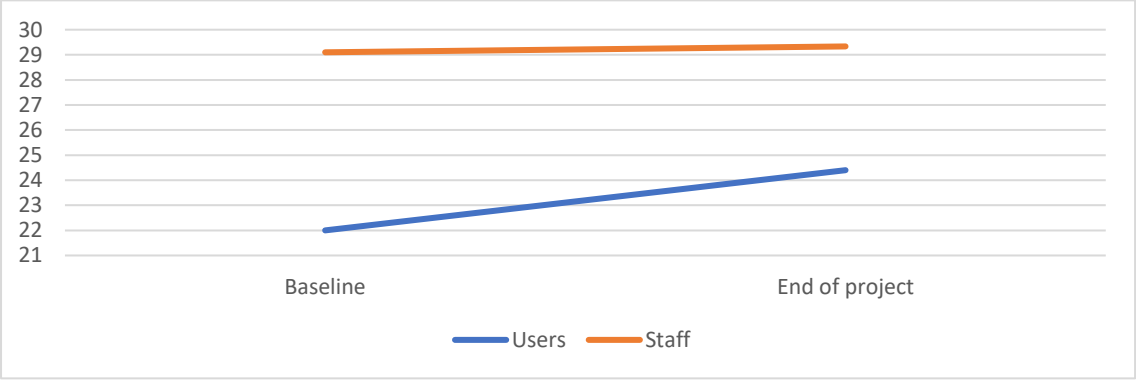
		N	% of Total
Age			
	0-4 years	0	0%
	5-17 years	0	0%
	18-25 years	15	9%
	26-64 years	67	42%
	Unknown	77	48%
Gender			
	Male	123	77%
	Unknown	36	23%
Ethnicity			
Asian		18	11%
	Other Asian	18	
White		28	18%
	White English & Irish	28	
Black		17	11%
	Other Black	17	
Mixed		3	2%
Unknown / Not Stated		93	58%
Total		159	

Source: Database provided by Tower Hamlets

Figure 4.1 provides a comparison of mental wellbeing scores of patients, as measured by the SWEMWBS, at baseline and at the end of the project.

The score improved for users between the baseline, where users of the service scored an average of 22 points in the SWEMWBS, and the end of project, where the average for service users was a score of 24. Staff SWEMWBS remained stable, going from 29.1 at the baseline level to 29.3 at the end of project.

Figure 4.1 – Comparison between baseline and end-of-project Staff and Patients' SWEMWBS scores



Source: Database provided by Tower Hamlets

Figure 4.2 provides a comparison of mental wellbeing scores of residents, as measured by the SWEMWBS, at the baseline and at the end of the project, as well as between those and the averages in England for the year 2017.

At the end of the project, service users' average score was in line with the average SWEMWBS score for men in England in the year 2017, if slightly higher.

Figure 4.2 – Comparison between residents' Baseline and End-of-Project SWEMWBS score and national scores for the year 2017

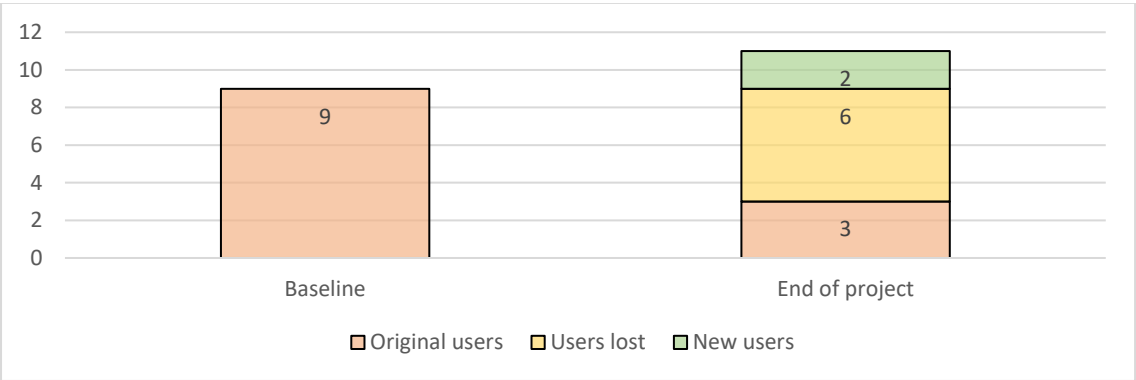
Source: Health Survey for England (2017)

How effectively has the trauma-informed approach been in reaching its target population?

Figure 4.3 provides a comparison between the number of original service users and the number of new service users and service users that had opted out by the end of project.

Out of the original 9 service users to whom the SWEMWBS was applied at the baseline level, 6 were lost by the end of project and 2 new users had been gained. **Only 3 of the original users at the baseline level remained until the end of the project**. For Staff, only 1 participant was lost at the end of the project.

Figure 4.3 – Change in the composition of Salvation Army's participants between baseline and end of project



Source: Database provided by Tower Hamlets

Providence House

Table 7.1 provides a broad overview of the profile of participants within the Providence Row project, according to their gender, age and ethnicity.

The total number of beneficiaries was 40, out of which the largest age group was 26 to 64 years old (26). There were more male participants (26) than female participants (14). **The largest ethnic group was white English and Irish (29) followed by black (8)**. Within the black ethnic group, black African (5) was the largest group, followed by black Caribbean (3).

The number of residents that completed a wellbeing questionnaire was **20 or 21 and the number of members of staff to have completed the questionnaire was 7 or 8;** this divergence is due to one form which was unclear whether it was filled in by a staff member or a resident.

Of all 40 participants, **32 were at risk of homelessness, 31 were unemployed or NEET and 26 were men.**

Table 7.1 – Demographic distribution of participants on the Providence Row project

		N	% of Total
Age			
	18-25 years	2	5%
	26-64 years	26	65%
	65 plus years	12	30%
Gender			
	Male	26	65%
	Female	14	35%
Ethnicity			
Asian		1	3%
	Chinese	1	
White		29	73%
	White English & Irish	29	
Black		8	20%
	Black African	5	
	Black Caribbean	3	
Mixed		1	3%
Other		1	3%
Total		40	

Source: Database provided by Tower Hamlets

This project used the full WEMWBS instead of the short WEMWBS. Average scores obtained from responses were used as an indicator of the collective wellbeing at baseline and at end of project. **There were 27 to 29 participants at the baseline levels, between 20 and 21 of them were service users and between 7 and 9 of them were staff.** At the end of project, there were 29 participants. **This project did not made distinction between staff and service users when compiling the scores,** and it did not specify whether any participants had left or joined between the baseline and the end of project.

Score improved for participants between the baseline, where participants scored an average of 40.1 points in the WEMWBS, and the end of project, where the average score was 44.8 (Figure 5.1).

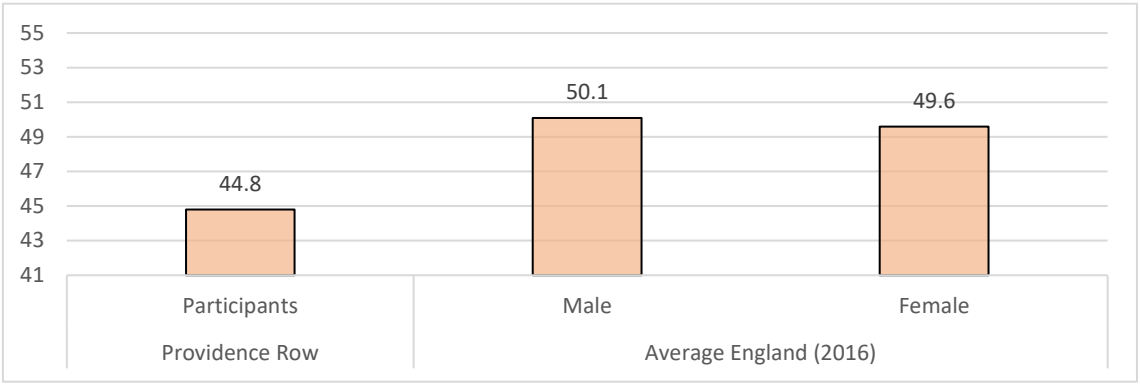
Figure 5.1 – Residents and Staff WEMWBS average score at baseline and end of project

Source: Database provided by Tower Hamlets

Figure 5.2 provides a comparison of mental wellbeing scores of participants, as measured by the WEMWBS, at the baseline and at the end of the project, as well as between those and the averages in England for the year 2016.

At the end of the project, **participants' average score was below the average WEMWBS** score for both men and women in England in the year 2016, 44.8 to 50.1 and 49.6 respectively.

