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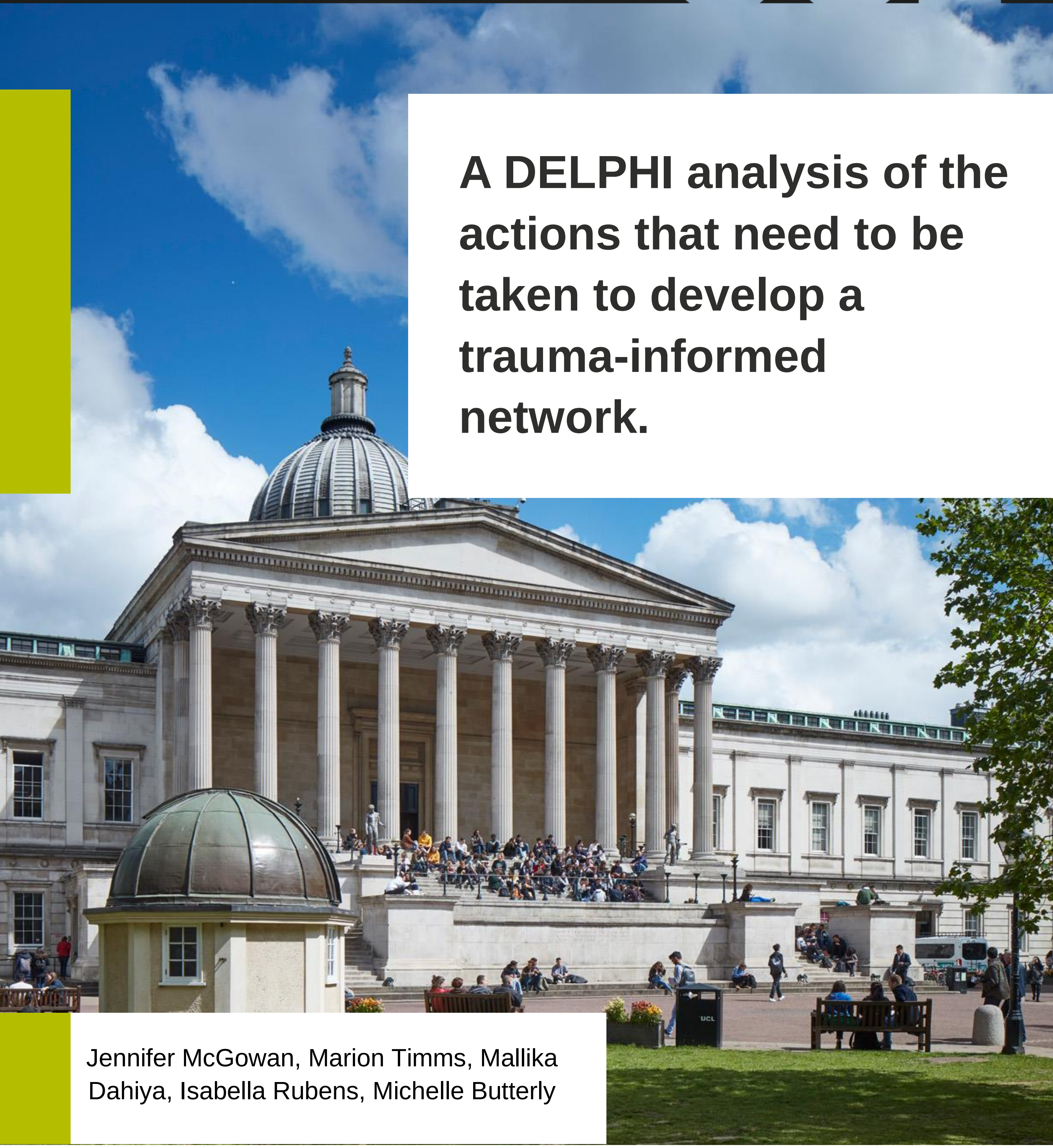

A DELPHI analysis of the actions that need to be taken to develop a trauma-informed network.

Jennifer McGowan, Marion Timms, Mallika Dahiya, Isabella Rubens, Michelle Butterly

Camden and Islington
Trauma-informed network

Fulfilling Lives in Islington & Camden

Resilience Research Group

UCL PALS

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a. Key words:

Social care; trauma-informed; DELPHI; social support; network of care

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1. Study team

a. Investigators

Dr Jennifer McGowan (PI), Lecturer, Department of Experimental Psychology (University College London); *Resilience Research Group:* JM is a health psychologist and epidemiologist with a background in resilience research and DELPHI analysis. JM will be providing experience on DELPHI analysis, and development of the research plan and will be providing scientific oversight. JM will be supported by a team of researchers (below).

Marion Timms, *Department of Experimental Psychology,* Division of Psychology and Language Sciences*,* University College London (UCL).

Mallika Dahiya, *Department of Organisational and Business Psychology,* Division of Psychology and Language Sciences*,* University College London (UCL).

Isabella Rubens, *Department of Experimental Psychology,* Division of Psychology and Language Sciences*,* University College London (UCL). IR is a research assistant with a background in mental health, resilience and trauma.

b. Collaborators and collaborating organisations

i. Fulfilling Lives in Islington and Camden (FLIC)

Michelle Butterly, *Single Homeless Project; Fulfilling Lives in Islington and Camden.*

The Fulfilling Lives programme is a £112 million investment over 8 years supporting people who are experiencing multiple disadvantages. The programme funds local partnerships in 12 areas across England to test new ways of ensuring individuals receive joined up and person-centred services which work for them.

The Fulfilling Lives programme funded local partnerships in 12 areas across England to test new ways of working to ensure that people experiencing multiple disadvantage are better able to manage their lives and have positive encounters with services that are more appropriately designed to meet their needs. In this programme, 'multiple disadvantage' is defined as people who experience two or more overlapping needs including homelessness, a record of current or historical offending, substance misuse, and mental ill health.

FLIC (Fulfilling Lives in Islington and Camden) is a learning programme designed to create positive changes to the lives of people experiencing multiple disadvantage, through collaboration with local partners, insights from Co-production, and learning from systems change experiments. FLIC are part of SHP, the vision, mission and values can be found here: https://www.shp.org.uk/values.

i. Camden and Islington Trauma Informed Network

In June 2021 FLIC established the Camden and Islington Trauma Informed network to advocate for trauma-informed approaches across the entire system. Camden and Islington trauma-informed network is the collective effort of people with lived experience and those in roles across sectors. They formed with a shared interest to connect the disparate trauma-informed approaches across the system and create a shared language and approach. The network advocates for trauma-informed approaches that are rooted in the wider system by bringing people together and connecting conversations. They believe that we are stronger together and need representation of the many, not the few.

The Camden and Islington Trauma Informed Network partnered directly with UCL during this project, and the results of this analysis are intended to direct and facilitate the further development of this network.

ii. Participating Organisations

Our very great thanks to all the organisations and people with lived experience who shared their thoughts, expertise, and examples with us during this process. We would like to thank:

All of our lived experience participants

Camden Council Integrated Early Years,

Camden Council,

Change Grow Live Camden

FLIC

Hopscotch Women's Centre,

James Wigg Practice

London Borough Camden,

NHS North Central London Clinical Commissioning Group,

One Housing

Pause Islington and Camden,

Single Homeless Project

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Executive Summary (1,000 words)

Trauma can be defined as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being"[1]. People who have experienced trauma are likely to require support from a range of services[2] across the lifespan. Clients who have experienced trauma are also at increased risk of being distressed or re-traumatized within the system as a result of their care experiences[3,4].

A 'Trauma-Informed Network' has been described as a group of interdisciplinary service professionals, community members, and organizations that support clients receiving care[5]. By collaborating these organisations and individuals improve their ability to build a continuity of effective and complimentary plans of care as the client moves between systems[6,7]. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset[5]. In this way a trauma-informed network can provide benefits not only for clients, but also for their families and communities, for care service organizations, and for staff[5].

There are however barriers to developing and maintaining a collaborative trauma-informed network. A recent proliferation of independent trauma-informed training programs being developed without 1) rigorous assessment of the quality of the information being disseminated[8-11], 2) communication or collaboration with associated organisations[12], or 3) agreement on the methodology being used by the clients at risk; thereby ironically developing interventions which themselves are not being 'trauma-informed'[13]. A key component of trauma-informed care is the participation of staff and clients, as well as organisations, in the development of that care[14,15] in order to redress inequalities in power and decision-making that may further exacerbate trauma symptoms[12]. As such it is integral that a consensus is reached on what trauma-informed care is, and how it should be attained, between all collaborating parties before trauma-informed care can be effective.

d. Aims

Camden and Islington Trauma Informed Network undertook the current study to utilise a combination of existing literature and the opinions of a panel of experts to develop an actionable list of components for developing a 'trauma-informed network', in line with a collaborative trauma-informed care approach. Our research questions were:

1. What components (theories, stakeholders, actions) are required when developing a trauma-informed network?
2. Which components are most important to developing a trauma-informed network?
3. What actions need to be taken in order to facilitate these components?

e. Methods

In order to develop this stake-holder approved plan of action, a stepwise process was utilised. This involved both item generation (the identification of relevant items), and item refinement (the process of confirming the most relevant items). Item generation involved: 1) a literature review of trauma-informed care research, and 2) a series of anonymous online questionnaires using DELPHI style analysis. Item refinement was processed through the DELPHI analysis in up to six iterations. All data was, by necessity, collected online and anonymously.

DELPHI analysis involves the anonymous collection of data from a group of experts originating from a wide range of backgrounds, aimed at developing an unbiased consensus (defined here as 70% agreement)[16]. Responses are sent between participants and a moderator, allowing all group members to participate and interact with each other's ideas while remaining anonymous. The current DELPHI analysis involved six rounds, each held 1-2 weeks apart between 7th January and 28th March 2022.

Ethical approval for this study was granted by the University College London ethical committee. The ethics number is: **EP/2021/017.**

f. Participants

Participants were selected through the Camden and Islington Trauma Informed Network working group. For the purpose of this analysis the panel included experts in social and healthcare, as well as people with lived experience of using the associated services. Our experts were defined as 'people with lived experience of trauma, or experience working in the care sector' (N=33). 26 participant experts were retained for the full length of the study (retention rate of 79%).

Participants were sent each questionnaire via an email link to either Gorilla (round 1) or SurveyMonkey (rounds 2-6) software. Two reminders were sent for non-responders: the first one week after the link was provided, and the second one working day before the deadline.

g. Results

A list of eight theories were identified as relevant to the development of a trauma-informed network. These theories would be beneficial to consider when developing the aims or remit of any trauma-informed network. Although the list of theories remained consistent across rounds, demonstrating certainty on what theories are important to the ethos of a trauma-informed network, no clear consensus was reached on the order of importance.

Agreement was reached that 34 stakeholders should be involved in decision-making. This group can be considered to be key stakeholders in any trauma-informed process, and **necessary** for appropriate trauma-informed decision-making. As such we recommend that these groups are actively recruited when developing a network or decision-making body.

Twelve actions were identified as key outcomes for a trauma-informed network. Consensus was also reached on the order of importance of these actions. As such we were able to provide an itemised outcome demonstrating the recommended focus of any trauma-informed network going forward, including the order in which these actions should be addressed. We recommend that this list is considered when allocating resources and staff time within the Camden and Islington Trauma Informed Network, as well as what should, and should not, be within the remit of a trauma-informed network.

h. Conclusion

Using DELPHI analysis we have provided a short-list of the most important aims, partners, and actions to consider when developing a trauma-informed network. We have also provided considerations on how these can be implemented, based on the comments and experiences shared by our expert participants during the DELPHI process. We recommend that these outputs are taken under consideration when directing the focus and development of the Camden and Islington Trauma Informed Network, such that resources can be most effectively allocated to both meet the needs of the service user population, and to best engage partner organisations.

Abstract (350 words)

Background: The outcomes of a traumatic experience can be wide-reaching, such that individuals who have experienced trauma may be at an elevated risk for behavioural problems, mental health problems, and physical conditions. As such trauma experience may necessitate frequent interactions with the care system across the lifespan. In order to effectively meet the needs of this population multidisciplinary collaboration is required. However this collaboration is hindered by differences in definitions of 'trauma-informed care' between organisations, and a recent proliferation of independent trauma-informed training programs being developed without communication or collaboration with the clients at risk.

The current study aimed to utilise a combination of existing literature and a DELPHI analysis to develop an actionable list of aims, partners, and outcomes for developing a 'trauma-informed network'. Our research questions are: 1) What components are required when developing a trauma-informed network?, 2) Which components are most important to developing a trauma-informed network?, and 3) What actions need to be taken in order to facilitate these factors?

Methods: Item refinement was processed through the DELPHI analysis in up to six iterations aimed at developing an unbiased consensus (defined here as 70% agreement)[16]. All data was collected online and anonymously. Participant experts (N=33) were defined as 'people with lived experience of trauma, or experience working in the care sector'.

Results: A list of eight theories were identified as relevant to the development of a trauma-informed network, however no clear consensus was reached on the order of importance. Agreement was reached that 34 stakeholders should be involved in decision-making. Twelve actions were identified as key outcomes for a trauma-informed network. Consensus was also reached on the order of importance of these actions.

Conclusions: We have provided a short-list of the most important aims, partners, and actions to consider when developing a trauma-informed network. We have also provided considerations on how these can be implemented, based on the comments and experiences shared by our expert participants during the DELPHI process. We recommend that these outputs are taken under consideration when directing the focus and development of a trauma-informed network.

1. Background

a. Trauma

Trauma can be defined as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being"[1]. Trauma can occur whenever an individual experiences an event (such as assault, injury, or threat of death) that they are unable to prevent, stop, or psychologically process[17]. This can entail commonly recognised forms of trauma (e.g. physical assault, homelessness, child abuse), but also experiences such as cancer diagnoses or paediatric illness[2]. For some individuals the reactions to a traumatic event are temporary, whereas for others trauma may have more severe, prolonged, or enduring consequences[5].

The outcomes of a traumatic experience can be wide-reaching and overlap, such that individuals who have experienced trauma may be at an elevated risk for behavioural problems (substance use disorders, avoidance, decreased engagement, engagement in high-risk behaviours), mental health problems (e.g., depression, anxiety, stress, hostility, detachment), and physical conditions (fatigue, sleep disorders, digestive changes, hyperarousal, elevated cortisol levels), amongst many other symptoms[5,18-20]. Many of these 'symptoms' in turn may exacerbate the risk of 1) the other symptoms[21], 2) developing adult health problems (e.g. sexually transmitted disease, obesity, ischemic heart disease, and cancer)[22], 3) increased difficulty in maintaining employment or housing, or increased risk of incarceration, and therefore 4) further trauma[2,23,24].

As such, people who have experienced trauma are likely to require support from a range of services[2], and trauma experience may necessitate frequent interactions with the care system across the lifespan. In order to best support these individuals, there is a growing awareness the impact of trauma on emotional, physical, and functional impairment[2] in health and care systems including; child welfare services, the criminal justice system, the physical health care system, the military, schools, and universities[11].

While there are great benefits to the recognition of trauma within these institutions, clients who have experienced trauma are also at increased risk of being distressed or re-traumatized within the system as a result of their care experiences[3,4]. This can occur through a repetition of environment (e.g. feelings of lack of control, being told to relax, or being confined) or touch (e.g. in the case of violence-related trauma) during care which mimics the feelings that the client experienced during their prior trauma experience[25-27]. It can also occur in relation to the distress felt in response to diagnosis. For example, childhood sexual abuse survivors have been shown to experience the resurgence of previously unrecognized memories of abuse and subsequent trauma symptoms as the result of cancer diagnosis and treatment[28]. Trauma-survivors may therefore experience distress, dissociation, or other uncomfortable symptoms in response to seemingly non-invasive health care procedures, such as the tightness of a blood pressure cuff, the angle of the chair at a dental appointment, the confinement of an MRI machine, or the weight of an x-ray apron[4].

b. A trauma-informed network

In order to effectively meet the needs of this population while reducing the risk of re-traumatisation, health and social care must by necessity be trauma informed. As defined by the Substance Abuse and Mental Health Services Administration[1] 'trauma-informed care' (TIC) comprises of four elements: 1) realizing the widespread impact of trauma; 2) recognizing how trauma may affect children, families, staff, and others in the system; 3) responding by applying TIC knowledge into practice; and 4) resisting re-traumatization. Instigating this system may involve changes to the classic health-care model, organisational training, and mindfulness on how trauma may be triggered or manifest. It could, for example, involve changes to provider behaviour (e.g. taking longer during screening to reassure the client[29], or talking them through the procedure[30]), reassessing routine procedures on a case-by-case basis (e.g. in the need for, or modifications to, cervical cancer screenings)[31], and empowering clients by providing them with more agency in relation to their care (e.g. through confirming willingness to participate in treatment or acknowledging self-expertise in relation to symptoms[4])[32].

More than this, researchers across disciplines agree that multidisciplinary collaboration is a principal element of trauma-informed care[4,29,33-35]. In order for trauma-informed care to meet the needs of its clients it must span multiple care organisations, such as of addiction treatment[36,37], physical therapy[6], psychiatric care[38,39], palliative care[7], gynecology[4], dentistry[27], and prison services[40]. It is important that care is consistent across each of these services, and that each is trauma-informed: both individually and as a collective, to prevent multiple potential incidents of re-traumatization. In other words, a 'network' of care is required.

A 'Trauma-Informed Network' is a group of interdisciplinary health, education, and human service professionals, community members, and organizations that support clients by providing access to evidence-based resources and support[5]. By collaborating these organisations improve their ability to develop accessible support[29], to provide stream-lined and appropriate referals[5], and to build a continuity of effective and complimentary plans of care as the client moves between systems[6,7]. For example, routine mental health screenings in HIV clinics may provide appropriate referrals and support to clients struggling with their condition (or how they were infected) that may otherwise be missed. Reducing the number of unfamiliar environments that a client is required to navigate, or the number of times that they are required to recount their symptoms (by sharing notes between organisations) reduces the risk of re-traumatization and may put clients more at ease[33], improving the accessibility and continuity of care and reducing drop-out[4]. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset[5]. In this way a trauma-informed network can provide benefits not only for clients, but also for their families and communities, for care service organizations, and for staff[5].

c. Limitations in the current use of 'trauma-informed network'

There are barriers to developing and maintaining a collaborative trauma-informed network. These can be as simple as variations in definitions of 'trauma-informed care'[4] between organisations, or as complex as differences in capability in terms of adequate private space or time for disclosure, expertise, or the ability to reduce opportunities for re-traumatization (for example in the case of prisons)[4]. As Hanson and Lang[10] communicated; developing too broad a definition of what it means to be 'trauma-informed' makes it impossible to communicate about, implement, or evaluate trauma-informed practices at a collaborative level.

There is also the problem of a recent proliferation of independent trauma-informed training programs being developed without 1) rigorous assessment of the quality of the information being disseminated[8-11], 2) communication or collaboration with associated organisations[12], or 3) agreement on the methodology being used, by the clients at risk; thereby ironically developing interventions which themselves are not being 'trauma-informed'[13]. A key component of trauma-informed care is the participation of staff and clients, as well as organisations, in the development of that care[14,15] in order to redress inequalities in power and decision-making that may further exacerbate trauma symptoms[12]. As such it is integral that a consensus is reached on what trauma-informed care is, and how it should be attained, between all collaborating parties before trauma-informed care can be effective.

d. Aims of the current study

Many people utilising social care experience multiple disadvantages (e.g., homelessness, substance addiction, disability, mental health issues, etc.) and therefore need to access several services concurrently. Currently these services work independently, meaning that there is substantial overlap in effort and support provided, but little collaboration in the language used, or advice provided.

The current study aims to utilise a combination of existing literature and the opinions of a panel of experts including care providers, care organisations, and people with lived experience to develop an actionable list of components which are required by the UK's care network, in order to develop a 'trauma-informed network'.

We intend to do this using a DELPHI analysis such that each participant will have an equal voice in the development of this list, and the associated weight provided to each item. Our research questions are:

4. What components (theories, stakeholders, actions) are required when developing a trauma-informed network?
5. Which components are most important to developing a trauma-informed network?
6. What actions need to be taken in order to facilitate these components?

The results will be used to provide a report including an itemised list of what actions need to be taken in order to develop a 'trauma-informed network' in a real-world setting. In this way we intend to develop a research-led collaborative approach to trauma-informed care.

2. Research Design and analysis

This project intends to develop a hierarchical plan of action, based on 360-degree stakeholder engagement of organisations involved in social care (councils, charities, NHS organisations, people with lived experience), which can be used to develop an effective, collaborative trauma-informed network. The results can be used not only to streamline the Camden and Islington Trauma Informed Network, but also to identify the factors which are likely to be effective in wider network contexts.

In order to develop this stake-holder approved plan of action, a stepwise process is required. This involves both item generation (the identification of relevant items), and item refinement (the process of confirming the most relevant items).

Item generation involved: 1) a literature review of trauma-informed care research, and 2) a series of anonymous online questionnaires using DELPHI style analysis. Item refinement was processed through the DELPHI analysis in up to six iterations. All data was, by necessity, collected online and anonymously. For the purpose of this study, we were interested in components relating to three main questions:

1. What theories should be implemented in a trauma-informed network?
2. What stakeholders should be engaged in the work of a trauma-informed network?
3. What actions should be taken by a trauma-informed network, in order to enable trauma-informed care?

a. Literature review

We searched white literature (published research papers) for quantitative and qualitative research articles reporting on trauma-informed care. We also searched the grey literature, including organisational reports and websites for trauma-informed care recommendations. A full list of search terms is available below:

> [allintitle]: "*Trauma-informed AND network OR care OR barriers OR treatment OR practise OR practice OR principles OR care OR framework*"

Searches were run on google search and google scholar. As we were searching for the components that trauma-informed care is based on, the methodology of the paper was not considered. Instead, any relevant papers were reviewed for pertinent information.

Additionally, the following search strategy was used:

> White literature was sorted by year (newest first) such that more relevant and up-to-date literature was explored first. The search was stopped once no papers on a new search page provided new codes. At this point the literature was believed to have reached saturation. Papers were accepted from the past ten years (since 2011) as earlier literature was considered to be outdated.

