‘We are on a journey’: implementing trauma informed approaches in Northern Ireland - Executive summary report

Implementing Trauma Informed Approaches in Northern Ireland

Executive Summary

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Abbreviations

ACE:	Adverse Childhood Experience
CYP:	Children and young people
DSM:	Diagnostic and Statistical Manual of Mental Disorders
EPPOC:	cross-Executive Programme on Paramilitarism and Organised Crime
HSC:	Health and Social Care
REA:	Rapid Evidence Assessment
PTSD:	Post Traumatic Stress Disorder
SAMHSA:	Substance Abuse & Mental Health Services Administration USA
SBNI:	Safeguarding Board for Northern Ireland
TIA:	Trauma Informed Approach
TIC:	Trauma Informed Care
TIP:	Trauma Informed Practice
V/C:	Voluntary and Community
YJA:	Youth Justice Agency

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Introduction

This Executive Summary synthesises the findings of an organisational review of the implementation of Trauma Informed Approaches (TIAs) in Northern Ireland (NI) commissioned by the Safeguarding Board for NI (SBNI) through funding by the cross-Executive Programme on Paramilitarism and Organised Crime (EPPOC). A full Report has also been produced and is available to download from the SBNI website. This introductory section clarifies adopted terminology and provides a summary of the study methodology. The following sections outline key study findings, organised via the core themes identified through the research process (i.e., TIA conceptualisation; TIA implementation; outcomes and perceived benefits; and implementation enablers, barriers and challenges). The Executive Summary concludes with the recommendations for the advancement of TIA implementation in NI.

A brief note on terminology and conceptualisation

The overarching term of **Trauma Informed Approaches (TIAs)** has been adopted in this review to encompass Trauma Informed Practice (TIP) and Trauma Informed Care (TIC) as a means to reflect the relevance of TIAs for organisations which do not provide frontline services as well as those which do.

TIA Implementation domains: In the interest of achieving relevance for this cross-sector TIA organisational implementation review, we have sought to merge and adapt the primary TIA implementation frameworks available, i.e., SAMHSA's (2014) ten implementation domains; Hanson and Lang's (2016) implementation framework for child welfare and justice settings; and the Trauma and Learning Partnership Initiative framework (Cole et al., 2013), which considered the development of trauma-sensitive schools. The following overarching framework is thus proposed encompassing three core implementation domains (organisational development; workforce development and support; and service design and delivery). It should be noted that these implementation domains are interlocking, with initiatives requiring attention in more than one domain to sustain change.

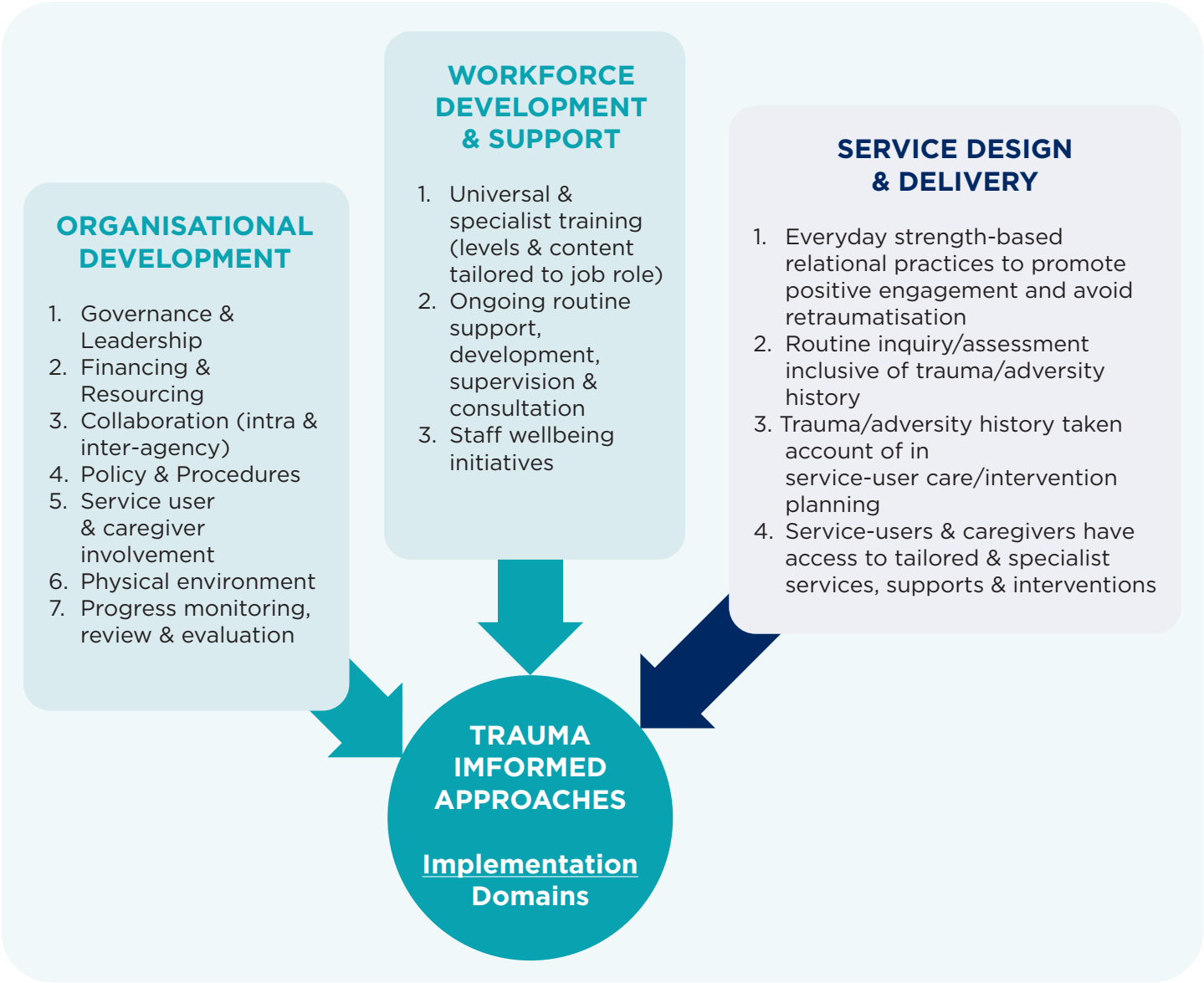
Within each overarching domain, there are specific implementation foci or indicators which require attention. However, not all implementation indicators will be relevant to every organisation, dependent upon their purpose and mandate. For example, the service design and delivery domain may have different resonance dependent upon whether the organisation is a frontline service provider or a strategic development, commissioning or governance body (See Figure 1).

1. Organisational development: this implementation domain includes a range of organisational activities to promote and embed whole system change. These include consideration of governance and leadership; financing and resourcing; review of policies and procedures; collaboration within the organisation and inter-agency collaboration; the physical environment; enhanced service user and caregiver involvement; progress monitoring, review and evaluation.

2. Workforce development and support: this domain is inclusive of different levels of training directly related to promoting staff understanding of the impact of trauma on service users/caregivers (and themselves), as well as ongoing routine support/ supervision/consultation to embed desired practice changes; staff wellbeing support is also considered in this domain.

3. Service design and delivery: this domain includes targeted activities to embed trauma-informed practices in an organisation's routine service delivery (e.g., an intentionality towards enhanced relational connection and engagement with service users/caregivers; reduced use of isolation, restraint, etc.); the integration of service users' trauma history into assessment, planning and intervention; and increased access to tailored trauma-focused services and interventions, where appropriate (i.e., specialist interventions for specific service user cohorts, such as group work or therapeutic modalities).

Figure 1: TIA Implementation Domains



Methodology Overview

The methodology for this organisational review of the implementation of trauma informed approaches in NI is based on an implementation science approach. This approach aims to bridge research-practice challenges in real-world settings, integrating consideration of both process and outcomes, to accelerate the development, delivery and sustainability of public health approaches (Theobald et al., 2018). Such methodology is in keeping with the Outcomes Based Accountability (OBA) approach, adopted by NI Executive in the Programme for Government, and integrated into previous SBNI TIP Project Review Reports.

This organisational review consists of four distinct components. Each component – detailed below – builds on the findings of the other elements. The outputs of all four components have been brought together in the following sections of this Executive Summary.

