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PROFIADAU NIWEIDIOL MEWN PLENTYNDOD
ADVERSE CHILDHOOD EXPERIENCES

'Trauma-informed': Identifying Key Language and Terminology through a Review of the Literature

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Acronyms and Abbreviations

ACE	Adverse Childhood Experience
DSM-V	Diagnostic and Statistical Manual of Mental Disorders
ECM	Enhanced Case Management
OoHc	Out of Home Care
PTSD	Post Traumatic Stress Disorder
SAMHSA	The Substance Abuse and Mental Health Services Administration
YJB	Youth Justice Board
YJS	Youth Justice System
PPI	Projects, Programmes, and Interventions
TRM	Trauma Recovery Model

Section 1: Introduction

1.1 Background

Over the past decades, the concept of a trauma-informed approach has gained momentum in the fields of psychology, psychiatry, developmental science, education, public health, criminal justice, and social work (Champine et al., 2019). This has largely stemmed from the pioneering adverse childhood experience (ACE) study by Felitti et al. (1998) and a growing body of related research which demonstrates the harmful effects of childhood exposure to traumatic events on health, behavioural health, education, employment, and criminal justice system involvement across the life span (Copeland et al., 2018 cited in Champine et al., 2019).

Although the link between traumatic events and poor health outcomes is consistently documented, the terminology and components of trauma-related approaches and practices studied by researchers and used by practitioners are less clearly and consistently presented. Terms such as trauma-informed practice, trauma-informed care, trauma-informed approach, and trauma-informed systems are used widely and often interchangeably to refer to the broad notion of a programme, organisation or system that is designed to support children and families experiencing trauma; however these terms are often not clearly or consistently operationalised (Hanson et al., 2018 cited in Champine et al., 2019). The aim of this study is to explore the terminology and language in use around the concept of trauma-informed.

1.2 The Impact of Trauma on Childhood Development

ACEs are traditionally understood as a set of ten traumatic events or circumstances occurring before the age of 18 which have been shown to increase the risk of adult mental health problems and debilitating diseases. Five ACE categories are forms of child abuse and neglect, which are known to harm children and are punishable by law, and five represent forms of family dysfunction that increase children's exposure to trauma. ACEs include physical abuse; sexual abuse; psychological abuse; physical neglect; psychological neglect; witnessing domestic abuse; having a close family member who misused drugs or alcohol; having a close family member with mental health problems; having a close family member who served time in prison; parental separation or divorce on account of relationship breakdown (Asmussen et al., 2020).

Multiple international studies, including those conducted in the UK, confirm a strong and graded relationship between the number of ACEs experienced during childhood and the risk of chronic diseases and mental health problems in adulthood (Bellis et al., 2014, Hughes et al., 2021). ACEs are associated with poor educational achievement and the development of a wide range of harmful behaviours, including smoking, increased alcohol consumption, drug use, risky sexual behaviour, violence and crime. They are also linked to the development of diseases such as diabetes, mental illness, cancer and cardiovascular disease, and ultimately to premature mortality (Riley et al., 2019). Experiencing four or more ACEs, in comparison to experiencing no ACEs, typically:

- doubles the risk of obesity, physical inactivity, and diabetes.
- triples the risk of smoking, cancer, heart disease or respiratory disease.
- quadruples the risk of sexual risk-taking, mental health problems and problematic alcohol use.
- increases the risk of problematic drug use and interpersonal and self-directed violence seven-fold (Asmussen et al., 2020).

Such chronic stressors in childhood have been described as ‘toxic stress’ with the potential to adversely impact cognitive functions, affecting learning and memory. These changes are thought to impact how an individual adapts to future adverse experiences and the chance of developing health-harming behaviours. Given the vast array of consequences associated with a toxic stress response in early childhood, prevention of toxic stress is critical for promoting health and reducing health disparities in vulnerable families (Condon and Sadler, 2019). In addition to prevention or mitigation strategies, the ability to address ACEs and recover from adversity has led to the recognition of the importance of a trauma-informed philosophy that integrates the understanding of trauma into policy and practice (Kimple and Kansagra, 2018).

1.3 The Importance of a Trauma-informed approach

The Substance Abuse and Mental Health Services Administration (SAMSHA) defines trauma-informed care as a programme, organisation, or system that is trauma-informed, realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist in re-traumatization (SAMSHA, 2014:11). The importance of responding to, healing from, and preventing trauma is a priority for trauma-informed practice which involves providing a sense of safety, conducting activities with trustworthiness and transparency, providing peer support, collaboration and empowerment through providing a voice and a choice and responding appropriately in the context of cultural, historical, and gender issues (SAMSHA, 2014 cited in Danielson and Saxena, 2019).

Initially, trauma-informed care principles were developed for clinical care treatment and therapy settings. Service providers and clients were able to contextualise an individual’s choices and circumstances in terms of the experiences they have had, and to respond with solutions that are compassionate and humane (Danielson and Saxena, 2019). It is argued that if we hope to help traumatized people, then we must create safe environments to help counteract the long-term effects of chronic stress. Additionally, for healing to occur, people often need to put the experience into a narrative and share it with themselves and others since without words, the traumatic past is experienced as being in the ever present and words allow us to put the past more safely in the past where it belongs (Bloom, 1999). Further, while people can learn to be helpless as a result of adversity, interventions designed to help people overcome traumatizing experiences must focus on mastery and empowerment while avoiding further experiences of helplessness (Bloom, 1999). Increasingly, these principles are being adapted for work with communities and organisations. This approach can help everyone involved to better understand and respond to the needs of individuals, organisations, and communities with a trauma history in a way that is empowering but does not inadvertently traumatize them further (Danielson and Saxena, 2019).

1.4 Trauma-informed Policy and Practice in Wales

In Wales, evidence indicates that half of all the adults had experienced at least one ACE and that by the age of 49, 24.9% of individuals with four or more ACEs reported having been diagnosed with one or more chronic diseases, compared to 6.9% for those with no ACEs (Bellis et al., 2015). As a result, the policy and legislative context in Wales is supportive of addressing ACEs and recent legislation puts children at the heart of co-produced, sustainable policymaking (Star, 2019).

The Well-being of Future Generations Act (Wales) committed to improving equity and health across the country, improving outcomes for people in Wales who have ACEs and providing the foundation for all public services to work collaboratively towards an integrated life course approach to wellbeing (Welsh Government, 2015). ‘Prosperity for All: The National Strategy’ includes action to prevent ACEs and mitigate their impact by creating ‘ACE aware’ public services, building children and young people’s resilience and piloting ‘Children First’, a community led approach to reducing ACEs and improving resilience (Welsh Government, 2017). Finally, ‘A Healthier Wales: our Plan for Health and Social Care’ (Welsh Government, 2019) recognises the lifelong importance of addressing adversity experienced in childhood (Di Lemma et al., 2019).

In Wales, training in trauma-informed care has been implemented for a variety of frontline workforces and promising examples of an ACE-informed approach which emphasise the importance of trauma-informed skills are to be found in a range of sectors including the police, education, housing and youth justice (Di Lemma et al., 2019). Mixed method analysis to evaluate the training intervention consisted of the Attitudes Related to Trauma-Informed Care - ARTIC 35 or 45 pre and post psychometric survey (Baker et al., 2016) and semi structured interviews (with the exception of the upscaled policing training which utilised a survey designed for the study) (Glendinning et al., 2021, Grey and Woodfine, 2018, Newbury et al., 2019, Ford et al., 2019, Barton et al., 2018).