Grey literature was searched for on Google up until new pages no longer provide further trauma-informed activities or needs. When no links on a google search page provide new codes, the search term was abandoned. An image search was also conducted to identify relevant models of trauma-informed care.

Four independent researchers (JM, IR, MD, MT) searched the literature and extracted relevant components about the structure of trauma-informed care, and actions taken to make care trauma-informed. This was used to develop the item pool. The number of times that each concept or action appeared in the literature was also recorded.

Two independent researchers (JM, IR) assessed the resulting list of items for accuracy and completion. Equivalent items were discussed and combined or removed. Agreement was reached on the saturation of the literature.

b. DELPHI analysis

DELPHI analysis involves the anonymous collection of data from a group of experts originating from a wide range of backgrounds, aimed at developing an unbiased consensus[16]. Responses are sent between participants and a moderator, allowing all group members to participate and interact with each other's ideas while remaining anonymous. This allows for the development of an unbiased group consensus.

The DELPHI process can be summarised as the following steps:

i. Collect unprompted components from participants (e.g. actions a trauma-informed network should take), using a questionnaire.
ii. Combine these components (anonymously) with those from the literature and send back to all participants, asking them to identify those that they feel should remain on the list.
iii. Send the list of components back to participants to vote on, along with the level of consensus reached, and the anonymous comments of previous participants. Ask them to vote again on which components should remain or be removed based on the collective responses from the previous round.
iv. Repeat until consensus (70% agreement) is reached, or until it is clear that no consensus will be reached (often 6 rounds), taking into account participant comments at each round.

This process allows for all participants opinions and ideas to be given equal value, and equal value with what has been identified in the literature. It also allows that, regardless of background, each participant is equally involved in the choice of components of actions which are deemed 'important', and that only commonly agreed components are sustained and developed into actions.

Additionally, as we were interested in not just developing a list of trauma-informed actions, but also a *hierarchy*, we added the following round:

i. Ask participants to rank the components in order of importance.
ii. Provide the ranked list – based on the average rankings for each item – to the participants for approval or rejection.
iii. Provide alternative orders of lists to participants based on participants feedback, with the aim of gaining consensus on the preferred order of components.
iv. Repeat until consensus is reached, or until it is clear that no consensus will be reached (often 6 rounds), taking into account participant comments at each round.

c. Participants

Participants were selected through the Camden and Islington Trauma Informed Network working group (funded by FLIC). The FLIC programme funds local (C&I) initiative to test new ways of working to ensure that people experiencing multiple disadvantages are better able to manage their lives and have positive encounters with services that are more appropriately designed to meet their needs. The 'Camden and Islington Trauma Informed Network' is already in development, and so they have access to active members of care providers, care organisations, and people with lived experience.

Recruitment emails (*see appendix C*) were sent to each participating organisations by the Camden and Islington Trauma Informed Network, explaining what the DELPHI experiment would involve and hoped to achieve. The information sheet (*see appendix B*) was also provided as part of this email. Any employee of these organisations was welcome to participate. 'Camden and Islington Trauma Informed Network' also provided a recruitment email to people with lived experience of trauma, as identified through participation in one or more 'Camden and Islington Trauma Informed Network' working groups. People with lived experience were additionally offer £10 compensation for their time per survey completed.

Interested participants emailed the research team directly and were provided with email links to the DELPHI questionnaires as they became available. Prior to the first round participants were sent an information sheet detailing the aims and methods of the study (*appendix B*). This sheet was also provided at the start of the first questionnaire, along with a consent form (*appendix A*) which participants had to agree to participate in the study. Participants were free to withdraw from the study at any time, including during completion of the consent form.

iii. Expert sample

For the purpose of a DELPHI analysis, a sample of as little as three experts is considered adequate, as the method aims to develop an expert consensus, rather than an exhaustive amount of data. As such it is important to select people who are knowledgeable in the field of study and represent a range of relevant viewpoints on the topic at hand[41]. Between 10-50 experts are recommended for most topics, dependent on the scope of work[42].

For the purpose of this analysis the panel included experts in social and healthcare, as well as people with lived experience of using the associated services. Our experts were defined as 'people with lived experience of trauma, or experience working in the care sector'.

40 experts agreed to participate in the DELPHI. Of these, seven were excluded from the analysis: five participants did not participate in any of the six rounds, one participant withdrew from the project, and one was excluded as the research team were unable to get in contact. This resulted in a sample size of 33 experts: 14 (42%) were people with lived experiences, and 19 (58%) were staff from participating organisations. Of the staff participating, the expert participant panel included representatives from *London Borough Camden, Camden Council, Pause Islington and Camden, Change Grow Live Camden (N=2), FLIC (N=3), Hopscotch Women's Centre, NHS North Central London*

Clinical Commissioning Group, Camden Council Integrated Early Years, Single Homeless Project (N=2), James Wigg Practice, and One Housing (N=2). This group consists of organisations working in housing, drug use, homelessness, family planning, domestic abuse support, children's services, healthcare services, and wider borough government.

Within these organisations, our expert staff group consisted of management (*N*=7; Managers, Heads of departments, service manager, team manager, programme manager, CEO), team leads (*N* =5; leads, commissioners, coordinators), and care staff (*N*=3; social workers, GPs, mental health support officers).

26 participant experts were retained for the full length of the study (retention rate of 79%), with a range of participants (3-9) not providing responses at varying rounds. The break-down of participants by round is provided in *table 1* below.

Table 1. The number and percentage of participants participating in each round of the DELPHI, given as a total, and by category (staff or service user).

	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6
Participants (total) (N=33)	30 (91%)	29 (88%)	30 (91%)	27 (82%)	24 (73%)	26 (79%)
Participants (lived experience) (N=14)	14 (100%)	14 (100%)	14 (100%)	12 (86%)	14 (100%)	14 (100%)
Participants (staff) (N=19)	16 (84%)	15 (79%)	16 (84%)	15 (79%)	10 (53%)	12 (63%)

d. The current analysis

The current DELPHI analysis involved six rounds, each held 1-2 weeks apart between 7th January and 28th March 2022.

Participants were sent each questionnaire via an email link to either Gorilla (round 1) or SurveyMonkey (rounds 2-6) software. Two reminders were sent for non-responders: the first one week after the link was provided, and the second one working day before the deadline.

i. Consensus

Consensus (70% agreement) was used to identify theories, partners, and actions commonly agreed by the expert panel to be required in order to run an effective trauma-informed network. 70% agreement is widely considered to demonstrate consensus in a panel of experts[43].

Below we provide a summary of the questions asked at each round, in order to develop the final list of aims for a trauma informed network. A full description of the content of each round is also provided on *pages 24-32*.

ii. A summary of the DELPHI rounds

1. In the first round experts were provided with a brief description of DELPHI analysis, as well as a consent form and information sheet. They were asked to individually list all the components (theories, partners) that they believe are integral to trauma-informed care, and what actions a trauma-informed network should take in order to reach these aims. This allowed for the development of a baseline list of items, uninfluenced by the researchers.
2. In round two, the baseline list from the previous round was combined with the item pool identified from the literature and the full list was provided to all participants for comment. The experts were asked to identify components and actions which they agreed were a) important to trauma informed care, and b) should be part of a trauma-informed network's aims. Participants were given open text boxes to allow them to suggest any further additions. The order of the items was randomised for each participant. These responses were combined, giving scores to the items based on the frequency with which they were identified as 'important' by the participants.
3. In round three, participants were provided with lists of theories and actions, broken down into 1) those with over 70% agreement (consensus to include), those with between 31-69% agreement (undecided), and those with under 30% agreement (consensus to exclude) asked to 1) identify any that they feel should be removed or kept as part of the aims of a trauma informed network, and 2) rank the remaining (included) options from the most to least important.
4. In round 4 the short-list of approved items (theories and actions) was returned to participants, and they were asked rank them in order of importance. Average ranks were developed and fed back to participants in round 5.

5. In round 5 participants were provided with a suggested list of theories and actions for a trauma informed network, in order of importance. They were also provided with the comments given by participants in the previous round to explain their choices. They were asked to confirm whether they were happy with the order of this list and, if not, provide their reasoning.
6. Based on the comments and agreement attained in round 5, several alternatively ordered lists were developed and sent back to participants for approval. Participants were asked to vote on their preferred list. They were also given the opportunity to provide further comments for inclusion in the report.

As well as these questions, at each stage participants were asked "Do you have any other comments that you would like to bring to our attention?". This gave them space to identify to us anything that we hadn't covered that they felt was important for us to know about trauma-informed care. Participants were also given a contact email each week which they could use to identify any queries or concerns.

The aims and questions asked in each round are provided in full detail in the following pages. The results of these rounds can be accessed on *page 33*.

iii. Round 1 (collecting opinions)

The first round of the DELPHI was designed to collect opinions from the expert participants, with as little interference from the research staff as possible. The questions were designed to prompt winder thought on the topic of trauma-informed practise without influencing the participants' responses. Participants were asked to consider trauma-informed theory

Additionally this questionnaire was used to collect consent from all participants via an integrated consent form and information sheet (*appendices A and B*), and to collect basic demographic information to better identify the expertise of our audience. We collected information on whether the participant was a staff member or service user, and, if a staff member, we asked that they provide the name of their organisations, occupation, and number of years worked.

Figure 1. The questions asked to participants in round 1 of the DELPHI analysis

In round 1 we asked participants:

- What, in your opinion, does it mean to be trauma-informed? You may wish to consider ideas, outcomes, personal feelings or experience, or components of a system. Please provide as many suggestions as you would like:
- What organisations or individuals do you feel should be involved in a trauma-informed approach?
- What actions, in your opinion, are needed in order to be trauma-informed? You may wish to use your examples above in order to develop your response. Please provide as many suggestions as you would like.

The outcomes of round 1 were then added to the list of theories, organisations, and actions that were identified in the literature in order to develop a comprehensive list of trauma-informed care needs. This list is then provided back to the expert participants in round 2, so that they can confirm which they, as a group, agree are important.

iv. Round 2 (confirming importance)

The second round of DELPHI was broken down into two separate sections.

The first section aimed to provide back a full list of concepts related to trauma-informed care, as identified from round 1 participants and from the literature, such that the collective group of experts could identify which concepts they felt were correct, important, and should be included in the development of the trauma-informed network. These were presented in a randomised order, such that viewer fatigue could not impact the likelihood of a concept being chosen.

This is the longest round of the DELPHI analysis, as it is important that the viewpoints of **all** participants (as expressed in round 1) are given equal consideration and weight. All responses from round 1 were presented anonymously as a list, and participants were asked to tick which concepts they felt were important to keep.

In particular many of the actions provided were complex. It was important to provide these actions as described by participants or the literature, but large actions can be difficult to digest. As such we provided the actions verbatim, but **bolded** words which summarised the main outcome of that action, such that participants could quickly identify the intention.

Participants were also provided with a second opportunity to identify any theories, organisations, or actions that they felt were missing from this list. This allowed them to feed back to us on whether we had correctly represented their intentions, but also to identify any new thoughts that were prompted by the list provided (as it can be difficult to identify all relevant concepts 'dry' in round 1). This opportunity was provided after each question (in italics below).

Figure 2. The questions asked to participants in round 2a of the DELPHI analysis

In round 2a we asked participants:

- Below is a list of **theories** about what trauma-informed care should aim to do, as identified in the previous round. Please identify next to each whether or not you agree that is important to becoming trauma informed.
- Below we provide a list of the **individuals or organisations** that could be an active participant of designing and implementing trauma-informed care, as identified in the previous round. Please identify next to each individual/organisation how important you consider it to be.
- Below is a list of **actions** which some people believe that trauma-informed care should include, as identified in the last round. Each include a concept (**in bold**) and wider description of potential associated actions. Please indicate which you agree with. Please base this on the **concept**, rather than needing to agree with the full wider description (which we will cover in another round).
- *We have done our best to remain true to the ideas that you provided to us in the first round, but if you feel that we have missed an important point then please do let us know in the feedback boxes.*
- *Do you have any further additions to this list that you would like to be considered?*

The second section aimed to focus participants towards a 'trauma-informed network' specifically. Based on their responses to the first half of the round, they were provided with shorter lists of all the theories, organisations, and actions that they themselves identified as important. They were then asked to identify which they felt should be the responsibility of a *trauma-informed network*, rather than trauma-informed care more specifically. This allowed us to identify both the wider environment in which trauma-informed care should exist, as well as the needs and actions that should be the remit of the developing network.

To prompt the change in focus, participants were provided with the following information:

"The next questions will cover a **trauma-informed network** specifically, rather than focusing on trauma-informed care (don't worry, you're almost done!). It will use your answers to the above questions to narrow down what you feel should be the aims of a **trauma-informed network**, rather than organisations more generally.

A trauma-informed network can be defined as "a group of interdisciplinary professionals, community members, and organizations that support clients and organisations to become trauma-informed." 'Camden and Islington's trauma-informed network' is an example of a trauma-informed network."

Figure 3. The questions asked to participants in round 2b of the DELPHI analysis

In round 2b we asked participants:

- Below we provide a list of the **theories** that **you** have identified as important, from the previous section. Please identify next to each whether you feel that this should be the responsibility of a trauma-informed network, rather than an individual organisation.
- Below we provide a list of the **individuals and organisations** that **you** have identified as important, from the previous section. Please identify next to each whether you feel that should be part of a trauma-informed network, rather than an individual organisation.
- Below we provide a list of the **actions** that **you** have identified as important to a trauma-informed approach in the sections above. Please identify next to each whether you feel that this should be the responsibility of a trauma-informed network, rather than an individual organisation.

The percentage of participants identifying each component as 'important' was collated and used to inform the later development of the questionnaire. Specifically, components with 70% consensus was considered to be 'important'[43], and included in our recommendations for policy. Components with consensus under 30% were deemed to not be commonly held to be important, and so were removed. Any components with 31-69% consensus were fed back to participants for further consideration in the next round. The results for each round are depicted under 'results' below, as well as the final findings.

v. Round 3 (reaching consensus on important concepts)

The remaining rounds of the DELPHI are used to build consensus around the components that should be included in a trauma-informed network. Components are fed back to participants, along with comments and percentage agreement from previous rounds, and participants are given the chance to review the feedback and amend their decision (or not).

For round three participants were provided with the theories, organisations, and actions from round 2 divided into a) those with 70% or above consensus, to confirm their agreement (or not), b) those with between 31-69% agreement, to review whether they should remain in the list, and c) those with under 30% agreement, to confirm that they can be deleted.

Any additional components identified by participants in the free-text boxes in the previous round were also included for consideration by the group. The questions for round 3 are displayed on the next page.

Figure 4. The questions asked to participants in round 3 of the DELPHI analysis

In round 3 we asked participants:

Theories

- Below we provide a list of the **theories** that received **high support** in the previous round, and the percentage of support that they have received (in bold). Please identify which you believe **should be removed** from the list of requirements for a trauma-informed network. *If you select an option other than 'none of the above' then please use the free text box at the end of the page to explain your rationale.*
- Below we provide a list of the theories on which **no consensus was reached** in the previous round, and the percentage of support that they have received (in bold). Please identify which options you agree **should remain** part of a trauma-informed network's aims.
- Below we provide a list of the **theories** that **did not receive high support** in the previous round, and the percentage of support that they have received (in bold). Please identify any that you feel should be **added into** the list of requirements for a trauma-informed network. *If you select an option other than 'none of the above' then please use the free text box at the end of the page to explain your rationale.*

Individuals and organisations

- Below we provide a list of the **individuals and organisations** that received **high support** in the previous round, and the percentage of support that they have received (in bold). Please identify that you believe **should be removed** from the list of requirements for a trauma-informed network. *If you select an option other than 'none of the above' then please use the free text box at the end of the page to explain your rationale.*
- Below we provide a list of the **individuals and organisations** on which **no consensus was reached** in the previous round, and the percentage of support that they have received (in bold). Please identify which options you agree **should remain** part of a trauma-informed network's aims.
- Below we provide a list of the **individuals or organisations** that **did not receive high support** in the previous round, and the percentage of support that they have received (in bold). Please identify any that you feel should be **added into** the list of requirements for a trauma-informed network. *If you select an option other than 'none of the above' then please use the free text box at the end of the page to explain your rationale.*
- Additionally, the following individuals/organisations were **identified by participants** in the previous questionnaire as further considerations. Please identify any that you agree **should be included** in the list above for future waves.

Actions

- Below we provide a list of **actions** that received **high support** in the previous round, and the percentage of support that they have received (in bold). Please identify next to each whether you believe it **should be removed** from the list of requirements for a trauma-informed network. *If you select an option other than 'none of the above' then please use the free text box at the end of the page to explain your rationale.*
- Below we provide a list of the **actions** on which **no consensus was reached** in the previous round, and the percentage of support that they have received (in bold). Please identify which options you agree **should remain** part of a trauma-informed network's aims.
- Below we provide a list of the **actions** that **did not receive high support** in the previous round, and the percentage of support that they have received (in bold). Please identify any that you feel should be **added into** the list of requirements for a trauma-informed network. *If you select an option other than 'none of the above' then please use the free text box at the end of the page to explain your rationale.*
- Additionally, the following **actions** were **identified by participants** in the previous questionnaire as further considerations. Please identify any that you agree **should be included** in the list above for future waves.

At this point participants have had three chances to confirm their preferences for components related to a trauma-informed network. The percentages of agreement were calculated and compared to the previous round to identify whether there had been any large changes in consensus (indicating a lack of certainty). None were identified – no concepts changed 'importance' boundaries - and so this list was considered to be a final and comprehensive list of theories, organisations, and theories related to trauma-informed networks, as agreed by our group of expert participants.

The outcomes from this round were used to create a short-list of choices to provide to participants over the next few rounds.

vi. Round 4 (developing priorities)

By round 4 we had reached consensus on the theories, organisations, and actions that should be included in a trauma-informed network. We now switched focus to building a hierarchy of theories and actions, such that we could identify the *most important* aims and actions for the trauma-informed network to focus on, based on expert consensus. Participant experts were given the short-list of approved (70% or above consensus) theories and actions identified from the previous round, and asked to reorder them in order of importance.

'Organisations' were removed from further study at this point, as it was not considered appropriate to prioritise certain risk groups in this way.

Figure 5. The questions asked to participants in round 4 of the DELPHI analysis

In round 4 we asked participants:

- Below we have included the **theories** that you have identified as important to a trauma-informed network. Please **drag and click to move these in order of priority based on your own opinion**. *With 1 being highest priority and 8 being lowest priority.*
- If you would like to provide the reasoning for your choices above, please use the comment box below.
- Below we have included the **actions** that you have identified as important to a trauma-informed network. Please **drag and click to move these in order of priority based on your own opinion**. *With 1 being highest priority and 12 being lowest priority.*
- If you would like to provide the reasoning for your choices above, please use the comment box below.

Responses were compared and combined such that mean scores were developed for each item. A priorities list drawn up based on the average score for each item.

vii. Round 5 (confirming priorities)

Based on the outcomes of round 4, we developed a ranked list of theory and action priorities and provided this list back to the participant experts for comment. We asked participants to approve or refuse the list, and explain what changes (if any) they would like to see. To aid their decision-making process, participant responses from round 4 were provided, explaining their rationale for the orders chosen.

Figure 6. The questions asked to participants in round 5 of the DELPHI analysis

In round 5 we asked participants:

- Below we have included the ranked list of theories that you have identified in order of highest priority to lowest priority to a trauma-informed network. **Please confirm whether you are happy with the order of this list.** *With 1 being highest priority and 8 being lowest priority.* Are you happy with this list?
- Below we have included the ranked list of actions that you have identified in order of highest to lowest priority to a trauma-informed network. **Please confirm whether you are happy with the order of this list.** *With 1 being highest priority and 12 being lowest priority.* Are you happy with this list?

Where consensus (over 70% agreement) was reached on a list, the list was considered 'approved' for use. Where consensus was below 70% we developed alternative priority lists. Based on the responses from this round, we created three competing priority lists for 'theories'. Each list considered the responses and rationale provided by participants in round 5 and combined them where possible. No competing lists were created for 'actions', as consensus was reached on approval for the list provided.

viii. Round 6 (reaching consensus on hierarchical priorities)

In the final round we provided the participant experts with the competing priority lists developed from responses to round 5. Participants were asked to vote on their preferred list, with the aim being to develop consensus.

Figure 7. The questions asked to participants in round 6 of the DELPHI analysis

In round 6 we asked participants:

- Below we have provided three variations of the list of theories which are of highest to lowest priority to a trauma-informed network. These lists are derived from the comments we received from the previous round. **Please consider the order of theories of each list and choose the order you agree with most.** Which list do you **most agree** with?
- If you have any comments you would like to be included in the final report, please use the comment box below.

Following this round consensus was reached for all requested data. The final results, along with the data collected across all six rounds, are provided under 'results' below. The implications of these results for the development of a trauma-informed network are provided under '*Discussion and implications*'.

ix. Duplicate data

In some instances participants provided duplicate responses to one or more questionnaires. Where participants provided one complete and one incomplete response, only the data from the complete response was included in the analysis. Where both responses were either complete or incomplete, the most recent response was kept as it was assumed that this most accurately reflected the participants current opinion.

e. Ethical considerations

Ethical approval for this study was granted by the University College London ethical committee. The ethics number is: **EP/2021/017.**

7. Results

a. Developing trauma-related concepts for analysis

i. Trauma-informed literature

90 resources (31 (34.4%) academic papers and 59 (65.6%) grey literature) relevant to the aims of this study were identified from the literature search as being relevant to trauma-informed care, or trauma-informed networks. Of these, four were duplicate papers and one provided no useable statement, resulting in a total of 85 resources being used to develop the literature-based list of statements. The resources included were reviewed by JM and BR, who agreed that saturation of relevant concepts had been met, and so that further analysis of the literature would not be productive.

The dates of publication of the included resources (where known) ranged from 2011-2021, with most resources being published between 2016 and 2017. The origin was primarily the USA (N=59, 65.6%), the UK (N=22, 24.4%), Australia (N=8, 8.9%) and Canada (N=2, 2.2%). There were resources from 77 separate organisations, of which 44 (48.9%) were charitable organisations, 19 (21.1%) were universities or research centres, and 12 (13.3%) were government departments or centres.