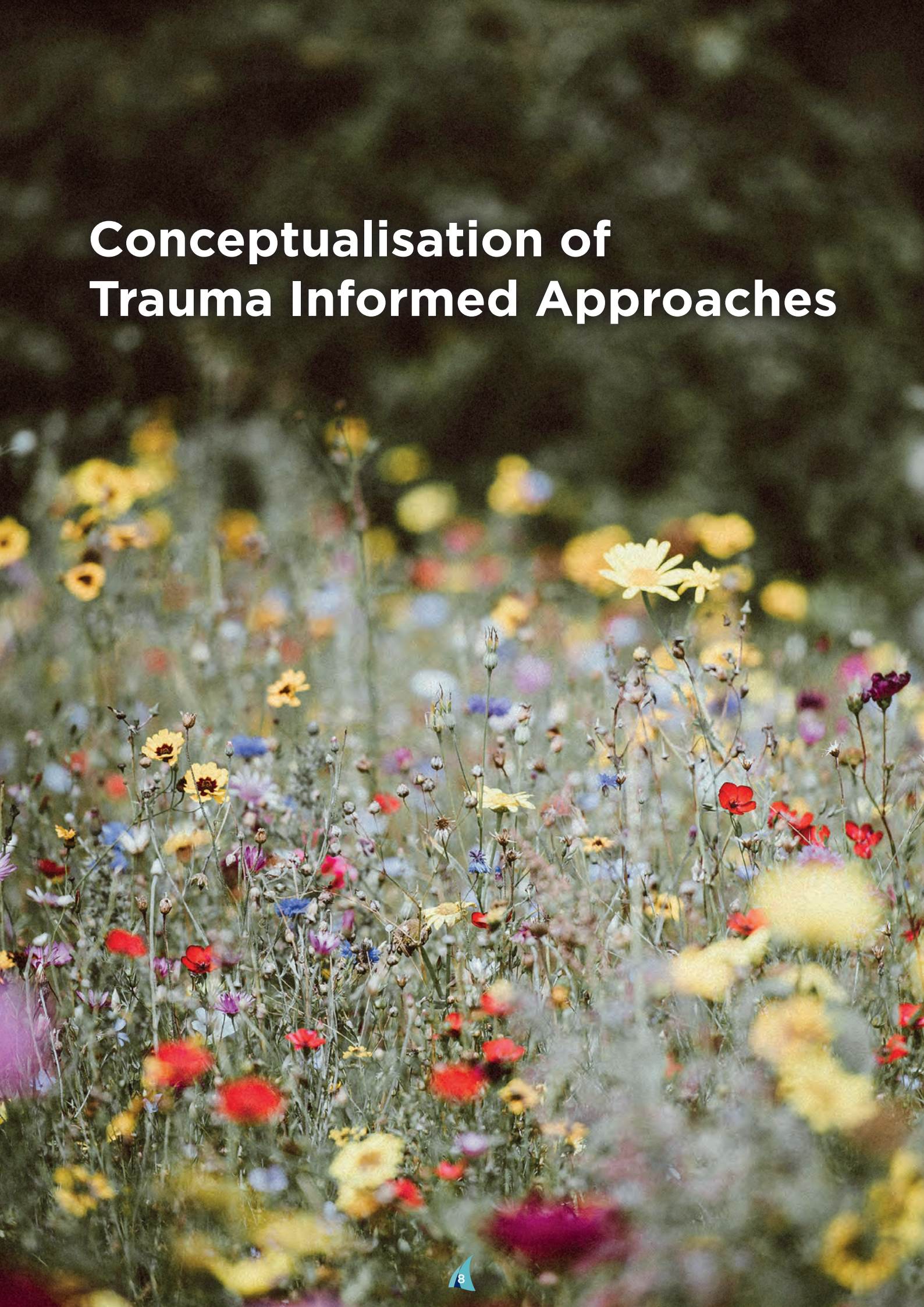
1. A **Rapid Evidence Assessment (REA)** of national and international literature reviews about the implementation of TIAs: This REA builds on the findings of the systematic evidence review conducted by QUB team members on behalf of SBNI in 2018-19 (Bunting et al., 2019a), identifying and synthesising data from publications in the intervening years. This REA focuses on the key components of effective TIA implementation to embed and sustain TI organisational developments in diverse real world settings; and methods for the evaluation of effectiveness. In total, **30 reviews** were included.

2. Progress Mapping of TIA implementation across key sectors and organisations in NI: This element of the organisational review involved a bespoke structured **online survey** to map the progress of SBNI member agencies, partners and other organisations and services in implementing Trauma Informed Approaches. In total, **53 organisational or service responses** were included for analysis. Survey submissions represented organisations and services within diverse sectors and settings, and of different sizes, target populations and geographical areas served. Both regional and non-regional services were represented although adult services were a clear minority of received submissions. Over half of the survey responses reported upon TIA implementation in large organisations of over 500 employees.

3. A **Strategic Overview** of senior professionals' assessment of TIA implementation in their sector or area of expertise: **Eight sector-specific/ regional focus groups with (a total of 52) senior professionals and managers** were conducted to establish an overview of leaders' assessment of TIA implementation to date in different sectors and the region as a whole, and views about the future advancement of TIAs in NI.

4. Four Mixed-Methods Case Studies of selected cross-sector TIA implementation initiatives in NI: This element of the review aimed to establish a comprehensive understanding of the implementation of Trauma Informed Approaches in four different organisational settings, enquiring about: *what was implemented; how it was implemented; what difference did it make and to whom; as well as perceived implementation enablers and barriers within the service context.* It sought to capture important organisational learning which could be applied to other service settings, helping provide a vision for ongoing TIA development. The four case studies were selected to include different types of service settings as well as statutory and voluntary/community organisations of different sizes, serving both child and adult populations. The four case studies were: **Fane Street Primary School** (Statutory, Education, child/family); **Youth Justice Agency** (Statutory, Justice, child/family); **Salvation Army and Thorndale Parenting Service** (Voluntary/Community, Social Care/Multiple Settings, child/family and adult); and **Belfast Inclusion Health Service** in the Belfast HSC Trust (Statutory, Health, adult).

Conceptualisation of Trauma Informed Approaches



In this section, we outline how Trauma Informed Approaches have been conceptualised, both in the international literature but also in Northern Ireland, according to the key informants to this study.

TIA Conceptualisation: The International Context (REA findings)

A number of included papers reviewed (e.g., Bailey et al., 2018; Bargeman et al., 2022; Phung, 2022) make explicit reference to a lack of definitional consensus on the use of terminologies such as trauma informed care (TIC), trauma informed practice (TIP) or a trauma informed approach (TIA). This absence of conceptual clarity was noted as potentially problematic in a previous child welfare TIC evidence review conducted by a QUB research team (Bunting et al., 2019b). Importantly, Bargeman et al. (2022) propose that to be able to define TIC, the term 'trauma' requires definition in the first instance. The most frequent definition of 'trauma' articulated in the papers reviewed is that by the Substance Abuse & Mental Health Services Administration USA (SAMHSA, 2014) which first developed the concept of trauma informed care (TIC). This definition clearly orientates toward individual-level experience but understands trauma impact to be wide-ranging, including many far-reaching consequences in people's lives and relationships:

"individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and 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"
(SAMHSA, 2014, p.7)

Indeed, the Adverse Childhood Experiences (ACEs) research (Felitti & Anda, 1997; Bellis et al., 2014) was frequently cited in the papers reviewed (e.g., Avery et al., 2021; Bunting et al., 2019; Jackson & Jewell, 2021; Mahon, 2022). This body of research has drawn attention to the prevalence of childhood adversity and the detrimental impact of multiple adversities on an individual's outcomes across the life course, critically influencing the emergence of the concept of TIC. It draws close attention to the relational nature of many adversities and the subsequent need for 'relational repair' in the helping relationship. Thus, every service user-provider interaction is considered an intervention with the potential for therapeutic benefit or indeed the risk of further harm (e.g., Frederick et al., 2021; Triesman, 2016).