In terms of the criminal justice system, McCartan (2020) recognises the need for a multi-disciplinary approach, particularly within the probation service. This acknowledges the importance of working with individuals who offend, in a trauma-informed way, to understand the impact of past events on their behaviour. It is argued that appropriate trauma-informed interventions within the criminal justice system may help to reduce the impact of trauma (Rowles and McCartan, 2019). Trauma-informed approaches have also been advocated in the Welsh Youth Justice System (YJS). Trauma is recognised as being cumulative with no standard single reaction with regard to trauma responses (Youth Justice Board, 2017). There has been a reduction in the number of children in the YJS, however, many of the children who are accessing the YJS are persistently offending and have complex needs and experiences of trauma (Ministry of Justice, 2018) with 41% on the child protection register, almost two thirds had experienced early childhood trauma and neglect and nearly half had experienced domestic abuse (either as a witness or a direct victim) (Johns et al., 2017).

In response, the Youth Justice Board (YJB) Cymru issued a call to practice which resulted in the Enhanced Case Management (ECM) being developed and piloted (Evans et al., 2020). The ECM is a psychology-led approach which involves multi-agency case formulation to understand a child's individual life-course including developmental needs and strengths (Glendinning et al., 2021). The ECM seeks to align with the 'Child-First' definition offered by the YJB which featured in the Youth Justice Blueprint for Wales 2019 and is incorporated into YJB Strategic Objectives 2020-2021. The ECM is grounded in the Trauma Recovery Model which includes layers of intervention that correspond with underlying developmental/psychological need in order to mediate adverse effects of trauma prior to intervention (Skuse and Matthew, 2015).

Following positive evaluation of the ECM (Cordis Bright, 2017), trauma-informed practice is included as a guiding principle in the Youth Justice Blueprint for Wales 2019 (Ministry of Justice and Welsh Government, 2019). The YJB describe the basics of trauma-informed as involving training for practitioners on the influence of trauma on development and attachment; the recognition that some individuals require specialist care which differs from a trauma-informed service; there should be a focus on underlying need behind presenting behaviours; practitioners require a robust support system to protect against vicarious trauma (clinical supervision is advocated); there should be room for flexibility with regard to tailoring plans to meet the needs of the children; trauma-informed practice should be universally practiced with all children regardless whether there is a disclosure of trauma and, finally, trauma may influence resiliency levels which practitioners must consider when working with children (Youth Justice Board, 2017).

In other research, a recent report undertaken by the ACE Support Hub (Walker et al., 2021) explored how trauma-informed terminology or approaches were being utilised in Wales. This report found that projects, programmes, and interventions (PPIs) used many different words relating to trauma-informed, for example, trauma aware; trauma sensitive; trauma enhanced; trauma focused and trauma specialist. The findings indicate that the term trauma aware depicts the most basic level of being trauma-informed, while trauma specialist refers to the most advanced level. PPIs associated the term trauma-informed with ACEs, being ACE aware or ACE-informed. While the term psychologically-informed was used by several PPIs, the definition varied. A significant number of PPIs made associations between being trauma-informed and preventing vicarious trauma.

In terms of key approaches, Walker et al. (2021) found that staff training was deemed essential, to ensure consistency of understanding, terminology, and definitions within an organisation. However, the sources of this training varied with many developing and delivering training "in house". When working with service users, approaches included being person-centred, looking at the whole person and their life history, being needs-led and empowering the person through strengths-based ways of working. Staff work in a way to ensure the safety of the service users and are non-judgemental, also, where possible, staff should be relatable to the service user, and build a positive relationship with them. PPIs recognise the impact of vicarious trauma and work to ensure staff are given reflective spaces, regular supervisions and support.

Further, where needed, interventions were tailored to the individual and targeted at boosting the resilience of the person. Being trauma-informed requires a move away from medical models and being process-led, to being person-led, giving the service user choices, and offering appropriate support and interventions in a non-medicalised way. Collaboration and multiagency working are essential to delivering holistic care and support. All daily interactions (spoken and written) with another person (service user and co-workers) are kind and considerate. Sentences are framed positively. The well-being of the individual is given precedence. This includes being aware of culture, gender, ACEs, disabilities and individual differences. Physical environments also need to be trauma-informed. They need to be accommodating, comfortable and safe. Spaces should be designed to give service users a sense of belonging and normalisation (Walker et al., 2021).

1.5 Study Aims

A recent Welsh Government report highlights the work that has been done in Wales in relation to increasing awareness in respect of ACEs, as well as the next steps in respect of ‘what works’ to prevent and support people with ACEs. The report also highlights that while there has been a drive to encourage trauma-informed support, there is a lack of clarity in respect of the language and definitions used (Welsh Government 2021).

To address this lack of clarity in respect of the language and definition used in relation to the term ‘trauma-informed’, this study will undertake a scoping review of the international literature to explore how the term is used and operationalised across a range of settings. This study is a collaboration between Wrexham Glyndwr University as they undertake a journey to become a trauma and ACE informed University, and the ACE Support Hub.

In conjunction with a review which explores how trauma-informed terminology or approaches were being utilised in Wales (Walker et al., 2021), the findings will inform the development of a National Trauma Practice Framework.

Section 2: Methods

2.1 Research Questions

To address the project aims, this study will use a scoping review to identify the relevant literature. In general, the purpose for conducting a scoping review is to identify and map the available evidence, including to identify types of available evidence and to identify key characteristics or factors related to the concept (Munn et al., 2018). This study will address three research questions:

How is Trauma, Trauma-informed and related concepts defined in the literature and how has this definition changed over time?

How has a Trauma-informed approach been operationalised across different settings?

What are the criteria for an adherence to a Trauma-informed approach?

To address these research questions, a scoping review was undertaken in two stages:

Stage One was a wide-ranging search of the literature relating to the definitions of Trauma and Trauma-informed and to explore how these definitions have changed over time and to identify key models.

Building on Stage One, Stage Two was a 'review of reviews' consisting of a supplementary search of the international published literature to identify systematic reviews of literature related to trauma-informed approaches and interventions. Searches were undertaken in October 2021 and the following search strategy was used.

2.2 Search Strategy (Stage 2)

The following databases were searched:

- Pubmed
- British Nursing Index
- Cochrane Library
- Assia

Search terms included

- trauma-informed approaches
- trauma-informed language
- trauma-informed care mental health
- trauma-informed care
- trauma-informed and community
- trauma sensitive
- trauma aware
- trauma responsive

2.3 Inclusion and Exclusion Criteria

To be included, papers had to be a systematic review published within the last five years and be related to trauma-informed interventions within a range of settings. The focus had to be high income countries and be in the English language. Papers published before 2016, primary studies and those relating to interventions in low- or middle-income countries were excluded.

DeCandia et al. (2014) notes the distinction between ‘trauma focused’ services or therapies for the treatment of posttraumatic stress disorder (PTSD) and ‘trauma-informed’ care, part of an ecological approach in which trauma-informed care can be viewed as a ‘universal design’ for survivors, provided to all, by all. While ‘trauma focused services’ and ‘trauma-informed care’ are often used interchangeably, trauma focused services involve clinical intervention which seeks to address and heal trauma-related symptoms whereas trauma-informed care can be understood as a framework to help support changes in culture, policies and practices of organisations (DeCandia et al., 2014). While there is a wealth of literature relating to trauma focused services, the focus of this review is trauma-informed care and, as such, literature detailing trauma focused services is outside the remit of this review.

2.4 Analysis

Selected records were imported into reference management software (Endnote), duplicates were removed, and each record was title screened. Remaining records were exported into a excel spreadsheet and abstract screened. The final stage was to undertake full paper screening which left 17 articles in the final sample (Appendix A). For each paper, extracted data included the setting and population investigated as well as the key aspects of operationalising a trauma-informed approach. Given the diversity of settings, findings are presented in a narrative summary in Section 4.