Population and trauma explored

The type of trauma being explored was categorised in 36 papers (40%). Of these, 17 (47.2%) focused on adverse childhood experiences, six (16.7%) focused on vicarious trauma in care providers, six (16.7%) focused on retraumatisation of clients within health and social care, three (8.3%) focused on sexual and domestic violence, and one each (2.8%) focused on PTSD and traumatic injuries.

The population of interest was not specified in many resources, and so was assumed to include any person with trauma experience. Of those that did provide a specific population of interest (N=43,47.8%), 20 (46.5%) focused on the care of children and adolescents, 12 (27.9%) focused on practitioners and care providers, five (11.6%) focused on adults with trauma experiences, two (4.7%) focused on prison populations, and one (2.3%) each focused on survivors of sexual violence, refugees and asylum seekers, people abused in childhood, and students in clinical training.

A full list of the literature is summarised in *table 2,* and is available in full in *appendix D*.

Table 2. The trauma-informed literature identified in our review, displayed in relation to date and origin of publication, type of trauma and trauma population explored (N=90.

Category	N (%)*
Type of literature	
White	31 (34.4%)
Grey	59 (65.6%)
Origin of paper	
Country of origin	*90 (100%)*
USA	59 (65.6%)
UK	22 (24.4%)
Australia	8 (8.9%)
Canada	2 (2.2%)
Organisation type	*77 (100%)*
Charity	44 (48.9%)
Research	19 (21.1%)
Government	12 (13.3%)
Trauma explored	
Type of trauma	*36 (40.0%)*
Childhood experience	17 (47.2%)
Vicarious trauma	6 (16.7%)
Retraumatisation	6 (16.7%)
Sexual/domestic violence	3 (8.3%)
PTSD	1 (2.8%)
Traumatic injury	1 (2.8%)
Population of interest	*43 (47.8%)*
Children/adolescents	20 (46.5%)
Care provider	12 (27.9%)
Adults	5 (11.6%)
Prison population	2 (4.7%)
Survivors of sexual violence	1 (2.3%)
Refugees/asylum seekers	1 (2.3%)
Childhood abuse survivor	1 (2.3%)
Clinicians in training	1 (2.3%)

*Note that percentages are given as a proportion of data known (shown in italics).

An additional analysis of the text of these articles also identified reference to the following groups who may require trauma-informed care: service providers (N=32, 36%), allied health professionals (N=15, 17%), caregivers (N=14, 16%), parents/families (N=12, 13%), adults with trauma experience (N=11, 12%), communities (N=5, 6%), first responders (N=2, 2%), educators (N=2, 2%), and people in recovery, trainees, support staff (e.g. front desk staff, cleaners, porters etc.), tribal communities, behavioural health workers, broader social networks, counsellors, employed caregiver, Health and behavioural healthcare professionals, medical professionals, Mental healthcare providers, and administrative professionals (N=1 each, 1%).

Trauma-related theories, partners, and actions

From these 85 resources, 2,210 statements relating to trauma-informed care were extracted. Concepts identified in only one source were removed, unless they were deemed by the research group to be important to present to participants for comment. Concepts were removed if they were too abstract to action (e.g. 'hopefulness') or related to specific interventions or theories (e.g. yoga, CBT, medical model, music therapy, neuroeducation) - which are beyond the scope of this paper to advise on the use of.

These statements were assessed for duplications, and were combined into specific concepts related to trauma-informed theory, trauma-related partners or individuals, and trauma-related care actions.

This resulted in a total of 168 distinct trauma-related concepts: 24 theories, 71 partners or individuals, and 73 actions. These can be found in *appendix E*.

ii. DELPHI analysis

In the first round of the DELPHI analysis, participants identified 370 concepts relating to trauma-informed theories, partners, or actions. These were compared with those identified from the literature and either combined with existing concepts or added to the concept list as appropriate. This resulted in a total of 180 distinct trauma-related concepts: 24 theories, 86 partners or individuals, and 74 actions.

The additional partners or individuals to involve in trauma-informed care that were not identified in the literature were: care staff, consultants, landlords, 'experts', discharge teams, pharmacists, employment and pension agencies, dentistry, legal advice services, refugee/immigration services, disability and benefit services, and banking.

The additional trauma-informed action identified by our experts was to "facilitate **engagement** with services (find clients who don't engage, try to re-engage clients who fail to attend, identify systemic issues (e.g. poverty) which may cause trauma)".

The lack of additional concepts identified by our participants further demonstrates that saturation of concepts was reached. The full list of concepts identified through the DELPHI analysis can be found in *appendix E*.

b. Identifying the concepts important to the development of a trauma-informed network

In round 2 of the DELPHI analysis the expert panel identified the theories, partners, and actions that they felt were important to trauma-informed care. They were then asked to identify which were important for a trauma-informed network specifically. In round 3 they were provided with the same list, along with the percentage agreement from the previous round, and asked to confirm or reassess their choices.

i. Theories

Of the 24 theories presented, 16 (67%) reached consensus agreement that they were important to trauma-informed care. None were agreed to be unimportant.

Of these theories, two reached consensus as being required for a trauma-informed network. This rose to nine in round three. The agreed theories were:

Table 3. The theory concepts which reached consensus as 'important' in round 3, along with the % agreement reached

Realises the widespread impact of trauma, stress and adversity within our society.	100%
Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals.	92.86%
Understanding, recognizing, and responding to the effects of trauma (e.g. physical, mental, emotional, social, behavioural).	83.33%
Collaboration - making decisions with the individual and sharing power.	76.67%
An emphasis on exploring and learning from history, gender, race, and cultural context.	73.33%
Minimize the risk of secondary traumatization (e.g. in staff responding to client trauma).	73.33%
A strengths-based perspective, emphasising people's capability for growth, healing and resilience.	70.00%
Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions.	70.00%
Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services.	70.00%

Additionally in round 3 two theories were agreed to be unimportant to a trauma-informed network. These were "Catching PTE (people with trauma experience) as they are ˜falling" not after they have fallen. 43%", and "Asks "Who do you want to be?" 7%".

ii. Partners

Of the 71 partners presented, 37 (52%) reached consensus agreement that they were important to trauma-informed care. Five options (data managers, licensing agents, banking, accrediting bodies, and general business/industry) were agreed to be unimportant.

Of these partners, 20 reached consensus as being required for a trauma-informed network. This rose to 34 in round 3. The agreed partners were:

Table 4. The partner concepts which reached consensus as 'important' in round 3, along with the % agreement reached

PTEs (people with trauma experience)	100%
Service providers ('on the ground' staff)	100%
Experts in TIC	100%
Primary care physicians (GPs)	100%
Substance Abuse and Mental Health Services	100%
Health service providers	100%
Domestic violence and women's services	100%
Social services	100%
Trauma-informed leadership teams	100%
Mental health services (e.g. counsellors, behavioural therapists)	100%
First responders (e.g. emergency and acute services)	96.67%
Trauma-informed care champions	96.67%
Volunteers working with PTE (people with trauma experience)	96.67%
Offender support services	96.67%
Peer–run and community organization	96.67%
Homelessness and housing services	96.67%
Residential care	93.33%
Disability and benefits services	93.33%
psychologists	90.00%
Commissioners	90.00%
Education settings (e.g. schools, university, nurseries)	90.00%
Supported accommodation for people with mental health problems	83.33%
Refugee/immigration services	80.00%
Department of Social Services	80.00%
homelessness services and agencies	80.00%
Nurses and midwives	76.67%
Criminal justice system and police	76.67%
Adoption/foster care and child/family services	76.67%
all education professionals - not just special ed	73.33%
Care staff	73.33%
Councils	73.33%
Policymakers	70.00%
Correctional settings and prisons	70.00%
Non-profits and charities	70.00%

Additionally consensus was reached that the following partners were not required for a trauma-informed network: data managers, the public, licensing agencies, accrediting bodies, banking, general business/industry, media agencies, and dentistry. The percentage agreement for these concepts can be found in *appendix F*.

iii. Actions

Of the 73 actions presented, 52 (71%) reached consensus agreement that they were important to trauma-informed care. None were agreed to be unimportant.

Of these theories, three reached consensus as being required for a trauma-informed network. This rose to eleven in round 3. These were:

Table 5. The action concepts which reached consensus as 'important' in round 3, along with the % agreement reached

Educate the workforce about trauma (recognize the signs and symptoms of trauma, and understand how it impacts PTE and families).	100%
Create a shared understanding (framework) of trauma-informed care, protocols, language and value system	96.67%
Provide all staff with training/professional development opportunities in Trauma-informed care (e.g. awareness, signs and symptoms, prevent re-traumatisation, screening, response, adaptation, follow-up, safety and boundaries, de-escalation, effectively managing emotions, responding to individuals who disclose personal crises, strengths focused planning).	93.33%
Promote readily available and updated information on trauma into general knowledge for staff, clients, and families - its impact, appropriate responses, and treatment (e.g. on websites, video, webinars, mailing lists, leaflets, handbooks, manuals)	93.33%
Acknowledge the need for universal trauma awareness/understanding about the widespread impact of trauma (prevalence and outcomes).	90.00%
Encourage the use of available research to inform trauma care. 68%	80.00%
Embed trauma-informed principles in all areas of practice, consistent between organisations. 64%	80.00%
Identify a diverse group of recognised leaders, champions, and/or planning committee roles to oversee trauma-informed changes and review progress (including community members and PTEs). 54%	76.67%
Develop and sustain a trauma-informed organisational culture, that shape organizations to be more trauma-sensitive in their work. 61%	76.67%
Promote best practice (evidence-based and evidence-informed trauma-specific practices). 68%	76.67%
Training staff in the art of empathic communication (good listening, understanding and finding the words to convey accurate empathy, respecting the client's expertise). 61%	73.33%

Additionally consensus was reached that 19 actions were not important to a trauma-informed network. This rose to 28 in round 3. These can be found in the table in *appendix F*.

c. Developing a short-list of key aims and actions

In round 4 we presented participants with the agreed lists of theories and actions and asked them to rank them in order of importance. This list was then fed back to them in two further rounds for comment and approval.

i. Theories

Participants found it extremely difficult to reach consensus on any hierarchical order of theories or actions for the trauma-informed network. The hierarchy developed in round 4 was approved by only 54.17% of participants in round 5, and so an additional round was needed, collating the comments and scores from rounds 5 and 6 to provide further options for this hierarchy.

The list of theories from round 4, in order of importance, was as follows:

Table 6. The theory concepts which reached consensus as 'important' in round 5, along with average ranking given (with lower ranks being more important)

Priority	Theory	Average round 4 score (range 1-12)
1	An emphasis on exploring and learning from history, gender, race, and cultural context	3.56
2	Collaboration - making decisions with the individual and sharing power	3.84
3	Minimize the risk of secondary traumatization (e.g. in staff responding to client trauma)	4.12
4	Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions	4.28
5	Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services	4.32
6	Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals	4.84
7	Realises the widespread impact of trauma, stress and adversity within our society	4.88
8	Understanding, recognizing, and responding to the effects of trauma (e.g. physical, mental, emotional, social, behavioural)	6.16

Additionally participant comments identified fundamental differences in the way that the hierarchy was approached, with some participants thinking sequentially (a must occur before and others focusing on first the individual and then society.

Figure 8. Example participant feedback on developing a hierarchy for theory-related concepts

Example participant feedback on developing a hierarchy for theories:

- *"Two elements to the responses - one if focused on the individual which I think needs to be the priority, and the second on society and learning from the past. The final two are regarding not making the same mistakes - having learnt from the past."* (Round 4)
- *"First, we need to understand trauma and its impact before we can do anything else. Then we need to work to ensure services don't retraumatize people, and all the rest of the goals are how we ensure services aren't retraumatising. Race, culture, and gender have been seriously overlooked in work around trauma and therefore learning about this is key."* (Round 4)
- *"PRACTICAL steps should be the priority."* (Round 5)
- *"I believe 7 and 8 need to be moved to 2 and 3, respectively. I don't think it's wise to tend to the individual until one understands the widespread nature and common effects of trauma in general."* (Round 5)

Despite a sixth round, the consensus on the order of importance for theories remained low. Out of the three options provided, the preferred choice was List C (provided below in *table 7*), although this still only reached 56.00% approval. This is compared to 24.00% for List A and 20.00% approval for list B (*see appendix G for all three lists*).

Although no consensus was reached on a clear hierarchy for the most important theories for a trauma-informed network to work towards, the preferred option was as follows:

Table 7. The theory concepts which reached consensus as 'important' in round 6, based on feedback from participants

Priority	Theory
1	Understanding, recognizing, and responding to the effects of trauma (e.g. physical, mental, emotional, social, behavioural)
2	Realises the widespread impact of trauma, stress and adversity within our society
3	Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals
4	Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services
5	Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions
6	Minimize the risk of secondary traumatization (e.g. in staff responding to client trauma)
7	Collaboration – making decisions with the individual and sharing power
8	An emphasis on exploring and learning from history, gender, race, and cultural context

This is the opposite of the list above, based on the average rank ratings of participants in round 4. As this demonstrates the lack of consensus available on this task, and over three rounds no change in opinions was apparent, it was concluded that no further rounds would be beneficial in developing a consensus.

ii. Actions

The priority list of actions for a trauma-informed network reached consensus in round 5, with 70.83% of participants agreeing with the list as presented. This list, in order of importance, is given on the next page.

Table 8. The action concepts which reached consensus as 'important' in round 5, along with average ranking given (with lower ranks being more important)

Priority	Action	Average round 4 score (range 1-12)
1	Provide all staff with training/professional development opportunities in Trauma-informed care (e.g. awareness, signs and symptoms, prevent re-traumatisation, screening, response, adaptation, follow-up, safety and boundaries, de-escalation, effectively managing emotions, responding to individuals who disclose personal crises, strengths focused planning)	5.38
2	Educate the workforce about trauma (recognize the signs and symptoms of trauma, and understand how it impacts PTE and families)	5.71
3	Build ongoing collaboration between critical services and sectors to increase continuity of care (e.g. exchange information, streamline referral processes, coordinate assessments and care, plan and deliver services in collaboration, share good practice, have a central contact for clients)	5.75
4	Promote readily available and updated information on trauma into general knowledge for staff, clients, and families - its impact, appropriate responses, and treatment (e.g. on websites, video, webinars, mailing lists, leaflets, handbooks, manuals)	5.96
5	Encourage the use of available research to inform trauma care	6.04
6	Identify a diverse group of recognised leaders, champions, and/or planning committee roles to oversee trauma-informed changes and review progress (including community members and PTEs)	6.5
7	Develop and sustain a trauma-informed organisational culture, that shape organizations to be more trauma-sensitive in their work	6.5
8	Training staff in the art of empathic communication (good listening, understanding and finding the words to convey accurate empathy, respecting the client's expertise)	6.88
9	Create a shared understanding (framework) of trauma-informed care, protocols, language and value system	7.08
10	Acknowledge the need for universal trauma awareness/understanding about the widespread impact of trauma (prevalence and outcomes)	7.13
11	Promote best practice (evidence-based and evidence-informed trauma-specific practices)	7.13
12	Embed trauma-informed principles in all areas of practice, consistent between organisations	7.96

d. Content analysis

As well as the primary DELPHI analysis, we also reviewed the comments made by participants about their experiences of trauma-informed care. Below we present common themes and examples of current experiences that may be taken into consideration when developing support for trauma-informed care at a network level. Select examples are provided below to demonstrate the outcomes being discussed. A full link of responses is provided in *appendix H*. Note that the participant speaking has not been given due to the small sample size, to protect anonymity.

i. Lived experience of trauma

Participants took this opportunity to highlight the sustained and debilitating effects of trauma. In particular participants highlighted that trauma can happen to anyone, and so carers need to be made aware of its prevalence and signs.

“I would also like to say that just because a client, patient, or member of the public presents well i.e., well-dressed well-groomed as opposed to disheveled and looking tired, professionals need to be aware that they could still be suffering from PTSD and so the same procedural questioning and discussion should go on.” (Round 1)

“Too much focus on assumptions people must be on low income, have no job, be a homeless person an immigrant, or an offender to be worthy of help. Too much funding is given out for this but not other situations of the population.” (Round 2)

“As someone whose trauma doesn't relate to history, gender, race and cultural context I feel quite offended and excluded as though some types of trauma are being given higher status and importance than others.” (Round 4)

“Classism, racism and sexism was apparent in my treatment by many service providers and to this day I'm asked irrelevant questions about whether I grew up in social housing, if I live in social housing now, what job my mum did and on a recent NHS psychologist's diagnosis report it was noted that I'm a black girl (I'm actually mixed race and often mistaken for other races) who grew up in social housing with a mum on a low wage, with no relevance other than, I can only assume, to signal to the people he was referring me to that I'm not worthy of treatment as I was then told I wouldn't be offered any trauma support and never have been nearly 20 years after first being abused, which continued until a few years ago because it was never acknowledged.” (Round 3)

Several participants highlighted their own experiences of re-traumatisation within the care service. This included feeling unheard or unseen. In particular they reiterated the need for integrated care across services, such that trauma does not need to be continually reintroduced, and addressing trauma early on in the care process. Several reported experiencing difficulties receiving support due to long wait times or complex processes. A need for a better understanding of how trauma presents was vocalised.

"Preventing secondary traumatic stress - stop the need to keep repeating yourself to many different people by having a single point of contact. Privacy - ensure that a patient's privacy is always maintained." (Round 1)

"I spent 6 months in secondary care, and no one asked about what had happened to me. I am now getting treatment for it 2 decades later, and 3.5 decades after the traumatic event." (Round 1)

"People with comorbidity and trauma are ignored on every level excluded and further traumatised" (Round 2)

"provide fit for purpose up to date mental health support stop putting people in years waiting lists that never see the light of day which only causes more mental health impairment as well as re-traumatisation" (Round 2)

"Set up services that aim to solve the barriers a traumatised person faces this must be free not some long winded set of hoops that discounts most people from being able to access." (Round 2)

"Often when I've been at my most vulnerable and most in need of support, I've had the least help as I haven't been able to access it due to an increased fear of going out. I've been told I must leave services because of lateness or missed appointments, but if they had understood how trauma presents itself sometimes then they could have engaged with me in a different way by, for example, offering a phone appointment rather than discharging me for not feeling up to attending in person appointments." (Round 4)

"People who have experienced trauma often lack trust and therefore being shown empathy is important. It's also important that there is ongoing collaboration as I have often been abandoned with no support after bringing up traumatising events after being promised support that has never materialised. This feels re-traumatising as you're made to share triggering information and then feel you've been misled when it leads to nothing." (Round 4)

ii. Difficulties with responding to trauma

Participants commented on the difficulties inherent in developing or supporting trauma-informed care: specifically that trauma can be difficult to identify – both for staff and clients, and that staff are not always supported in their trauma-informed development. They emphasised the need for careful training to identify and treat trauma.

"PTSD is often 'invisible' to both professionals and clients, and their family members. Sufferers can have devastating outcomes because of their stress disorder. The 'invisibility' makes it a very dangerous illness and therefore one that needs as much publicity, training, and awareness of its existence as possible." (Round 1)

"I think it is hard for frontline workers and services to be trauma-informed when politics is enforcing the hostile environment/cutting funding to essential services/increasing police powers/essentially pushing for the exact opposite of everything we are trying to do. E.g., there is

seemingly nothing we can do about the lack of suitable social housing or a regulated rental market, which is a huge issue for all our clients, or the lack of mental health beds. It feels like continually trying to do the impossible and make the best of an awful situation with extremely limited resources." (Round 1)

Staff also freely identified that care was not necessarily currently trauma-informed, but expressed an interest in learning how to implement this within their own organisations.

"My Service is not trauma-informed but I am interested in how it could be becomes so." (Round 1)

"I would want to explore and learn more about trauma-informed and to develop necessary skills which could be positive for the rest of my life and coping techniques with the trauma." (Round 1)

iii. Steps towards trauma-informed care

Participants also took the opportunity to reiterate actions that were most important to them, and to the success of a trauma-informed network. Actions which were considered especially important for a trauma-informed network to be involved in included sustained engagement with service users, and service user representation at the decision-making level.

"I think there should be a sustained level of engagement with service users to test their understanding and the proposals. It's difficult to get representation from all the different target groups since trauma can be anywhere and affect people of all ages and social groups." (Round 1)

"An organised engagement with PTE that are working on recovery. Constituted bodies of lived experience groups could assist further recovery and help at the consultation level. Maybe representatives of these constituted groups could take their views to other levels of decision making where there isn't a direct elected representation of the population who identify as PTE" (Round 3)

Participants emphasised the need to avoid 'trauma-informed care' being implemented at a superficial level. Enforcement from a trauma-informed network or other governing body was encouraged to improve accountability.

"Now, 'trauma-informed care' is a buzz word. I'm worried that it is overused without it's true meaning being taken on board. I think there may need to be more research into how someone can be fully trained in this area and what this looks like if they were. What skills will they possess? It's not a tick box exercise but the way you speak to a vulnerable person, your mannerisms / conduct. Not judging and labelling and retriggering, but rather; listening to understand. And being kind and empathetic and treating the individual in a respectful and gentle way." (Round 1)

"Could there be a body who looks at a case where the traumatised individual was not sufficiently supported at the time of their distress retrospectively e.g., the police not sufficiently investigating a crime, the council leaving a tenant with ongoing unacceptable living conditions" (Round 3)

"Stop Council housing services only paying lip service to being trauma-informed and enforce accountability and sanctions for non-compliance provide mechanisms for service users to report re-traumatisation exclusion and being ignored. Question places like council housing who can provide trauma support for a few minority groups but fail to do so for all minority groups or even groups in general Look at sectors of society that are without services and excluded and realise this is traumatising i.e., autism / neurodiversity sensory diversity and physical disability as well as trauma." (Round 2)

"Make accountability mandatory requirement and sanctions for services be they local charity or any other kind of council funded or national type of service who retraumatise people" (round 2)

"Many of these are what a TIN might advocate for, rather than the network's own actions. Nonetheless, I see the TIN as having roles in providing education/awareness materials/training, and it also must model TI practice within its own structures and day-to-day working." (Round 3)

8. Discussion and implications

The current study aimed to develop a hierarchical plan of action, based on academic literature and 360-degree stakeholder engagement of organisations involved in social care (councils, charities, NHS organisations, people with lived experience), which can be used to develop an effective, collaborative trauma-informed network. We conducted a literature review, followed by a six-round DELPHI analysis in order to answer the questions:

1. What theories should be implemented in a trauma-informed network?
2. What stakeholders should be engaged in the work of a trauma-informed network?
3. What actions should be taken by a trauma-informed network, in order to enable trauma-informed care?