There are a number of trauma-related terms in this field that are often, sometimes mistakenly, intertwined and conflated. A key distinction to be made is between **'trauma-informed'** and **'trauma-focused'** services or interventions. Trauma-focused or trauma-specific *services* commonly refer to those services that work directly with individuals who have had particular experiences known to be traumatic in nature (e.g., domestic violence, conflict related experiences etc.). Trauma-focused or trauma-specific *interventions* refer to particular treatments, such as therapies for specific trauma-related symptoms such as Post Traumatic Stress Disorder (e.g., EMDR, Trauma-CBT), or broader interventions that are tailored toward specific life experiences (e.g., group work with young people who have experienced domestic violence).

In contrast, **TIP, TIC and TIA**, which tend to be used interchangeably in the literature (Bunting et al., 2019a), "do not aim to elicit a description of trauma, nor address it directly" (Davidson et al., 2022, p. 3). Instead, the broader term of 'trauma informed' refers to **a whole-system organisational change framework** that aims to develop coherent cultures, policies and practices across systems of service delivery to enhance service user engagement and provide more effective care (Bunting et al., 2019a; DeCandia, 2014). 'Trauma-informed' approaches recognise that many service users, patients or clients of health, social care, education and justice services will have been impacted by potentially traumatic adverse experiences across their life course, and therefore a more responsive form of service delivery is required. SAMHSA (2014) thus articulated six key principles (safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; cultural, historical and gender issues), and four assumptions which should underpin all trauma informed service delivery. The assumptions are commonly referred to as the four 'R's:

"A program, organization, 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."
(SAMHSA, 2014, p.9)

Becoming a trauma-informed organisation is therefore considered as not a one-off activity (Lewis et al., 2023) or a "standalone intervention that can be delivered in silo" (Phung, 2022, p. 7). It is instead an organisational transformation process which requires systemic culture change and ongoing work at all levels of the organisational hierarchy, rather than simply training or screening (Lowenthal, 2020). As such, it is recognised that implementing a trauma informed approach is complex, as organisations and systems differ widely. It has also been described as "a framework to guide complex systems" (Phung, 2022, p.7). A TIA is therefore articulated as:

"a comprehensive, whole-system approach... that is theoretically grounded, developmentally informed and is flexible enough to be adapted to each organization's unique context"
(Lowenthal, 2020, p. 188).

Some of the literature reviews included in this REA explored how (and indeed whether) different research studies defined and operationalised TIC, TIP or TIA (Bargeman et al., 2022; Bendall et al., 2021; Davidson et al., 2022; Morton Ninomiya et al., 2023). In general, review authors found that many (even most) studies did not specifically define or operationalise the approach adopted, while others simply employed popular definitions. SAMHSA's (2014) guiding principles and core assumptions noted above appeared to be the most widely utilised (Bendall et al., 2021; Brown et al., 2022; Davidson et al., 2022).

TIA Conceptualisation in Northern Ireland

Similar to the REA findings, a certain level of concept confusion was evident in the empirical work undertaken in Northern Ireland. Indeed, strategic focus group organisational representatives noted that the terms of trauma and trauma informed care/practice/approaches were not uniformly understood. Some argued that these concepts had become so commonplace and diffusely understood that they had lost some of their usefulness, becoming relegated to a 'buzzword' or 'the latest thing in fashion' with limited meaning and the potential for misunderstanding. Participants across the study components reported concern that TIAs risk being perceived as tokenistic in the absence of clarity.

"Some people maybe feel that the term is just the latest thing that's in fashion, it's actually maybe lost its meaning, it's been bandied about for a long time, but actually doesn't mean anything."
(Cross-sector/Regional Focus Group)

Strategic focus group and survey respondents commonly pointed to a perceived lack of relevance of TIAs in many adult settings:

"ACEs are viewed as being only for CYP [children and young people] services... [there is] difficulty recognising the impact that this has across the lifespan exacerbated by traumatic events/distress in adulthood."
(Survey submission - Frontline organisation, HSC, Statutory)

This challenge was reiterated by participants from non-frontline organisations (such as strategic development, advisory, governance and commissioning organisations):

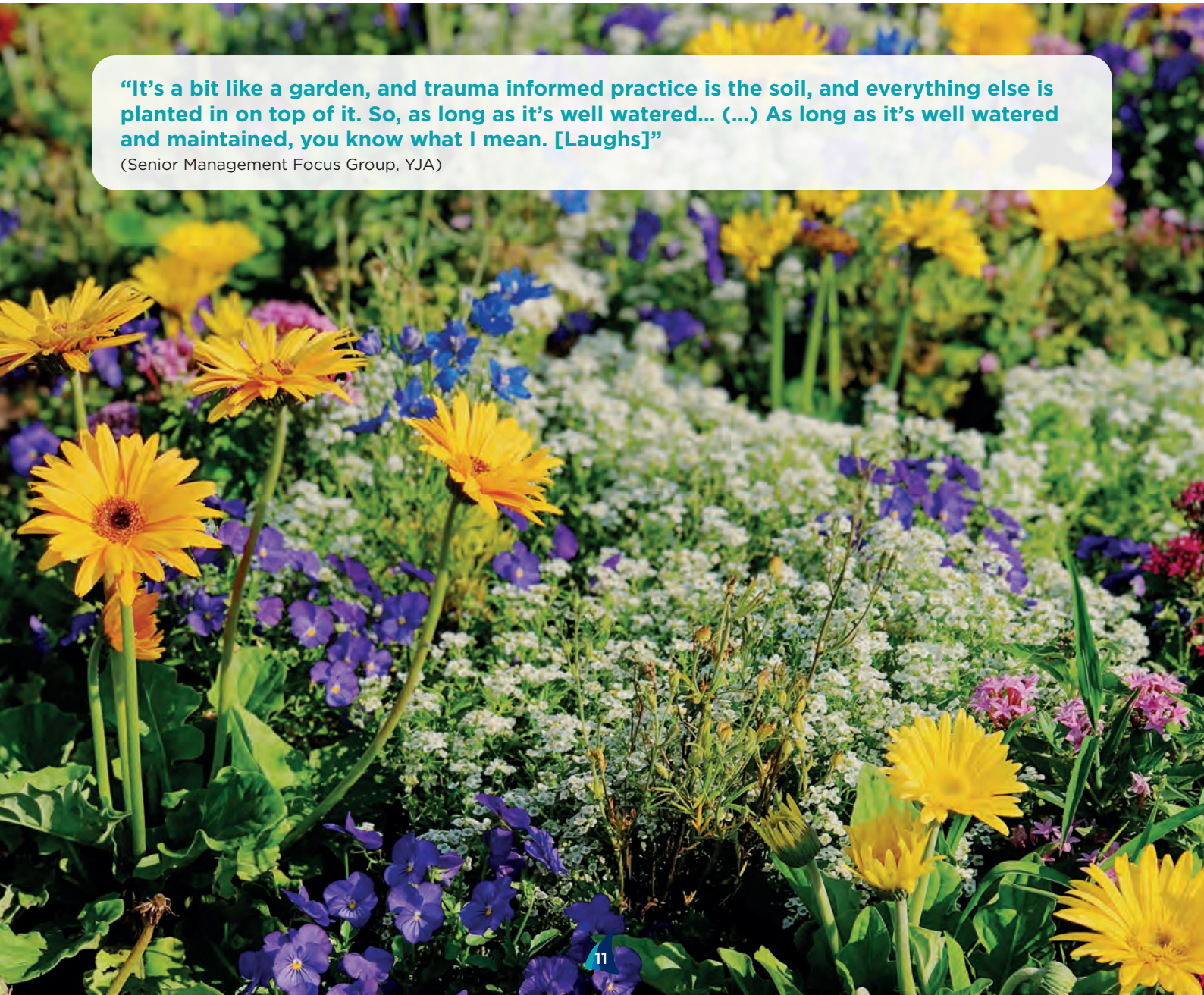
"[It] sounds superficial but the 'branding'. Often our experience is that people assume that 'trauma' refers to a very specific, niche set of roles as opposed to something systemic - this is especially the case when it comes to organisational design. The focus seems to be on frontline delivery."
(Survey submission - Non-Frontline, Multiple settings, Statutory)

In addition, many respondents across the different study elements argued that practice in their own settings had already been trauma-informed before the language or concept was introduced. In such cases, a TIA was often equated with compassionate, nurturing or relationship-based practice or community engagement. Similarly, it was expressed that a number of current practice initiatives (such as restorative practice; reducing restrictive practices), while not specifically named as trauma-informed, were underpinned by similar principles.