Section 3: Trauma-informed; Terminology and Language

3.1 Defining Trauma

The word 'trauma' has Greek origins, meaning 'wound'. Trauma refers to both the exposure to a traumatic experience or experiences and refers to the effects of that exposure (The National Child Traumatic Stress Network, 2021). Trauma is defined by the SAMHSA as:

> ***"…an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being".*** (SAMSHA, 2014:7)

Personal or individual trauma refers to an event which happens to an individual. It may be a single occurrence such as a car accident, assault or physical attack or multiple or prolonged occurrence such as abuse, neglect or household difficulties (Center for Substance Abuse, 2014). In addition to the direct effect of personal trauma on the individual, indirect trauma may also be experienced by those who know the affected person through emotional repercussions (Center for Substance Abuse, 2014), known as vicarious or secondary trauma (Treisman, 2021). Further, while personal or individual trauma may also encompass medical or birth trauma, some medical traumas can affect entire communities or societies, such as Ebola and Coronavirus (Treisman, 2021).

Complex trauma refers to both the exposure to, and the effects of, the cumulative impact of multiple relational (interpersonal) traumas during development. These can include neglect, abuse and disrupted attachment and can have severe, persistent, wide ranging and enduring consequences, notably around the capacity to regulate emotion, maintain a stable sense of self and sense of the self as worthy, and to make and maintain relationships (Blue-Knot, 2021, The National Child Traumatic Stress Network, 2021, Hopper et al., 2010).

Cultural or identity trauma occurs around various elements of identity and culture, for example, racism, sexism or homophobia. These may be complex and multi-layered because it not only encompasses direct but also vicarious experiences (Treisman, 2021). Interlinking with cultural/identity trauma is the concept of 'insidious trauma' which conveys the experience of living under persisting oppressive conditions (Brown, 1994). Closely associated with cultural/identity trauma is collective/community trauma. Collective/community trauma refers to events which affect collectives of individuals with shared characteristics and may be direct or indirect (Keynan, 2018). Collective trauma can be defined as a 'blow to the basic tissues of social life that damages the bonds of attaching people together and impairing the prevailing sense of community' (Erikson, 1976:194).

Historical trauma (also referred to as intergenerational, multigenerational or inherited trauma) concerns emotional, psychological and social coping mechanisms, interconnections and trains of trauma which may be carried down through generations (Fraiberg et al., 1975, Treisman, 2021). Originally described as an intergenerational form of Post- traumatic Stress Disorder (PTSD) (Brave Heart, 2003), historical trauma is a combination of two concepts: historical oppression and psychological trauma (Gone, 2014). Historical trauma may occur after an event, for example, war or genocide, which, via the resulting fractures in the community, transmits across generations influencing socio-structural elements and identity. Intergenerational transmission may occur through parenting relationships (absorption of emotional state by children) and biologically via epigenetics (heritable changes in the genome which influence the function of the genomic DNA) (Yehuda and Lehrner, 2018).

Bereavement is defined as 'the condition of having lost a loved one to death' (American Psychological Association, 2020). An interface exists between trauma and bereavement with bereavement being understood contemporarily as the reshaping and continuation of the attachment bond with the deceased

without their physical presence (Rubin et al., 2012). Experiencing bereavement can influence the behavioural, emotional, intrapersonal and interpersonal ways in which an individual perceives the world around them, therefore resulting in symptoms of trauma (Malkinson et al., 2000, Rubin et al., 2017).

Toxic stress or trauma which occurs during an individual's developmental trajectory is known as developmental trauma. Developmental trauma concerns itself with any resulting developmental delays stemming from trauma including, but not limited to, emotional, psychological, social and neurological (Treisman, 2021). Trauma in childhood is associated with attachment, emotion and autobiographical memory impairments which influences the ability to build a logical image of oneself (Goodman et al., 2010). Relational and attachment trauma is woven into developmental trauma due to the interference of trauma on the development of a secure and healthy attachment relationship (Baer and Martinez, 2006). Where insecure attachments are experienced, individuals may struggle with later-life relationships (Baer and Martinez, 2006) and emotional understanding due to it being steered by emotional and behavioural responses to attachment-connected events (Main et al., 1985).

Trauma experienced during the adolescence phase of life is thought to have a negative impact on personal identity due to interconnection with adult character evolvement (Berntsen and Rubin, 2006). Trauma which occurs during young adulthood may overshadow positive schemas associated with this stage of the life cycle and influence culturally shared norms which are created during this period (Berntsen and Rubin, 2004). Midlife trauma exposure may lead to unhealthy psychological adaptions due to the socio-cognitive developments and age-related emotional regulation associated with this stage of life (Gross et al., 1997). Finally, trauma in older adulthood can negatively influence well-being due to the potential decline in social support networks which is typical during this phase of the life cycle (Brewin et al., 2000).

3.2 Addressing the Impact of Trauma

Early trauma has consequences for how human beings respond to stress. Trauma and adversity in children, such as sexual, physical or emotional abuse or abandonment alter the child's physical stress mechanisms since adversity during infancy results in chronically high levels of the stress hormone cortisol, which can disturb normal brain development with lifelong repercussions (Maté, 2012). A traumatic experience impacts many aspects of development in childhood, the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world are all profoundly altered by traumatic experience (Bloom, 1999). This is because the experience of overwhelming terror destabilizes our internal system of arousal, and people who have been traumatized lose the capacity to 'modulate arousal' and tend to stay irritable, jumpy, and on edge. Children, within the responsive and protective care of adults develop the ability to modulate the level of arousal however children who are exposed to repeated experiences of overwhelming arousal may never develop normal modulation of arousal. Under such circumstances, people may turn to substances, like drugs or alcohol, or behaviours like sex or eating or even engagement in violence, all of which help them to calm down, at least temporarily (Bloom, 1999).

In 1992, Herman posited that chronic abuse causes serious psychological harm and proposed a new diagnosis of complex PTSD to validate the link between trauma symptoms and preceding traumatic experience for survivors of complex trauma (Herman, 1992). Subsequently, Complex PTSD was included in the World Health Organisation's International Classification of Diseases (ICD-11) in 2018 and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) has widened PTSD criteria to accommodate the constellation of symptoms experienced by survivors of complex trauma. In 1994 and 1995, Bloom published papers articulating the Sanctuary Model within in-patient programs and schools (Bloom, 1994, Bloom, 1995) . Bloom's work dovetails with Herman's, sharing the premise that childhood trauma is *"a causative factor"* in psychiatric and social disorders, and is more accurately conceived as an injury with post traumatic sequalae and is a 'normal' response, *"post-traumatic stress reactions are essentially the reactions of normal people to abnormal stress"* (Bloom, 1995).

Becoming trauma-informed is captured by the shift from 'What's wrong with you?' to 'What's happened to you?' (Bloom, 1995). Sweeney and Taggart (2018) argue that as a society, moving towards a trauma-informed perspective brings the attendant responsibility of addressing and preventing trauma. The phrase 'trauma-informed' is now used to denote frameworks, programs and organisations that wish to reflect their awareness of trauma and the actions they have taken to mitigate the impact of complex trauma within their domain (Hanson and Lang, 2016). As such, becoming trauma-informed moves beyond awareness of what trauma is and into organisation wide understanding and implementation that is anticipated to improve the outcomes for people who have histories of trauma. Thus, becoming trauma-informed and ACE aware is a process firstly of developing awareness and secondly of implementing changes to improve the outcomes for people who have encountered complex trauma or adversity. Additionally, trauma-informed approaches have a social justice component, recognising the role that structural inequality plays in maintaining trans-generational cycles of adversity and trauma (Tebes et al., 2019).