The outcomes of this report as related to these aims are summarised below, along with suggestions for their application. They are based on panel agreement of 70% or above, as collected through an anonymous, scientific procedure, and so are considered to demonstrate the majority view of the associated stakeholders. However, for a wider understanding of the theories, partners, or actions relevant to trauma-informed care more widely we recommend reviewing the results section in detail.

a. Trauma-informed concepts – support for a trauma-informed approach

Trauma-informed concepts were identified and extracted from a wide range of resources, including reports developed by policymakers, charitable organisations, and educational institutes. Although the majority of papers were for the USA, there was a significant proportion (26%) from the UK. The literature also incorporated a wide range of care needs, including adverse childhood experiences, sexual and domestic violence, PTSD, and traumatic injuries vicarious trauma in care providers, retraumatisation of clients within health and social care. As such the importance of trauma-informed care to all stages of the care system is clearly recognised. This is a field of growing interest which is likely to continue to gain relevance to care organisations. As such it is prudent of care organisations to begin to develop a plan of action at this point in time.

Although the literature surrounding trauma-informed care, and trauma-informed networks, is growing, the literature review demonstrated great diversity in the concepts and outcomes considered, with no clear consensus apparent in the aims or outcomes of trauma-informed network. A total of 168 distinct trauma-related concepts were extracted: 24 theories, 71 partners or individuals, and 73 actions. With the addition of participant expert responses in the first round of DELPHI, this number increased to 180 distinct trauma-related concepts: 24 theories, 86 partners or individuals, and 74 actions.

This demonstrates the vast range of ways in which trauma-informed care can impact care delivery, and so the importance of a clear plan of action when attempting to develop a trauma-informed care response. Only one further action was identified by our participants, further demonstrating that saturation of concepts was reached, and so that the results of this report can be considered to accurately reflect the trauma-informed knowledge base.

Additionally, there was great overlap between the actions identified spontaneously by expert participants and the existing literature (*see appendix E*). Only ten (13.5%) of the actions identified from the literature were not also identified by our participants. This demonstrates great levels of agreement between our panel experts and existing experts and thus further validates the expertise of the panel involved. It also clearly demonstrates the accomplished capabilities of care providers and service users to comprehensively assess their care needs. We strongly recommend the inclusion of such partners in any subsequent trauma-informed decision making.

b. What theories should be implemented in a trauma-informed network?

A list of eight theories were identified as relevant to the development of a trauma-informed network. These theories would be beneficial to consider when developing the aims or remit of any trauma-informed network. They could also be used to direct teaching and learning within organisations associated with the network.

Although the list of theories remained consistent across rounds, demonstrating certainty on what theories are important to the ethos of a trauma-informed network, no clear consensus was reached on the order of importance. As such we strongly recommend that this list is not used hierarchically, and that the aims are considered with equal importance.

These aims are:

Figure 9. A list of aims necessary for developing a trauma-informed network, as identified through the DELPHI analysis

A list of aims necessary to a developing a trauma-informed network:

- Understanding, recognizing, and responding to the effects of trauma (e.g. physical, mental, emotional, social, behavioural).
- Realise the widespread impact of trauma, stress and adversity within our society.
- Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals.
- Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services.
- Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions.
- Minimize the risk of secondary traumatization (e.g. in staff responding to client trauma).
- Collaboration – making decisions with the individual and sharing power.
- An emphasis on exploring and learning from history, gender, race, and cultural context.

A key component of trauma-informed care is the participation of staff and clients, as well as organisations, in the development of that care[14,15] in order to redress inequalities in power and decision-making that may further exacerbate trauma symptoms[12]. Engagement with service users across the development and implementation of a trauma-informed network was emphasised at each round of the DELPHI analysis. Service users reported feeling ignored or invisible in care and stressed that the same should not happen within the network, or when planning for future care outcomes.

Participants similarly identified the need to prevent re-traumatisation within the care setting, which can occur through a repetition of environment (e.g. feelings of lack of control, being told to relax, or being confined) or touch (e.g. in the case of violence-related trauma) during care which mimics the feelings that the client experienced during their prior trauma experience[25-27].

The expert panel also cautioned against heavy emphasis on any aims relating to history, gender, race, or culture as these could lead to harmful stereotyping, or imbalances in the care being provided to people with trauma. Although these were considered to be important concepts within the individual trauma experience, they should **not** be used to target care.

Three theories were agreed to beyond the scope of a trauma-informed network. These were: “Understand that until an individual is safe physically and emotionally from violence and abuse, recovery is not possible.”, “Catching PTE (people with trauma experience) as they are falling not after they have fallen.”, and “Asks "Who do you want to be?"”. In other words, it was considered beyond the scope of a trauma-informed network to control the lived environment of people in care, to identify ‘at-risk’ service users who do not yet have a trauma experience, or to help people with trauma experiences to reach their potential.

c. What stakeholders should be engaged in the work of a trauma-informed network?

The list of partners who were agreed to be important to the development and decision-making of a trauma-informed network was extensive, as it to be expected when responded to wide reaching systemic issues such as trauma.

100% agreement was reached that the following stakeholders should be involved in decision-making. This group can be considered to be key stakeholders in any trauma-informed process, and **necessary** for appropriate trauma-informed decision-making. As such we recommend that these groups are actively recruited when developing a network or decision-making body:

Figure 10. A list of priority partners necessary for developing a trauma-informed network, as identified through the DELPHI analysis

A list of stakeholders necessary to a trauma-informed network:

- PTEs (people with trauma experience)
- Service providers ('on the ground' staff)
- Experts in Trauma-informed Care
- Primary care physicians (GPs)
- Substance Abuse and Mental Health Services
- Health service providers
- Domestic violence and women's services
- Social services
- Trauma-informed leadership teams
- Mental health services (e.g. counsellors, behavioural therapists)

Additionally, the following stake-holders all reached consensus as important partners for any trauma-informed network. Where possible, they should also be engaged when developing trauma-informed actions:

Figure 11. A list of partners necessary for developing a trauma-informed network, as identified through the DELPHI analysis

A list of stakeholders important to a trauma-informed network:

- First responders (e.g. emergency and acute services)
- Trauma-informed care champions
- Volunteers working with PTE (people with trauma experience)
- Offender support services
- Peer–run and community organization
- Homelessness and housing services
- Residential care
- Disability and benefits services
- psychologists
- Commissioners
- Education settings (e.g. schools, university, nurseries)
- Supported accommodation for people with mental health problems
- Refugee/immigration services
- Department of Social Services
- homelessness services and agencies
- Nurses and midwives
- Criminal justice system and police
- Adoption/foster care and child/family services
- all education professionals - not just special ed
- Care staff
- Councils
- Policymakers
- Correctional settings and prisons
- Non-profits and charities

Consensus was also reached that the following partners were **not** required for a trauma-informed network: data managers, the public, licensing agencies, accrediting bodies, banking, general business/industry, media agencies, and dentistry. However as identified by our participants, this does not mean that they are not important to the implementation of trauma-informed care: simply that the panel did not believe that they should be included in decision-making. People who have experienced trauma are likely to require support from a range of services[2], and trauma experience may necessitate frequent interactions with the care system across the lifespan. In order to best support these individuals, it is likely that a trauma-informed network will need to collaborate with a wide range of health and care systems including addiction treatment[36,37], physical therapy[6], psychiatric care[38,39], palliative care[7], gynecology[4], dentistry[27], and prison services[40]. It is important that care is consistent across each of these services, and that each is trauma-informed: both individually and as a collective, to prevent multiple potential incidents of re-traumatization.

d. What actions should be taken by a trauma-informed network, in order to enable trauma-informed care?

Twelve actions were identified as key outcomes for a trauma-informed network. Consensus was also reached on the order of importance of these actions. As such we are able to provide an itemised outcome demonstrating the recommended focus of any trauma-informed network going forward, including the order in which these actions should be addressed. We recommend that this list is considered when considering the allocation of resources and staff time within the 'Camden and Islington Trauma Informed Network', as well as what should, and should not, be within the remit of a trauma-informed network.

For the sake of comprehensiveness we have provided this list exactly as coded from participants and the trauma-informed literature. However in panel discussion it may be decided that there is overlap in the network's actions or outcomes between concepts. It is likely in particular that there are several actions which can be met concurrently. This should be discussed within the network panel when developing network targets.

The actions identified by the expert panel are provided below:

Figure 12. A list of actions necessary for developing a trauma-informed network, as identified through the DELPHI analysis

A hierarchical list of encouraged trauma-informed actions:

1. Provide all staff with training/professional development opportunities in Trauma-informed care (e.g. awareness, signs and symptoms, prevent re-traumatisation, screening, response, adaptation, follow-up, safety and boundaries, de-escalation, effectively managing emotions, responding to individuals who disclose personal crises, strengths focused planning).
2. Educate the workforce about trauma (recognize the signs and symptoms of trauma and understand how it impacts PTE and families).
3. Build ongoing collaboration between critical services and sectors to increase continuity of care (e.g. exchange information, streamline referral processes, coordinate assessments and care, plan and deliver services in collaboration, share good practice, have a central contact for clients).
4. Promote readily available and updated information on trauma into general knowledge for staff, clients, and families - its impact, appropriate responses, and treatment (e.g. on websites, video, webinars, mailing lists, leaflets, handbooks, manuals).
5. Encourage the use of available research to inform trauma care.
6. Identify a diverse group of recognised leaders, champions, and/or planning committee roles to oversee trauma-informed changes and review progress (including community members and PTEs).
7. Develop and sustain a trauma-informed organisational culture, that shape organizations to be more trauma-sensitive in their work.
8. Training staff in the art of empathic communication (good listening, understanding and finding the words to convey accurate empathy, respecting the client's expertise).
9. Create a shared understanding (framework) of trauma-informed care, protocols, language and value system.
10. Acknowledge the need for universal trauma awareness/understanding about the widespread impact of trauma (prevalence and outcomes).
11. Promote best practice (evidence-based and evidence-informed trauma-specific practices).
12. Embed trauma-informed principles in all areas of practice, consistent between organisations.

Participants additionally stressed the importance of a trauma-informed network having actionable outcomes and providing accountability within organisations such that 'trauma-informed' does not become a 'buzz-word' while care inequalities go unaddressed. Any network seeking to encourage trauma-informed care across organisations should further consider how this accountability can be addressed or trauma-informed outcomes can be measured such that the risk of retraumatisation is minimised.

There was also concern over focusing on the 'past' of trauma care, rather than the future, and recognition that there is a lack of current evidence or application of high-quality trauma care. There is a proliferation of independent trauma-informed training programs being developed without 1) rigorous assessment of the quality of the information being disseminated[8-11], 2) communication or collaboration with associated organisations[12], or 3) agreement on the methodology being used by the clients at risk; thereby ironically developing interventions which themselves are not being 'trauma-informed')[13]. This gap has also been identified above under our literature review, where it is evident that current understanding of trauma-informed care is mixed. This should be considered when looking to the existing literature to develop trauma-informed actions or assessing the acceptability of current care interactions with service users.

A list of 28 actions which were *not* considered to be the remit of a trauma-informed network were developed. These actions were identified as important for trauma-informed care more generally but were wider agreed to be beyond the scope of a trauma-informed network. We recommend that this list is reviewed when developing action plans to avoid allocation of resources to areas of low impact. This is not to say that these actions are without purpose, only that the outcome should be weighted carefully against the effort involved. For the sake of brevity this list is provided in *appendix F*.

e. Applicability

The outcomes of this report are based on 70% or above agreement amongst our expert panel, made of up key stakeholder of trauma-informed care in Camden and Islington. This sample included people with lived experience, and representatives from organisations working in housing, drug use, homelessness, family planning, domestic abuse support, children's services, healthcare services, and wider borough government. Representatives included care staff, team leads, and management and so represent a wide range of investment.

However there are always limitations to applicability. In particular it should be noted that the participants of this study are likely to be those with high prior investment in implementing trauma-informed change. The participants for this study were not only willing to volunteer their time to engage in the DELPHI process but were also recruited from the 'Camden and Islington Trauma Informed Network' working group, and so demonstrate particularly high levels of engagement. The same may not be true of all staff in social care. This will need to be taken into consideration when actioning the outputs of this study.

f. Conclusion

There are barriers to developing and maintaining a collaborative trauma-informed network. These can be as simple as differences in definitions of 'trauma-informed care'[4] between organisations, or as complex as differences in capability in terms of adequate private space or time for disclosure, expertise[4]. Using DELPHI analysis we have provided a short-list of the most important aims, partners, and actions to consider when developing a trauma-informed network, as identified through a literature search and panel engagement with expert stakeholders. We have also provided considerations on how these can be implemented, based on the comments and experiences shared by our expert participants during the DELPHI process.

The results of this analysis can be used not only to streamline the 'Camden and Islington Trauma Informed Network', but also to identify the factors which are likely to be effective in wider network contexts. We recommend that these outputs are taken into consideration when directing the focus and development of the Network, such that resources can be most effectively allocated to both meet the needs of both the service user population, and to best engage partner organisations.

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5. Appendices

a. Appendix A, consent form sent to all participants

CONSENT FORM FOR GENERAL POPULATION IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: A modified DELPHI analysis of the actions that need to be taken to develop a trauma-informed network

Department: UCL Experimental Psychology

Name and Contact Details of the Researcher(s): Jennifer McGowan Jennifer.a.l.mcgowan@ucl.ac.uk, name of student

Name and Contact Details of the Principal Researcher: Jennifer McGowan Jennifer.a.l.mcgowan@ucl.ac.uk

Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee: Project ID number: ___________

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. Please save a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	*I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction and would like to take part in this survey	

1.	*I consent to participate in the study. I understand that my personal information (email address) will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing.	
1.	**Use of the information for this project only** *I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications.	
1.	*I understand that my information may be subject to review by responsible individuals from the University (to include sponsors and funders) for monitoring and audit purposes.	
1.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
1.	I understand the direct/indirect benefits of participating.	
1.	I understand that the aggregate data will be used anonymously to provide a report for FLIC, and may be used for a research publication.	
1.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
1.	I agree that my anonymised research data may be used by others for future research. No one will be able to identify you when this data is shared.	
1.	I am aware of who I should contact if I wish to lodge a complaint.	
1.	Use of information for this project and beyond: I would be happy for the data I provide to be archived at UCL. I understand that other authenticated researchers will have access to my anonymised data.	
1.	I understand that I will be asked questions about trauma and I consent to this	

Click to Confirm your agreement as detailed above

b. Appendix B – Information sheet provided to all participants

This study has been approved by the Experimental Psychology Research Department's Ethics Chair [Project ID: __________]

A modified DELPHI analysis of the actions that need to be taken to develop a trauma-informed network

Department: UCL Experimental Psychology

Name and Contact Details of the Researcher(s): Jennifer McGowan Jennifer.a.l.mcgowan@ucl.ac.uk, Name of student conducting the project

Name and Contact Details of the Principal Researcher: Jennifer McGowan Jennifer.a.l.mcgowan@ucl.ac.uk

You are being invited to take part in a research project. Before you decided it is important for you to understand why the research us being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Dear Sir or Madam,

Thank you for considering participation in this study, which we are running to identify the principles and actions which organisations and people with lived experience within Camden and Islington believe are required in order to develop a trauma-informed network. The results of this study will be presented in a report which can be used to influence policy and future social care funding, as well as a published paper.

Who is running the study?

My name is Dr Jennifer McGowan and I am a lecturer from the Experimental Psychology department at University College London. I am running this study alongside Michelle Butterly from Fulfilling Lives Islington and Camden (FLIC), a government organisation developed to support trauma-informed care. This study has been reviewed and approved by the UCL department ethics committee [project number].

What is the study about?

Trauma can be defined as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being". People who have experienced trauma are likely to require support from a range of services, and trauma experience may necessitate frequent interactions with the care system across the lifespan.

In order to effectively meet the needs of this population, health and social care must by necessity be trauma-informed. More than this, in order for trauma-informed care to meet the needs of its clients it must span multiple care organisations as a 'trauma-informed network'. It is important that care is consistent across each of these services, and that each is trauma-informed: both individually and as a collective, to prevent multiple potential incidents of re-traumatization. In other words, a 'network' of care is required.

A key component of trauma-informed care is the participation of staff and clients, as well as organisations, in the development of that care. As such it is integral that a consensus is reached on what trauma-informed care is, and how it should be attained, between all collaborating parties before trauma-informed care can be effectively attained.

The current study aims to utilise a combination of existing literature and the opinions of a panel of experts to develop an actionable list of components which are required in order to develop a 'trauma-informed network'.

What will happen to me if I take part?

In order to achieve these aims we would like to ask you to be involved in a DELPHI analysis. A DELPHI analysis is a series of anonymous online questionnaires (between 4 and 6) which is used to pool the opinions of a wide range of experts in order to reach a consensus. Over several questionnaires, the responses and opinions expressed by participants are collected are provided to all other participants anonymously, such that every opinion has equal weight, and no one expert leads the conversation.

The DELPHI analysis will involve a maximum of six rounds, each held 1-2 weeks apart. Each questionnaire will take between 10-30 minutes to complete.

The questionnaires themselves will ask questions such as:

1. What components are required when developing a trauma-informed network?
1. Which components are most important to developing a trauma-informed network?
1. What actions need to be taken in order to facilitate these factors?

Why have I been chosen?

In order to get a well-rounded picture of what a trauma-informed network should look like from the perspective of all the members, we are looking for several representatives from each partner organisation of FLIC. We would like you to take part as we value your opinion on how this network should be run, and what its focus should be.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a version of this information sheet to keep and be asked to sign a consent form. You can withdraw at any time, including after the study is complete, without giving a reason and without it affecting any benefits that you are entitled to.

What are the possible disadvantages and risks of taking part?

We do not anticipate any severe disadvantages from taking part in our survey. You can contact us if you have questions or wish to follow up to further.

What are the possible benefits of taking part?

Benefits will include the final report, which will be provided to your organisation and can be used to further develop trauma-informed policy.

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified to any of the other participants, or in any ensuing reports or publications. The data from this study will be stored securely on UCL’s data protection network.

What will happen to the results of the research project?

The results will be presented in a report to FLIC and their partners. They may also be published in an academic paper. You will not be identified in any report or publication. The data collected during the course of the project might be used for additional or subsequent research.

What if something goes wrong?

Please contact Jennifer McGowan on Jennifer.a.l.mcgowan@ucl.ac.uk should they wish to raise a complaint. Should you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee – ethics@ucl.ac.uk

Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This ‘local’ privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our ‘general’ privacy notice:

For participants in health and care research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the ‘local’ and ‘general’ privacy notices.

The lawful basis that will be used to process your personal data is: 'Public task' for personal data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

Contact for further information

Please contact **Jennifer McGowan Jennifer.a.l.mcgowan@ucl.ac.uk** for further information.

Please save this information sheet to keep hold of this information.

Thank you for reading this information sheet and for considering to take part in this research study. In order to take part, please click on the link provided to move to the consent form and first questionnaire.

LONDON'S GLOBAL UNIVERSITY

shp
preventing homelessness
transforming lives

Fulfilling Lives in Islington & Camden

BIG LOTTERY FUND
LOTTERY FUNDED

o all participants

UCL PALS

Have your say on the development of Camden and Islington's Trauma Informed Network

Participate in an online study!

This study is being run by UCL in conjunction with Fulfilling Lives Islington and Camden (FLIC) on behalf of the Camden and Islington's Trauma Informed Network.

Are you involved in health and social care in Camden and Islington, either as a staff member or a client? We're interested in **your views** on how this network can become trauma-informed.

We are looking for experts from **all parts of the system:** people with lived experience of using services, client facing staff, commissioners, and decision makers.

What's the study about?

A key component of trauma-informed care is the input of staff and clients in the development of that care. Before trauma-informed care can be effectively achieved a consensus must be reached on what trauma-informed care is, and how it should be accomplished. This study intends to develop this consensus.

What's involved?

Volunteers engage in a short series of online questionnaires exploring what actions a network must take in order to be trauma informed. The responses are collected anonymously, such that every opinion has equal weight, and no one expert leads the dialog.

Camden and Islington
Trauma-informed network

Fulfilling Lives in Islington & Camden

Resilience Research Group

UCL PALS

Questionnaires will be sent out between **December and February**. This study will involve a maximum of six rounds, held 1-2 weeks apart. Each questionnaire will take between 10-30 minutes to complete.

A thank you for sharing your expertise and time

For your time and expertise, we will be able to offer £10 high street stores voucher for **each completed survey.**

Vouchers will be provided for people filling in the surveys who:

- Are filling in this survey as someone with/sharing lived experience and service user perspectives and are not filling in the survey as part of their paid role

You will receive vouchers **via email:**

- £20 vouchers after first 2 completed surveys
- £40 vouchers after final 4 completed surveys

How will the results be used?

The results of this study will be used for a report to inform policy and social care funding.

How to get involved

Contact **Jennifer McGowan** at Jennifer.a.l.mcgowan@ucl.ac.uk if you would like to take part.

What is Trauma-Informed Support and the Trauma-Informed Network?