"There are HSC areas where policies such as reducing restrictive practice, MCA [Mental Capacity Act] legislation etc. are very pertinent, and therefore adhered to. Whilst this is TIP, I don't think that they would be perceived under that heading."

(Survey submission - Frontline organisation, HSC, Statutory sector)

In this regard, case study senior managers used interesting analogies (i.e., a garden and a coat rack) to describe how trauma informed principles acted as an underpinning/overarching framework for the many ways TIAs were actualised in diverse service settings. Such analogies were thought to help organisations, managers and practitioners understand the rationale behind aligned change initiatives across an organisation, from human resources to estate management, to policy development and frontline practice.



"It's a bit like a garden, and trauma informed practice is the soil, and everything else is planted in on top of it. So, as long as it's well watered... (...) As long as it's well watered and maintained, you know what I mean. [Laughs]"

(Senior Management Focus Group, YJA)

"So the way that I've always... described [TIP to staff], is almost like the principles are like a coat rack. This is the thing that you've already done and you've already been wearing. This is just something to hang your coat on now. So you've got names and phrases and understanding (...) So it gives people a sense for... trauma informed practice (...) this is not something that's overwhelming and overloading you (...) this is something that gives you a sense of relief. That's the thing that I'm doing. And when I do that now, I am much more mindful of it because I can give it a name... [it's] meaningful(...) ... [practice] becomes much more intentional."

(Senior Management Focus Group, Salvation Army)

Finally, across the organisational survey and strategic focus group components of this review, TIAs were commonly articulated to have particular resonance to the NI context, given the collective history of political conflict and its pervasive impact.
Thus, the need for further clarification was proposed to ensure a shared understanding of TIA implementation as credible whole system transformation. Specific issues included:

- the distinction between trauma, trauma-informed and trauma-focused services;
- an understanding of how TIAs take account of structural issues (e.g., poverty), social inequalities, and their intersection (e.g., gender, race, ethnicity, disability);
- the relevance of TIAs for all organisations engaged in service design, delivery and policy development including the adult sector and non-frontline services; and
- how TIAs align with other strategic imperatives (e.g., restorative relationship-based practices, service user/carer involvement, early intervention, reducing restrictive practices, staff wellbeing and Outcomes Based Accountability).

Implementation of Trauma Informed Approaches

In this section, we give an overview of how TIAs have been implemented to date in NI, in respect to the three core implementation domains, identifying areas of progress as well as gaps. See Figure 1 for rationale and further information regarding adopted TIA implementation domains (i.e., organisational development; workforce development and support; and service design and delivery).

TIA Implementation: The International Context (REA findings)

The international literature indicates that effective TIA implementation demands multiple strategies used over longer time periods in order to embed sustainable changes in the broader service system, across organisational culture and policy (Fernandez et al., 2023; Lowenthal, 2020).

"Meaningful change requires ongoing work and the participation of all levels of the organizational hierarchy to be sustained, especially in complex service systems where change is difficult and where the dominant service delivery paradigm may be incompatible with TIC principles." (Lowenthal, 2020, p. 184).

TIA Implementation in Northern Ireland: Overview Progress

TIAs are currently being implemented across all sectors (statutory, voluntary and community) and diverse service settings (education, health, justice, social care, multiple settings) in NI. These include regional, Council-area, Trust-wide and more local services. However, implementation progress was found to vary widely across the organisations and agencies that participated in this study.

For instance, while TIA initiatives were reported in both child and adult services, organisations and agencies serving children appear to have been implementing TIAs for a longer period and to a larger extent than adult services. The relevance of TIAs to the adult sector was not thought to be universally recognized, with implementation perceived as lagging behind.

Survey findings indicated that trauma-informed implementation initiatives are currently being undertaken in different types of organisations across NI, including frontline services and non-frontline strategic development, support, advisory, governance and commissioning organisations. Frontline service implementation included whole-organisation implementation as well as specific projects or services within the wider organisation. Despite this breadth of implementation, it was noted that TIA implementation to date, in NI, has been largely associated with frontline service provision, with further work thought to be required to conceptualise and support implementation in non-frontline organisations. Some implementation domains and indicators were more likely to be deemed as not relevant for non-frontline organisations.

In general, whole-system transformation was recognised by study participants (survey, focus groups and case studies) as challenging to achieve, irrespective of the size of the organisation. The additional challenges of implementing TIAs across large, complex multi-site/disciplinary/departmental organisations and systems of care (e.g., Health and Social Care Trusts, large voluntary sector organisations with multiple services) were clearly acknowledged.

Study participants from larger organisations spoke of a range of strategies adopted to assist with this task. These included the development of pilot projects, which could help envision what trauma informed change looked like, and from which organisational learning could be cascaded; building strategic connections with aligned services or initiatives across the wider organisation; and the development of implementation structures and processes that could help people 'join the dots'.

The analogy of a 'journey' was repeated across all sector-specific focus groups and case studies, when referring to TIA implementation progress, noting the need for constant review and revision in light of learning:

"... our strap line is we're on the journey to becoming a trauma informed organisation. And I do think it's a journey. I don't think it's a destination. I think... your staff teams change, your management changes, other priorities come in and you're constantly having to revisit what we've learned... You know, you've implemented something. You think that's grand. Then you realise, actually... is anybody actually doing what we've supposed to have implemented? You're going back. You're reminding people, you're building in mechanisms to evaluate and review, and then... You're going back again, so it's a constant journey."
(Senior Management Focus Group, YJA)

Key messages for successful TIA implementation by service leaders included:

- the central importance of message consistency across the service system, recognising that initiatives themselves are context-dependent and thus likely to vary;
- promoting such message consistency was thought to demand building connections with aligned initiatives across the organisation;
- developing a shared leadership vision;
- having a detailed knowledge and understanding of the service system, and thus a sense of what steps are required for successful implementation in a particular agency context;
- making a small start (somewhere) and building on these foundations to cascade the learning;
- understanding implementation as a 'journey' with the need for constant revision in light of learning; and
- recognising the central importance of staff involvement and support throughout.

Organisational Development: The International Context (REA)

In the wider international context, Organisation Development components of TIA implementation (commonly thought to include governance and leadership; financing and resourcing; policy and procedures development; service user/caregiver involvement; physical environment; intra and inter-agency collaboration; progress monitoring and evaluation) are considered to be of primary importance to effective TIA implementation (Fernandez et al., 2023). Thus, as previously mentioned, multiple strategies are required over time to embed sustainable change in the broader service system.

Successful TIA implementation has been specifically linked to reviewing and amending organisational **policies and procedures**, following recommended TIC guidelines and adopting refinements, such as service user involvement, alongside activities within other domains (e.g., ongoing staff training) (Oral et al., 2020).

Leadership buy-in has also been shown to be required to make meaningful organisational changes (Lowenthal, 2020; Mahon, 2022; Phung, 2022). Indeed, securing leadership buy-in was identified as critical in a range of studies within various reviews in the health sector (Bendall et al., 2021; Brown et al., 2022; Huo et al., 2023), the child welfare sector (Bunting et al., 2019b), and the education sector (Phung, 2022; Wassink-de Stigter et al., 2022). This was reported to be achieved through offering initial training to directors and senior managers, establishing implementation teams and local champions (who mobilised resources), developing implementation plans, and examining organisation readiness (Bunting et al., 2019b).

Financing and resourcing were mentioned as key components of successful TIA implementation within the organisational development domain. In fact, in many reviews, insufficient budget was seen as a central barrier to implementation (e.g., Mahon, 2022).

Intra and inter-agency **collaboration** was also deemed a fundamental element of organisational development which is integral to successful TIA implementation in different sectors (e.g. Avery et al., 2021; Bendall, 2021; Brown et al., 2022; Mahon, 2022; Wassink-de Stigter et al., 2022).

Following on from the collaboration element of the organisational development domain, some reviews also identified **service user and caregiver involvement** or the involvement of wider stakeholders through co-production (in the planning, design and delivery of services) as a key implementation activity in various sectors (Mahon, 2022), including the health sector (Bendall et al., 2021; Lewis et al., 2023), the child welfare sector (Bunting et al., 2019b), and the education sector (Avery et al., 2021).