Figure 5.2 – Comparison between WEMWBS score at end of project for Providence Row and national scores for the year 2017



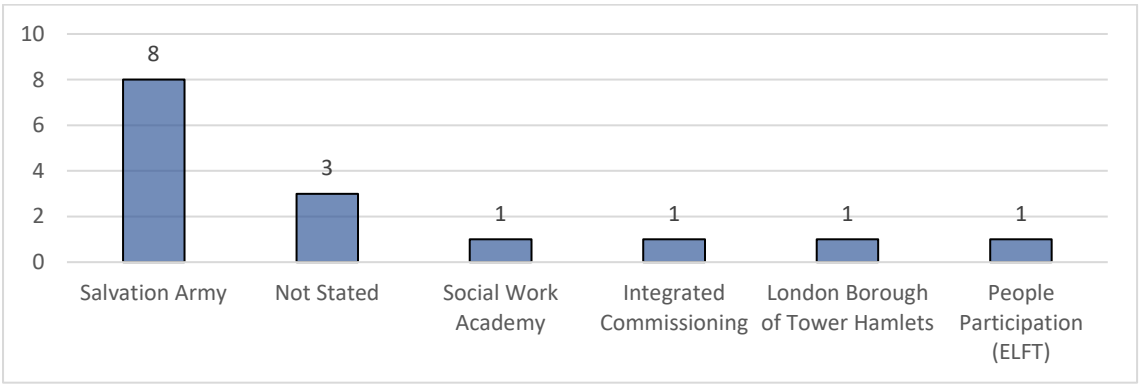
In summary, we can see that the wellbeing and health scores across the pilot sites varied across and within the projects in comparison to the national average scores. In the employment and skills pilot, staff and service users reported higher than the national average, with **service users reporting a higher score than the staff.** In the maternity service, **staff scored themselves higher than the national average, whereas the patients scored significantly lower than the national average**. In the Salvation Army hostel site, **staff scored significantly higher than the national average**, whereas **residents scored on par with the national average**. In Providence House, scores were not distinguishable, and the **collective score reflected the national average.**

4.4 Stakeholder survey

The section below presents the findings from the stakeholder survey, where we elicited responses into implementation and mainstreaming the programme to Tower Hamlets Council Public Health Team internal and external partners, who are invested at some level in the success of the trauma-informed programme work.

Figure 6.4 shows the organisational affiliation of survey participants, where **most participants are stakeholders from the Salvation Army project**.

Figure 6.4 – Distribution of stakeholders by organisation

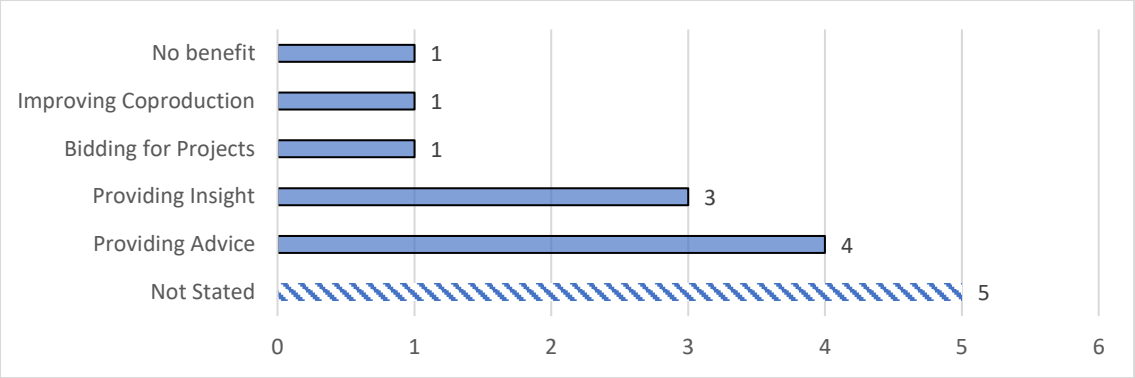


Source: Database provided by service stakeholder survey

Are participants experiencing any recent losses, gains or other changes when exposed to the trauma-informed initiative?

Stakeholders reported trauma-informed approach services had helped their respective organisations by **providing advice, insights, help with bidding for projects, funds and grants and improved co-production** (Figure 6.5).

Figure 6.5 – Perceived benefits of service from stakeholders

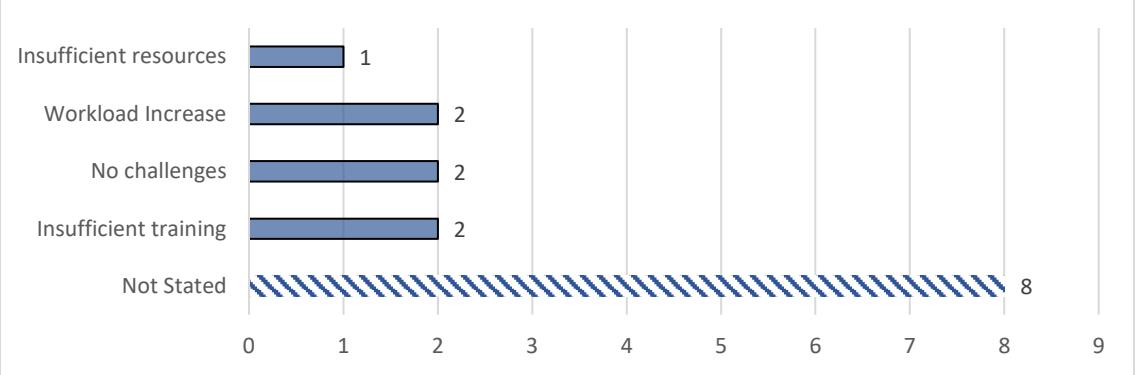


Source: Database provided by stakeholder survey

What have been some of the challenges so far in engaging (recruiting workforce and residents? (e.g., entry points, referral mechanisms)

Stakeholders reported insufficient training (in trauma-informed and sensitivity approaches), an **increase in workload** (requiring more personnel and funding) and **insufficient resources as main challenges** with services that use or will use trauma-informed approaches (Figure 6.6).

Figure 6.6 – Challenges in services when assessing trauma-informed approaches

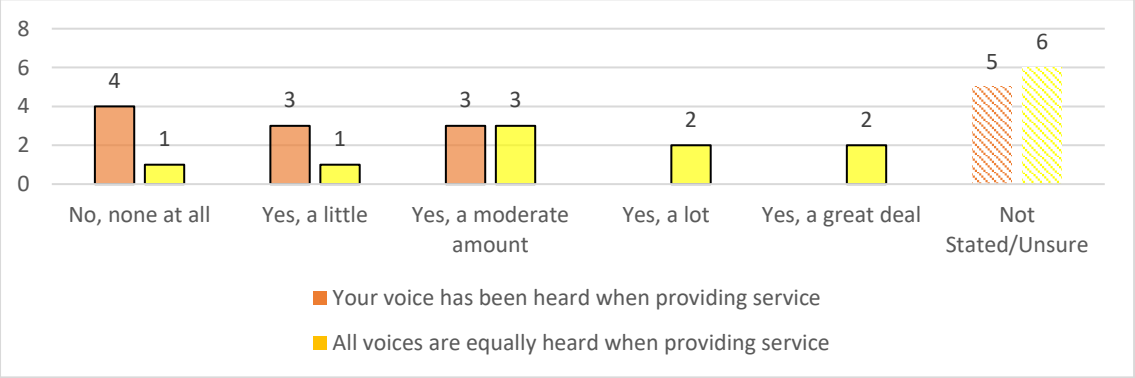


Source: Database provided by stakeholder survey

What do participants and providers view as the best aspects of the initiatives?

Stakeholders evaluated their own voices as not having much presence within the design and discussion of projects; however, they acknowledge that voices were generally equally heard across the service (Figure 7.1).

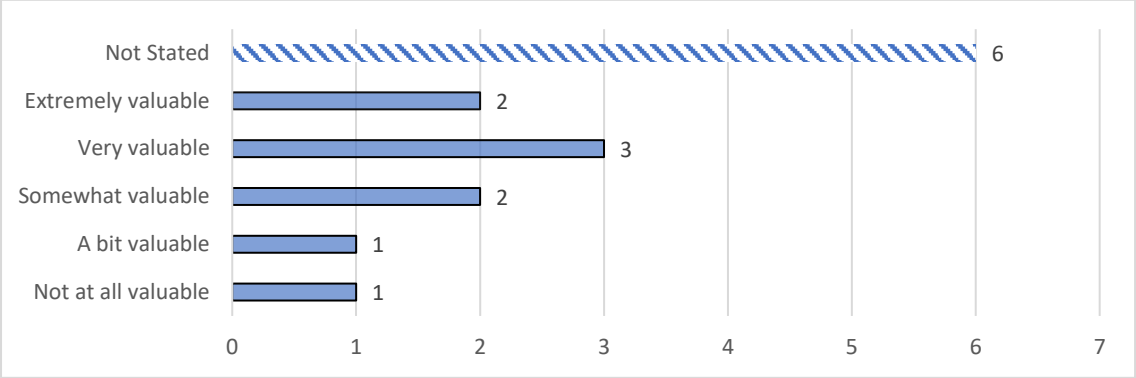
Figure 7.1 – Stakeholders' assessment of the presence of diverse voices in comparison to the presence of their own voice within trauma informed projects.



Source: Database provided by stakeholder survey

Research participants generally considered that a **trauma-informed approach across services was highly valuable,** with 2 participants describing it as extremely valuable, 3 participants describing it as very valuable and 2 participants describing it as somewhat valuable (Figure 7.2).