Trauma-Informed Support

- Understands people's history, life experiences and pain
- How these experiences have shaped how we cope, react and sometimes behave
- Instead of asking 'what's wrong with you', it asks 'what's happened to you?'
- Provides support that is **non-judgmental, genuinely caring and understanding**

Trauma-Informed Network

- **Brings together lots of people in Camden and Islington** who think everyone deserves trauma-informed support and to be understood, valued, and genuinely cared for
- It includes **people who design, run and work in services, and people with lived experience of accessing services**
- We want to **work together** to make sure all services in Camden and Islington can provide this type of support

Contact Michelle (FLIC Mental Health Lead) to get involved 😊

MButterly@shp.org.uk

d. Appendix D – list of literature explored (white and grey)

number	Literature (hyperlink)	Type (white, grey)	Year	Organisation/funder	Country	Context (population of interest)	Trauma type explored
1	https://www.mhcc.org.au/wp-content/uploads/2018/05/nticp_strategic_direction_journal_article__vf4_-_jan_2014_.pdf	Grey	2013	Mental Health Coordinating Council (MHCC)	Australia	Long term aim of preparing a toolkit for Trauma-Informed Care and Practice. cultural shift in policy reform across mental health in Australia	
2	https://www.pacesconnection.com/g/aces-in-education/fileSendAction/fcType/5/fcOid/480528347493407227/fodoid/480528347493407226/Trauma-Informed%20Classrooms_Transformational%20Schools_Unlocking%20the%20Door%20to%20Learning_24%20pages.pdf	Grey	2014	Education law center	USA	Methods of making schools more trauma informed	
3	https://www.tandfonline.com/doi/full/10.1080/15299732.2017.1253401	Grey	2017	Oregon State University	USA		
4	https://www.tandfonline.com/doi/full/10.3402/ejpt.v4i0.20274	Grey	2013	University of California	USA	Chances of retraumatization amongst juveniles in prisons	
5	https://link.springer.com/article/10.1007/s10826-017-0987-y	Grey	2018	Temporary Assistance for Needy Families (TANF)	USA		
6	https://www.sciencedirect.com/science/article/pii/S1499404620300683#!	Grey	2020	Drexel University, Philadelphia,	USA	Trauma-informed programming incorporates healing-centered	

						approaches to address previous exposures to trauma.	
7	https://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063	Grey	2013	Chadwick Center for Children & Families	USA	Details about Trauma and TIC (Trauma Informed Care) have evolved. Methods of future of improvement.	More specfific to children and generic
8	https://jamboard.google.com/d/1C3Aylk8fDDuGf-B4vqz8xedbKuW8ylKhzp7XXoPuFkM/viewer?f=0	Grey	2021	SHP/FLIC	UK	MY COPY TI Working Group 29 July (JAM BOARD DETAILS PROVIDED BY SHP - Michelle)	
9	https://jamboard.google.com/d/1G3GehtUHfzE8u-vd3X9K3A1h2izCR2A1wRD4u-JnS6A/viewer	Grey	2021	SHP/FLIC	UK	trauma informed care	
10	https://jamboard.google.com/d/1BUnRoNOq9Wtwvy_wD16ozbD0zekTGqNkXBfK6HPtoZM/edit?usp=sharing	Grey	2021	SHP/FLIC	UK	trauma informed care	
11	https://jamboard.google.com/d/1PCpDwn9xkvH5TRDv8YBnL96Rf6R9d0CI_lwl-wo168k/edit?usp=sharing	Grey	2021	SHP/FLIC	UK	trauma informed care	
12	https://jamboard.google.com/d/1-8A7lFwPsjSxh9D1kwAgtre2ZbcUKOSgItQsoZgc6rY/edit?usp=sharing	Grey	2021	SHP/FLIC	UK	trauma informed care	
13	https://jamboard.google.com/d/1VFby_ncSsYRz704Ac9VqHkJmdkiQhq9nhVfriIJSiH8/edit?usp=sharing	Grey	2021	SHP/FLIC	UK	trauma informed care	
14	https://www.fact.virginia.gov/wp-content/uploads/2020/01/Why-TICNs.pdf	Grey		FACT Virginia	USA		

15	https://www.thenationalcouncil.org/consulting-services/trauma-informed-resilience-oriented-care/	Grey		The National Council of Wellbing	USA		
16	https://www.oregon.gov/oha/HPA/dsi-tc/Documents/HRS-convening-CPCCO.pdf	Grey		Columbia Pacfific Health	USA		
17	https://www.childtrends.org/publications/how-to-implement-trauma-informed-care-to-build-resilience-to-childhood-trauma	Grey		Child Trend	USA		
18	https://napac.org.uk/trauma-informed-practice-what-it-is-and-why-napac-supports-it/	Grey	NK	The National Association for People Abused in Childhood (NAPAC)	UK	People Abused in Childhood	Retraumatisation in health and social service settings
19	http://grscan.com/scan-works-to-create-a-trauma-informed-child-welfare-system/	Grey	NK	Stop Child Abuse Now (SCAN)	USA	Children and Caregivers	Child abuse and neglect
20	http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html	Grey	NK	Buffalo Center for Social Research	USA		Trauma informed care and re-traumatization
21	https://www.fact.virginia.gov/wp-content/uploads/2019/04/Virginias-Trauma-Informed-Community-Networks-PDF.pdf	Grey	NK	Family & Children's Trust Fund of Virginia	USA		
22	http://www.ghrconnects.org/tiles/index/display?alias=hrticn	Grey	NK	Hampton Roads Trauma Informed Community Network (HRTICN)	USA		ACEs, childhood trauma

23	https://www.newschoolsnetwork.org/what-are-free-schools/free-school-views/what-is-a-trauma-informed-school	Grey		WAVE Trust	UK	Information about Trauma Informed School	
24	https://www.mhcc.org.au/project/trauma-informed-care-and-practice-ticp/	Grey		MHCC	Australia	TCIP. Focused on implementing in MHCC, Australia	
25	https://hogg.utexas.edu/3-things-to-know-trauma-informed-care	Grey	2019	Hogg Foundation-Mental Health	USA	Things to know about Trauma Informed Care	ACE
26	http://www.transformational-community-alignment.org/case-study-trauma-informed-services-network	Grey		Transformational Community Alignment (TCA)	USA		
27	https://www.worcestershire.gov.uk/info/20757/the_virtual_school/2184/virtual_school_training_and_bespoke_packages_for_schools/2	Grey		Worcestershire Children First	USA	Presence of Trauma Informed Worcestershire	Trianing program at schools level/ ACE
28	https://journals.sagepub.com/doi/full/10.3102/0091732X18821123	Grey	2019		USA		
29	https://bettercarenetwork.org/news-updates/events/trauma-informed-practice-what-works-with-children-and-families	Grey	2019	Better Care Network	UK	Conference event for TI practice in Birmingham	Institute for Recovery from Childhood Trauma and Family
30	https://carecompassnetwork.org/care-compass-networks-regional-trauma-informed-care-network-ccn-rtic/	Grey	2020	Care Compass Network	USA	Regional TI care network review (new york)	
31	https://cheac.org/2020/12/19/dhcs-osg-solicit-input-on-trauma-informed-network-of-care-roadmap/	Grey	2020		USA	California Department of Health Care Services	ACES

32	https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/	Grey		Trauma Informed Care Implementation Resource Centre	USA	Generic Information around a TIC	
33	https://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562	Grey	2018	Harvard Medical School (Publishing)	USA		
34	https://www.kingsfund.org.uk/blog/2019/11/trauma-informed-care	Grey	2019	The King's Fund	UK	Specific to NHS	
35	https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf	Grey	2016	SAMSHA	USA	Successful TIC - Published by the orgnization	
36	https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm	Grey		Centers for Disease Control and Prevention	USA		
37	https://theinnovateproject.co.uk/trauma-informed-practice/	Grey		The Innovative Project	UK	Generic Information	
38	https://www.bristolhealthpartners.org.uk/uploads/documents/2021-06-24/1624539664-bnssg-trauma-informed-practice-knowledge-and-skills-framework-march-2021-web-version.pdf	Grey	2021	BNSSG	UK	Knowledge around the Trauma Informed System	
39	https://www.lancsvrn.co.uk/wp-content/uploads/2020/07/Lancs-VRN-Trauma-Informed-toolkit.pdf	Grey	2020	The Lancashire Violence Reduction Network	UK	Toolkit	

40	https://engage.vic.gov.au/framework-trauma-informed-practice	Grey	2019	Engage Victoria	Australia	Framework for Trauma Informed Practice b y Department of Health	
41	https://professionals.blueknot.org.au/resources/trauma-specific-practice-when-working-with-complex-trauma/	Grey		Blue Knot Foundation	Australia	Trauma Specific Practice when working with people with Complex Trauma Experiences	Complex Trauma Therapy
42	https://emergingminds.com.au/our-work/guiding-principles/trauma/	Grey		Emerging Minds	Australia	Helpful video shown in the link to explain more about Trauma	
43	https://www.acesaware.org/ace-fundamentals/principles-of-trauma-informed-care/#	Grey		Aces Aware	USA		
44	https://www.kent.gov.uk/__data/assets/pdf_file/0005/107789/RELATE-framework.pdf	Grey		Space Matters	UK	information about RELATED Framework	
45	http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html	Grey		Buggalo Cener for Social Research	USA	What is a TIC	Retraumatization
46	https://napac.org.uk/trauma-informed-practice-what-it-is-and-why-napac-supports-it/	Grey		NAPAC	UK	Information about Related to Trauma Informed Approach	
47	https://www.thinknpc.org/resource-hub/trauma-informed-approaches/	Grey		New Philanthropy Capital	UK		
48	https://www.centreformentalhealth.org.uk/news/all-public-services-should-be-trauma-informed-better-support-women-says-new-report	Grey	2019	Centre for Mental Health	UK	Public services should be trauma-informed to better support women	
49	https://nnedv.org/spotlight_on/understanding-importance-trauma-informed-care/	Grey		NNEDV	USA	Importance of TIC	

50	https://smiadviser.org/knowledge_post/what-does-it-mean-to-be-trauma-informed	Grey		SMI ADviser	USA	What does it mean to be trauma-informed?	
51	https://case.edu/socialwork/centerforebp/practices/trauma-informed-care	Grey		Case Western Reserve Univeristy - Center for Evidence Based Practises	USA	TIC	
52	https://c4innovates.com/our-expertise/person-centered-strategies/trauma-informed-care/	Grey		C4 Innovations	USA		
53	https://www.childtrends.org/publications/5-ways-trauma-informed-care-supports-childrens-development	Grey	2016	Child Trends	USA	Ways Trauma-Informed Care Supports Children’s Development	
54	https://drive.google.com/file/d/1fCpjydsvSTXOm0u9yxd0HJ7f55QPbQ2E/view	Grey		Scarf	Australia	Trauma-Informed Approach	
55	https://mentalhealthactionplan.ca/tools/mental-health-training-framework/trauma-informed-care/	Grey		Community Mental Health Action Plan	Canada	What is Trauma Informed Care?	
56	https://www.air.org/sites/default/files/trauma-informed-care-instrument-one-pager-August-2016-rev.pdf	Grey		American Institute For Research	USA	Framework for Building Trauma-Informed Organizations and Systems	
57	https://www.sussex.ac.uk/collaborate/talent-for-your-business/continuing-professional-development/trauma-informed-practice	Grey		University of Sussex	UK	How is Trauma-Informed Practice to develop skills	

58	http://mhaustralia.org/	Grey		Mental Health Australia	Australia	TIP	
59	https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf	Grey	2014	SAMHSA's Trauma and Justice Strategic Initiative	USA		
60	https://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063	White	2013	Chadwick Center for Children and Families, Rady Children Hospital, San Diego	USA	children and their families	abuse, neglect and other traumas
61	https://oce.ovid.com/article/00003727-201507000-00003/HTML	White	2015	Department of Pediatric Dentistry, University of Illinois at Chicago	USA		sexual abuse, domestic violence, elder abuse and combat trauma
62	https://doi.org/10.3109/01612840.2015.1025319	White	2015	Duke University, School of Nursing, USA	USA	survivors of sexual violence	Sexual violence, intimate partner violence
63	http://advancesinsocialwork.iupui.edu/index.php/advancesinsocialwork/article/view/21311	White	2017	Portland State University	USA	those accessing services for mental health, addiction, juvenile system, welfare, healthcare, housing and education	
64	https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cb	White	2011	University of Buffalo	USA	migrants, refugees and aslyum seekers	trauma and PTSD

	b8051000000/Trauma-Informed-Care-and-Mental-Health.pdf						
65	https://psycnet.apa.org/fulltext/2014-24414-001.pdf?auth_token=3aab60db3e6e53734db3b0087515acf5202265eb	White	2014	Adelphi University	USA	practitioners	secondary/vicarious trauma
66	http://www.chcs.org/media/Brief-Key-Ingredients-for-TIC-Implementation-1.pdf	White	2016	Center for Health Care Strategies	USA	How the health care sector can address trauma	
67	https://link.springer.com/article/10.1186/s40352-017-0050-5	White	2017	Threshold GlobalWorks	USA	prison population, corrections officers, general population	ACEs, early trauma
68	https://journals.sagepub.com/doi/full/10.1177/1077559515615700	White	2015	Department of Psychiatry, University of Massachusetts Medical School	USA	Children	Childhood maltreatment
69	https://www.nature.com/articles/pr2015197.pdf	White	2015	Department of Pediatrics, University of Iowa	USA	children	ACEs, toxic stress and trauma
70	https://www.tandfonline.com/doi/abs/10.1080/01488376.2013.845131?casa_token=SYOoACUGdmkAAAAA:7Jo_vX41-3G6hHDMO7-L0r96XJ_LnjApS6SSz1RXHZeq2nDIBNYSshD4QoO57C24fBET2_80MUYKGQ	White	2014	University of Buffalo	USA	Social services providers/staff	general trauma in patients/burnout in staff
71	https://link.springer.com/content/pdf/10.1007/s10615-014-0481-6.pdf	White	2015	School of Social Work, Universty of Maryland	USA	Service providers in diverse settings	

72	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5968451/pdf/nihms962244.pdf	White	2018	Penn Injury Science Center, University of Pennsylvania	USA	adults	traumatic injuries
73	https://link.springer.com/content/pdf/10.1007/s12310-015-9161-0.pdf	White	2015	Department of Psychology, Tulanr University	USA	all ages, with trauma histories	ACEs and general trauma
74	https://onlinelibrary.wiley.com/doi/full/10.1002/jcop.21799?casa_token=JABNpFy7rjgAAAAA%3AvcC1UWYu-7Sgy6u4-pWTCBFzfM7jarIBq4GdizeaY9inEOdharKLKg0XgZko72OFD-ac2DwIlccFx3eY	White	2016	Boston College	USA	operationalizing efficacy of TIC	domestic violence
75	https://onlinelibrary.wiley.com/doi/abs/10.1111/josh.12568?casa_token=UfAqLDhGSnoAAAAA:1NwiKEJobKKJoJuwyAqjtj054z9y-AHYnvFitETstIhRkSBnUS9Pr-dl4wzkmPl2EPcONn43WUJYfb51	White	2017	Department of Maternal and Child Health, University of North Carolina	USA	School-aged children, particularly adolescents at a higher-risk of pregnancy	Childhood trauma, trauma and pregnancy
76	https://www.tandfonline.com/doi/abs/10.1080/08841233.2015.1030059	White	2015	School of Social Work, University of Buffalo	USA	TIC in education settings	Type of trauma not specified
77	https://www.whijournal.com/article/S1049-3867(15)00033-X/fulltext	White					
78	https://pediatrics.aappublications.org/content/148/2/e2021052580	White	2021	University of Massachusetts, Department of Pediatrics	USA	children, families	ACEs, childhood trauma

79	https://psycnet.apa.org/fulltext/2012-17897-001.pdf?auth_token=6473d6ffe0b6a54a69de877f1f251487844fe9cb	White	2012	University of British Columbia	Canada	adolescents	childhood trauma and PTSD
80	https://www.tandfonline.com/doi/full/10.1080/08841233.2015.1030059	White	2015	School of Social Work, University at Buffalo	USA	Students in clinical training	Vicarious traumatization and retraumatization
81	https://psycnet.apa.org/record/2011-20034-001	White	2012	Traumatic Stress Institute of Klinberg Family Centers	USA	Staff in child congregate care treatment settings	vicarious trauma
82	https://academic.oup.com/sw/article/62/2/105/2937786?login=true	White	2017	Barry University	USA	social workers	TIC, type of trauma not specified
83	https://onlinelibrary.wiley.com/doi/full/10.1111/jmwh.12674?casa_token=0tVzoR-uV5MAAAAA%3AAcZmhwe-pAemA-2d8q1wqANPKsJbcKe72Av1Mkoa5Ra_Cy2yInMQdIju1lTA4RNVst5gpOBWK0aiXMiR	White	2017	School of Social Work, University of Buffalo	USA	TIC in maternity care/midwifery	ACEs
84	https://journals.sagepub.com/doi/abs/10.1177/1049731518766618?casa_token=3WXaBh_7LXwAAAAA:-wWerw1wyrfzhvDhg7WpTPBNIFA-j0_FQvnQLiNyorSkGkWKk_TpgZaupqqJCSHbmvv4G0Bh5MmCAw	White	2018	Institute on Trauma and Trauma Informed Care, University of Buffalo	USA	measuring efficacy of a TIC implementation project	not specified
85	Trauma-informed care: An ecological response	White	2015	Center for Social Innovation	USA	children	exposure to traumatic stress during childhood

86	https://www.ncbi.nlm.nih.gov/books/NBK207195/	White	2014	Center for Substance Abuse Treatment	USA	Common Trauma informed practices	Extremely helpful examples covering all types of traumas
87	https://journals.sagepub.com/doi/abs/10.1177/1077559516643785?casa_token=kz2UlG4d4dkAAAAA%3AkfiFUK8yprEASLIT_M7ak-vfS0mUz8bhHhi8J42KTwCO9Gg8m8647SpwG_lbcL5oY1drsFF8p4Xosg&journalCode=cmxa	White *commentary	2016	Harborview Center for Sexual Assault and Traumatic Stress	USA	children	commentary on papers about understanding and applying TIC in diverse human service organisations
88	https://www.cfp.ca/content/64/3/170.short	White *commentary	2018	Queen's University	Canada	family medicine, children and young people	ACEs
89	https://onlinelibrary.wiley.com/doi/full/10.1111/inm.12012?casa_token=g2bh_bSFng0AAAAA%3Am-yTn_-P40Uk-en8fx15-sF31HNRFqzeU9VuQaYm-1vGYOZI8qT5Z9RmujQYRHZPSJUpxUYIKq0KPvm-	White *Lit Review	2013	Department of Health and Human Services, State-Wide and Mental Health Services	Australia	mental health nursing providing TIC	
90	https://www.actionaces.org/wp-content/uploads/2019/06/Frameworks-for-Becoming-Trauma-Informed_FINAL-PDF-v3.pdf	White/Grey		Gloucestershire County Council	UK	Methods of becoming a Trauma informed Framework	

e. Appendix E, The list of concepts as identified from the literature and our panel of experts on Round 1 of the DELPHI.

The list of concepts is divided below into theories, partners, and actions. The number and percentage of times that each concept appeared in the participant responses and the literature are provided, and concepts are given in order prevalence of appearance in the literature. This number can be over 100% if the same participant has identified a concept more than once. Concepts identified by participants only (not apparent in the literature) are highlighted in yellow.

i. List of theory-related concepts, along with their prevalence in the literature and in round 1 participant responses.

		participants		literature	
	Theory-related concept	N	%	N	%
1	trustworthiness - clarity, consistency, relationships, and Interpersonal Boundaries in care	39	130.0	46	51.1
2	Always Empower, Never Disempower: Avoid battles for power with PTE	10	33.3	44	48.9
3	Realises the widespread impact of trauma, stress and adversity within our society	36	120.0	43	47.8
4	seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals	10	33.3	40	44.4
5	collaboration - making decisions with the individual and sharing power	9	30.0	38	42.2
6	promote physical and psychological safety	3	10.0	34	37.8
7	a strengths-based perspective, emphasising people's capability for growth, healing and resilience.	8	26.7	29	32.2
8	seek to understand, rather than pathologise (shift from “what is wrong with you?” to “what is happening with you?”)	11	36.7	28	31.1
9	avoiding stigmatizing and punishing PTE	8	26.7	23	25.6
10	an emphasis on exploring and learning from history, gender, race, and cultural context	6	20.0	21	23.3
11	minimize the risk of secondary traumatization (e.g. in staff responding to client trauma)	2	6.7	21	23.3

12	strives to understand the whole of an individual (e.g. life experiences, environment) who is seeking services.	4	13.3	19	21.1
13	PTE are seen as unique individuals who have experienced extremely challenging situations and have managed as best they could. Care must occur at an individual level, based on the person's needs.	11	36.7	15	16.7
14	move towards, and support, recovery	0	0.0	11	12.2
15	understanding, recognizing, and responding to the effects of trauma (e.g. physical, mental, emotional, social, behavioural).	0	0.0	7	7.8
16	choice - individual has choice and control	0	0.0	3	3.3
17	understand that an individual’s experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions	0	0.0	2	2.2
18	understand that an individual’s experience of trauma can greatly influence his or her receptivity to and engagement with services	0	0.0	2	2.2
19	asks “Who do you want to be?”	0	0.0	1	1.1
20	move toward a culture of health, which recognizes that all aspects of people's lives should support active and healthy living	0	0.0	1	1.1
21	catching PTE as they are ‘falling’ not after they have fallen	0	0.0	1	1.1
22	replaces the labelling of PTE or PTEs as being “sick,” resistant or uncooperative with that of being affected by an “injury.”	0	0.0	1	1.1
23	helps PTE to acknowledge, understand, and practice new ways of building relationships, managing emotions, imagining a future, and practicing self-care	0	0.0	1	1.1
24	Trauma Informed services understand that until an individual is safe physically and emotionally from violence and abuse, recovery is not possible	0	0.0	1	1.1
	TOTAL	30		90	

ii. List of partner-related concepts, along with their prevalence in the literature and in round 1 participant responses.

		participants		literature	
	Partner-related concept	N	%	N	%
1	employers (managers, supervisors, program administrators)	3	10.0	15	16.7
2	education settings (e.g. schools, university, nurseries)	10	33.3	15	16.7
3	health service providers	17	56.7	13	14.4
4	mental health services and professionals (e.g. counsellors, behavioural therapists)	21	70.0	13	14.4
5	community members	4	13.3	12	13.3
6	trauma informed leadership teams (TILS)	2	6.7	12	13.3
7	policymakers	0	0.0	10	11.1
8	special education professionals	0	0.0	9	10.0
9	administrative and support staff, (front-desk workers, security guards, porters, and driver)	8	26.7	7	7.8
10	caregivers (e.g. parent, guardian)	1	3.3	7	7.8
11	social services	9	30.0	7	7.8
12	governance board/local authorities	3	10.0	6	6.7
13	criminal justice system and police	10	33.3	5	5.6
14	family and friends	1	3.3	4	4.4
15	instructors/trainers	2	6.7	4	4.4
16	primary care physicians (GPs)	6	20.0	4	4.4
17	service providers ('on the ground' staff)	8	26.7	4	4.4
18	volunteers working with PTE	5	16.7	4	4.4
19	academic researchers,	7	23.3	3	3.3
20	first responders (e.g. emergency and acute services)	2	6.7	3	3.3

21	HR staff	3	10.0	3	3.3
22	PTE (service users)	9	30.0	3	3.3
23	staff learning new practises (training, residency, fellowship)	0	0.0	3	3.3
24	adoption/foster care and child/family services	6	20.0	3	3.3
25	peer–run and community organization	1	3.3	3	3.3
26	government agencies	2	6.7	3	3.3
27	judges	0	0.0	2	2.2
28	Nurses and midwives	5	16.7	2	2.2
29	homelessness and housing services	13	43.3	2	2.2
30	correctional settings and prisons	1	3.3	2	2.2
31	religious institutions	0	0.0	2	2.2
32	activists	0	0.0	1	1.1
33	commissioners	2	6.7	1	1.1
34	data managers	0	0.0	1	1.1
35	the public	5	16.7	1	1.1
36	trauma informed care champions	0	0.0	1	1.1
37	household food insecurity (HFI) services	0	0.0	1	1.1
38	Department of Social Services		0.0	1	1.1
39	domestic violence and women's services	3	10.0	1	1.1
40	councils	2	6.7	1	1.1
41	accrediting bodies	1	3.3	1	1.1
42	licensing agencies,	0	0.0	1	1.1
43	media agencies	0	0.0	1	1.1
44	military	1	3.3	1	1.1
45	nonprofits and charities	6	20.0	1	1.1

46	offender support services	0	0.0	1	1.1
47	residential care	1	3.3	1	1.1
48	stakeholder groups	0	0.0	1	1.1
49	Substance Abuse and Mental Health Services	4	13.3	1	1.1
50	general businesses/industry	13	43.3	1	1.1
51	care staff	3	10.0	0	0.0
52	consultants	1	3.3	0	0.0
53	landlords	1	3.3	0	0.0
54	experts in TIC	1	3.3	0	0.0
55	discharge teams	1	3.3	0	0.0
56	pharmacists	1	3.3	0	0.0
57	employment and pension agencies	8	26.7	0	0.0
58	dentistry	1	3.3	0	0.0
59	legal advice services	2	6.7	0	0.0
60	refugee/immigration services	2	6.7	0	0.0
61	disability and benefits services	4	13.3	0	0.0
62	banking	1	3.3	0	0.0
	TOTAL	223		204	

iii. List of action-related concepts, along with their prevalence in the literature and in round 1 participant responses.