Strengths-based approaches are encompassed within trauma-informed philosophy and acknowledge an individual's personal adaption to build resilience during or after the occurrence of trauma (Bent-Goodley, 2019, Elliott et al., 2005, Young, 2017). Therefore, professionals and practitioners must seek to assemble a rounded perspective of the individual, including their strengths, instead of merely focusing on their traumatic background (Evans and Coccoma, 2017). Another consideration to be made is of the social, emotional and developmental age of an individual which will not always replicate the chronological age. This is because some individuals have been denied the opportunity to learn new skills and, where developmental trauma exists, individuals may be slightly delayed (Treisman, 2021). This may manifest through certain behavioural responses due to a lack of understanding. Certain models, such as the Trauma Recovery Model (TRM), which was originally developed for children serving sentences at secure children's homes or subject to accommodation orders, addresses this by sequencing interventions in line with a child's individual development and mental health need (Skuse and Matthew, 2015).

SAMHSA's widely cited concept of a trauma-informed approach is established in a set of four assumptions and six key principles which draw the line between a trauma-informed approach and trauma-specific services. The first of the four assumptions is that individuals at all levels of the organisation have a basic realization about trauma and its effects on others. This means understanding behaviour/responses through a coping-mechanism lens which has been used to soothe and guide the individual through experiences. Also, consideration should be given to how the symptoms of trauma may present as a barrier within other services/settings. The second assumption is that individuals within the organisation should recognise the signs of trauma which may be characteristic-specific and may be the reason an individual (including staff) have accessed the service. The third assumption is when the organisation responds through the application of trauma-informed principles and embeds change at all levels, this involves careful consideration of language, behaviour and policies which acknowledge the experiences of trauma. The fourth assumption is that a trauma-informed approach seeks to resist re-traumatization of individuals accessing the service and staff working for the service, this involves identifying and making appropriate changes to potential triggers and trauma-inducing practices which may be harmful to healing (SAMSHA, 2014).

SAMSHA's six key principles of a trauma-informed approach are an amalgamation of a variety of concepts/models (Bloom and Farragher, 2011, Farragher et al., 2005, Harris and Fallot, 2001a). The first principle outlined as fundamental to a trauma-informed approach is safety, where all individuals using the service or working for the service feel physically and psychologically safe. The second is trustworthy and transparency, where decisions and actions are conducted with transparency to ensure the maintenance of trust. The third principle is peer support, whereby individuals with lived experience are the key drivers for building safety, trust and using their narrative to promote healing. The fourth is collaboration and mutuality which involves the recognition that everyone at all levels of the organisation has a role to play in becoming trauma-informed meaning a balancing of power may be required. The fifth is empowerment, voice and choice to ensure that staff and individuals accessing the service have their strengths recognised and expanded upon, where an underlying belief exists that healing from trauma is possible and individuals accessing the service are supported to actively participate in decision making. Finally, the sixth principle is the recognition of cultural, historical and gender issues where actions are taken to move past biases and there is embedding of responsive policies with regards to cultural needs; this also involves acknowledging and addressing historical trauma (SAMSHA, 2014).

3.3 Changing Definitions

While trauma-informed practice has been growing internationally, a universal definition does not exist and, as such, organisations and practitioners create their own definitions (Menchuner and Maul, 2016). The number of academic publications using the term trauma-informed have increased year on year since 2010. A search of PubMed (National Library of Medicine, US) returned 1517 results (search date: 30/7/2021); of these 1470 (97%) were published in the last ten years. Last year almost 400 papers were published and 300 have already been published in 2021.

Definitions of trauma-informed care over the last 20 years include:

2001: ***"To be trauma-informed means to know the history of past and current abuse in the life of the consumer with whom one is working ... [and to] understand the role that violence and victimization play in the lives of most consumers of mental health and substance abuse services and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment"*** (Harris and Fallot, 2001b).

2005: ***"All staff … from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of people being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization"*** (Elliott et al., 2005).

2006: ***"The provision of "trauma-informed care" is a seminal concept in emerging efforts to address trauma in the lives of children, as well as adults. Trauma-informed care has many facets. It refers to recognition of the pervasiveness of trauma and a commitment to identify and address it early, whenever possible. Trauma-informed care also involves seeking to understand the connection between presenting symptoms and behaviours and the individual's past trauma history. As a practice and set of interventions, trauma-informed care involves professional relationships and interventions that take into account the individual's trauma history as part of efforts to promote healing and growth. At the most basic level, trauma-informed care involves the provision of services and interventions that do no harm – e.g., that do not inflict further trauma on the individual or reactivate past traumatic experiences. Beyond this, trauma-informed care helps the individual to heal"*** (Hodas, 2006).

2010: ***"Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment"*** (Hopper et al., 2010).

2014: ***"A program, organisation, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization"*** (SAMSHA, 2014) .

2020: ***"A trauma-informed approach orients to the way in which people are treated more broadly and holistically at a systemic level***

- ***Is not clinical treatment***
- ***Recognises that many problems, disorders and conditions are trauma-related***
- ***Requires staff training to act appropriately on this awareness***
- ***Rests on the foundational principle of 'do no harm'***
- ***Understands the effects of stress on the brain and body***
- ***Considers what has happened to a person rather than what is 'wrong' with a person***
- ***Regards `symptoms' as outgrowths of coping strategies***
- ***Is sensitive to the client's comfort levels and to the way in which a service is delivered (not just what the service is)***
- ***Works with (rather than `doing to' or `for') the client"***

(Kezelman and Stavropoulos, 2020)

2020: ***"Trauma-informed organisation is aware of the prevalence and impact of trauma and engages in universal precaution for re-traumatization by anchoring in the five guiding values and principles [safety, trust, collaboration, empowerment and choice identified by Harris and Fallot]. A Trauma Sensitive organisation deliberately looks at all levels of operation/ functioning in order to respond to others in a way that is sensitive potential trauma histories. A Trauma Specific organisation offers evidence-based, trauma treatments interventions specifically designed to treat and help individuals heal from trauma"*** (The Institute on Trauma and Trauma-Informed Care, 2020).

3.4 Models of a Trauma-informed Approach

Early implementations of trauma-informed care included Bloom's Sanctuary Model which evolved from her early work in therapeutic communities and is now an independent commercial model (Bloom, 2013); Harris and Bergman's Community Connections (Harris and Fallot, 2001b) and the Women's Co-occurring Disorders and Violence study (WCDVS) (Elliott et al., 2005).

The definitions, values and practices trialled have been distilled into freely available comprehensive implementation guidance, notably Blue Knot Foundation's Organisational Guidelines for Trauma-informed

Service Delivery and SAMHSA's Concept of Trauma and Guidance for a Trauma-informed Approach which forms the basis of most other guidance available, including guidance produced by The University of Buffalo (The Institute on Trauma and Trauma-Informed Care, 2020, Kezelman and Stavropoulos, 2020, SAMSHA, 2014). The original principles of safety, trust, collaboration, empowerment and choice identified by Harris and Fallot have been retained in Blue Knot's Guidance but augmented by SAMHSA to: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment voice and choice, and cultural historical and gender issues (SAMSHA, 2014, Harris and Fallot, 2001b).

Hanson and Lang (2016) reviewed seven trauma-informed frameworks used in the US identifying 15 components of trauma-informed care over three domains of, workforce development, trauma-focused services and organisational environment and practices. Only two components ***'Required training of all staff in awareness and knowledge on the impact of abuse or trauma'*** in workforce development and ***'Use of standardized, evidence-based screening/assessment measures to identify trauma history and trauma-related symptoms or problems'*** in trauma-focused services were common to all frameworks. However, within the domain of organisational environment and practices six frameworks identified the need for ***'Written policies that explicitly include and support trauma-informed principles'***, ***'Procedures to reduce risk for client re-traumatization'*** and ***'Procedures for consumer engagement and input in service planning and development of a trauma-informed system'*** (Hanson and Lang, 2016). Notably SAMHSA scored highest, covering 13 of the 15 identified components omitting to measure staff proficiency to demonstrate trauma-informed practice and having a defined professional role related to trauma-informed approaches (Hanson and Lang, 2016).