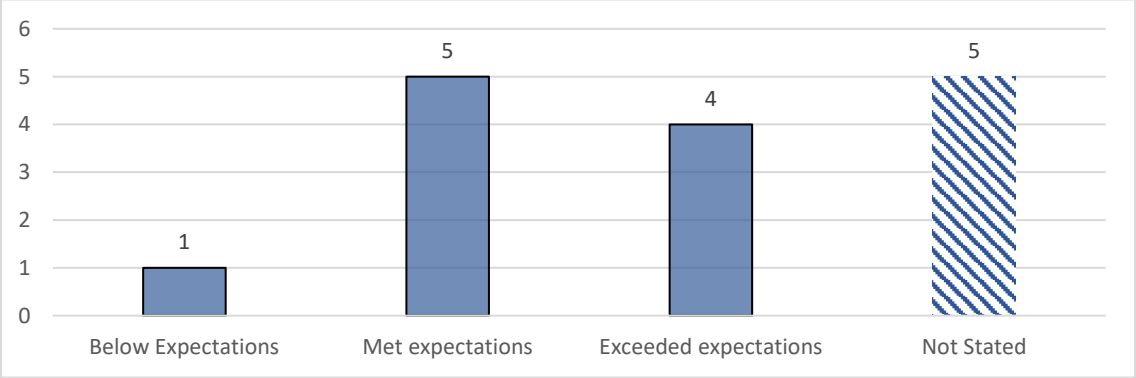
Figure 7.2 – Stakeholders' assessment of the value of trauma-informed approaches across services



Source: Database provided by stakeholder survey

Four participants considered that **engagement with the public health team on trauma-informed approaches generally benefited their projects** above what they had been originally expecting, while 5 participants considered that this engagement fulfilled the expectations they had (Figure 7.3).

Figure 7.3 – Expectations of benefit of engagement with the public health team on trauma-informed approaches



Source: Database provided by stakeholder survey

4.5 Service user survey (programme wide)

Table 8.1 provides a broad overview of the profile of service users that completed the survey according to their gender, age and ethnicity.

The total number of participants was 27, out of which the largest age group was 35 to 44 years old (9). There were more female (18) participants than male (9) participants. The largest ethnic groups were Asian (18), white (3) and black (3). Within the Asian group, Asian Bangladeshi was the largest ethnic group (13).

The largest religious group was Muslim (18), followed by No religion (4), Christian (3) and Agnostic (1). One participant declined giving information about their religious affiliation.

Four participants described themselves as disabled, whereas 21 participants described themselves as non-disabled. One participant declined giving information about their disability status.

Five participants described themselves as waged, whereas 8 participants described themselves as unwaged; 14 participants declined giving information about their wage status.

Table 8.1 – Demographic distribution of service users

	N	% of Total	% of Group

Age				
	16 to 24	7	26%	
	25 to 34	7	26%	
	35 to 44	9	33%	
	45 to 54	3	11%	
	55 to 64	1	4%	
Gender				
	Female	18	67%	
	Male	9	33%	
Asian		18	67%	
	Asian Bangladeshi	13		72%
	Asian British	4		22%
	Asian Indian	1		6%
Black		2	7%	
	Black British	1		50%
	Black Somalian	1		50%
White		3	11%	
	White British	3		
Mixed		2	7%	
	White & Asian	1		50%
	Other Mixed	1		50%
Arab		1	4%	
Unknown		1	4%	
Total		27		

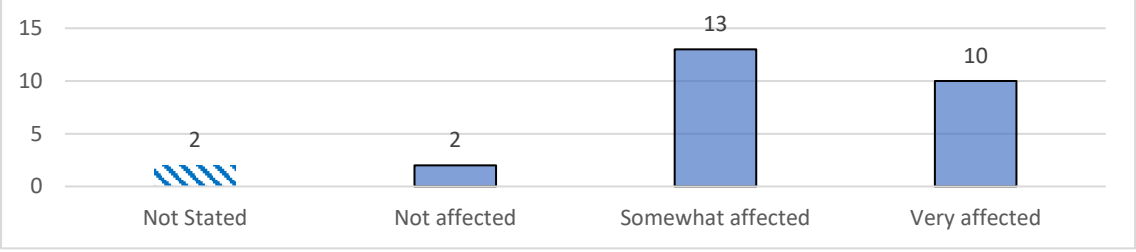
Source: Database provided by service user survey

Amongst service users who had completed the survey, 6 participants declared that the trauma-informed approached did not have any effect, positive or negative, in their lives, 2 participants declared that trauma-informed approaches had a positive effect in their lives, and 1 participant declared that trauma-informed approaches had a negative effect in their lives. Four participants declared that the service had helped them learn coping mechanisms, 10 participants declared the service had not helped them learn coping mechanisms and 13 participants were unsure or did not state their opinion.

What are participants' expectations and/or goals?

Most users declared having been affected by the pandemic, with 13 users declaring to have been somewhat affected (e.g., self-isolation, infection, loss of revenue) and 10 users declaring to have been very affected (loss of job, loss of loved ones; Figure 8.1).

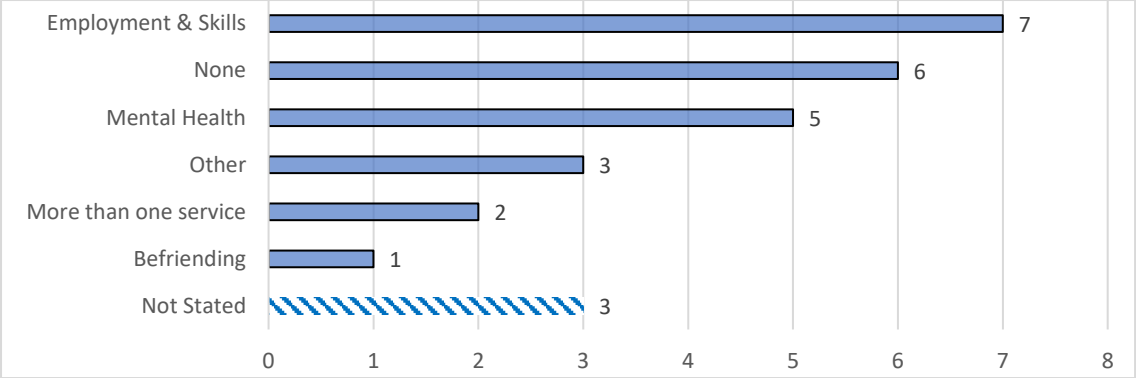
Figure 8.1 – Degree in which the pandemic has affected users' lives



Source: Database provided by service user survey

Amongst the services used, most research participants **(7) came from the Employment and Skills programme,** 5 participants were involved with programmes related to Mental Health and 2 research participants were involved with more than one service (Figure 8.2).

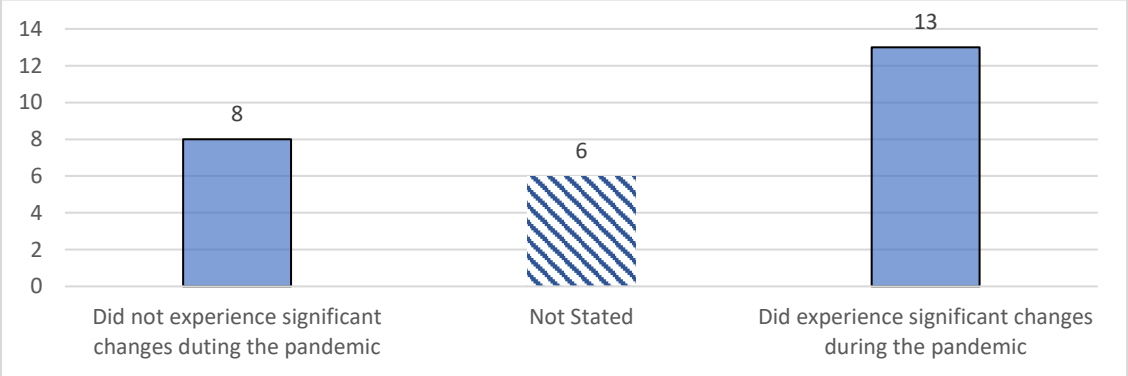
Figure 8.2 – Services used by the participants



Source: Database provided by service user survey

13 participants described the pandemic as having significantly changed their lives, while 8 participants did not feel like the pandemic had significatively impacted their lives (Figure 8.3).

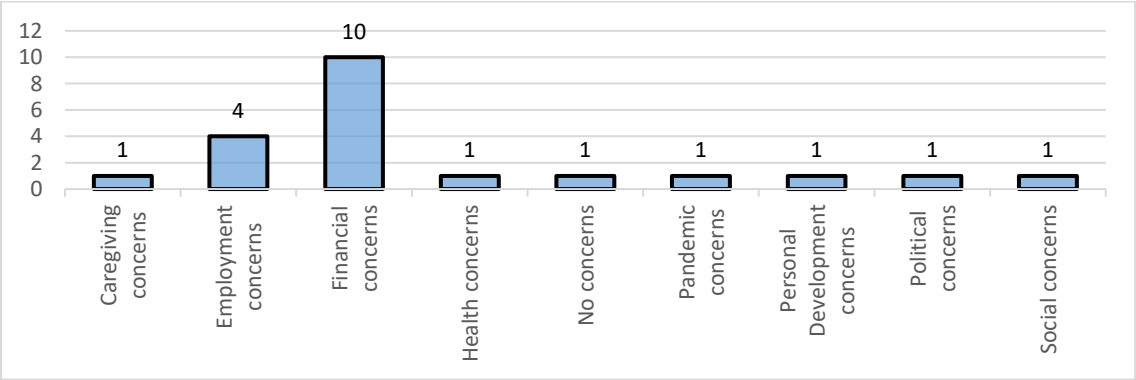
Figure 8.3 – Changes in users' lives during the pandemic



Source: Database provided by service user survey

Most participants (10) declared that their primary source of concern during the pandemic was of a **financial nature**, while 4 participants shared concern regarding their employment status. Only 1 participant declared not having had any particular concern during the pandemic (Figure 8.4).