		Participant		Literature	
	Action-related concept	N	%	N	%
1	provide all staff (including non-clinical and leadership) with **training/professional development** opportunities in TIC (e.g. awareness, signs and symptoms, prevent re-traumatisation, screening, response, adaptation, follow-up, safety and boundaries, de-escalation, effectively managing emotions, responding to individuals who disclose personal crises, strengths focused planning)	38	126.7	44	48.9
2	Empower PTEs by providing education on how to **enhance self-efficacy** through treatment (e.g. Self-management techniques, self regulation, relationship management, independence, development of a self-care plan)	10	33.3	41	45.6
3	acknowledge the need for **universal trauma awareness**/understanding about the widespread impact of trauma (prevalence and outcomes)	36	120.0	40	44.4
4	develop and sustain a trauma-informed **organisational culture**, that aim to shape organizations to be more trauma-sensitive in their work	2	6.7	40	44.4
5	Facilitate client involvement and **equality of power in treatment planning** (e.g. participatory decision-making)	9	30.0	37	41.1
6	assess practices that could be **retraumatizing -** shape PTE's environments to avoid such triggers (e.g. sensations, contexts, sounds, sights, smells, objects, interactions, dynamics, places, or people that remind an individual of the original trauma)	10	33.3	36	40.0
7	training staff in the art of **empathic communication** (good listening, understanding and finding the words to convey accurate empathy, respecting the client's expertise)	50	166.7	36	40.0
8	review and write **policy** to be reflective of trauma-informed principles (e.g. trauma informed guidelines)	4	13.3	36	40.0

9	**educate workforce** about trauma (recognize the signs and symptoms of trauma, and understand how it impacts PTE and families)	28	93.3	35	38.9
10	promoting **best practice** (evidence-based and evidence-informed trauma-specific practices)	5	16.7	33	36.7
11	build **ongoing collaboratio**n between critical services and sectors to increase continuity of care (exchange information, streamline referral processes, coordinate assessments and care, plan and deliver services in collaboration, share good practice, have a central contact for clients)	4	13.3	32	35.6
12	**Routine, universal screening** for trauma exposure and related symptoms (including paper or verbal options) early in the care process	10	33.3	31	34.4
13	organization supports PTE's to make an **informed choice** over services they receive (e.g. by familiarize PTE with trauma-informed services, explaining treatment methodologies and of the rationale behind specific interventions, clear care boundaries, the value and type of trauma-related questions that may be asked during an intake process, how PTEs' traumatic experiences contribute to their overall health)	3	10.0	29	32.2
14	Developing health care settings and activities that ensure PTEs' **physical and emotional safety** (e.g. Ensuring that people are not allowed to smoke, loiter, or congregate outside entrances and exits, clear and identified exit routes, Keeping parking lots, common areas, bathrooms, entrances, and exits well lit, Monitoring who is coming in and out of the building)	3	10.0	27	30.0
15	a trauma-informed **environment or setting** (e.g. a predictable environment structured to take into account PTE needs such as to feel safe, supported, in control, or to reduce further trauma)	5	16.7	26	28.9
16	embed trauma informed **principles** in all areas of **practice**, consistent between organisations	2	6.7	26	28.9
17	create a **shared understanding** (framework) of trauma informed care, protocols, language and value system	5	16.7	25	27.8
18	Use a **strengths-focused perspective** to promote resilience (e.g. engage in efforts to recognise and strengthen the resilience and protective factors of PTE and families)	9	30.0	25	27.8

19	focus on the importance of **facilitating healing,** well-being and/or recovery, rather than pathologising or 'fixing' clients, or controlling recovery	12	40.0	25	27.8
20	promote **evidence generating practice** (Progress Monitoring and Quality Assurance) - keeping accurate records and testing outcomes to enable staff and PTE to evaluate their effectiveness. Constant analysis of health benefits versus emotional costs.	6	20.0	25	27.8
21	Provide care that is **inclusive** of the PTE’s racial, ethnic, and cultural background, and gender identity. Be sensitive to marginalisation.	6	20.0	23	25.6
22	change PR policies to **invest in/support staff** wellbeing (increase resilience, empower, provide counselling, reduce stress, burnout, and workload, allow mental health days, paid family leave and flexible work schedules, self-care, maintaining healthy interpersonal boundaries, awareness of the health risks that have been identified among staff who regularly engage with PTE, fostering a culture of trust so that staff can say when they are struggling to cope)	14	46.7	23	25.6
23	**reduce traumas** imposed by the system (ie. removal from the home, changes in placement, instability of relationships, use of coercion, seclusion and restraint, discipline or intimidation, inconsistent caregivers and caseworkers)	8	26.7	22	24.4
24	Develop strategies to support staff by minimizing and treating **secondary traumatic stress** (stress caused by experiencing and/or empathising with other's traumatic reactions).	3	10.0	21	23.3
25	provide **referrals for trauma treatment** as appropriate even if the client is not seeking care for trauma-related injury (e.g. by creating a referral resource).	4	13.3	20	22.2
26	encourage **stakeholder participation** at all levels of the organizational development process (e.g. engage PTEs, former clients, and staff in decisions on use of services, access needs, support needs, behavioral health program development, planning, and evaluation, training, board of directors)	16	53.3	20	22.2
27	promote readily available and updated **information on trauma** into general knowledge for staff, clients, and families - its impact,	6	20.0	19	21.1

	appropriate responses, and treatment (e.g. on websites, video, webinars, mailing lists, leaflets, handbooks, manuals)				
28	implement **procedures/protocols** which reflect trauma-informed principles	2	6.7	19	21.1
29	collect **trauma histories** of PTE in order to understand their background (e.g. to anticipate the interplay between elements of treatment and types of trauma/when it occurred in the life span)	4	13.3	18	20.0
30	identify a diverse group of **recognised leaders,** champions, and/or planning committee roles to oversee trauma informed changes and review progress (including community members and PTEs)	3	10.0	18	20.0
31	**accessible care** - equal access to quality treatment which takes account of the unique context of their life (e.g. accessible buildings, location, costs, language, times, and staff) - address the barriers that those affected by trauma can experience while accessing the care	6	20.0	17	18.9
32	Prior to treatment, creating **clear expectations** with PTEs about what proposed treatments entail, who will provide services, and how care will be provided, establish and consistent boundaries and clarity of what is expected in regards to tasks - and maintain these boundaries.	0	0.0	17	18.9
33	**co-occurring disorders** need to be addressed on some level in the treatment plan and setting (e.g. addiction, depression, grief, housing, nutrition, poverty, and other symptoms of trauma)	1	3.3	16	17.8
34	**funding and resource allocation** demonstrates the value of trauma-informed care (e.g. funding is contingent upon eliminating harmful practices, PTE are compensated for their consultancy, continuing education credits or certifications are given for trauma informed education).	10	33.3	16	17.8
35	embed effective **trauma-specific treatment** strategies within all services to manage the behavioral and emotional symptoms of traumatic stress	17	56.7	15	16.7
36	Initiate use of appropriate formal, reliable, and valid **trauma-related screening and assessment tools**.	1	3.3	14	15.6
37	active **support from leadership** for implementing and sustaining a trauma-informed approach (who are themselves trauma aware)	6	20.0	14	15.6

38	Enable **peer support** workers — individuals with lived trauma experiences who receive special training	1	3.3	13	14.4
39	support positive relationships in the client's life by providing **caregiver support** groups and training (developing a strong social support network of family, friends, and community)	1	3.3	13	14.4
40	create organizational documentation and structure that supports its **ongoing commitment** to becoming trauma-informed **(**e.g. an intentional statement on the organization's commitment to promote trauma recovery)	7	23.3	13	14.4
41	resources for **mentoring/supervision**, helping staff address trauma/self reflect/develop their approach	3	10.0	12	13.3
42	addressing trauma requires a **multi-agency approach** requiring formal pathways for coordination and integration of services	3	10.0	11	12.2
43	encourage the use of **available research** to inform trauma care	6	20.0	11	12.2
44	Staff check **Assumptions,** Realize when you are making assumptions. be mindful of our own values and beliefs/bias, and are aware of our behaviours, personal reflection and education about one's own implicit and explicit biases	12	40.0	10	11.1
45	generate **buy-in** throughout the organization (staff at all levels change their behaviours , actions and policies in keeping with a TIC approach) by clearly communicating the rationale and benefits of trauma informed care	3	10.0	10	11.1
46	leverage and strengthen the healing value of traditional **cultural and community connection** (e.g. Community Outreach and Partnership Building, engagement with community stakeholders)	8	26.7	9	10.0
47	organizational operations and decisions are conducted with **transparency** about what is being offered and what is possible	4	13.3	9	10.0
48	identify and implement **prevention efforts** against trauma occuring initially (e.g. before treatment is required)	3	10.0	8	8.9
49	assess organisation's **readiness** to become trauma informed (to instigate change)	0	0.0	8	8.9
50	**Hire staff** suited for trauma-informed work (workforce development) — based on previous experience with relevant PTE	4	13.3	7	7.8

	populations, personal trauma experience, training, and personality (empathy, non-judgment, and collaboration).				
51	give people opportunity to **give feedback** about their experience which drives the direction of the care plan (and respond to this feedback).	1	3.3	7	7.8
52	providing **welcoming** care organisations, such that PTE feel able to approach the service (e.g. Using welcoming language on all signage, greeting people in a welcoming manner when they first walk into the building)	0	0.0	7	7.8
53	embedding continuous **quality improvement.** Implement quality improvement measures as needs and problem areas are identified	4	13.3	7	7.8
54	support strategies that encompass **family-based** approaches to trauma intervention.	0	0.0	6	6.7
55	**physical spaces** are available to engage and support people in the service (e.g. inclusive spaces where PTE can go to calm down, think, or reflect, common areas which are welcoming and privacy is respected, sex-specific spaces)	3	10.0	6	6.7
56	**conceptualise**/operationalize intended outcomes of TIC (create measurable outcomes). e.g. Develop an implementation & goal attainment plan to allow for progress to be checked and corrections made.	1	3.3	6	6.7
57	structured a**ccountability/oversight** which responds to failings within the service (e.g. site visits, feedback and reports)	4	13.3	6	6.7
58	implement **follow-up protocols** at the end of treatment, imlementation of a post-treatment plan, regular verbal check-ins	0	0.0	5	5.6
59	care should include **screening of resilience**, not just trauma	0	0.0	5	5.6
60	**Re-screening** for trauma should be avoided. (e.g.through sharing of information across services, such that trauma does not need to be relived more often than necessary)	2	6.7	5	5.6
61	develop **public education campaigns** to inform about trauma, akin to those used in antismoking efforts, vaccination promotion, and seat belt use.	3	10.0	5	5.6
62	PTE feel **valued** in their opinions (e.g. open encouragement /ease of access to get involved in their care/practices)	1	3.3	5	5.6

63	**Facilitate disclosure** of trauma through protocol and procedure (e.g. by being non judgemental, allowing time, screening protocols, privacy and confidentiality)	2	6.7	5	5.6
64	Create an initial **infrastructure** to initiate, support, and guide changes (e.g. an implementation planning guide)	1	3.3	5	5.6
65	recognize that every person's experience is unique and requires an **individualized approach** based on their capabilities	11	36.7	4	4.4
66	TIC begins with the **first contact** a person has with any program, institution, or service system	0	0.0	4	4.4
67	leveling of **power differences among organizational staff** from direct care staff to administrators, to support shared decision-making	5	16.7	4	4.4
68	respond in **timely** ways that help to support recovery, taking the time necessary to establish strong relationships	1	3.3	4	4.4
69	**monitor PTE** comfort/distress (non-verbal behaviours)	0	0.0	4	4.4
70	advocate for individuals affected by trauma.	0	0.0	3	3.3
71	**educating PTE** about trauma to help normalize traumatic stress reactions, make new meaning of his or her trauma history or symptoms, and explain how it relates to their current behaviours or well-being.	5	16.7	3	3.3
72	incorporate **group therapy** approaches	0	0.0	2	2.2
73	**solve barriers to living**: help low income PTE gain employment skills, secure employment and reach self-sufficiency, (e.g. a financial empowerment curriculum, nutrition education and budgeting, identify suitable housing, provide food & sanitary care).	4	13.3	2	2.2
74	facilitate **engagement** with services (find clients who don't engage, try to re-engage clients who fail to attend, identify systemic issues (e.g. poverty) which may cause trauma)	3	10.0	0	0
		30		90	

f. Appendix F, This list of concepts with % expert approval at the end of round 3.

The list of concepts is divided below into theories, partners, and actions. The percentage agreement that each concept received from the expert panel is provided, and concepts are given in order of percentage agreement from high to low. Concepts with agreement above 70% were 'approved' and moved into round 4 (indicated in green). Those with agreement below 30% were collectively considered to beyond the scope of a trauma informed network.

i. List of theory-related concepts, along with their percentage approval in round 3 participant responses.

Items	%
Realises the widespread impact of trauma, stress and adversity within our society	100%
Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals	92.86%
Understanding, recognizing, and responding to the effects of trauma (e.g. physical, mental, emotional, social, behavioural).	83.33%
Collaboration - making decisions with the individual and sharing power.	76.67%
An emphasis on exploring and learning from history, gender, race, and cultural context.	73.33%
Minimize the risk of secondary traumatization (e.g. in staff responding to client trauma).	73.33%
A strengths-based perspective, emphasising people's capability for growth, healing and resilience.	70.00%
Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions.	70.00%
Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services.	70.00%

Strives to understand the whole of an individual (e.g. life experiences, environment) who is seeking services.	63.33%
Avoid stigmatizing and punishing PTE (people with trauma experience).	60.00%
Helps PTE (people with trauma experience) to acknowledge, understand, and practice new ways of building relationships, managing emotions, imagining a future, and practicing self-care.	56.67%
Seek to understand, rather than pathologise (shift from what is wrong with you? to what is happening with you?).	56.67%
PTE (people with trauma experience) are seen as unique individuals who have experienced extremely challenging situations and have managed as best they could.	53.33%
Promote physical and psychological safety.	50.00%
Trustworthiness - clarity, consistency, relationships, and Interpersonal Boundaries in care.	50.00%
Move toward a culture of health, which recognizes that all aspects of people's lives should support active and healthy living.	46.67%
Choice - individual has choice and control over their care.	40.00%
Move towards, and support, recovery.	36.67%
Always Empower, Never Disempower: Avoid battles for power with PTE (people with trauma experience).	33.33%
Replaces the labelling of PTE (people with trauma experience) as being sick,resistant or uncooperative with that of being affected by an injury	33.33%
Understand that until an individual is safe physically and emotionally from violence and abuse, recovery is not possible.	30.00%
Catching PTE (people with trauma experience) as they are €˜falling' not after they have fallen.	26.67%

Asks "Who do you want to be?"	10.00%

ii. List of partner-related concepts, along with their percentage approval in round 3 participant responses.

Items	**%**
PTEs (people with trauma experience)	100%
Service providers ('on the ground' staff)	100%
Experts in TIC	100%
Primary care physicians (GPs)	100%
Substance Abuse and Mental Health Services	100%
Health service providers	100%
Domestic violence and women's services	100%
Social services	100%
Trauma informed leadership teams	100%
Mental health services (e.g. counsellors, behavioural therapists)	100%
First responders (e.g. emergency and acute services)	96.67%
Trauma informed care champions	96.67%
Volunteers working with PTE (people with trauma experience)	96.67%
Offender support services	96.67%
Peer–run and community organization	96.67%
Homelessness and housing services	96.67%
Residential care	93.33%
Disability and benefits services	93.33%
psychologists	90.00%
Commissioners	90.00%
Education settings (e.g. schools, university, nurseries)	90.00%
Supported accommodation for people with mental health problems	83.33%
Refugee/immigration services	80.00%

Department of Social Services	80.00%
homelessness services and agencies	80.00%
Nurses and midwives	76.67%
Criminal justice system and police	76.67%
Adoption/foster care and child/family services	76.67%
all education professionals - not just special ed	73.33%
Care staff	73.33%
Councils	73.33%
Policymakers	70.00%
Correctional settings and prisons	70.00%
Nonprofits and charities	70.00%
Universities for mental health, social care/work, nursing etc.	66.67%
Special education professionals	63.33%
young people leaving care	63.33%
Discharge teams	60.00%
The engagement and participation teams part of social housing providers	60.00%
Caregivers (e.g. parent, guardian)	56.67%
Employers (managers, supervisors, program administrators)	56.67%
Employment and pension agencies	56.67%
Governance board/local authorities	56.67%
Instructors/trainers of staff	50.00%
Consultants	50.00%
Legal advice services	50.00%
Government agencies	50.00%
Academic researchers	46.67%

Household food insecurity (HFI) services	46.67%
Judges	43.33%
Family and friends	43.33%
Pharmacists	40.00%
The public	36.67%
Community members	36.67%
Activists	36.67%
Staff learning new practises (training, residency, fellowship)	36.67%
Military	36.67%
Landlords	33.33%
Administrative and support staff, (front-desk workers, security guards, porters, and driver)	33.33%
Dentistry	33.33%
Religious institutions	33.33%
Stakeholder groups	33.33%
HR staff	26.67%
Media agencies	23.33%
Accrediting bodies	20.00%
Data managers	13.33%
General businesses/industry	13.33%
Licensing agencies	6.67%
Banking	6.67%

iii. List of action-related concepts, along with their percentage approval in round 3 participant responses.