Reviews exposed a general lack of **progress monitoring and evaluation** regarding TIA implementation, with a noted absence of measuring the outcomes of TIA initiatives (particularly clinical outcomes) and the impact on service users and families (Mahon, 2022). Similarly, there was less mention of consideration around the **physical environment** in the literature reviewed.

Organisational Development in Northern Ireland

Analysis of organisational survey responses indicated that the indicators within this implementation domain (see Figure 1) with most progress reported were 'Collaboration' and some elements of 'Leadership and Governance'. In contrast, 'Progress Monitoring, Service Improvement and Evaluation', and 'Resourcing' were those with least reported progress. 'Policy and Procedures', and 'Service User Engagement and Involvement' indicators were reported as more progressed within frontline organisations and projects/services than non-frontline organisations.

Survey responses as well as senior managers and professionals across the sector-specific strategic focus groups reported a general embracing of trauma-informed principles, with different levels of **governance and leadership** buy-in noted. Many described the development of some form of implementation teams and structures. However, progress within this implementation domain was noted to have been constrained by a range of barriers, including the lack of funding and prioritisation often afforded to TIA implementation within both statutory, voluntary and community sector organisations. The need for greater integration with governmental strategic priorities was articulated by many.

"Whilst there is a TIP leadership group, there is no finance/commissioning attached. This is a challenge as embedding TIP into a large organisation requires commissioned posts to ensure... that implementation can occur. The staff involved are enthusiastic and see the value/need for the workforce to be trauma informed however they are promoting TIP in addition to completing the other roles/ responsibilities they hold."

(Survey submission - Frontline organisation, HSC, Statutory)

Progress was reported in providing more trauma-informed service delivery across different sectors, with some 'excellent pockets of practice' acknowledged in organisational survey submissions, the sector-specific focus groups and the case studies. However, the development of a more strategic commitment by way of whole-system trauma-informed **policy development** was seen as the next priority for many study participants. Given the wide-ranging nature of the task in hand to achieve both organisational and regional consistency, it was acknowledged that there was a need for systematic and incremental implementation as well as additional context-relevant support.

Participants across all study elements indicated that progress had been made in some areas regarding **service user and caregiver involvement** in service development. A number of organisations and service leaders in different settings spoke highly of the creation of Youth Forums, Student Councils and other participatory practices (e.g. 'talk boxes') with children and young people, or enhanced consultation with adult service users. However, many noted that there remained 'much work to be done' in this area:

"...there is much progress ensuring that clients and their families are involved and have the opportunity to contribute to the organisation...However, there is still much work to be done to ensure that clients/service-users have a wide range of opportunities to safely influence the way we operate and what we can offer."

(Survey submission - Frontline service, Health, V/C sector)

While there was a clear aspiration toward working more **collaboratively across agency and operational boundaries**, many survey respondents and focus group senior managers and professionals lamented that in practice this was difficult to achieve for a range of reasons, including a sense that everyone was 'looking after their bit'. Case studies reported that where inter-agency and multidisciplinary collaboration had been successfully achieved (e.g., the co-location of CAMHS practitioners in area teams; family support services provided in the school setting; outreach work with A&E Departments), it was perceived to have brought positive outcomes for both service users and staff.

"[collaboration is] present across the organisation but requires improvement internally and externally with other agencies and departments to avoid duplication firstly but also to ensure the right support at the right time. This obviously has its pitfalls - as I am sure the protective nature of service delivery is hindering a more robust cross sector / cross service approach."
(Survey submission - Non-Frontline, Education, Statutory)

"We have this vision of trying to not work in silos, but on the ground, it's really difficult to not do it,(...) You're trying not to do it, but everyone is sort of working in their own operational area... I wasn't even aware of those things... and how they interface. So that's been a bit of a frustration."
(HSC Trusts Focus Group)

Consistent with findings in the international literature, the **physical environment** was one element of TIA implementation that some sector-specific focus group participants felt had been largely overlooked to date, but which had the potential to enhance engagement. Some acknowledged that the buildings where staff worked and individuals received a service were *'absolutely not trauma informed'* (Cross-sector) and *'far from therapeutic'* (HSC Trusts). Some environments were variously described as 'horrendous', 'dire', 'not pleasant' or 'not fit for purpose' with acknowledgement that the environment can be traumatising in and of itself.

Some of the case studies spoke of how relatively small changes to the physical environment had been a good starting point on their implementation 'journey', making visible for both service users and staff the transition toward trauma-informed service delivery. Even 'small' physical changes were reported to make a huge difference to both staff and service users, with staff and service user consultation and involvement noted as an important part of the process.

"... the physicality of the offices.... [they] have definitely changed and it does feel warmer... (...) that's where we would see the young people, they like that room. It's just softer. There's pictures. There's, you know, fidget toys. There's...food as well in the room, and it's just a nicer environment."
(YJA Staff Focus Group)

"...what this has really taught us is that actually with intentionality, if you really seriously focus on the physical environment (...) that people either work in or come to live or receive their support... the benefits of that, I think, are even bigger than we had anticipated. (...) small things really matter. And this is just a small building, it's not purpose built. We just did a little bit of refurbishment too, but we did it with a lot of careful consideration and consulting with people (...) it really shows that actually with a little money, but with the right intention that actually a place and a space, the physical environment can make a massive difference and it can be... (...) an easy starting point."
(Salvation Army Staff Focus group)

Survey, focus group and case study participants identified important limitations to the **progress monitoring and evaluation** of trauma informed initiatives achieved to date in their service or sector. A fundamental question posed by several participants noted the evidence gap with regard to the added value of the training investment, particularly in relation to the service user experience. Relatedly, robust evaluation appeared to be lacking and noted as an area of priority to explore moving forward. Aligned with this aspiration was an acknowledgement by many of the need to re-think the concept of outcomes with regard to relevance and feasibility. For example, several participants noted that evidence of 'less trauma' was neither feasible nor the most appropriate measure. Others noted the usefulness of the Outcomes Based Accountability (OBA) framework but pointed to the need for further critical engagement with service users as an important element of this debate.

Workforce Development and Support: The International Context (REA)

Adequate **workforce training** is generally regarded as the foundation for the effective delivery of trauma-informed services (Bargeman et al., 2022) or the first step for an organisation to become trauma-informed (Purtle, 2020). Introductory TIA training to all staff has been recommended to precede full implementation (Mahon, 2022). However, it is also recognised that workforce training alone, especially when it is short and one-off, is insufficient with regard to embedding lasting practice change and thus has limited impact on its own (Lowenthal, 2020; Wassink-de Stigter et al., 2022).

In their review of TIA implementation in multiple sectors, Jackson and Jewell (2021) found that TIC training practices varied significantly across sectors, despite arising from the same foundational context. Workforce development initiatives mentioned in the literature reviewed ranged from a single training session, train-the-trainer sessions to the provision of regular supervision and the delivery of ongoing training (e.g. Huo et al., 2023). In Purtle's (2020) review of staff training in multiple sectors, most studies did not identify a specific training curriculum, and considerable variation was found in the amount of information provided regarding the content of the trainings and their approach.

In some reviews, the way staff training is delivered was identified as either an enabler or a barrier to successful TIA implementation. Common elements of workforce development identified as having a positive impact included:

- ongoing staff training (including booster sessions) and development (as well as follow-up support), as opposed to single, one-off sessions (Bunting et al., 2019b; Huo et al., 2023; Jackson & Jewell, 2021; Wassink-de Stigter et al., 2022);
- delivering training to a variety of staff at all levels of the organisation (Huo et al., 2023);
- practical learning elements (e.g. role plays) (Huo et al., 2023; Maguire and Taylor, 2019);
- including peer workers or staff with lived experience in the training delivery (Maguire & Taylor, 2019);
- training focus and structure to be delivered in partnership with the organisational leadership (Avery et al., 2021);
- space and time for staff to debrief and discuss difficulties on a regular and ongoing basis (Avery et al., 2021);
- a flexible format tailored according to needs (Huo et al., 2023);
- embedding training into orientation for new staff and making training compulsory (Huo et al., 2023); and
- on-site delivery (Huo et al., 2023).