In the UK, NHS Education for Scotland have adopted SAMSHA's definition of trauma and implement SAMHSA's definition of being trauma-informed as the foundational level of their knowledge and skills framework (NHS Education for Scotland, 2017, SAMSHA, 2014). In contrast, Lancashire's Violence Reduction Network has produced A Trauma-informed Organisational Development Framework (Lancashire Violence Reduction Network, 2020) which draws on SAMHSA's definitions of trauma and being trauma-informed but utilises Trauma-informed Oregon's phased approach to trauma which places the category of being trauma-informed at the pinnacle of the phasing. Trauma-informed Oregon in turn draw on SAMHSA's principles of trauma-Informed approaches (Trauma-informed Oregon, 2018).

In summary, the most common aspects of trauma-informed approaches are:

- 'Required training of all staff in awareness and knowledge on the impact of abuse or trauma'
- 'Use of standardized, evidence-based screening/assessment measures to identify trauma history and trauma-related symptoms or problems'
- 'Written policies that explicitly include and support trauma-informed principles'
- 'Procedures to reduce risk for client re-traumatization'
- 'Procedures for consumer engagement and input in service planning and development of a trauma-informed system'

The following factors link to the success of implementation:

- Senior leadership commitment and strategic planning
- Sufficient staff support
- Amplifying the voices of patients and families
- Aligning policy, procedures and programming with trauma-informed principles
- Using data to help motivate change

Section 4: Operationalising a Trauma-informed Approach

This section outlines the results of a supplementary search of the international published literature, which identified systematic reviews relating to the use of a trauma-informed approach. Of interest is the way that the concept of a trauma-informed approach is put into practice across settings. Settings include schools; child welfare; mental health services; health services; justice system; maternity and perinatal settings and system wide approaches.

4.1 School Setting

Table 1: School Setting

Author/Year	Setting	Population
(Avery et al., 2021)	School	School Pupils

Avery et al. (2021) argues that schools offer a unique environment to prevent and counter the impact of childhood trauma and there is substantial momentum for trauma-informed schoolwide approaches. However, considerable diversity exists in how trauma-informed interventions are delivered in schools and little is known about what constitutes the essential elements of a trauma-informed school. This study aimed to investigate empirical evidence for school-wide trauma-informed approaches that met at least two of the three essential elements of trauma-informed systems defined by SAMSHA (2014). The review identified four school-wide approaches and although heterogenous, the models shared core elements of trauma-informed staff training, organisation level changes and practice change with most models utilising student trauma screening. The models were primarily grounded in ecological, attachment, and trauma theories and whilst all had core components in common, they used a variety of approaches to practice change and delivery of support to staff. Models focused on the safety needs of students to reduce behavioural escalation, including sensory and calming supports and most studies provided additional supports to teachers to embed trauma-informed practices.

4.2 Child Welfare

Table 2: Child Welfare

Author/Year	Setting	Population
Bailey et al. (2019)	Child Welfare	Looked after Children
Bunting et al. (2019)	Child Welfare	Children

Bailey et al. (2019) undertook a review in relation to children living in out of home care (OoHC). Typically, children and young people are moved into OoHC due to physical, sexual or emotional abuse, neglect, or domestic violence. As a result, these children are likely to have experienced high rates of complex trauma and adversity and a failure to understand and address issues arising for children with a traumatic history can inadvertently aggravate symptoms and traumatise the child further. Initial evidence suggests that the application of trauma-informed care models may have significantly positive outcomes for children in OoHC however there is a lack of definition and a large degree of flexibility in how trauma-informed approaches are constructed (Wall et al., 2016 cited in Bailey et al., 2019).

Bunting et al. (2019) undertook a narrative synthesis of the various implementation strategies and components used across child welfare initiatives, with associated evidence of effectiveness. In recognising

the impact of childhood adversity on child and adult outcomes, trauma-informed services strive to build trustworthy collaborative relationships with children and the important adults in their lives, as well as improve consistency and communication across linked organisations and sectors, with the aim of mitigating the impact of adversity by supporting and enhancing child and family capacity for resilience and recovery.

Both Bailey et al. (2019) and Bunting et al. (2019) refer to Hanson and Lang (2016) who identified common elements of trauma-informed care in child welfare settings. These include:

1. Workforce Development (training staff on the impact of abuse or trauma; measuring staff knowledge and practice; strategies and procedures to address and reduce traumatic stress among staff; knowledge and skills in accessing evidence-based services).
2. Trauma Focused Services (screening/assessment to identify trauma history and symptoms; child's trauma history included in case record/plan; availability of evidence-based trauma-focused practices.
3. Organisational Change (collaboration, coordination, and information sharing; procedures to reduce risk for client re-traumatization; promotion of consumer engagement; provision of strength-based services; safe physical environment; written policies that include/support trauma-informed principles).

4.3 Mental Health Services

Table 3: Mental Health Services

Author/Year	Setting	Population
Bloomfield et al. (2020)	Mental Health Services	Adults
Bryson et al. (2017)	Mental Health Services	Young People
Lee et al. (2021)	Mental Health Policy	
Maguire and Taylor (2019)	Mental Health Services	Nurses
Nizum et al. (2020)	Mental Health Services	Adults
Wilson et al. (2021)	Mental Health Services	Nurses

Bloomfield et al. (2020) undertook a systematic review of intervention studies relating to trauma-informed care for adult survivors of developmental trauma with psychotic and dissociative symptoms. It was found that there was a lack of consensus on a definition of trauma-informed care, also, there was insufficient evidence to answer the question of what good trauma-informed psychosis care is. This review highlights the need to build an evidence base since it remains unclear which treatment works best for psychosis and research is needed to establish which elements are most effective for whom. It is also important to understand patients' experiences in their developmental and systemic context to enable clinicians to have a more comprehensive and holistic view of their patient's presentation. To conclude, this review highlights the urgent need for methodologically sound, high-quality research to enable shared, evidence-based decision making between clinicians and patients.

Bryson et al. (2017) undertook a realist systematic review of trauma-informed care literature relating to youth inpatient psychiatric and residential treatment settings. This is in recognition that many young people who receive psychiatric care have experienced various forms of emotional trauma. In response, psychiatric and residential facilities have embraced trauma-informed care, aligning service delivery with treatment principles and discrete interventions designed to reduce rates of re-traumatization through responsive and non-coercive staff client interactions. Five factors were instrumental in implementing trauma-informed care across a spectrum of initiatives: senior leadership commitment, sufficient staff support, amplifying the voices of patients and families, aligning policy and programming with trauma-informed principles, and using data to help motivate change. This review concludes that the reduction or elimination of coercive measures may be achieved by explicitly targeting specific coercive measures or by implementing broader therapeutic models; however additional research is needed to evaluate the efficacy of both approaches. Further, this review suggests that trauma-informed care initiatives which are comprehensive, theoretically grounded, and developmentally-informed and which seek to align all facets of treatment with the principles of safety, choice, and collaboration may reduce seclusion, restraint, and staff and patient injury rates.

Lee et al. (2021) uses a systematic mapping review to explore how a trauma-informed approach has been incorporated in Canadian Mental health policies. The findings indicate trauma-informed policies started emerging in 2010 and that there was an increased understanding of a broad definition and various types of trauma and an acknowledgement of its causes and impacts on multiple levels. However, the review identified the widespread use of different terminologies which may create confusion about what trauma-informed approach means in policy, research, and practice. Additionally, the review identified areas for improvement including the experiences of marginalized populations, explicitly centering cultural and gender sensitive approaches in trauma-informed approach policy initiatives, clarifying the standard definition of trauma-informed approach and its implementation services, and establishing indicators and evaluation methods for future research and policy directions.