Actions	**%**
Educate the workforce about trauma (recognize the signs and symptoms of trauma, and understand how it impacts PTE and families).	100%
Create a shared understanding (framework) of trauma informed care, protocols, language and value system	96.67%
Provide all staff with training/professional development opportunities in Trauma informed care (e.g. awareness, signs and symptoms, prevent re-traumatisation, screening, response, adaptation, follow-up, safety and boundaries, deescalation, effectively managing emotions, responding to individuals who disclose personal crises, strengths focused planning).	93.33%
Promote readily available and updated information on trauma into general knowledge for staff, clients, and families - its impact, appropriate responses, and treatment (e.g. on websites, video, webinars, mailing lists, leaflets, handbooks, manuals)	93.33%
Acknowledge the need for universal trauma awareness/understanding about the widespread impact of trauma (prevalence and outcomes).	90.00%
Encourage the use of available research to inform trauma care. 68%	80.00%
Embed trauma informed principles in all areas of practice, consistent between organisations. 64%	80.00%
Identify a diverse group of recognised leaders, champions, and/or planning committee roles to oversee trauma informed changes and review progress (including community members and PTEs). 54%	76.67%
Develop and sustain a trauma-informed organisational culture, that shape organizations to be more trauma-sensitive in their work. 61%	76.67%
Promote best practice (evidence-based and evidence-informed trauma-specific practices). 68%	76.67%

Training staff in the art of empathic communication (good listening, understanding and finding the words to convey accurate empathy, respecting the client's expertise). 61%	73.33%
Enable peer support workers (individuals with lived trauma experiences who receive special training). 54%	66.67%
A multi-agency approach requiring formal pathways for coordination and integration of services. 64%	66.67%
Build ongoing collaboration between critical services and sectors to increase continuity of care (e.g. exchange information, streamline referral processes, coordinate assessments and care, plan and deliver services in collaboration, share good practice, have a central contact for clients). 68%	66.67%
PTE (people with trauma experience) feel valued in their opinions (e.g. open encouragement /ease of access to get involved in their care/practices). 54%	63.33%
Educating PTE (people with trauma experience) about trauma - to help normalize traumatic stress reactions, make new meaning of his or her trauma history or symptoms, and explain how it relates to their current behaviours or well-being. 57%	63.33%
Advocate for individuals affected by trauma. 64%	63.33%
Review and write policy to be reflective of trauma-informed principles (e.g. trauma informed guidelines). 64%	63.33%
Focus on the importance of facilitating healing, well-being and/or recovery, rather than pathologising or 'fixing' clients, or controlling recovery. 50%	60.00%
Develop public education campaigns to inform about trauma (akin to those used in antismoking efforts, vaccination promotion, and seat belt use). 64%	56.67%
Understanding how the effects of trauma influence peoples behaviour, choices and relationships both social and with services, and that trauma-influenced response may be unconscious.	56.67%

Active support from leadership for implementing and sustaining a trauma-informed approach (who are themselves trauma aware). 39%	53.33%
Reduce traumas imposed by the system (e.g. removal from the home, changes in placement, use of coercion, seclusion and restraint, discipline or intimidation, inconsistent caregivers and caseworkers). 46%	53.33%
Address co-occurring disorders in the treatment plan and setting (e.g. addiction, depression, grief, housing, nutrition, poverty, and other symptoms of trauma). 50%	53.33%
Initiate use of appropriate formal, reliable, and valid trauma-related screening and assessment tools. 54%	53.33%
Create an initial infrastructure to initiate, support, and guide changes (e.g. an implementation planning guide). 57%	53.33%
Facilitate client involvement and equality of power in personal treatment planning (e.g. participatory decision-making). 43%	50.00%
Provide care that is inclusive of the PTE's racial, ethnic, and cultural background, and gender identity. Be sensitive to marginalisation. 39%	50.00%
Staff check their assumptions (be mindful of our own values and beliefs/bias, and are aware of our behaviours, personal reflection and education about one's own implicit and explicit biases). 43%	50.00%
Change PR policies to invest in/support staff wellbeing (e.g. increase resilience, provide counselling, reduce stress, burnout, and workload, allow mental health days, paid family leave and flexible work schedules, self-care, maintaining healthy interpersonal boundaries, awareness of the health risks that have been identified among staff who regularly engage with PTE, fostering a culture of trust so that staff can say when they are struggling to cope). 46%	50.00%
Avoid practices that could be retraumatizing (e.g. sensations, contexts, sounds, sights, smells, objects, interactions, dynamics, places, or people that remind an individual of the original trauma). 32%	46.67%
Recognize that every person's experience is unique and requires an individualized approach based on their capabilities. 36%	46.67%
Identify and implement prevention efforts against trauma occuring initially (e.g. before treatment is required). 43%	46.67%

Funding and resource allocation demonstrates the value of trauma-informed care (e.g. funding is contingent upon eliminating harmful practices, PTE are compensated for their consultancy, continuing education credits or certifications are given for trauma informed education). 43%	46.67%
Support staff by minimizing and treating secondary traumatic stress (stress caused by experiencing and/or empathising with other's traumatic reactions). 43%	46.67%
Use a strengths-focused perspective to promote resilience (e.g. engage in efforts to recognise and strengthen the resilience and protective factors of PTE and families). 46%	46.67%
A trauma-informed environment or setting (e.g. a predictable environment structured to take into account PTE needs such as to feel safe, supported, in control, or to reduce further trauma). 39%	46.67%
Implement procedures/protocols which reflect trauma-informed principles. 46%	46.67%
Create organizational documentation and structure that supports its ongoing commitment to becoming trauma-informed (e.g. an intentional statement on the organization's commitment to promote trauma recovery). 46%	46.67%
Generate buy-in throughout the organization (staff at all levels change their behaviours, actions and policies in keeping with a Trauma informed approach) by clearly communicating the rationale and benefits of trauma informed care. 50%	46.67%
Give the opportunity to give feedback about their experience which drives the direction of the care plan (and respond to this feedback). 50%	46.67%
Promote evidence generating practice (Progress Monitoring and Quality Assurance) - keeping accurate records and testing outcomes to enable staff and PTE to evaluate their effectiveness. Constant analysis of health benefits versus emotional costs. 54%	46.67%
Encourage stakeholder participation at all levels of the organizational development process (e.g. engage current/former clients and staff in decisions on use of services, access needs, support needs, behavioral health program development, planning, and evaluation, training, board of directors). 54%	46.67%

provide advocacy care / support workers to those who have multiple trauma and comorbidity disabilities. This help must be free.	46.67%
Look at sectors of society that are without services and excluded and realise this is traumatising i.e autism / neurodiversity sensory diversity and physical disability as well as trauma.	46.67%
Hire staff suited for trauma-informed work (workforce development) €” (e.g. based on previous experience with relevant PTE populations, personal trauma experience, training, and personality (empathy, non-judgment, and collaboration). 36%	43.33%
Structured accountability/oversight which responds to failings within the service (e.g. site visits, feedback and reports). 39%	43.33%
Provide resources for mentoring/supervision, helping staff address trauma/self reflect/develop their approach. 57%	43.33%
Help understand and model personal safety to PTE, possibly providing training so that the PTE can learn how to develop some sense of internal safety first of all.	43.33%
Stop Council housing services only paying lip service to being trauma informed and enforce accountability and sanctions for non compliance provide mechanisms for service users to report retraumatisation exclusion and being ignored.	43.33%
stop putting people in years waiting lists that never see the light of day which only causes more mental health impairment as well as retraumatisation	43.33%
Set up services that aim to solve the barriers a traumatised person faces this must be free not some long winded set of hoops that discounts most people from being able to access.	43.33%
Embed effective trauma-specific treatment strategies within all services to manage the behavioral and emotional symptoms of traumatic stress. 46%	40.00%
Integrating some aspect of a person's felt experience and connecting with the body, either through yoga or practices and approaches that recognise the importance of trauma being felt, stored and experienced in the body	40.00%

Leveling of power differences among staff from direct care staff to administrators, to support shared decision-making. 32%	36.67%
Support strategies that encompass family-based approaches to trauma intervention. 39%	36.67%
Embed continuous quality improvement. Implement quality improvement measures as needs and problem areas are identified. 43%	36.67%
Leverage and strengthen the healing value of cultural and community connection (e.g. Community Outreach and Partnership Building, engagement with community stakeholders). 46%	36.67%
Trauma informed care begins with the first contact a person has with any program, institution, or service system. 25%	36.67%
staff should be enabled to support each other as well.	36.67%
Include information / practices that include self care in the context of physicality and the body	36.67%
There should be a one stop shop for traumatised people where they then get directed to appropriate places.	36.67%
Provide welcoming, approachable care organisations (e.g. Using welcoming language on all signage, greeting people in a welcoming manner when they first walk into the building). 32%	33.33%
Develop settings and activities that ensure physical and emotional safety (e.g. Ensuring that people are not allowed to smoke, loiter, or congregate outside entrances and exits, clear and identified exit routes, Keeping parking lots, common areas, bathrooms, entrances, and exits well lit, Monitoring who is coming in and out of the building). 32%	33.33%
Provide caregiver support groups and training (developing a strong social support network of family, friends, and community). 39%	33.33%
Conceptualise/operationalize intended outcomes (create measurable outcomes). - e.g. develop an implementation & goal attainment plan to allow for progress to be checked and corrections made. 36%	33.33%
Respond in timely ways that help to support recovery, taking the time necessary to establish strong relationships. 21%	33.33%

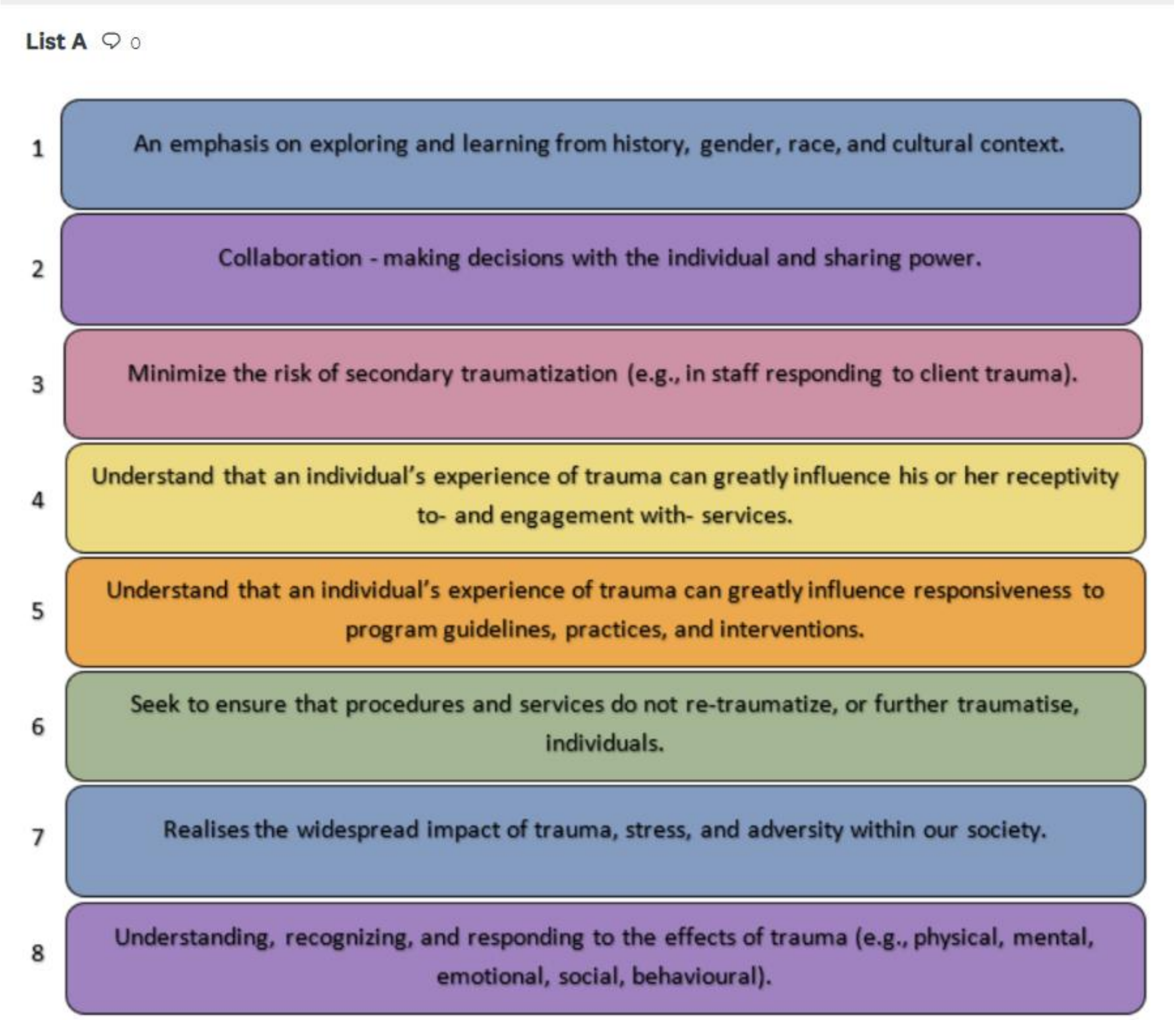
Solve barriers to living: help low income PTE (people with trauma experience) gain employment skills, secure employment and reach self-sufficiency (e.g. a financial empowerment curriculum, nutrition education and budgeting, identify suitable housing, provide food & sanitary care). 29%	33.33%
Provide routine, universal screening for trauma exposure and related symptoms (including paper or verbal options) early in the care process. 29%	33.33%
Provide education on how to enhance self-efficacy (e.g. self-management techniques, self regulation, relationship management, independence, development of a self-care plan). 32%	30.00%
Facilitate engagement with services (e.g. find clients who don't engage, try to re-engage clients who fail to attend, identify systemic issues (e.g. poverty) which may cause trauma). 39%	30.00%
Physical spaces are available to engage and support people in the service (e.g. inclusive spaces where PTE can go to calm down, think, or reflect, common areas which are welcoming and privacy is respected, sex-specific spaces). 14%	30.00%
Monitor PTE comfort/distress (non-verbal behaviours). 21%	30.00%
Facilitate disclosure of trauma (e.g. by being non judgemental, allowing time, screening protocols, privacy and confidentiality). 25%	30.00%
Implement follow-up protocols at the end of treatment, implementation of a post-treatment plan, and/or regular verbal check-ins. 29%	30.00%
Provide referrals for trauma treatment as appropriate even if the client is not seeking care for trauma-related injury (e.g. by creating a referral resource). 29%	30.00%
Reduce the focus on assumptions people have to be on low income, have no job, be a homeless person an immigrant, or an offender in order to be worthy of help.	30.00%

Do not fall into the trap that traumatised people can just self regulate and or adjust themselves to when others abuse them rather than look at supporting them or reporting the abuseful traumatising situations	30.00%
Make accountability mandatory requirement and sanctions for services be they local charity or any other kind of council funded or national type of service who retraumatise people	30.00%
provide fit for purpose up to date mental health support	30.00%
Supported accommodation for people with mental health problems, young people leaving care, homelessness services and agencies.	30.00%
Provide accessible care - equal access to quality treatment which takes account of the unique context of their life (e.g. accessible buildings, location, costs, language, times, and staff). 32%	26.67%
Support clients to make an informed choice over services they receive (e.g. by explaining treatment methodologies and of the rationale behind specific interventions, clear care boundaries, the value and type of trauma-related questions that may be asked during an intake process). 25%	26.67%
Collect trauma histories in order to understand a client's background (e.g. to anticipate the interplay between elements of treatment and types of trauma/when it occurred in the life span). 29%	26.67%
Conduct organizational operations and decisions with transparency about what is being offered and what is possible. 29%	26.67%
Train staff in body technics rather than having to talk about trauma as the initial means to discuss assessment, and treatment	23.33%
Avoid putting people in generic free for all support groups as the only solution rather than providing one to one support when people request this	23.33%
Assess organisation's readiness to become trauma informed (to instigate change). 39%	20.00%

Prior to treatment, create clear expectations with clients - about what the proposed treatments entail, who will provide services, and how care will be provided, establish and consistent boundaries and clarity of what is expected in regards to tasks - and maintain these boundaries. 21%	20.00%
Enforcement set up fines for council housing who refuse to stop retraumatising victims and provide trauma informed rehabilitation to those they already damaged.	20.00%
Ensure that single sex spaces are provided in line with the provisions under the Equality Act, and avoid confusion by ensuring 'sex' is recorded rather than 'gender' which is complex and fluid as a construct. Trans people and detransitioners may need their own spaces. Mothers may need their own spaces.	20.00%
An organised engagement with PTE that are working on recovery. Constituted bodies of lived experience groups could assist further recovery and help at the consultation level. Maybe representatives of these constituted groups could take their views to other levels of decision making where there isn't a direct elected representation of the population who identify as PTE	20.00%
Retrain any service with a SIGNPOSTING MENTALITY	20.00%
Re-screening for trauma should be avoided (e.g.through sharing of information across services, such that trauma does not need to be relived more often than necessary). 18%	16.67%
Care should include screening of resilience, not just trauma. 25%	16.67%
Question places like council housing who can provide trauma support for a few minority groups but fail to do so for all minority groups or even groups in general.	16.67%
Incorporate group therapy into approaches. 14%	6.67%

g. Appendix G, The three ranked list options for theory concepts provided to participants for review in round 6

Note that the concepts are the same in each list, only the order has changed.



List A 🗨 0

1 An emphasis on exploring and learning from history, gender, race, and cultural context.

2 Collaboration - making decisions with the individual and sharing power.

3 Minimize the risk of secondary traumatization (e.g., in staff responding to client trauma).

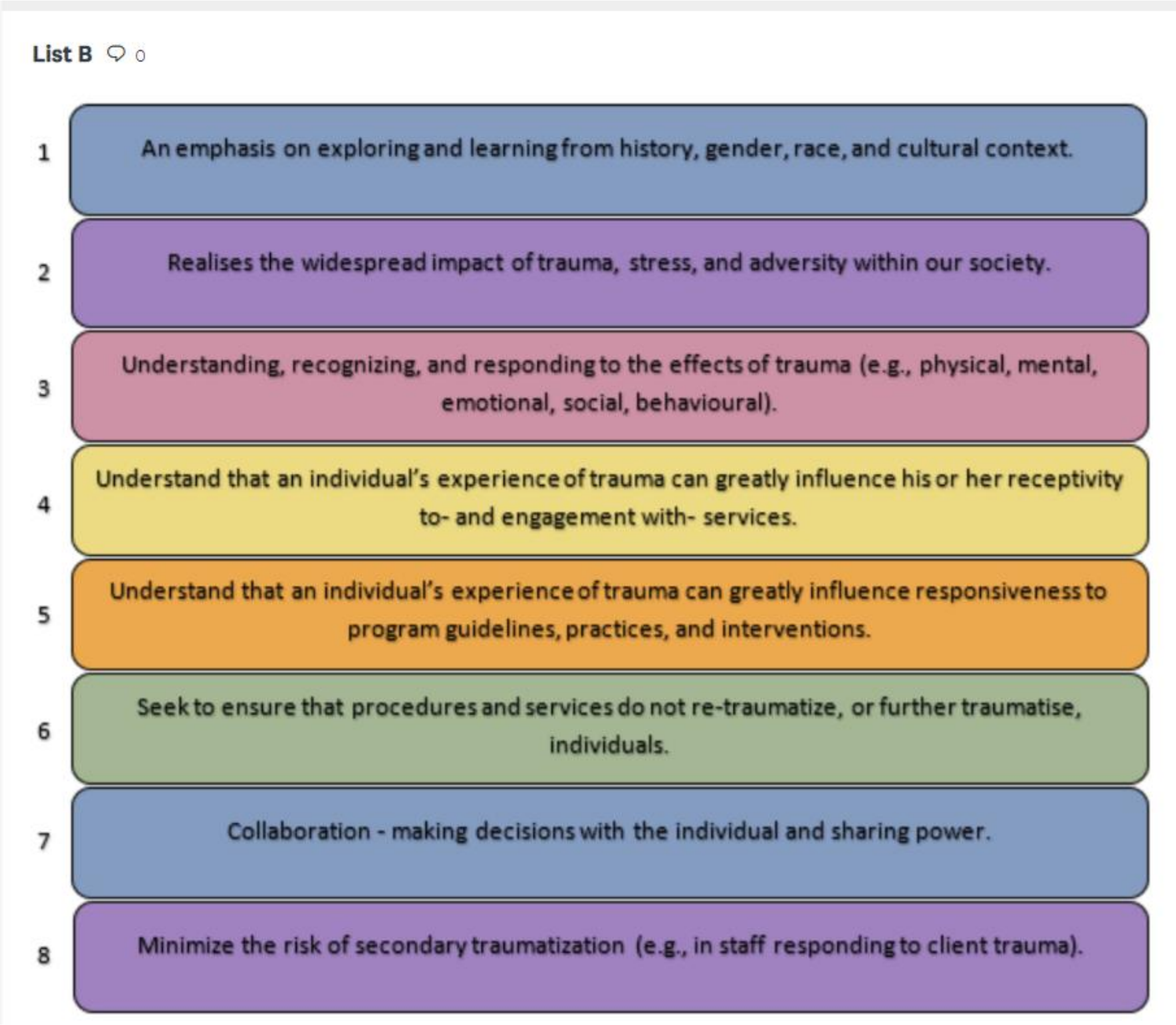
4 Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services.

5 Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions.

6 Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals.

7 Realises the widespread impact of trauma, stress, and adversity within our society.

8 Understanding, recognizing, and responding to the effects of trauma (e.g., physical, mental, emotional, social, behavioural).



List B 🗨 0

1 An emphasis on exploring and learning from history, gender, race, and cultural context.

2 Realises the widespread impact of trauma, stress, and adversity within our society.

3 Understanding, recognizing, and responding to the effects of trauma (e.g., physical, mental, emotional, social, behavioural).

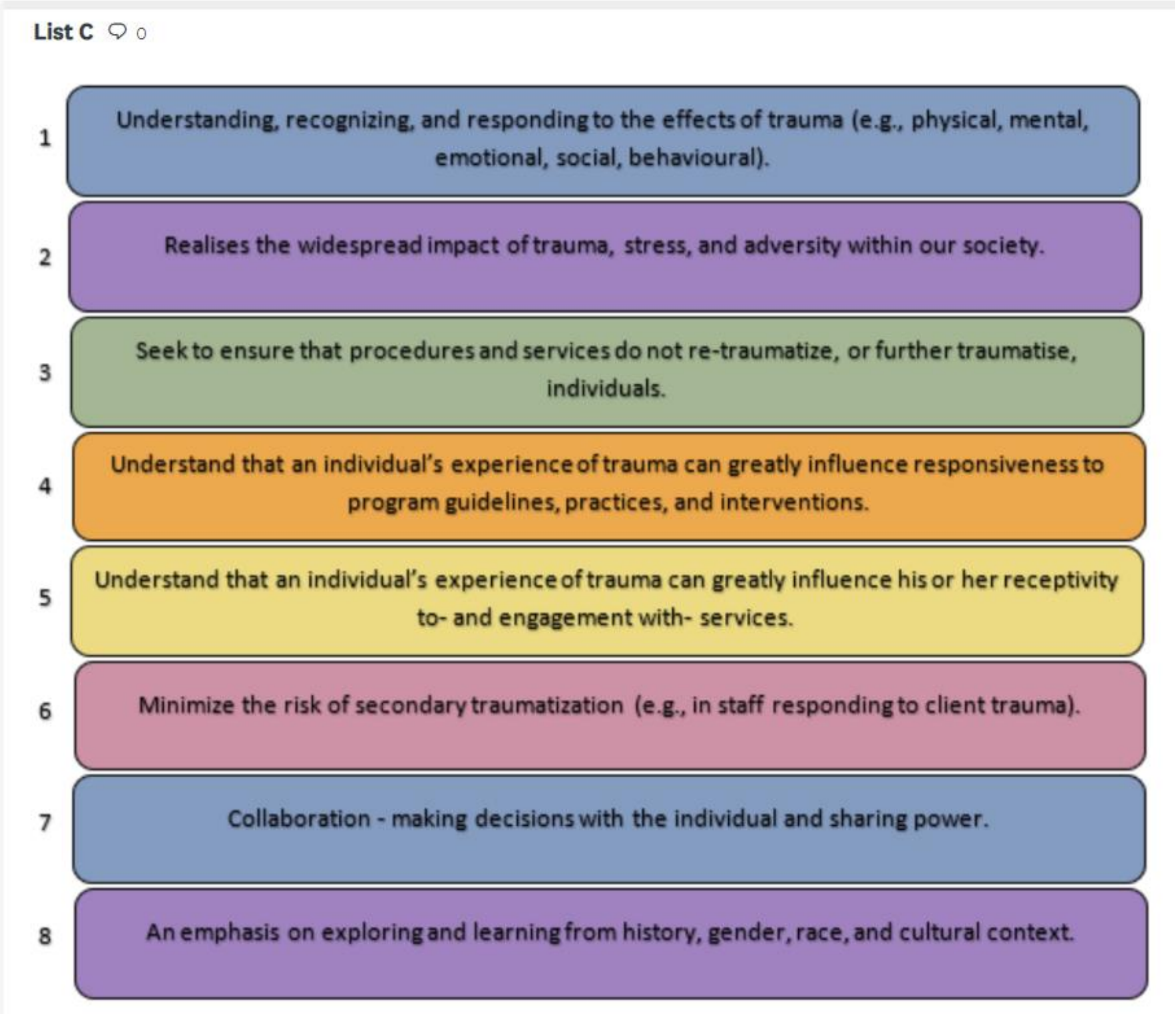
4 Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services.