Figure 8.4 – Users' principal concerns during the pandemic period

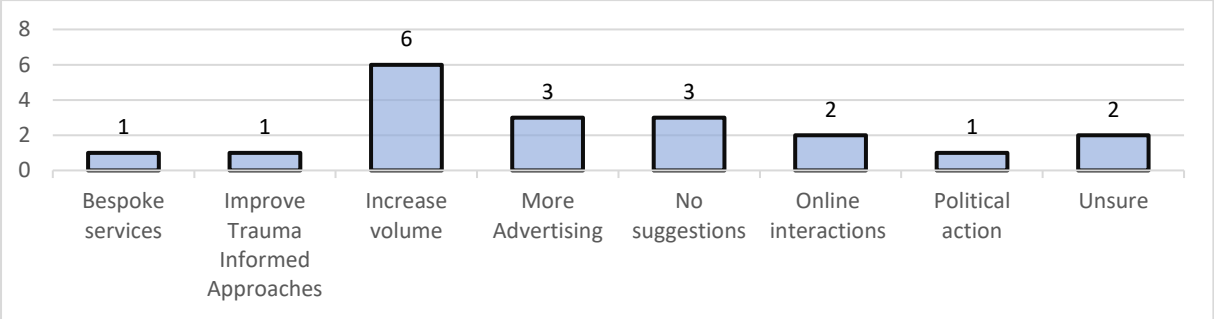


Source: Database provided by service user survey

What do participants and providers think could be improved?

Most users suggested that **service could be improved by increasing the volume of the service**, as they had expressed concerns that the service might **not be reaching enough people or in the most extensive way**, as well as more advertising to promote the service and expand reach amongst residents (Figure 5.8). **Stakeholders suggested that the services required more resources (Funding, personnel and assets)**, more **training (especially trauma-informed training, but also sensitivity training) and more advertisement to extend reach and knowledge of the services** (Figure 9.1).

Figure 9.1 – Suggestions made by users about improving trauma-informed approaches



Source: Database provided by stakeholder survey

The following section builds a synthesis of the of the research participants accounts and looks at their insights into the effectiveness of implementing the trauma-informed pilots.

Key theme: Implementation *Whether the activities that Public Health set out to implement turned out as planned, and whether there are gaps in implementation (e.g., numbers and types of audiences the projects have reached, feedback including on quality of delivery)*

Implementation

(Sub-themes Place and Process)

- Did not properly learn coping mechanisms
- Insufficient attention paid to high workloads
- Create appropriate spaces for in-person services.
- Space/ place matters for working with NEET youth and homeless females
- More aware about their own wellbeing
- Need for self-care and detachment from TIA when not at work
- Training not in-depth enough. Training needs to be tailored to services
- Providing the right context-specific support
- Barriers to implementation is when IT is not practised by all
- Lack of resources
- Surface-level interventions
- Pilots were short a time to implement real change

Implementation

(Sub-themes People)

- Did not properly learn coping mechanisms
- Borough awareness is lacking
- Changes in service policies is needed
- Funding needed to continue TI work
- Feeling unsafe to implement and how to cope with trauma
- Staff not working TI with each other resulting in toxic office space
- Staff feeling attacked doing co-production
- Low level engagement of services users in co-production activities
- Lack of participation from other staff members. Plans to establish participatory group.

Engagement with stakeholders (residents, senior leadership groups, staff) in discussions about these topics as well as barriers, practices to build on, and priorities for action:

"We are rolling out our own TI programme (as part of the project with BBBC) in a form of an event on the 17th of June. Trying to teach and engage young people aged 18-24 about what trauma is, what trauma looks like … Event is designed to encourage young people to talk e.g., playing games, Q&A session, massages."

"A lot of negative feedback is generated from women feeling like they had a poor birthing experience, that could be due to intervention they weren't sure of, or the language that midwives use"

"Lack of time meant that we were not able to perform outreach and reach targeted residents and partners"

"Client group involvement in co-production of service … Co-production sessions aims to explore how TI can be represented in the service: bringing staff and client understanding together, coming up with ideas together. Online

catch-up session aiming to keep on track and discuss what can be done -> aiming towards a shared understanding"

"Reflective conversation at the end of the co-production: The reflective conversations will be useful to discuss what is feasible to maintain this, what can they actually do/implement in a continuous basis."

"Public engagement event: part of co-production organised by client for clients"

"We put passion into it and knew people would get something from it. Everyone engaged."

"Everyone who came to the session had a really positive conversation, it got people thinking – one woman wanting to bring her son to future events; one man said it was the most amazing experience and he got everything he wanted from it, the massage was the highlight. Another said that post pandemic they had been isolated, this has really helped them get out there, let themselves go a bit."

"Reflections needed: Regular reflection by staff in team meetings"

"So, there was one session when we went through each of the trauma informed principles and had really in-depth conversations and they were like, it was probably for me one of my favourite parts of the session, because people were being really reflective, like really interrogating these goals…"

"…there was a lack of participation in the reflections, no one brought up the tensions experienced in the group discussions…"

"The other reason why this project is successful is because this is a reflective practice with staff (across staff teams), so they can marry up learning and opportunities in different ways."

The research participants accounts point to the challenges and opportunities in implementing trauma-informed approaches in their different services, which have been echoed in studies. Layne, et al. (2011) outlines key learnings are to **move from foundational trauma knowledge in training practices, to more trauma-specific trauma knowledge**. A toolkit is provided for this. Secondly, this framework should be developed from a clinical standpoint. In terms of gathering **data related to service user trauma**, suggests Layne, using **segmented and incremental methods for practitioners to formulate hypothesis**, discern relevant fact and plan **a step-by-step method supporting trauma-informed practices**. The work of Denise et al. (2016) advocates a specific system using a **Solution-Focused Trauma-Informed Care system** to shift individuals and systems from a problem-solving focus to solution building. This technique should **provide individuals with concrete skills, language and knowledge to effectively avoid re-traumatisation.** The core tenets and techniques of solution-focused practice are about **promoting trustworthiness, offering choice, establishing collaboration and fostering empowerment.** The integration of solution-focused practices and trauma-informed care offers an alternative to the problem-solving method and promotes the development **of surface practice of trauma informed practice to deeply embedded service changes.** Both aforementioned texts highlight **learning needs as moving on from foundational knowledge on trauma to more advanced knowledge** for service leads and staff.

Triesman's (2018) work was undertaken with the Winston Churchill Trust to develop working principles in trauma-informed practice that ensures that its **application is not a tick-box exercise**, and that aspects of trauma-informed practice were supported in its integration into services. It critically examined what particulars of trauma-informed practice helped to deliver better services. Most significant was looking at trauma-informed practice in greater depth than adverse childhood experiences. Conclusions from the study were:

- Trauma-informed practice should be **standard practice across institutions**.
- More work **needs to be done for evaluations** that show how effective trauma-informed practice is.
- Too **much emphasis is placed on ACEs as part of trauma-informed practice**, and other aspects of trauma need to be integrated into a trauma-informed approach.
- More integrated support for trauma-informed practice from **government services and community** organisation who share service users.
- **Embracing the uniqueness of all organisations** and how this effects trauma-informed practice based on the subcultures of each organisation.

The following three examples focuses on the implication of trauma-informed practice for specific user groups, rather than in a broad sense. Muskett's (2014) work had at its core mental health nursing provisions. Regarding the expanding notion of trauma-informed practice, nurses in the study were confused as to **how to add trauma-informed practice values** which were already embedded into their core professions. A key learning in this document was to reduce seclusion and restraint of service users as much as possible. However, nurses view this a **utopian concept**, given the acuteness of patient need as seen through multiple readmissions. Given this, the report outlines six ways to implement and **further embed trauma-informed practice** in acute mental health settings. They were as follows:

- **active leadership support**, **role modelling**, and **engagement in trauma-informed principles**
- data collection (e.g., seclusion and restraint incidents)
- **rigorous debriefing** and prevention-focused analysis of events that do occur
- **trauma-informed education** and **skill development of staff**
- use of **a range of assessments** (e.g., trauma, risk and strengths identification) and tools to teach self-management of illness and emotional regulation
- involvement and inclusion of consumers at all levels of care.