For example, Avery et al. (2021, p. 392) argued that:

"enabling teachers to be active participants in their training along with encouraging staff to express the challenges and systemic barriers they experienced, showed benefits as part of the intervention design."

However, this implementation domain is not just about the training. Although mentioned less frequently in the studies in the included reviews and probably requiring additional focus (Bunting et al., 2019b), the critical importance of **ongoing workforce development and support** was acknowledged (Bargeman et al., 2022; Bunting et al., 2019b; Mahon, 2022), with increasing recognition that secondary or vicarious trauma among frontline staff needs to be properly addressed (e.g., Bargeman et al., 2021; Mahon, 2022). While 'self-care' is noted as an important element of TIA implementation in some literature, it has also been argued that "the full onus on individual staff members to support their well-being in light of the known effects of secondary trauma is not sufficient" (Thomas et al., 2019, p. 447).

Workforce Development and Support in Northern Ireland

The organisational/service survey findings indicated good implementation progress in the workforce development and support domain, particularly in terms of staff training. **Workforce development** was also central to most sector-specific focus group discussions, where it was identified as one area that has seen significant progress in NI. Training, and in particular universal training, was generally perceived by participants (in sector-specific focus groups but also in case studies) as key to TIA implementation, with most commenting that the training had been particularly useful in providing a greater awareness and sharper focus on childhood adversity and trauma-related issues among all levels of employees. This was perhaps unsurprising as many reported training as the first step to introducing a trauma-informed frame of reference to their workforce. It was also noted as the central objective of the first phase of the SBNI TIP project.

"Our focus has been on the workforce development. (...) that's the big one really, in terms of the direction of travel, largely because of the size of the organisation, it's where... you need to build capacity in order to be able to infiltrate some of those other domains."
(HSC Trusts Focus Group)

An important strength of the training to date in NI appears to have been the multiplier effect. While some noted an ongoing need for universal training for all levels of employees, several sectors had invested in cascading training through the organisation by adopting approaches such as train-the-trainer, thus extending the reach of initial awareness-raising efforts in different ways.

In terms of advancement, participants across the study elements recognised the need to be able to choose flexibly from a suite of universal and more *specialist training programmes* which are culturally appropriate to NI, but also tailored to the skill-level, experience and context of staff taking part.

"People get frustrated because they feel that's too basic for me or (...) do I really need to know... all of this in my job as a shop manager or, (...) a business services person? So I think that tiering and that tailoring to need and expertise and knowledge is really important."
(Community & Voluntary Sector Focus Group)

As well as utilising the TIA training resources developed by the SBNI TIP project to good effect, a number of organisational/service survey submissions and case studies reported how they had independently sourced additional training that was tailored to their context or a specific need, e.g., trauma-informed inquiry, trauma-informed supervision. Such external training was, on occasion, accompanied by follow-up sessions and ongoing leadership consultation. In addition, some staff had been encouraged to develop specialist skills in particular areas e.g. systemic practice and family work, alternative therapies etc.

Increased attention to **workforce support and wellbeing**, in part influenced by the COVID pandemic, was an area where many participants across the different elements of this study thought some progress had been made regionally. However, it was also argued that there remained significant work to be achieved, particularly in light of critical workforce recruitment and retention challenges reported across sectors and settings in NI.

Staff were frequently appreciated as a critical and 'valuable' resource for TIA implementation, with 'investment' in staff wellbeing and involvement thought to reap rewards for the organisation as a whole and in service user outcomes.

"If we're going to influence the ethos and the environment and the culture within the school, we need to look at it... for everybody within the school. And starting off with staff emotional health and wellbeing... because if we don't have staff who are emotionally intelligent... who feel valued and feel part of the ethos and whatever, we're not going to get anywhere with our children and young people."
(Education Focus Group)

Acknowledgement of staff personal adversity, as well as the challenges of the work itself in many frontline services, led organisations to consider the critical importance of workforce supports when embedding a trauma-informed, 'compassionate and caring' work culture for staff as well as service users. In this regard, participants across the study elements noted significant development in the increased organisational offering of workforce wellbeing initiatives, e.g., external short-term counselling, mindfulness/yoga classes.

"Staff are considered our most valuable resources... As an organisation, [we] rolled out trauma informed practice to all staff at its basic level, however [this service] operate at a level of trauma responsive practice to enable us to contain the levels of vulnerability that children and their family present."
(Survey submission - Frontline Project/service, Health, V/C sector)

However, while some progress was perceived to have been made in the more general staff wellbeing domain, more limited progress was reported in the development of consistent workforce support mechanisms, such as supervision, reflective practice or critical incident de-briefing. Where progress had been made, participants spoke of structured reflective practice with external facilitation; enhanced shift handovers; an 'open door policy' for staff access to senior managers or colleagues; as well as specific efforts to build supportive collegiate relationships and forums where more challenging experiences could be explored.

Overall, however, there was a general acknowledgment across all study elements that there was still 'a lot to do' to address the impact of the work on the worker, and the potential for vicarious trauma in many sectors and settings.

"...the focus of my work so far has been looking at providing better debriefing for frontline staff...we're sort of providing some preventative and buffering support, but ... how do we develop that further, because they don't have the same... supervision arrangements."
(HSC Trusts Focus Group)

Integrating trauma informed principles into staff grievance and disciplinary processes was recognised by some senior respondents as an area in need of further development.

Service Design and Delivery: The International Context (REA)

Many studies in the included reviews, especially within the child welfare sector (Bunting et al., 2019b) and healthcare sector (Bendall et al., 2021; Brown et al., 2022; Lewis et al., 2023; Oral et al., 2020), explored the implementation of **universal screening** processes (as a means to understand a person's history of adversity/ trauma and/or mental health conditions/ difficulties). While trauma screening had been considered an essential part of TIAs within multiple sectors, there appears to be wide variation in how it is conducted (Bendall et al., 2021). Various difficulties and barriers to screening have been identified, including resource allocation, time constraints, utility and appropriateness of screening instruments, as well as staff resistance due to not feeling suitably prepared and trained (Mahon, 2022). Staff were reported to be often reluctant to undertake trauma screening as they did not feel suitably prepared or qualified and were afraid to 'open a can of worms' (Mahon, 2022; O'Dwyer et al., 2021). It was reported that even when staff in clinical settings were confident in screening service users, some indicated that they did not know how to respond after a disclosure of trauma (Maguire & Taylor, 2019). As Bargeman et al. (2022) argues, across all systems, staff are resistant to trauma screening in the absence of a clear protocol on how to respond and if they perceive the system to be unable to respond appropriately by providing effective and accessible therapeutic services.

Trauma-focused therapeutic interventions were reported in many of the studies in the reviews included in this REA, particularly in health and child welfare settings. However, reviews also highlighted the importance of enhancing **everyday relational practices** as central to improving service user outcomes across settings. For instance, in schools, punitive reactive measures were replaced with restorative, strengths-based and skill-building approaches, which was strongly supported by evidence-based literature (Avery et al., 2021). In healthcare settings, Morton Ninomiya et al. (2023, p. 14) in their review of services and programmes supporting pregnant and parenting women using alcohol during pregnancy, showed how a sense of safety and trustworthiness (i.e., key TIC principles) was cultivated and achieved "when program and service staff were consistently non-judgmental, welcoming, and respectful with women accessing supports". The authors also found evidence of the use of routine strengths-based and skill-building approaches, with programmes being flexible around women's lives, for example not penalising them for missing appointments or offering to meet service users in their own homes or somewhere they felt comfortable. Indeed, approaches, programmes or services that included service user choice, in additional to everyday relational practices were found to be highly effective in terms of service user outcomes.

Thus, in some reviews, how services were provided was acknowledged as a crucial element of TIA implementation. It was recognised that implementation in this service design and delivery domain could be achieved via holistic care of service users and their families, addressing need through relationship-based practice, as well as additional screening and referral to specialist services (Oral et al., 2020).

Service Design and Delivery in Northern Ireland

Organisational survey responses reported progress in the Assessment and Intervention domain, particularly across frontline projects and services (and to a lesser extent frontline organisations), and with regard to integrating knowledge of service users' history of trauma and adversity into service planning and delivery. Many sector-specific focus group senior professionals noted how TIA implementation in their organisation/service had brought renewed energy to frontline practice development, seen as the 'bread and butter' of everyday engagement. A general shift towards 'more holistic and meaningful understanding' of service users' lives and behaviours was also observed.