5 Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions.

6 Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals.

7 Collaboration - making decisions with the individual and sharing power.

8 Minimize the risk of secondary traumatization (e.g., in staff responding to client trauma).



List C 0

1 Understanding, recognizing, and responding to the effects of trauma (e.g., physical, mental, emotional, social, behavioural).

2 Realises the widespread impact of trauma, stress, and adversity within our society.

3 Seek to ensure that procedures and services do not re-traumatize, or further traumatise, individuals.

4 Understand that an individual's experience of trauma can greatly influence responsiveness to program guidelines, practices, and interventions.

5 Understand that an individual's experience of trauma can greatly influence his or her receptivity to- and engagement with- services.

6 Minimize the risk of secondary traumatization (e.g., in staff responding to client trauma).

7 Collaboration - making decisions with the individual and sharing power.

8 An emphasis on exploring and learning from history, gender, race, and cultural context.

h. Appendix H, List of participant free-text responses per round

Comments from Round 1:

- PTSD is often 'invisible' to both professionals and clients, and their family members. Sufferers can have devastating outcomes because of their stress disorder. The 'invisibility' makes it a very dangerous illness and therefore one that needs as much publicity, training, and awareness of its existence as possible. I would also like to say that just because a client, patient, or member of the public presents well i.e., well-dressed well-groomed as opposed to disheveled and looking tired, professionals need to be aware that they could still be suffering from PTSD and so the same procedural questioning and discussion should go on.

- I think there should be a sustained level of engagement with service users to test their understanding and the proposals. It's difficult to get representation from all the different target groups since trauma can be anywhere and affect people of all ages and social groups. A commitment to consultation and some level of research addressed directly to people who have personal experience should be an important part of the process from inception to completion.

- I think it is hard for frontline workers and services to be trauma-informed when politics is enforcing the hostile environment/cutting funding to essential services/increasing police powers/essentially pushing for the exact opposite of everything we are trying to do. E.g., there is seemingly nothing we can do about the lack of suitable social housing or a regulated rental market, which is a huge issue for all our clients, or the lack of mental health beds. It feels like continually trying to do the impossible and make the best of an awful situation with extremely limited resources.

- Preventing secondary traumatic stress - stop the need to keep repeating yourself to many different people by having a single point of contact. Privacy - ensure that a patient's privacy is always maintained.

- Trauma is about disconnection (dissociation), that might be between the mind and the body or between thoughts and feelings and / or between self and other. A style of working that seeks to integrate, in whatever way that is relevant should be encouraged.
Body based activities for managing stress and better-quality psychoeducation should be commonplace across mental, physical and all health and human services.

- How important it is for service users to get the care they deserve.

- My Service is not trauma informed but I am interested in how it could be becomes so.

- A lot of the incidents that occur on wards could likely be avoided if a trauma informed approach was used and staff stopped responding to their patients punitively.

- I would want to explore and learn more about trauma informed and to develop necessary skills which could be positive for the rest of my life and coping techniques with the trauma.

- Now, 'trauma informed care' is a buzz word. I'm worried that it is overused without it's true meaning being taken on board. I think there may need to be more research into how someone can be fully trained in this area and what this looks like if they were. What skills will they possess? It's not a tick box exercise but the way you speak to a vulnerable person, your mannerisms / conduct. Not judging and labelling and retriggering, but rather; listening to understand. And being kind and empathetic and treating the individual in a respectful and gentle way.
- I spent 6 months in secondary care, and no one asked about what had happened to me. I am now getting treatment for it 2 decades later, and 3.5 decades after the traumatic event.
- Highly educated people I've had sessions with from Tavistock, CDAT, CANDI etc seem to lack empathy, ask classist and racist irrelevant questions, and discuss sexual abuse in a crude way, make me upset and then refer me for support that doesn't materialise. Professionals still seem to lack training, time, and empathy as I've still never had any trauma focused support nearly 20 years after first being abused which carried on because services there to protect people didn't help me.

Comments from Round 2:

Theories

It should apply to how staff are enabled to support each other as well

- Understanding how the effects of trauma influence people's behaviour, choices, and relationships both social and with services, and that trauma-influenced response may be unconscious.
- Help understand and model personal safety to PTE, possibly providing training so that the PTE can learn how to develop some sense of internal safety first. possibly though body technics rather than having to talk about trauma as the initial means to discuss assessment, and treatment.
- Integrating some aspect of a person's felt experience and connecting with the body, either through yoga or practices and approaches that recognise the importance of trauma being felt, stored, and experienced in the body.

Individuals

- Voluntarily sector providers.
- all education professionals - not just special ed.
- Who are trauma informed leadership teams I have not come. I have across any. I do not know what HFI high street services like MIND AgeUK SHP in fact is any service you get signposted around in Islington for example has no clue about trauma and only retraumatises I would say it's important to retrain any service with a SIGNPOSTING MENTALITY and stop them retraumatising people. There

should be a one stop shop for traumatised people where they then get directed to appropriate places. None of these services have a clue about AUTISM / comorbidity / neurodiversity / Sensory impairments.

- psychologists

- I think the list of people who should design the service is very different from the list of people who should implement it. I don't necessarily think landlords are in a good position to design trauma informed services, but they are in a very good position to implement it.

- The engagement and participation teams' part of social housing providers

- Universities for mental health, social care/work, nursing etc. Supported accommodation for people with mental health problems, young people leaving care, homelessness services and agencies.

Actions:

- provide advocacy care / support workers to those who have multiple trauma and comorbidity disabilities. This help must be free. Enforcement set up fines for council housing who refuse to stop retraumatising victims and provide trauma informed rehabilitation to those they already damaged.

- Stop Council housing services only paying lip service to being trauma informed and enforce accountability and sanctions for non-compliance provide mechanisms for service users to report re-traumatisation exclusion and being ignored. Question places like council housing who can provide trauma support for a few minority groups but fail to do so for all minority groups or even groups in general Look at sectors of society that are without services and excluded and realise this is traumatising i.e., autism / neurodiversity sensory diversity and physical disability as well as trauma.

- People with comorbidity and trauma are ignored on every level excluded and further traumatised

- Too much focus on assumptions people must be on low income, have no job, be a homeless person an immigrant, or an offender to be worthy of help. Too much funding is given out for this but not other situations of the population. Do not fall into the trap that traumatised people can just self-regulate and or adjust themselves to when others abuse them rather than look at supporting them or reporting the abusive traumatising situations

- Avoid putting people in generic free for all support groups as the only solution rather than providing one to one support when people request this

- Make accountability mandatory requirement and sanctions for services be they local charity or any other kind of council funded or national type of service who retraumatise people

- provide fit for purpose up to date mental health support stop putting people in years waiting lists that never see the light of day which only causes more mental health impairment as well as re-traumatisation

- Set up services that aim to solve the barriers a traumatised person faces this must be free not some long winded set of hoops that discounts most people from being able to access.

- Ensure that single sex spaces are provided in line with the provisions under the Equality Act and avoid confusion by ensuring 'sex' is recorded rather than 'gender' which is complex and fluid as a construct. Trans people and de-transitioners may need their own spaces. Mothers may need their own spaces.

- I found some of this quite difficult to understand, some verging on similar themes, it got me quite disorientated

- An organised engagement with PTE that are working on recovery. Constituted bodies of lived experience groups could assist further recovery and help at the consultation level. Maybe representatives of these constituted groups could take their views to other levels of decision making where there isn't a direct elected representation of the population who identify as PTE

- Include information / practices that include self-care in the context of physicality and the body

Comments from Round 3:

- For Question 13 I've ticked the six actions because they seem to me to be pertinent points that would be talked about during training of personnel, amongst other things of course.

- I don't have words to 'explain the rationale' of why I've ticked what I have, other than just to say that I think they should be included. I'd like to comment that they surveys take longer than the suggested times.

- Could there be a body who looks at a case where the traumatised individual was not sufficiently supported at the time of their distress retrospectively e.g., the police not sufficiently investigating a crime, the council leaving a tenant with ongoing unacceptable living conditions

- The own spaces comment I think could be widened to having more categories of people that would require personal space be it gender / sex/ disability/ mother / other / diversity/ religion etc

- More specialised NHS support should be available as I was made to focus on my depression and anxiety and not on the trauma that worsened my symptoms, which made me feel like the problem and didn't hold perpetrators accountable. Services that were supposed to support me were negligent which I feel makes them complicit. Classism, racism and sexism was apparent in my treatment by many service providers and to this day I'm asked irrelevant questions about whether I grew up in social housing, if I live in social housing now, what job my mum did and on a recent NHS psychologist's diagnosis report it was noted that I'm a black girl (I'm actually mixed race and often mistaken for other races) who grew up in social housing with a mum on a low wage, with no relevance other than, I can only assume, to signal to the people he was referring me to that I'm not worthy of treatment as I was then told I wouldn't be offered any trauma support and never have been nearly 20 years after first being abused, which continued until a few years ago because it was never acknowledged.

- a lot of Q12 is repetitive. It's quite confusing to read and think, 'did I not just already tick that?' Although a lot of Q14 is true, I think some needs to be rephrased in a way that is neutral and more 'actionable' as statements, as currently, it sounds like complaints, and it perhaps didn't want to appear like that.

- Q 11 - Providing training to all staff without a context of what the body is or what role the staff are doing is a bit meaningless. The accountant and the I.T. team, the ground maintenance and the purchasing clerk probably don't need it so much. Seems like a thing for individual organisations to take on as part of their own processes where relevant. Maybe merge with the workforce question, and make it "the relevant workforce"? Q 13. Re-screening. Some people may not be ready to disclose traumatic events for some time. It took me 16 years to be able to speak about the event. I think people do need to be re-asked, plus new things happen all the time. Trauma is not only in the past. I also believe that we are sensitive to information sharing. This involves disclosing sensitive personal detail to people who we do not know and have not consented to as we don't know who they are. Sharing "for healthcare purposes" kind of vague tick boxes has led me to opt out of all information sharing via my central record - which has a downside of course but I'd rather have to grant permission each time than have unknown people knowing such personal information. I am currently in trauma therapy. I am told that talking about it helps to process the event and that each time I tell my story I am a step closer to being healed. Having to repeat thing might not be fun but it might also be helping the person, but they don't realise it. Physical spaces I think should be in as there is a big default drift towards therapy all happening over video link. If we don't state this is important it is going to be lost. I am involved in research into remote consultations, and they are not as good as face to face.

- Women who have been victims of male violence do need sex specific spaces and are entitled to them under the Equality Act. There is also a move towards the loss of these rights, so I think it needs to be stated. The design of a physical space can be helpful. Being able to leave your trouble behind in the room and walk away is better than having therapy on zoom in your own home. Your head does not stop when the therapist logs off. We need to hang on to the physical spaces as real estate is being flogged off at pace and scale. Referrals are hard to obtain and there needs to be transparency about the nature of the gate keeping and wait times.

- Many of these are what a TIN might advocate for, rather than the network's own actions. Nonetheless, I see the TIN as having roles in providing education/awareness materials/training, and it also must model TI practice within its own structures and day-to-day working.

Comments from Round 4:

Theories:

- Extremely hard to rank as many of these will be born in mind concurrently. Crucial that there is no re-traumisation and that a societal and wider context is understood.

- Difficult to prioritise, some lower are still important.

- Often when I've been at my most vulnerable and most in need of support, I've had the least help as I haven't been able to access it due to an increased fear of going out. I've been told I must leave services because of lateness or missed appointments, but if they had understood how trauma presents itself sometimes then they could have engaged with me in a different way by, for example, offering a phone appointment rather than discharging me for not feeling up to attending in person appointments.

- Two elements to the responses - one if focused on the individual which I think needs to be the priority, and the second on society and learning from the past. The final two are regarding not making the same mistakes - having learnt from the past.

- The primary aim of a trauma-informed response must be to understand, recognise, and respond to the effects of trauma.

- These don't seem like theories as such. Some are also very similar and could be best merged, maybe.

- I feel like they are all equally as important, hard to prioritize one.

- I think points 7 and 8 are incorporated in point 1 and point 4

- First, we need to understand trauma and its impact before we can do anything else. Then we need to work to ensure services don't retraumatize people, and all the rest of the goals are how we ensure services aren't retraumatising. Race, culture, and gender have been seriously overlooked in work around trauma and therefore learning about this is key.

- Understanding, recognising the effect, and standing on their point of view can help service provider react as soon as possible and provide the best fitted service to them.

- UNDERSTANDING THE WHOLE PICTURE IS VERY IMPORTANT.

- Trauma impact is exceedingly an individual experience with a cumulative effect over a lifetime. This needs to be considered with each service user. It must be understood from an intersectional point of view to be helpful, and all trauma informed staff must be aware of their ability to inadvertently re-traumatise.

- I think many of these may co-exist (e.g., 1, 2 4, & 5 go together).

Actions:

- Please note for question 2 I have felt able to make a choice and put create an order that I'm happy with. However, for question 4 I feel that the statements are predominantly of very similar value, and many are also very similar to each other, so I don't think it is possible to put them in order of preference. I have considered this very carefully. I therefore haven't altered the arbitrary order that I was originally presented with.

- People who have experienced trauma often lack trust and therefore being shown empathy is important. It's also important that there is ongoing collaboration as I have often been abandoned with no support after bringing up traumatising events after being promised support that has never materialised. This feels re-traumatising as you're made to share triggering information and then feel you've been misled when it leads to nothing.

- Should start with creating shared understanding, endorsement from leadership and ppl across system, then can start doing work of raising awareness, educating, exploring approaches.
- I would say point 5-7 are all the same kind of thing as are 8-10.
- We need to start with a diverse group of leaders if we are going to truly consider the impact of race, gender, and culture on experiences of trauma (1). These leaders and organizations need to work collaboratively together to develop a shared understanding of trauma informed practice (2-3), before they can start identifying/offering training to staff and shaping organizational culture (4-11), and then research will help to support all the above (12).
- THEY ARE ALL VERY IMPORTANT, HARD TASK
- Mutual understanding and empathetic communication help bonding and building rapport. Identifying their needs according to their diversity needs helps understanding their needs and support.
- 1 & 2 underpin all other active approaches, without these it's impossible to know what we're all referring to.

Comments from Round 5:

- Points 7 and 8 address and are pertinent to what I've assumed this research is about because they are worded in a general way and therefore cover a) clinical trauma, from a distressing life experience, b) trauma caused by discrimination and judgementalism, c) trauma caused by unempathic experiences with the public and or professionals) points 7 and 8 are worded in a general way which covers a, b and c whereas to my mind points 1 to 6 are heavily biased towards b.
- Personally, I don't agree with the order of numbers 1 and 8, and also don't think it fits with the comments made above. The things I don't agree with are that I think that number 8 should be much higher up the list. If the majority put it at the bottom then fair enough but I'm surprised. You say that you have given the comments to explain the rationale for the order, but one of the comments says "The primary aim of a trauma-informed response must be to understand, recognise, and respond to the effects of trauma" and yet despite the fact that the person has described it as the primary aim, you have put the point that relates almost word for word to that at the bottom of the list, which seems strange to me. Likewise another comment highlights the importance of 'Understanding and recognizing the effects of trauma' which again looks to be a quote from number 8. In my opinion number 8 is the most important not the least, how can that wording be seen as less important than all the others? I also don't agree that number 1 should be at the top, as while history, gender, race and cultural context are of course important, not everyone's trauma is related to those issues, and many peoples' trauma may have nothing to do with those aspects, so the top of the list should be a theme which encompasses and helps ALL those affected by trauma, and doesn't exclude those whose trauma doesn't relate to 'history, gender, race and cultural context'. As someone whose trauma doesn't relate to history, gender, race and cultural context I feel quite

offended and excluded as though some types of trauma are being given higher status and importance than others. Of course those areas are very important but top place should be given to a theme that doesn't exclude anyone and can be applied to all those affected by trauma. Therefore, again, I would see number 8 as more important as it seems to cover everything in one sentence, and doesn't exclude anybody. Regarding the other comments, they seem to show a cross section of most of the themes, and I can't therefore see why they provide a rationale for the order given. I don't have a problem with the order given, apart from numbers 1 and 8, as mentioned, but if the comments are forming the rationale, what of those participants who gave an order but didn't give comments, is there order seen as less important? If the order is influenced by the comments then it will be inherently skewed and will encourage bias cos what we seeing is not 'the rationale' it is a list of comments that SOME participants made, so we are not hearing in this comments section from the other participants, who presumably didn't give comments when they submitted their chosen order, but still had their views about why they were putting them in a certain order.

- 8is my highest priority, 1 my lowest

- PRACTICAL steps should be the priority. If you reverse the list so 8 is top it would be better. Reverse order would be pretty much perfect. Too many aims though.

- I really disagree with looking to the past. Historical context is historical and can distort the experiences and reality of what is happening now and what is relevant. I feel strongly that we should be forward looking. The data from the past is not so good. Our foundation needs to be evidence based and much historical information is anecdotal or missing - not even collected. We need to be based on facts not feelings to have any impact. I prefer to focus on the commonality of trauma rather than the differences between the demographics. It can be something which unites us or divides us and I feel this approach is going to divide.

- I believe 7 and 8 need to be moved to 2 and 3, respectively. I don't think it's wise to tend to the individual until one understands the widespread nature and common effects of trauma in general.

- I would reorder the selection number 8 would be my most priority and in the number 1 because RACE GENDER I feel isnt something that should be discussed as an issue TRAUMA IS TRAUMA no matter what creed Gender etc otherwise its hierachy making of TRAUMA i.e a white man is supposed to be worse than a black woman or vice versa or why we even have to divide gender at all I wouldnt want to make TRAUMA something that then gets inequality priorities drawn over. it should encompass diversities to include everyone

- I think number 8 is more relevant than number 1. History and people's backgrounds are relevant, as exclusions I've faced being mixed race and bi have been ignored, and all the professionals I've ever spoken to since childhood have been white and mostly male, but I don't understand how that can be more important than number 8 as taking a holistic response would have the most impact on individual's lives. I would rather professionals helped me with my social skills, isolation, mental and physical symptoms and the effect of trauma on my lifestyle. I'm not comfortable talking to white staff about racism and I've been dismissed when I've tried to discuss sexuality. I'm worried that even if staff were trained they would stereotype me based on my background as lgbtq and bme people are all lumped together which doesn't really help us as individuals.

- Your rationale makes perfect sense. I think your rationale should be the list of theories in priority. What I am saying is that your 'list' does not match your rationale. It is completely the reverse.

- As I considered all of the categories crucial, there wasn't much in it in terms of ranking. However as proposed that makes logical sense.

- Yes, and no. I like the emphasis on being intersectional. But if the primary aim of a trauma-informed response must be to understand, recognise, and respond to the effects of trauma - how can this be last on the list?

Actions:

- The main thing is having the right attitude - vocational - need to be empathetic, dedicated etc. My preferred order is: number 1 'educate the workforce', number 2 'develop and sustain' , number 3 'identify a diverse', number 4 the one on empathy, position 5 'create a shared', number 6 'provide all staff', number 7 'embed trauma informed principles', number 8 'build ongoing collaboration' , number 9 'promote best practise', number 10 'acknowledge the need' , number 11 'promote readily available', number 12 the one on research.

- 1 is my lowest and 12 issue highest priority

- 4,5,6 are the most important. some of these are vague. will take too long. no consensus or discussion about how they will be done makes it hard to imagine them being effective. Your explanatory text makes sense but don't correspond with the ranking. There may be competing perspectives too so how will they be resolved? There isn't always a shared understanding.

- Disagree with 1 and 2 being top. It's beyond our scope. We cannot impose training on other parties. They have to make their own decisions.

- I would reorder the selection number 8 would be my most priority and in the number 1 because RACE GENDER I feel isnt something that should be discussed as an issue TRAUMA IS TRAUMA no matter what creed Gender etc otherwise its hierarchy making of TRAUMA i.e. a white man is supposed to be worse than a black woman or vice versa or why we even have to divide gender at all I wouldn't want to make TRAUMA something that then gets inequality priorities drawn over. it should encompass diversities to include everyone

- I come from a highly bottom-up approach but again as envisaged this seems a logical way to make systematic change.

- I think 1-2-10 should be closer together. How can we educate the workforce without any agreement about who needs that and what good looks like? This feels like a gap in training content which should be highlighted.

Comments from round 6

- Exploring history is a bit of a rabbit hole and times change. Cultural contexts shouldn't be over shadowed by society of the past. We need to be recovery focused, not dwelling on past injustices.
- My top two priorities would be to ensure that services and processes do not re-traumatize people, and to consider race, gender, religion, ethnicity and culture when it comes to trauma. List A comes the closest to keeping both of these near the top
- C because I believe taking a holistic approach is the only way someone who has experienced significant trauma has any chance of fully recovering.
- list C because it focuses on trauma not about gender or race disability wasn't mentioned in that and trauma is universal List C because it brings it back to trauma not another fight about GENDER RACE Or CULTURE that's not an inclusive list of categories because it doesn't mention other minorities
- Working in a tailored way with individuals means that some of the categories might be more pertinent than others. So it's incredibly hard to set a therotecial framework per se.
- All of these points are really high priority - it doesn't really matter the order, so the critical thinking in making these decision is very fine
  This list is the only one that has collaboration the highest. Collaboration is fundamental to being trauma-informed and so is a non-negotiable which is my reason for my choice.

Partners

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