Maguire and Taylor (2019) explored trauma-informed education and its training implications for nurses working in forensic mental health on the basis that by adopting a trauma-informed approach, forensic mental health nurses can better understand their patients' traumatic experiences, improve their therapeutic relationships, and engage patients in collaborative care. The review found that organisations and their staff must recognize that operational change and ongoing training is required and where a forensic service or organisation is seeking training for trauma-informed practice, there must be an organisational commitment to fully adopting and embedding the trauma-informed approach. This includes the provision of trauma-informed support, clinical supervision, and regular meetings, all of which contribute to trauma-informed care of patients and clients, as well as staff well-being. In addition, the delivery of trauma-informed care training should be prioritized starting with those nurses who, as well as directly benefiting from the training through changes to their personal practice, have the capacity and ability to support and, where applicable, train their colleagues and peers. Finally, there must also be a recognition that ongoing training will be required.

Nizum et al. (2020) undertook a systematic literature review to identify nursing interventions within four weeks of a mental health crisis with a secondary focus on identifying particular interventions that included trauma-informed principles. Trauma-informed principles of practice include the following: promoting safety, trustworthiness and transparency, fostering collaboration and mutuality, supporting empowerment, choice and control, providing opportunity for peer support, and generating awareness and responsiveness to cultural, historical, and gender issues (SAMSHA, 2014). The review supports a principle-based approach to providing brief intervention, as well as technology-assisted interventions in the period immediately following crises, including those arising from disasters, with an emphasis on supporting the active involvement of persons experiencing crisis in ways that are connective, empowering, collaborative, skill-building, and strengths-based. Integration of a trauma-informed framework to crisis intervention that is driven by the core principles of safety (psychological, emotional, physical), trust, choice, collaboration, and shared power allows providers to bring to awareness an acknowledgement of the prevalence and impact of trauma in the lives of individuals and communities but also to recognize the signs of the impact and respond in ways that seek to avoid re-traumatization through routine processes of care (SAMSHA, 2014). A trauma-informed approach to crisis intervention helps to ground clinical interventions on a common understanding that prioritizes not only what intervention is provided to persons in crisis but how we provide interventions in ways that feel safe and promote resilience.

Wilson et al. (2021) reviewed primary studies examining trauma-informed care in mental health inpatient units from a mental health nursing perspective. Trauma-informed care is referred to as both an approach to care and as a model of care and its purpose is to heighten staff awareness of the widespread impact of trauma, recognition of the symptoms of trauma, and to guide responses at both a system and individual level that resist trauma and re-traumatization in the provision of care for consumers. This review demonstrates that there is a lack of uniformity around the principles of trauma-informed care also, that for true and purposeful application of trauma-informed care, those processes which may be traumatising for mental health nurses, experiences of compassion fatigue, burnout syndrome and vicarious trauma coupled with increasing operational demands, a focus on task-based care and increasing concerns for safety need to be explored since if the parallel processes are not examined, a truly integrated trauma-informed mental health system will fail to thrive.

4.4 Health Services

Table 4: Health Services

Author/Year	Setting	Population
Bendall et al. (2021)	Health Services	Young People
Cullen et al. (2021)	Health Services	First Nation (Indigenous) Women
Han et al. (2021)	Health Equity	Marginalised Populations
Oral et al. (2020)	Health Care	Professionals
Purtle (2020)	Health Care	Professionals

There is a growing consensus that outpatient health services for young people (aged 12–25 years) need to deliver trauma-informed care to ameliorate the effects of trauma, offer safe treatments, and avoid re-traumatizing individuals. However, while trauma-informed care has become a familiar term for many professionals, its operating definition lacks clarity. Through content analysis, Bendall et al. (2021) identified 10 components of trauma-informed care as it has been operationalised in practice: seven of these occurred at the system-level (interagency collaboration; service provider training; safety; leadership, governance and agency processes; youth and family/carer choice in care; cultural and gender sensitivity; youth and family/carer participation), and three involved trauma-specific clinical practices (screening and assessment; psychoeducation; therapeutic interventions).

Cullen et al. (2021) undertook a systematic review to understand how primary health care services can provide equitable and effective care for First Nations women (the term First Nations refers to indigenous peoples). This review highlights the importance of strengthening and supporting the workforce, as well as embedding cultural safety within intersectoral partnerships and ensuring adequate resourcing and sustainability of initiatives. Recommendations for how to integrate trauma-informed responses within health settings when caring for women experiencing violence and abuse centre on sensitively screening for a trauma history, developing trust with service providers, minimizing patient distress, and enabling patient autonomy, and providing multidisciplinary care and referrals. Through this lens, responses to trauma are seen as adaptive and supportive of resilience and in practice this means that women are affirmed rather than blamed or pathologized for responses to trauma and coping mechanisms. Browne et al, (2016 cited in Cullen et al., 2021) have developed an evidence-based framework for promoting equity-oriented health care for First Nations peoples. This framework considers the colonial experience and ongoing racism and discrimination in order to link trauma and violence to current health care experiences by First Nations peoples. The framework is operationalised around three key dimensions of care that are interrelated and overlap: (1) culturally safe, (2) contextually tailored, (3) trauma and violence informed.

The purpose of the study by Han et al. (2021) was to appraise the types, setting, scope, and delivery of trauma-informed interventions and associated outcomes in recognition that there is a growing body of the literature on trauma-informed and culturally competent care as essential elements of promoting health equity, yet no prior review has systematically addressed trauma-informed interventions. The review concluded that there is inconsistent evidence to support trauma-informed interventions as an effective approach for psychological outcomes. Future trauma-informed interventions should be expanded in scope to address a wide range of trauma types such as racism and discrimination. These findings suggest the need for more rigorous and continued evaluations of the trauma-informed intervention approach and for a wide range of trauma types and populations.

Oral et al. (2020) conducted a systematic review of studies that focused on trauma-informed care implementation within healthcare settings, state-wide trauma-informed care implementation, impact of ACEs on health outcomes, impact of trauma-informed care on health outcomes and evaluation of trauma-informed care implementation. Trauma-informed care in healthcare systems is a multilevel, organisational framework to understand and respond to the impact of trauma on both survivors and healthcare providers.

Purtle (2020) undertook a systematic review of studies that evaluated the effects of organisational interventions that included a trauma-informed staff training component. This is in light that staff training about trauma-informed practice are potentially instrumental to fostering trauma-informed organisational and systems change,

but evidence about the effects of these trainings has not been assessed or integrated. The review found that staff knowledge, attitudes, and behaviours related to trauma-informed practice improve immediately after participating in a trauma-informed training, but it is less clear whether these changes are retained over time and translate into client outcomes. Trauma-informed organisational interventions appear to have the most meaningful impacts on client outcomes when the intervention includes other components (e.g., organisational policy changes) in addition to trauma-informed trainings for staff. The review recommends that evaluations of trauma-informed trainings should use established, validated, and reliable instruments to assess the effects on participants, additionally that policies that mandate, fund, or incentivize trauma-informed trainings should also support organisational policy changes that are aligned with the principles of trauma-informed practice.