Across all study elements, and in particular the case studies, a diverse range of (sometimes small but nonetheless) significant service delivery changes were articulated, which were intended by participants to embed an enhanced relational stance in their everyday practice:

Enhanced positive and holistic engagement with service users and their family/network – practices included efforts to extend a 'welcome' by embedding 'meet and greet' in everyday routines; explicitly recognising service user strengths or appreciating challenges; meeting people 'where they are at'; 'seeing the person, before the problem' and taking time to get to know the service user; meaningful efforts to build relationships with service users based on 'safety', 'trust, 'empathy', 'compassion', 'honesty' and 'transparency' regarding involvement in decision-making; restorative practices that focused on emotional regulation and relational repair rather than punitive measures.

Enhanced family or network engagement and support was spoken of as an essential part of developing a holistic understanding of children or adult service users 'as a whole' and ensuring meaningful involvement with the important people in service users' everyday lives over time.

Enhanced assessment (and enrolment processes in school settings) with greater appreciation and integration of service user (and family) life histories or 'back story' was used as a mean to understand presenting behaviours or challenges, and plan useful intervention. This included the adoption of a 'children first' philosophy in youth justice settings.

Enhanced service user support was reported by some organisations/services, with staff members trained to provide a wider range of interventions to service users in-house or on their premises (such as enhanced family work, theraplay or access to alternative therapies).

Enhanced service user advocacy had emerged as a significant component of collaborative engagement with other involved agencies or professionals, informed by this appreciation of the service user and family 'journey'.

Enhanced service user/caregiver participation was also reported by a range of organisations/projects, with intervention tailored toward service user goals (not provider goals) and some level of involvement in service development.

Enhanced outreach and service collaboration was reportedly used to ensure service users' needs were better met. This meant offering flexible and creative ways to engage, and paying attention to additional needs (such as neurodivergence, learning difficulties, language skills, cultural differences) - e.g., 'going out to' service users; delivering services in alternative settings; using school settings as a hub for other service provision.

Early intervention was reported by many services as a means to promote better outcomes for service users, intervening before crisis or escalation, and diverting people (where appropriate) away from the justice system.

Enhanced record-keeping and information-sharing meant that significant thought was being given to what was recorded and how, in the understanding that language constructs particular narratives. Case study participants spoke of writing reports clearly and 'compassionately' while holding the service user in mind, in the knowledge that these might be shared with other involved agencies and the service user themselves.

However, there were perceived challenges to these practice advancements. While some organisations/services spoke of extending their service offer, ensuring timely **access to external trauma-focused services**, when appropriate, was a reported challenge in this implementation domain. Participants across study elements spoke of inadequate provision and lengthy waiting lists for some specialist services or therapeutic support in NI.

"The only disadvantage (...) is identification without any support. If there's high levels of people going... you're all really traumatised. Everybody's got the language but (...) there's nothing done about it."

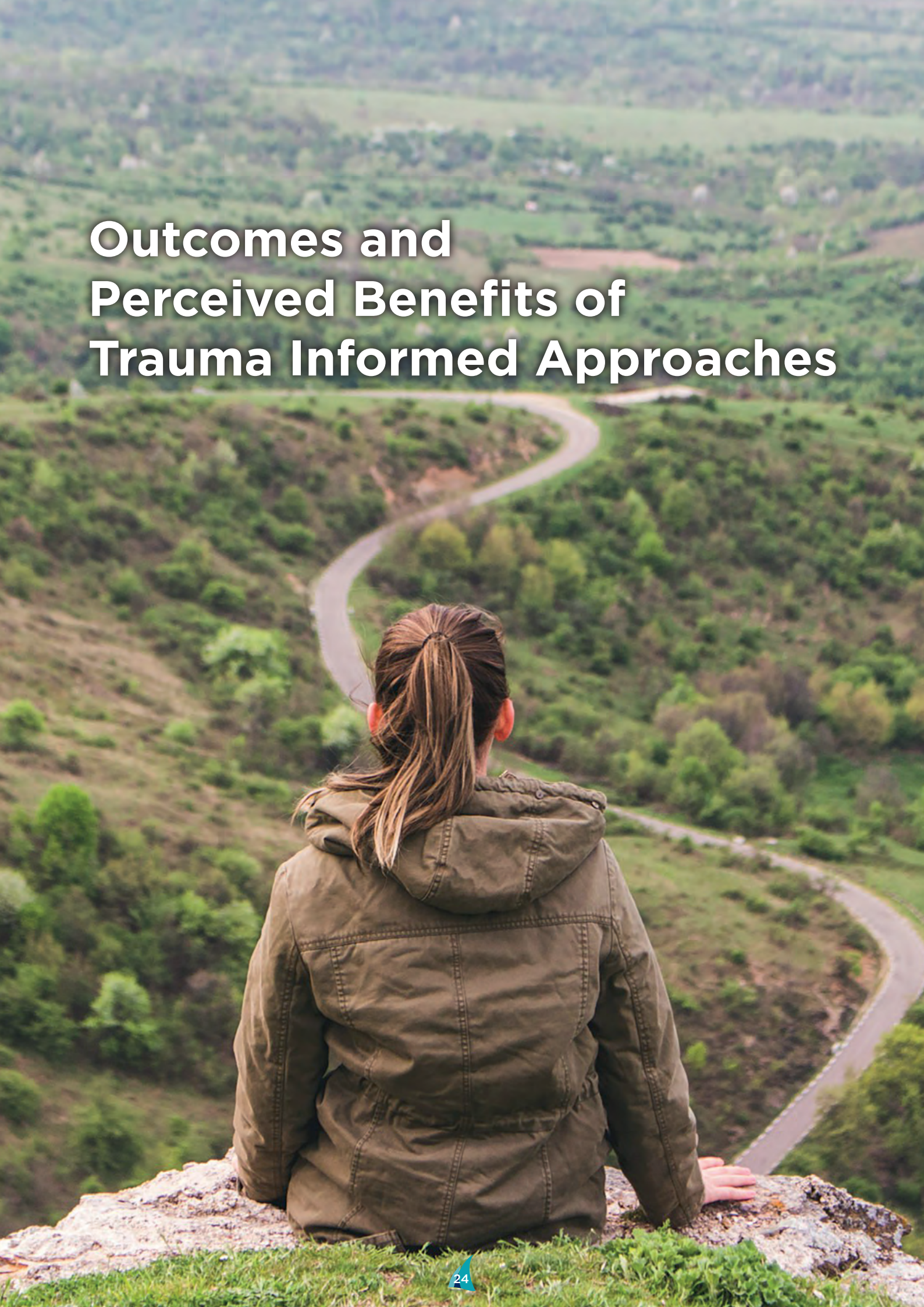
(HSC Trusts Focus Group)

In addition, there was clear acknowledgement that further focused efforts were required regarding **practices that may retraumatise** in many service settings.

"A lot of (...) the work of my team is... driven by recognising the impact of trauma on victims and also that the justice system itself can be traumatic to victims and witnesses. So it's about actually... trying to take the trauma out of the system and out of the system structures."

(Department & Regulators Focus Group)

Outcomes and Perceived Benefits of Trauma Informed Approaches



In this section, we discuss the outcomes and perceived benefits of TIAs as reported upon in the international literature (REA findings) and the NI fieldwork undertaken as part of this organisational review of TIA implementation (i.e. organisational/service survey, sector-specific focus groups, case study research). A summary of the combined findings is presented in Table 1.