Again, trauma-specific practices in provisions working regularly with trauma sufferers are critically analysed by Wilson et al. (2017). Focusing on mental health nursing, this sought to clarify the challenges experienced by mental health nurses in embedding trauma-informed practice into acute inpatient settings in Australia. A systematic search of electronic databases was undertaken to identify primary research conducted on the topic of trauma-informed care. A narrative review and synthesis of the 11 manuscripts retained from the search was performed. The review highlights that there is an urgency for mental health nurses to **identify their role in delivering and evaluating trauma-informed practices inclusive of undertaking training and clinical supervision**, and to engage in **systemic efforts to change service cultures.** Five themes were identified:

- therapeutic relationship
- recovery
- choice and control
- seclusion and restraint
- the environment.

Kulkarni's (2018) work is another example of a trauma-specific provision learning. It considered programmes serving partner violence where trauma specific service gaps remain, particularly for the most marginalised and vulnerable groups. Kulkarni's work advocates a **feminist, trauma-informed framework** with overviews of **intersectional** (e.g., survivor-centred, culturally specific) and **power sharing authentic relationships, individualised services and robust systems advocacy**. These approaches have the potential to narrow service gaps if organisations can embed key elements into **programme design, implementation and evaluation** processes. The key learning from this work advocates:

- expanding survivors' roles/input
- **strengthening funding streams** and **organisational commitment** to **anti-oppressive, survivor-defined, trauma-informed services**
- forging cross-sector advocacy relationships
- building knowledge through research and evaluation.

Singh et al. (2020) studied in trauma-informed practices highlights provisions involving violence. They explored community-based organisations that support mothers and children experiencing violence in relationships. The article suggests that the experiences of interpersonal violence for women can be viewed as part of **a collective trauma** on the basis of one's gender, in addition to violence itself being traumatic. The key takeaways include **training, implementation, and evaluation** of interpersonal violence interventions to **understand changes in the capacity of service providers** working in trauma specific

cases. **Impact came from developing safe spaces, modelling safe and healthy relationships, and serving families and promoting positive and nurturing parent–child relationships.** Facilitators described that the implementations in service enhancements occurred through trauma specific training received as having a positive impact in trauma-informed and relational practices evident in changes in organisational attitudes and practices.

Safety in interpersonal interaction and physical spaces?

Collaborative, trusting environments within staff teams and with clients:

> "*Main aim is to work more collaboratively, to listen, to work and engage with people in a more TI approach. So, the way we speak, listen, and support people"*
>
> *"One of the goals is to increase informal social interactions/communications that would increase trust and relationships so that residents can relay their support needs more openly and honest"*
>
> *"… how the service support people to make people feel empowered, safe, and that they can build trusting relationships"*
>
> *"It has enabled me to take a different approach in dealing with people. Most clients are young people"*
>
> *"It helps manage relationships; it puts considerations for others that we do not always know what is going on in their lives"*
>
> *"Risk management is critical, that is why having psychologists, therapists are important to ensure clients are not left with only airing out their trauma without being supported."*

Staff capacity, pressures and increased workloads:

> *"Staff turnover is challenging as it affects relationships and continuity."*
>
> *"Detaching at the end of the day can be difficult. If we embed things into people's roles. How do people stretch themselves in a positive way, giving them transferable skills."*
>
> *The wellbeing sessions have highlighted the need for individual and team support: "Access to counselling and reflective practice for those that opt in. Need an individual and a team approach."*
>
> *"It has really impacted on my workload. It's been hectic. It is a lot of work. People within the group need to get involved a lot more. We've had some staff changes and Kickstarters [changes]. Lots of changeovers. People not staying in the group through the duration."*

Establishing safe, welcoming and interesting physical environments for clients and staff:

> *"They had to find a space that was comfortable for everyone."*
>
> *"People are only coming in for specific appointments, then leaving, there's less to do than attend appointments. We want to open it up, do a job search, create a space for people"*

Trauma-informed working within staff teams:

> *"Being trauma informed and being self-aware should come together: and this was not always present. She felt that some of the conversations did not provide the safe space- the staff participants felt a bit attacked by criticism."*
>
> *"I didn't enjoy the experience. It's given me a lot to reflect on, seeing people in a different light, it changed the dynamics between some of our colleagues, not for the better."*
>
> *"The work fell on a few people and there was a disagreement in the direction of the project which took away the momentum"*

Building relationships and shared understandings: staff–clients, staff–staff and clients–stakeholders, staff–stakeholders:

> *"Time to build relationships and not to rush it."*
>
> *"Staff and clients shared understandings: the project has the scope for staff client relationships to be developed, the expectations brought closer, shared understanding of trauma and sensitive communication"*

"Residents and staff shared understanding: they both see and feel the impact of the relationship building work. they have to spend good time with staff and residents that they understand the goals, what the input they can/should do that makes sense to them in their everyday work or everyday life"

"The whole process is about relationship building with staff and with residents. (also, with the interviewee) a lot of this work has been ongoing for years"

"It is a continuous process of relationship building between staff and residents – it is not an endpoint which is the co-production anchor. It is a process of checking-in, how they were doing how they might do better."

"In our team we worked together well because we know about project management and an itinerary. What role Juli had in overseeing that. We had targets. It was a Project Cycle."

"Stalls promoting partner organisations instead of several representative speakers would have increased engagement between our service users and community-based organisations."

Empowerment, voice and choice are supported; individuals' strengths and experiences are recognised and built upon:

"Project was advertised to residents to try and get their involvement and have a say, to feel empowered by speaking to us of what they think could be done better."

"Every change that we have been directly coming from the residents/service users, so it is what they are expecting"

"Re-framing or re-defining experiences and work paths within TIA"

"Some approaches may already have elements of trauma-informed. This made it easier to explain or coach the staff on this project. As an example, if staff gets shouted at by a resident, staff are able to reflect and discuss on the potential contributors to the behaviour without taking it personally … It has helped us look at incidences differently and de-escalate situations better"

"It's about the approach, supporting the person to the goal rather than expecting the goal to be met."

"Being more self-aware and understanding the people's behaviour and making excuse for others. Asking the right questions to have clients open up and seek support for their trauma."

"I think it's important, in terms of how we behave and respond to clients. It's been an eyeopener to be fair."

Raising awareness, capacity building and agency: both staff and residents taking ownership over the work and engaged in the co-production/participatory groups with shared responsibilities:

"The aim of the co-production was that the people gain awareness of TI and generate ideas of what could be done for a TI service. Also, to build capacity in the client and staff team as well."

"Get more people involved and delegate tasks a bit more. There wasn't a team leader – We don't want to give up, we want to push things forward. We need more people to be involved! So, we need to change working as a group – people having roles and responsibilities, focusing vs turning up when they feel like"

"Establish a work path Working group, where staff and clients come together to talk about improving the service."

"The Employment & Skills service works to support people into work who have multiple barriers ranging from poor skills, generational worklessness, health problems, DV and other abuse, debt low self-esteem, etc"

"Dividing up tasks and working together as a group. People could be taught about group dynamics, take ownership of your idea."

Reflexivity in co-production, integrate feedback systems:

"I think the initial training on identifying/recognising and responding to trauma was very informative and allowed some good self-reflection for both staff and clients."

"There will be staff feedback on changes but maybe we need to think about getting residents feedback more often."

Giving clients and staff a choice finding the right way to contribute or engage:

"Improving residents' engagement: They can never do enough communicating, enough time to get people on board, learning the differences between residents and how they can ensure their input (e.g. giving access to

someone with physical disability, someone who is very digitally minded and want to give input that way) being mindful of giving people a choice and a range of ways for involvement."

"It's good to have this type of project but people shouldn't feel like they have to participate in such a project. It should be optional; it takes away from the joy and the passion from the whole thing if people feel like they have to be there."

Flexibility and sharing responsibility:

"[The success of making it work as a team was…] realising that the world doesn't revolve around this project, what we say doesn't necessarily go. It was our baby and we wanted to make it work. There was so much we had to put through Comms, you have to take a step back and realise that the world doesn't revolve around you, you have to be nice to people. You can't do it all on your own. Gives the Kickstarters a different view of the work and Kickstarters didn't want to let their team down, people had smaller responsibilities. Giving people smaller responsibilities. I hate relying on other people to do things, but that's not how you work as a team."

"It needs to be clear that everyone will need to work to drive it forward."

"Not impose a certain structure to engage with patients."

The following section builds a synthesis of the of the research participants accounts and looks at their insights into the learning gained from implementing the trauma-informed pilots.