4.5 Justice System

Table 5: Justice System

Author/Year	Setting	Population
Branson et al. (2017)	Justice System	Young People

Branson et al. (2017) undertook a systematic review to identify publications that defined trauma-informed care or recommended specific practices or policies for the youth justice system. This is in recognition that trauma disproportionately affects youth involved with the youth justice system with an estimated 70–90% of youth offenders having experienced one or more types of trauma, including high rates of physical or sexual abuse, witnessing domestic violence, and exposure to violence in school or the community. In addition, it is increasingly recognised that front-line justice system professionals are frequently exposed to traumatic stressors in the line of duty and a growing literature reveals high rates of moderate to severe traumatic stress symptoms in samples of correctional staff, probation officers, law enforcement and attorneys. This review found eight specific practice or policy recommendations with relative consensus: universal screening/assessment of youth for trauma related impairment; providing evidence based trauma specific treatment; practices/policies that address the needs of diverse groups of youth; access to social supports for youth and families; prioritising youth and family preferences for services; staff training; policies procedures to promote a safe environment and eliminating or reducing harsh/coercive practices.

4.6 Maternity and Perinatal Settings

Table 6: Maternity and Perinatal Services

Author/Year	Setting	Population
Mosley and Lanning (2020)	Maternity and Perinatal Settings	Birth Assistants (Doula)

Mosley and Lanning (2020) acknowledge that trauma and trauma-related health conditions are common during pregnancy, but there is little evidence and guidance on how doulas (trained lay birth assistants in the US) can provide trauma-informed care. The purpose of this narrative review is to critique and synthesize the existing evidence for trauma-informed doula care and to offer guidelines for practice. Trauma-informed doula care centres on six principles: safety; trustworthiness and transparency; peer support with other survivors; collaboration and mutuality; resilience, empowerment, voice, and choice; and social, cultural, and historical considerations. In practice, this includes universal trauma-informed doula care offered to all clients, trauma-targeted care that can be offered specifically to clients who are identified as trauma survivors, and connection to trauma specialist services. The tiered approach to trauma-informed doula care includes universal trauma-sensitive approaches, trauma-targeted services for clients who are survivors of trauma, and linkages to trauma specialists as needed.

4.7 System wide Approaches

Table 7: System wide Approaches

Author/Year	Setting	Population
Champine et al. (2019)	System Wide Approaches	

A systematic review by Champine et al. (2019) identified 49 systems-based measures that were created to assess the extent to which relational, organisational, and community/system practices were trauma-informed. To date, most measures of trauma-informed approaches have emphasized individual assessments and although individual-level measures are essential, systems-based measures offer opportunities not only to assess whether systems are equipped to support individual-level changes in outcomes, but also whether they can support broader systems-level changes to support the health of communities (Matlin et al., 2019 cited in Champine et al., 2019). This review aims to contribute to a more integrated understanding of multilevel issues related to measuring a trauma-informed approach. Whereas individual-level practices primarily target individual attitudes and behaviours, relational practices often focus on improving family, peer, and interpersonal processes. In addition, organisational practices include interventions in various settings (such as schools and workplaces) and community/ systems practices focus on serving whole communities as well as service systems (Magruder et al., 2017, Tebes et al., 2019). Thus, this framework prioritizes an array of interventions that operate across multiple levels within an individual's broader ecology.

Section 5: Discussion

Early experiences of trauma and adversity are linked to poor health and social outcomes which, without intervention tend to be perpetuated down generations (Brown et al., 2009, Oh et al., 2018, Gilbert et al., 2009, Marmot, 2020). The ability to address ACEs and recover from adversity has led to the recognition of the importance of a trauma-informed philosophy that integrates the understanding of trauma into policy and practice (Kimple and Kansagra, 2018). Through a scoping review of the literature, this study has explored the language and terminology around the term trauma-informed, providing definitions of key terms and examples of how trauma-informed is operationalised across a range of settings.

5.1 Summary

The concept of trauma-informed service systems was first introduced into the literature by Harris and Fallot in 2001 (Harris and Fallot, 2001a, Harris and Fallot, 2001b). Since then, several researchers and stakeholder groups have attempted to define a trauma-informed care approach. These definitions include broad principles or domains of trauma-informed care (staff education and client-centred service planning) and/or recommendations for specific trauma-informed practices or policies (mandatory trauma training for all staff or universal screening of clients). Although there is general agreement in the literature that trauma-informed care refers to the integration of trauma awareness and understanding throughout an organisation or service system, there is currently no consensus-based definition on the particular practices or policies that comprise this approach for any service system (Branson et al., 2017).

Although a universally agreed upon definition of 'trauma-informed' is currently lacking, implicit in being trauma-informed is holding four main premises: (1) that exposure to trauma is widespread and has pervasive impacts; (2) believing that healing from trauma is possible; (3) that relationships play a key role in the process of change; and (4) that safety is critical for healing and preventing further impact (Avery et al., 2021).

While there is consensus in terms of the overarching approach that constitutes trauma-informed practice, the literature indicates that the way it is operationalised will vary according to the setting. In the school setting, models shared core elements of trauma-informed staff training, organisation level changes and practice change as well as some models utilising student trauma screening (Avery et al., 2021). For child welfare settings, common elements of trauma-informed care include workforce development, trauma focused services and organisational change (Hanson and Lang, 2016). Across mental health services, the literature indicates that, for youth inpatient psychiatric and residential settings, five factors were instrumental in implementing trauma-informed care: senior leadership commitment, sufficient staff support, amplifying the voices of patients and families, aligning policy and programming with trauma-informed principles and using data to help motivate change (Bryson et al., 2017).

Two reviews focus on staff training within mental health settings (Maguire and Taylor, 2019, Wilson et al., 2021). It was recognised that when a service is seeking training for trauma-informed practice, there must be organisational commitment to fully adopting and embedding the trauma-informed approach, including support, supervision, regular meetings and recognition that training is ongoing (Maguire and Taylor, 2019). Additionally, it was acknowledged that these processes may be traumatising for clinicians who may experience compassion fatigue, burnout syndrome and vicarious trauma, therefore a focus on task-based care and safety needs to be explored to ensure that a truly integrated trauma-informed mental health system is achieved (Wilson et al., 2021).

Within health services, Bendall et al. (2021) identified 10 components of trauma-informed care as it is operationalised in practice; seven at the system level: interagency collaboration; service provider training; safety; leadership; governance and agency processes; youth and family/carer choice in care; cultural and

gender sensitivity; youth and family/carer participation and three which involved trauma specific clinical practices, screening and assessment; psychoeducation and therapeutic interventions. In a maternity and perinatal setting, Mosley and Lanning (2020) identify six principles for trauma-informed doula care: safety; trustworthiness and transparency; peer support with other survivors; collaboration and mutuality; resilience, empowerment, voice and choice and social, cultural, and historical considerations.

The need for equitable and effective care for all communities was highlighted, with an evidence-based framework for promoting equity-oriented health care. This framework considers ongoing racism and discrimination to link trauma and violence to current health care experiences and is operationalised around three key dimensions of care that are interrelated and overlap: culturally safe; contextually tailored; trauma and violence informed (Cullen et al., 2021).

In the justice setting, Branson et al. (2017) identifies eight practice or policy recommendations with relative consensus: universal screening/assessment for youth trauma related impairment; providing evidence based trauma specific treatment; practices/policies that address the needs of diverse groups of youth; access to social supports for youth and families; prioritising youth and family preferences for services; staff training; policies procedures to promote a safe environment and eliminating or reducing harsh/coercive practices.

A key principle of trauma-informed care is including service users at the organisational and planning levels; it is also important to include the perspectives of marginalized groups known to experience high rates of trauma and mental ill-health, such as the LGBTQIA community, since their voices can be lost in large-scale consensus efforts (McCormick et al., 2018 cited in Bendall et al., 2021).

Finally, system wide approaches prioritise a range of interventions that operate across multiple levels within an individual's broader ecology and offer opportunities to assess whether systems are equipped to support individual level changes in outcomes but also whether they can support broader systems-level changes to support the health of communities (Matlin et al., 2019 cited in Champine et al., 2019).