Key theme Learning*: Learnings for future action on becoming more trauma-informed in Tower Hamlets (e.g., helpful practices, gaps, areas for improvement, key considerations). This includes advice on what long-term measures of effectiveness/implementation to consider for future programmes and interventions.*

Learning

(sub-theme: Trustworthiness)

- Training increased workforce understanding of trauma
- Reflexive practice is needed to increase transparency
- Transparency is a key principle for local TI approaches
- Transparency in staff communication
- Communicating everything with service users, but on a level that they easily understand
- Learners were happy to train TIP as it would raise their awareness of working with service users experiencing personal trauma
- Increase service users involved in co-producing the design of the service and consistently done
- Understanding trauma also helped improve and build relationship with all parties
- Uncertainty about how much trauma-informed working could really help

Learning

(sub-theme Cultural, historical and gender issues)

- Services are not inclusive or representative of BME residents and wider marginalised communities
- Limited recognition of young people's trauma and how to support them in housing, education or training
- Services need to be humanised to recognise clients' unique biographies
- Consistent failure to engage LGBTQ+ and other targeted populations
- Dealing with subjectivity in TIP e.g., filling paperwork for employment might be re-traumatising for someone
- Reluctance to take part in study due to concerns being unaddressed in past studies
- Training should include face to face

Trustworthiness and transparency in the way operations and decisions are conducted

Building trust and relationships with clients:

"We have been looking at how we can continue and what we can put within our organisation. Perhaps smaller aspects e.g., continuity of staff to a resident to build trust. Hopefully this can improve someone's experience"

"We have had conversations. We put our foot out there to engage with local residents – and found that people do want to seek support. It's been a learning curve – building respect, navigating barriers, being aware about mental health."

Clear and simple processes for clients and clarity in expectations for staff:

"Having a simple model of change i.e. Quality of Improvement methodology to make the changes"

"Clearer guidelines in project briefing, such as around the financial process"

Context and audience specific and appropriate working approaches for TIA:

"*Non appropriate approach: BBBC used to generic approach and discussions to be relevant for moving the service to be more TI"*

"Lot of indirect work that the residents don't know about in terms of how staff thinking of and feeling about the residents and how that translates into care and support planning, which residents might not pick-up on directly."

Transparency in communication processes and challenges:

"It is not just about the activities but whose idea was it in terms of empowerment, in terms of choice, then how do they make that space safe, ie the safety aspects of TIA. They do not hide these things, they talk to people, they are transparent. It does not matter what the change idea is, it is trauma informed if there is some leadership there, choice there, empowerment there, they thought about the safety"

"We've been blessed with the team that we have. We were on the phone, we got clarity from an early point, we had the same vision and the same drive. It's very easy to ignore an email but people didn't. People played different roles. Everyone put in the work, we worked as a team. Some members were saying 'My manager is telling me not to focus on this'. [The approach was] if there's something you can't do, just email us."

"We purchased items from Amazon through our business support team – this included our complimentary gift cards to go in our goodie bags – they never arrived and after speaking to the support team, they told us that they didn't put the order through in the end."

Cultural, historical and gender issues are addressed, and historical trauma is acknowledged

Acknowledging historical and cultural and race related trauma:

"We are moving some of the barriers to better understand how your past can shape who you are. It can shift your thought-process. It definitely encourages the staff team to look at behaviours more empathically and holistically and respond accordingly."

"There were some really great conversations about privilege and race, and also a lot about like ... informed choice and almost like written agreements."

Cultural competencies and culturally appropriate services:

"To make the service more diverse she contacted an organisation working with Somali women who don't speak English and got help from Edna, an appointed Somali engagement officer"

"Her role involved reaching out to the wider communities (ethnic communities, LGBTQ, etc.) referred to the service, making the appropriate assessments and allocating appropriate counsellors to those clients

"People wanted to bring relatives with them and faith groups – it's about having inclusive conversations - educating ourselves and other people"

Representation of different demographic figures: age, gender, and ethnic and disabled groups:

"Plans to establish a participatory group: they will be a built-in feedback mechanism but also representing the interest of service users: getting different demographic figures involved to represent a range of service users"

"Getting different demographic figures involved to represent a range of service users."

"Obstacles are unwillingness to engage and participate with or without mental health issues, some are very much engaged. Challenged to due socio-economic situation, raising cost, job market, education, hopelessness and lack vision for the future."

"Overrepresented group according to data, young white British males. NEET, more are not in in Education employment or training."

"Our original age target was 18-24, but after sending out the invites, we only had two people within this target group respond. We found that after sending out the invites – the age range of 30-45 was more responsive to the approach, we do feel that the 30+ are more aware of their trauma and more willing to get the help and participate in mental health events."

Service improvement projects where services engage residents and staff in adopting trauma-informed approaches

"It provides ways for staff and residents to engage that is not task-focused, giving the opportunity to feel equal, and having fun with each other and strengthening the relationships."

"It makes us understand better how to operate as a functional, normal being after having traumatic impact. It also changes how we speak to each other (staff). It allows us to give the support clients truly need."

Co-production and participatory approaches:

"Part of the methodological commitment to trauma-informed change processes is to have an ongoing co-production with residents on projects and having ways residents can engage with the practice"

"Embedding those programmes to get residents engage in/understand trauma. It has enabled us to respond appropriately, for us to teach them."

*"If you are **consistent and persistent** on offering people opportunities, they will take them up/engage."*

"Co-production focus: what/how it could be represented in the employment and skills services, what are the things they were already doing, what more/different they could potentially do? Bringing those ideas together and making them more concrete: everyone just getting down to their project plans and into their project teams"

"The kind of barriers they had that they had to solve as part of the project is things like digital inclusion, having a shared platform with staff and residents, but during the life of the project they solved this and now the project team members have the same level of access to resources than the staff team."

Embedded TI approaches and integrated services:

"Making sure everybody does the project so that it becomes what everybody does and not just a discreet project – becoming embedded in the service and ensuring sustainability of the project."

"Balancing and encouraging participation without coming off harassing people. Keeping up enthusiasm to keep going is also a challenging."

"Whole journey from registration to end – everyone needs to be trauma informed. Every staff of Tower Hamlets need to adopt that trauma informed approach – we are responsible for our residents. We have to have more trauma informed questions in the registration process and offer trauma informed sessions and refer to suitable partners for help for those who need it"

Feedback mechanisms through participatory conversations:

"She is a patient experience midwife. She speaks to pregnant women using maternity service at RL to collect their feedback and use the feedback to impact changes and improve the service. She shares the common themes with other midwives and managers. She is currently running the TIA project at Royal London on her own."

"… Created a monthly meeting with 2 other patient experience advisors to share anything findings from TIA to make sure that they are consistent throughout all 3 sites and that women in all areas are getting the same information, and from any feedback they receive"

Staff wellbeing focus:

"Much focus is on making patients happy and forget about staff's feelings and a huge chunk of this project has actually been on staff wellbeing, what makes them feel better and make them more likely to provide better care"

"We hadn't had equivalent team building sessions before. We ran a go karting event and have more plans."

Resident engagement strategies and raising awareness of services:

"Service has not been enhanced as per respondents' knowledge."

"Keep engagement with people who use the service, appointments etc multiple reminders. When turn up they are likely to remain engaged, hurdle – get them into the first appointment… but also try to be more outward with social media etc, as an unofficial impression."

"Increased participation can be achieved by delivering future mental health awareness events, open to all work path clients 18- to 24-year-olds, single parents and over 50's along with a guest or relative. Creating a greater environment of openness may assist in removing the stigma attached to reaching out for mental health support."

Research participants accounts provide valuable insight into a range of learning for future action on becoming a more trauma-informed borough. Several the research participant's short-term outcomes are reflected in current literature. Sweeney et al. (2018) provide a range of outcomes in settings where trauma is prevalent, and organisations in which trauma-informed approaches were not regularly practised. The article emphasis **intersectionality and approaches to working with a trauma-informed lens**. The article highlights, as is argued in this report, that trauma-informed practice is **entering various organisations with different capacities to deliver** (e.g., **mental health settings, homelessness and family/juvenile court settings)** acknowledging the rates of trauma through data and mechanisms considers the specific

impact on **gender and cultural background and heritage**. Significantly highlighted, are practices that are **addressing power imbalances** by engaging with service users through **collaboration and choice** when dealing with trauma. From a policy standpoint, Sweeney et al.'s (2018) and Kennedy (2020) on best practice focus on the formulation of trauma-informed practice policy, which address **interpersonal, process and structure**. As a result, practice outcomes included **reviewing trauma-informed policy at individual organisations,** providing **access to specialist trauma services** and more **intentional engagement in lived experience** of trauma-informed services. Further outcomes included more **engagement from mental health professionals** and more **trauma-specific statutory training**.

Other literature has focused on outcomes for adverse childhood experiences (ACEs) as one trauma-informed approach. Ko et al.'s (2008) body of work has focused on ACEs within education, childhood healthcare and juvenile justice. The study illustrates the **need for early intervention with services** that work with children. The outcome of reviewed services is shown to have **increased the quality of care for children** by practitioners working through a trauma lens and trauma specific. This is observable in increases in **screening for trauma exposure**, **sharing of ACE resources** and ensuring **information is shared to enable continuity of care across service systems**. The article set recommendations for service systems to approach systems more effectively. Le Brocque et al. (2017) and Ko et al.'s text (2008) studies on also stress the further work to **develop trauma identification resources**, **allowing specific traumas to be identified as part of a systems approach** as well as for trauma approaches being differentiated for utilization across the system.

The concept of ACEs impacting childhood and progression into adulthood has been examined by the WAVE Trust (2021), who considered ACEs across four sectors of education, health, housing and policing. A total of 72 senior practitioners with experience of implementing trauma-informed practice contributed to the briefings, which highlights the profound impact when applied through whole-system efforts to tackle ACEs by engaging services across the life course. For example, with a trauma-specific trauma-informed approach in an acute mental health ward, numbers of incidents requiring physical intervention and rapid tranquilisation dropped. **Patients showed improvements** across standardised treatment outcomes (e.g., for anxiety levels). **Staff injuries and vacancies became much rarer, and staff morale is high.** The stresses the need for a trauma-specific view on ACEs presents as being required across services and in instances of childhood (Ko et al., 2008; Le Brocque et al., 2017; Sweeney et al., 2018) and for ACEs that follow on to impacting children into adulthood (WAVE Trust, 2021; Davies et al. (2021).

The following section builds a synthesis of the of the research participants accounts and looks at their insights into the short-term outcomes from implementing trauma-informed approaches and lens in the dife service.

Key theme: Outcomes *Short-term outcomes of the activities, from a range of perspectives (e.g., residents, staff, managers, senior leaders) and what the key enhancing and influencing factors have been (e.g., constraints, facilitators)*

Outcome

(Sub-theme. Collaboration and mutuality)

- Excessive workloads have been pointed out as a reason for burnout and lack of efficiency in the pilot.
- Only works if relationships are established, within and between services. It is a big job to become trauma informed; it needs a strong basis of co-working.
- Staff expressed lack of proper training
- Need for wider system thinking
- More TI awareness within the borough is needed
- No one talks about the borough
- Borough politics and change of Mayor impacts on TI
- Discrepancies between TH policies and provider delivery requirements of TI
- Co-production of ideas among partners

Outcome

(Sub-theme Services users & staff)

- Understanding how trauma-informed ways of working helped with matters of inclusivity, belonging and being more empathetic in our interactions
- Workforce are focused on COVID-recovery plans and do not have the time to fully engage in TIP.
- Clients feel as though the TI practice has been supportive
- Planning events for clients have been cancelled and rescheduled
- Some staff do not feel the TIP training helped to build upon practice
- Some staff feel that their practice has not changed enough post training to say they are TI informed.
- The TIP training did not help to raise voices of all clients
- Individual voices are often lost in the collective voice
- Training reinforced good practice
- Barriers to success are distant and disengaged staff

Collaboration and mutuality between different roles. Partnering and levelling power

Collaborations within staff teams:

> *"…staff speak to each other differently. We listen, we respond differently. This has shown us a different level of empathy that we really needed."*
>
> *"There are 3 groups in the team – client, staff, client and staff groups. We are the client group. The other groups have their own initiatives"*
>
> *"People were working in different teams, it was difficult to put pressure on the other team members who had less capacity."*
>
> *"Difficult as she is doing everything on her own including planning. She went into this project with other members of staff and then it was reduced to two and then the 2nd person also pulled out. They didn't want to do it because they couldn't cope with the workload"*

Working with external agencies and stakeholders – trauma-informed approaches awareness between services:

> *"It has highlighted how external agencies might not be trauma-informed. It varies within the individual you work with. It is how we do the joint working. For example, some residents who are high risk and have multiple agencies involved have trauma due to these agencies involved"*
>
> *"Multi-pronged approach and having multiple stakeholders, not just residents but also senior management involved"*
>
> *"Council doesn't always feel that trauma-informed is priority/supported – doesn't require reporting if there's any incident"*
>
> *"Partnerships have been developed through TI programme i.e. East London NHS Trust participating in Talking Therapies in TH. Working closely to target young people."*
>
> *"Events such as these would be more effective if combined with a synchronised, borough-wide programme of events."*

Accountability mechanisms from external partners:

> *"External partners or commissioners checking in periodically is very helpful, because what they focus on grows and it is useful to talk about it. – this both to realise what they are doing and also reflexive monitoring"*

> *"We need to be helping our own colleagues, remind them that we're being trauma informed and holding ourselves accountable."*

Continuity of service provision and approaches:

> *"Continuity through having the support from management, weekly meetings with staff is helpful to make the changes."*

> *"We need to continue this work, not do it for a couple of weeks and forget about it. We need to ensure that we are still trauma informed and that we are leading by example."*

Approaches within the TIA pilots to generate change ideas:

> *"Trained and recruited pregnant women and staff. One group works with women involving them in the discussion about TIA and sharing experiences. The 2nd group has staff talking about how to become TIA and birth wise. The two groups will later come together, and survey will be used for evaluation"*

> *"Co-production 'produced' 3 workstreams, and 3 groups: 1 client group (Kickstarter YP), 1 client and staff and one staff. – All focused on different things: Client: providing safe, fun, inviting environments for clients where the focus is not only service provision, but a space where they feel safe and accepted and that staff is interested in them and in their experiences. Staff and client: changing physical environment, making it more inviting more colourful, less sterile, a place to feel chill and hang out. Staff: staff H&wb, activities that are fun because staff experienced a lot of traumas during the pandemic."*

Project management:

> *"Need a regular reliable project team and need people who are good at project management"*

> *"Considering having a project lead, either internal or external."*

Discrepancies between Tower Hamlets procedures and policies and provider delivery requirements (within the timeline) – need to streamline work processes:

> *"Due to other commitments from members of the team, we had delays in getting our marketing materials designed and then we had issues with our communications team with getting our flyer and merchandising approved with our logo that we wanted."*

> *"The 'Walk-In Back Rub' company wanted us to pay them before they arrived due to another team also booking them for the following week. This caused issues as we originally were going to pay them 30 days after the event as per the council's policy."*

> *"The turnaround was too quick for the way that the council operates. For example, the payments policy was difficult, we had to get the whole council involved. It's like a jigsaw at the council. On top of running our own daily job … The time it takes to get all those jigsaw pieces in place."*

The research participants account of the challenges and strengths in implementing a trauma-informed strategy is reflected in available literature. There has been limited research into implementing a strategy of trauma-informed approaches in public services. The Public Health England (2021) trauma-informed practice review was instrumental in shaping the notion of lack of data efficacy of trauma-informed practices. They produced a rapid evidence review focused on groups most vulnerable to trauma during the COVID-19 pandemic. However, it was not comprehensive in detailing service-specific needs in each of the reviewed services or identifying common steps or features to implementation (Lester, 2021; Kahan et al., 2020).

Other studies highlight the risk and protective factors of re-traumatisation, service provision **specific competencies and senior staff commitment and proper data usage** as essential features to trauma-informed practices and outcomes improve implementation (Bryson et al., 2017). Bryson et al work is a systematic review of implementation approaches of trauma-informed practices and provides a theoretical framework. However, it lacks the practical nuances relevant to each type of provision. Amaro et al.'s, (2008) argues for implementing a strategy to help trauma-specific and trauma-informed clinical services. Other studies have indicated that a shared theme is also needed to bring together **multiple approaches for trauma working** (Kahan et al., 2020; Bryson et al., 2017; Amaro et al., 2008) when applying a systems-wide approach. Another factor highlighted by Lester's (2021) is the recognition of trauma amongst staff and colleagues, who may suffer traumatic experiences that affect their own wellbeing. Implementing a strategy to recognise this matter stopped staff's personal traumas impacting and adding to issues faced by service users (Lester, 2021). To take account of **geographical and socio-culturally differences of service**, the reviewed articles stress there was a need for a systems-wide approach to make workforces trauma

informed, and to **translate this practice into trauma-specific approaches** relative to circumstances of service user and service provider disposition (Lester, 2021; Kahan et al., 2020; Bryson et al., 2017; Amaro et al., 2008).

5 Discussion and Conclusions

This study has reported on the Tower Hamlets evaluation focused on increasing awareness and to test pilots promoting trauma-informed ways of working. What is borne out by this study is that a business case should be developed by the Council that considers the physical, social, emotional and cultural environments in which residents live and work too hard-wire trauma-informed ways of working in organisations from across the borough. Otherwise, the risk is that trauma-informed ways of working are viewed as a fad and can be easily dropped by services who have been exposed to the programme. The commissioning process also needs to consider how best to establish purposeful targets, which are SMART, and which have longevity and are enshrined in a borough plan. The plan would provide a roadmap to ensure trauma-informed ways of working are sustainable across the borough and address the known barriers and weaknesses in the knowledge gap, design and implementation of trauma-informed practices which are considered both ‘place based’ and ‘service-specific’. The rapid evidence review highlight the follow set of features to strengthen the implementation of a trauma informed system-wide approach.