5.2 Implications for Policy and Practice

Hopper et al. (2010) argue that support for becoming trauma-informed is superficially common but lacks definition, methodical implementation, and standardised evaluation. In terms of definition, trauma-informed lacks specificity and terms are frequently blended and used interchangeably (Hanson and Lang, 2016). The evidence in this review notes a lack of consistency of a definition across a range of settings, including child welfare (Bailey et al., 2019); mental health services (Bloomfield et al., 2020); mental health policy (Lee et al., 2021) and health services (Bendall et al., 2021). As a result, multiple authors have identified the lack of consensus on the definition of trauma-informed care as a primary barrier to creating trauma-informed systems (Branson et al., 2017).

Compounding this variability, trauma-informed efforts are implemented differently over a wide range of service settings resulting in an urgent need for consensus on the components of trauma-informed care (Champine et al., 2019, Bendall et al., 2021). Many national policy directives require trauma-informed care training for professionals and that training is currently being implemented without benchmarks as to what this should entail (Bendall et al., 2021). Further, professionals also perceive considerable overlap between good practice and trauma-informed practice (Isobel et al., 2020, Hanson and Lang, 2016) so identifying what is unique to trauma-informed approaches, the value that can be added by adopting these features, and the difference that makes to staff and people using a service, is hard to measure.

Evaluating the effectiveness of a trauma-informed approach is similarly impacted by the lack of consistent definition and implementation. Effectiveness is measured by diverse and non-standardised measures and it is noted that the scarcity of research on measurement and evaluation of a trauma-informed approach makes it difficult to determine the effectiveness of initiatives and make decisions about the optimal approaches (Champine et al., 2019). Several reviews in this study note that the evidence of the effectiveness of a trauma-informed approach is limited. For example, Bendall et al. (2021) notes that given the limited literature available to date, it is not yet possible to ascertain whether trauma-informed care improves outcomes for young people accessing outpatient health care. In part, the problem is that outcomes vary, as a result, analysis of outcome targets suggests that the authors of the reviewed studies conceptualised improving screening, assessment,

and access to trauma-specific treatments as key goals of trauma-informed care in these settings. Bendall et al. (2021) concludes that the observed lack of consensus regarding many of the components of trauma-informed care is perhaps unsurprising given the lacking operational definition.

In addition, Bloomfield et al. (2020) found that there was insufficient evidence to answer the question of what good trauma-informed psychosis care is, highlighting the need to build an evidence base. Further, a review by Han et al. (2021) concluded that there is inconsistent evidence to support trauma-informed intervention as an effective approach for psychological outcomes. Finally, Purtle (2020) noted that while staff training resulted in an improvement of staff knowledge, attitudes and behaviours related to trauma-informed practice immediately after training, it was less clear where these changes were retained over time and translate into client outcomes.

Trauma intervention requires a comprehensive approach which includes 'trauma focused' clinical services to address post trauma responses, as well as universal strategies for creating 'trauma-informed' service systems. This is in acknowledgement that both are needed to address the scope of the problem and its potential consequences (DeCandia et al., 2014). While the literature around trauma focused services is not considered in this review, there are examples of reviews undertaken recently (Lewis et al., 2020, Bisson et al., 2021).

5.3 Strengths and Limitations

Scoping reviews are an ideal tool to determine the scope or coverage of a body of literature and are useful for examining emerging evidence (Munn et al., 2018). They are particularly useful when a body of literature exhibits a complex or heterogeneous nature since they have a great utility for synthesising research evidence and are often used to map existing literature (Peters et al., 2015). However, while scoping reviews can provide an overview or map of the evidence, they have inherent limitations because the focus is to provide breadth rather than depth of information in a particular topic (Tricco et al., 2016).

The supplementary search focused on identifying reviews, a strength of undertaking a review of reviews is that it allows the creation of a summary of reviews within a single document (Smith et al., 2011). This review provides an effective summary of how a trauma-informed approach is utilised across a range of settings. Additionally, since the focus was on high income countries, the findings are applicable to the Welsh context however, the majority of the studies were undertaken in the US with less evidence of research undertaken in the UK.

5.4 The Need for Further Research

As noted, the term trauma-informed has been criticised for a lack of an agreed definition, clarity around its expected outcomes, and evidence of clinical or cost effectiveness (Bendall et al., 2021) Consequently, there is a need for service sectors to develop operational definitions of trauma-informed care that capture practices; this would result in more consistency in ongoing practice within sectors and less "re-invention of the wheel" in initiatives, such as the development of definitions, guidelines, and training packages (Bendall et al., 2021).

Additionally, there is a need for more rigorous and continued evaluation of the trauma-informed intervention approach and a need to build an evidence base in terms of effective implementation of a trauma-informed approach across a range of settings as well as the need for the development of established, validated and reliable instruments to assess outcomes.

Section 6: Conclusion

While trauma-informed care has become a familiar term, there is a lack of clarity in terms of its operating definition. This is recognised as a barrier to creating trauma-informed services as well as having an impact on the ability to consistently implement and evaluate such approaches.

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YOUTH JUSTICE BOARD 2017. In-brief: Trauma-informed youth justice.

Appendix A:
Table of Included Papers (Search 2)

Author/ Year	Study Type	Title	Setting	Population
Avery et al. (2021)	Systematic review	Systematic Review of School-Wide Trauma-Informed Approaches	School	School Pupils
Bailey et al. (2019)	Systematic Review	Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings	Out of Home Care	Children and Carers
Bendall et al. (2021)	Systematic Review	A Systematic Review and Synthesis of Trauma-Informed Care Within Outpatient and Counselling Health Settings for Young People	Health Services	Young People
Bloomfield et al. (2020)	Systematic Review	Trauma-informed care for adult survivors of developmental trauma with psychotic and dissociative symptoms: a systematic review of intervention studies	Mental Health Services	Adults
Branson et al. (2017)	Systematic Review	Trauma-informed youth justice systems: A systematic review of definitions and core components	Justice System	Young People
Bryson et al. (2017)	Realist Systematic Review	What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review	Mental Health Services	Young People
Bunting et al. (2019)	Rapid Evidence Review	Trauma-informed Child Welfare Systems-A Rapid Evidence Review	Welfare System	Children
Champine et al. (2019)	Systematic Review	Systems Measures of a Trauma-Informed Approach: A Systematic Review		
Cullen et al. (2021)	Systematic Review	Integrating Trauma and Violence Informed Care in Primary Health Care Settings for First Nations Women Experiencing Violence: A Systematic Review	Health Services	First Nation Women
Han et al. (2021)	Systematic Review	Trauma-informed interventions: A systematic review	Health Equity	Marginalised populations

Lee et al. (2021)	Systematic Mapping Review	A trauma-informed approach in Canadian mental health policies: A systematic mapping review	Mental Health	
Maguire and Taylor (2019)	Systematic Review	A Systematic Review on Implementing Education and Training on Trauma-Informed Care to Nurses in Forensic Mental Health Settings	Mental Health	Nurses
Mosley and Lanning (2020)	Narrative Review	Evidence and guidelines for trauma-informed doula care	Maternity and Perinatal Settings	Birth Assistants (Doula)
Nizum et al. (2020)	Systematic Review	Nursing interventions for adults following a mental health crisis: A systematic review guided by trauma-informed principles	Mental Health	Adults
Oral et al. (2020)	Systematic Review	Nationwide efforts for trauma-informed care implementation and workforce development in healthcare and related fields: a systematic review	Health Care	Professionals
Purtle (2020)	Systematic Review	Systematic Review of Evaluations of Trauma-Informed Organisational Interventions That Include Staff Trainings	Health Care	Professionals
Wilson et al. (2021)	Integrative Review	Can mental health nurses working in acute mental health units really be trauma-informed?" An integrative review of the literature	Mental Health	Nurses

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