Implementation	*Description*
	Foundational training knowledge
	Trauma-specific training knowledge
	Training toolkit
	Move from foundational to advance knowledge
	Data gathering (e.g., formative and summative)
	Formulation of hypothesis
	Stet-by-step methods
	Solution-focused and ACE approaches across the system
	Avoid re-traumatisation
	Skills, knowledge and language
	Avoid surface level approaches
	Aim to deeply embed approaches for service changes
	Stannard practices across organisations
	Approaches need to be evaluated (e.g., a range of assessment tools)
	Integrated support across services who share clients
	Embracing the uniqueness of all service approaches
	Active leaders support
	Defining delivery roles
Principles	engagement of TI principles
	Offer choice
	Establishing collaboration
	Fostering empowerment
	Roel modelling
	Promoting trustworthiness
	Inclusive training and supervision
	Systematic efforts to change service cultures
	Collaboration and choice

Learning	Description
	Intersectionality (e.g., gender, 'race', ethnicity and class)
	Services/organisations have different capacities to deliver
	Interpersonal, process and structure
	Reviewing trauma-informed policy of services/organisations
	Access to specialist trauma services
	Intentional engagement in lived experience
	Engagement of mental health professionals
	Trauma specific statutory training
	Early interventions
	Enhancement of care and support
	Reduction in staff violence
	Improved outcomes for patients

Outcomes	Description
	Reduction in re-traumatisation of staff
	Data usage
	Senior staff commitment
	Specific competencies
	Shared theme to bring services and people together
	Multiple approaches
	Geographical and socio-culturally specific
	Recognition of difference approaches in the system
	Translation of learning into practice

The goals of this programme of work have been to respond to the traumatising and retraumatising effects of the pandemic on vulnerable populations, ensuring that public commissioned services are responsive to the complex needs of residents and staff. Crucial to the evaluation has been to better understand how a joined-up approach that treats the 'place', and not just the individual, as a provocation to problems or an exacerbation of historical health inequalities.

The Council's objective is to establish a system-wide trauma-informed, which mission is not helped by the lack of empirical evidence of what a context-specific trauma-informed framework should look like, or without a mature hypothesis for the borough. This hypothesis should take account of the interpersonal, process and structural drivers and barriers in the borough to implementing a systems-wide strategy. Trauma-informed ways of working is not a tick box exercise and the selection of approaches for different services should reflect their uniqueness but at the same time demonstrate continuity in approaches used with clients shared across services and along the life course. This requires senior staff commitment, policy reviews and development, strengthening training and supervision, adequate guidance support and resources to finally shape organisational culture to drive forward a trauma-informed practices and lens. This complexity and overlaying of needs were not fully considered at the set-up of the programme.

What is borne out in this study, is that a business case should be co-developed by the Council that considers the physical, social, emotional and cultural environments in which residents live and work too hard-wire trauma-informed ways of working into the system. In other words, what is required by the Council in collaboration with the anchor institutions is a cultural change in the system intentionally leading to a collective set of principles in providing trauma-informed services that will help staff on the ground to drive forward, unify and sustain established and emerging practices. Otherwise, the risk is that this trauma-informed programme is viewed as a fad and what has been achieved can be easily dropped by services who have competing pressure. The commissioning process also needs to consider how best to establish purposeful targets, that are SMART and have longevity and are enshrined in a Council business plan. The business plan would provide a roadmap to ensure trauma-informed ways of working are sustained across the borough.

5.1 Recommendations

Developing and delivering a strategic approach

The Council should:

- Lead anchor institutions to form a task and finish group to co-design and co-produce a **borough-wide trauma-informed strategy**.
- Discuss with anchor institutions how to **co-produce a trauma-informed business plan** for the borough alongside ways to strengthen funding streams and organisational commitment.
- Discuss with anchor institutions how to develop a **joint business case** (and commissioning specifications) for the continuation of a trauma-informed programme for the borough and to **establish a standard set of practices**.
- The Council and anchor institutions should:
- Focus on **culture change** to shape the strategic and business plans, which requires top-down and bottom-up engagement with the VCS and residents.
- Provide the workforce with **step-by-step guidance** on how to apply trauma-informed ways of working and lens in the borough and what success might look like.

Embedding participation across our organisation.

The Council should:

- **Assist anchor institutions** to further embed trauma-informed approaches in their core services by ***embracing the uniqueness*** of all organisations.
- Co-produce a borough wide trauma-informed **toolkit drawing on the unique approaches tested** and ran in the borough
- Ask anchor institutions to **gather and share data on related lived experience of trauma experienced by staff and clients to work on an evaulation framework** that shows formative and summative results to assist evidence-based decision making.
- Better monitor and find new ways to **support staff experiencing trauma** in the workplace and how to better communicate trauma-informed practice values far more widely.
- The implementation of a trauma-informed brought wide strategy (business case) should avoid overloading assigned coordinator(s) and **provide adequate resources and practical support**.

Working with our community sector

The Council should:

- Ask VCS how they can **support the voices of marginalised communities are heard at every stage** of the co-production process of a borough strategy, ensuring that the interpersonal aspect of trauma is not overshadowed by the procedural and structural concerns.
- The VCS should lead on **co-developing a mechanism** in partnership with the Council to ensure marginalised communities are empowered and supported to get involved in the co-production of a system-wide trauma-informed strategy.

Key skills and knowledge needed

The Council should:

- Engage with partners to develop a **shared understanding of what the goals, aims and** Talk **expectations** of a system-wide trauma-informed approach(es) for staff and residents.
- Talk with partners and **map trauma-informed training offerings** with a view of listing courses and/or pooling resources to maximise the reach to potential leaners.
- Lead on **co-developing and jointly commissioning** a statutory training programme and develop trauma identification resources to integrate the multiple approaches used in the borough.

- Work with partners to **provide specialist trauma training for professionals** to enable continuity of care across service systems and along the life course.
- Discuss with anchor partners how to **provide refresher training** that provides the VCS and Public sector workforce and clients with concrete skills, language and knowledge to effectively avoid re-traumatisation.
- Ensure that commissioned trauma-informed training is **interactive, working with small groups sizes, and provides real-world examples** to model best practice.
- Ask that contracted trainers are **culturally reflective** of the community of learners to establish trust and credibility to allow learners to have a safe space to identify and explore context-specific trauma.
- Discuss with strategic leads on how best to **engage senior managers' commitment** to attend training to build trust and confidence in frontline staff implementing trauma-informed approaches.
- Consider the design of the training programme to formulate a hybrid approach providing **foundational and advanced** knowledge.

To summarise, the mainstreaming of a trauma-informed approach across the borough will be complex, and it requires time, ongoing tailored training, guidance contextualised in a 'placed' based approach to best address the service-specific needs of the residents and staff in the borough. This holds transformative potential to create structural change, but it requires more resources (funding, personnel and assets), more training (especially trauma-informed training, but also sensitivity training) and more advertisement to extend reach and knowledge of the services.

5.2 Limitations

The wellbeing scale was showing signs of decrease in 2016; however, no further years have been found available. A cursory look at ONS data shows that the WEMWBS has stopped being used in favour of other methodologies, most notably the Annual Population Survey, at least in what pertains to evaluating general population wellbeing. Furthermore, the scale has been showing very little variance in between years. The SD is of 7, which is quite large and indicative of widespread from the mean. This means that the small variations observed might not be significant. A 27 persons sample taken as a baseline is not a big enough sample, and we can only compare its average to results from 2016, not knowing how much those results might have evolved in the following years. Also, the high SD might imply that the difference found might not be as significant. Furthermore, variations to be expected in the six-month period of intervention might likewise not be very significant.

5.3 Endnotes

According to data published in 2017, the national average of England using the Warwick–Edinburgh Mental Well-Being Scale (WEMWBS) in 2016 was 50.1 for men and 49.6 for women, declining from 2015 when the average was 51.7 and 51.5 respectively. This suggests an increase in the gap of mental wellbeing between men and women for this period.

Those living in the most deprived areas had average wellbeing scores of 48.6 for men and 47.3 for women, compared with 51.5 and 51.0 respectively among those living in the least deprived areas. The prevalence of probable mental ill health was greatest among men and women in the lowest quintile of equivalised household income, with 24% of men and 27% of women reporting a GHQ-12 score of 4 or more, compared with 13% of men and 17% of women in the highest income quintile. Men and women with a high GHQ-12 score had lower average wellbeing scores than those with lower GHQ-12 scores. Average wellbeing scores for those who scored at least 4 on the GHQ-12 were 40.8 for both men and women, compared with 53.3 for men and 53.4 for women with a GHQ-12 score of 0.

WEMWBS has a mean score of 51.0 in general population samples in the UK with a standard deviation of 7, which is rather high. However, the WEMWBS scores in England between 2010 and 2016 have remained stable, if declining. 2016 marked the lowest scores in the 6-year period, and no further years have been made available to assess evolution.

Data forwarded by the East London NHS Foundation trust from a 27 persons sample suggest a mean score slightly below the England averages found in 2016, at 39.7.

6 Appendix

	Organisation	Role
1	WAVE Trust	Founder & CEO
2	TH/RL Maternity Services	Project coordinator
3	Commissioning Manager	Commissioning Manager Founders
4	TH Adult Psychology Services	Trainer/Psychologist
5	Providence Row Housing	Support worker
6	Providence Row Housing	Support worker
7	Providence Row Housing	Support worker
8	Providence Row Housing	Support worker
9	Providence Row Housing	Support worker
10	Providence Row Housing	Support worker
11	Providence Row Housing	Project facilitator
12	Providence Row Housing	Contract Manager
13	Providence Row Housing	Data & Monitoring Advisor
14	Employment & Skills	Trainee
15	Employment & Skills	Trainee
16	Employment & Skills	Manager, LBTH Supported Employment
17	TH Adult Social Care	Service Quality & Development Lead
18	TH Public Health	Programme Manager, Healthy Young Adults
19	ELF Adult Psychology Services	Lead for Psychology & Psychological Therapies

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