Table 1. Outcomes and Perceived Benefits of TIAs

TYPE	SPECIFIC OUTCOMES (REA)	PERCEIVED BENEFITS (NI)
Service user & family/ caregiver	Service user satisfaction	Better service user experience (i.e. better-quality service, feeling valued/heard/understood, etc.)
	Service user/caregiver clinical, health, psychological, behavioural and/or educational outcomes (e.g., quality of life, family functioning, self-esteem)	Health & wellbeing, social (e.g. ability to engage with others), emotional & educational (e.g. readiness to learn) benefits
	Engagement with services (including rates of attendance) and compliance with treatment	Meaningful engagement & participation in services ('voice' & agency) (e.g., home-school links)
	Service user perceived safety	Access to more appropriate care, intervention & supports
	Parenting and family outcomes (e.g., parenting confidence, caregiver strain/stress, family safety and caregiver capacities)	Better understanding of trauma & its impact
		Enhanced family relationships
Staff	Staff trauma-informed knowledge, beliefs & attitudes	Improved understanding of TIP, trauma impact & service users' needs
	Staff readiness & confidence	Staff self-awareness and confidence
	Feeling supported & valued	Feeling supported, valued, consulted & included
	Staff satisfaction	Higher job satisfaction
	Staff stress	Improved health & wellbeing
	Staff perceived safety	Better relationships between staff & service users
	Staff capacity for trauma-informed practices	Enhanced practice skills, ability/capacity to respond
Service/System level	Seclusion & restraint rates	Fewer restraints & separations, less convictions
	Staff injury rates	Reduced staff sickness & vacancies
	Recidivism	Opportunity to consider/address the impact of political conflict in NI
	Cost savings	Potential for public sector cost savings
	Number and/or consistency of referrals	Increased staff retention
	Out-of-home placement stability/disruption	Reduced levels of state care & homelessness
	School suspension rates	Improved service consistency & collaboration due to common language of ACEs
	Number of behavioural incidents, critical & violent incidents	Reduced potential for re-traumatisation of all within the system

Outcomes and Effectiveness: The International Context (REA findings)

Although the REA indicated that in general, TIA implementation has been found to generate positive outcomes (as well as a few mixed results in particular areas), review authors note significant methodological limitations to the evidence gathered, in terms of study design (e.g. lack of longitudinal designs, small sample sizes, high attrition rates, etc.), measurement (e.g. validity and reliability of outcome measures and instruments) and analysis (Bailey et al., 2018; Bunting et al., 2019; Fernandez et al., 2023; Lowenthal, 2020; Maynard et al., 2019; McNaughton et al., 2022; Purtle, 2020).

Outcome measures used to assess TIA effectiveness in the literature reviewed were varied but tended to include mostly self-report instruments completed primarily by staff (e.g., ARTIC, COPE and TIOT[1]), but with some also completed by service users and families (e.g., CBCL[2]) (Fernandez et al., 2023). **Staff outcomes** measured across settings included: training satisfaction; staff's trauma-informed knowledge; staff's understanding of service-user behaviours; self-reported trauma-informed responses and practices, etc. **Service-user and family/caregiver outcomes** measured in the studies reviewed included service user satisfaction; service user trauma-related symptoms and indicators of family functioning, psychological functioning, health and social functioning. Finally, common **organisational outcome** variables included the frequency and duration of seclusion and restraint episodes as well as community level outcomes (e.g., number of successful linkages) (Fernandez et al., 2023).

Some outcomes were very much sector-specific, as Bargeman et al. (2021) noted. For instance, in the **youth justice system**, practices focused on minimising triggers in the court system and distress caused by restrictive measures, which had led to reductions in violent behaviour, the reduction or elimination of coercive forms of intervention (e.g., use of seclusion and restraints), and reduction in depression and PTSD symptoms among service users (Bargeman et al., 2021). Many of these outcomes were also linked to cost savings (Lowenthal, 2020). In **child welfare**, outcomes focused on placement stability, reducing distress caused by frequent placement changes, and providing birth and foster families with TIC knowledge and strategies (e.g., Bargeman et al., 2021; Bunting et al., 2019b). Studies identified a decrease in mental health symptoms, drug use, emotional/behavioural difficulties, and an increase in engagement and satisfaction within mental health treatment programs (Bargeman et al., 2021). Thus, as Bailey et al. (2018) argued, despite limited evidence, TIA implementation appeared to have a significantly positive impact on the lives of children and young people living in out-of-home care. In addition, a meta-analysis focusing on children involved with the child welfare system found that trauma-informed interventions showed a moderate positive impact on a range of child wellbeing indicators, including PTSD symptom reduction, behavioural problem reduction and other psychological wellbeing improvements (Zhang et al., 2021).

In the **schooling system**, positive outcomes were generally reported, including fewer suspensions, expulsions and disciplinary referrals, and improved academic performance (Cohen & Baron, 2021). However, in education settings, reviews revealed a scarcity of assessment of the overall impact of trauma-informed schools (Maynard et al., 2019; Phung, 2022). In fact, Maynard et al. (2019) did not find any evaluations rigorous enough to be included in their systematic review of TIAs in schools.

In **healthcare settings**, studies have found TIA implementation to have led to better access to mental health services, reduced health care costs, and a significantly decrease in the use of seclusion and restraint, including chemical restraint and prescribed sedative medications (e.g., Lowenthal, 2020; Oral et al., 2020). Other positive outcomes reported for service users in healthcare systems were increased quality of care, increased outpatient referral follow-up rates, and less time spent in restraints for patients experiencing mental health crises (Brown et al., 2022). Procter et al.'s (2023)

1 ARTIC refers to the Attitudes Related to Trauma-Informed Care Scale; COPE refers to Coping Orientation to Problems; and TIOT refers to the Trauma-Informed Organizational Toolkit.
2 CBCL refers to Child Behavior Checklist

review focused on outcomes of TIAs for suicide prevention. They found limited evidence, however, to draw conclusions on the impact of trauma-informed suicide prevention strategies, as evaluations were in their infancy and showed inconclusive impacts on suicidality at that point. Most studies focused instead on feasibility and implementation. Regarding outcomes for staff in health settings, many studies in the included reviews reported positive outcomes following TIA training (e.g., trauma-informed knowledge, attitudes, and beliefs; confidence and staff readiness; self-reported practices; satisfaction with training, etc.) (Bendall et al., 2021; Brown et al., 2022; Gundacker, 2020; Lewis et al., 2023; Maguire & Taylor, 2019; McNaughton et al., 2022).

Perceived Benefits in Northern Ireland

TIAs were universally perceived by NI study participants (across the study elements) as offering a wide range of potential short and longer-term benefits to service users and caregivers, staff/service providers, organisations and wider society. Cost savings to public sector financing were also envisaged in the longer term. Importantly, participants in this study reported no disadvantages associated with TIA implementation, bar expectations being raised that cannot be met due to inadequate resourcing or services not being available or accessible.

"There are no downsides to this at all. And actually sometimes that can be overlooked as well. (...) whether that be from a workforce point of view, organisational responsibilities, services to customers, the experience of customers. If you're doing all this stuff, it's just a better place for everybody. Simple as that."

(Cross-sector/Regional Focus Group)

In general, however, in many contexts, perceived benefits did not appear to have been systematically named, collected or analysed with the gap between perceived benefits and evidenced outcomes noted. Participants expressed concern that some TIA-related benefits are difficult to measure in numerical terms (e.g., organisational culture) with change not always evident over short time periods (i.e., longer term wellbeing impacts). Others stated that they were thinking differently about outcomes, seeking to embed what mattered to the service user into outcome measures.

Despite these limitations and challenges, survey respondents, focus group and case study participants went on to articulate a range of perceived benefits which they believed emanated from TIA implementation, many of which echoed REA findings.

In terms of **service user outcomes**, most of the outcomes reported in this study were related to enhanced service provision. Many respondents noted improvements in the service user experience such as: receiving a better-quality service, e.g. a more 'empathetic', 'kinder', 'compassionate', 'thoughtful' service; service users feeling valued, supported and/or understood; and better experience of accessing the service. Several respondents identified a range of outcomes related to increased effectiveness such as *improved service user health and wellbeing, and social, emotional and attainment outcomes.* Such outcomes, however, were not always clearly specified in measurable terms and it was not clear whether any current evidence existed to support such aspirations. Sector-specific focus group and case study participants also noted the need to extend consideration beyond traditional outcomes (such as academic achievement) to more fundamental health and wellbeing outcomes and the follow-on benefits across the life course. Other related positive impacts for service users and their networks, included the benefits of enhanced practice such as holistic assessment, and improved and *meaningful service engagement and participation* (i.e. 'voice' and agency).

Study respondents specified similar anticipated **outcomes for families and caregivers** related to the enhanced *family/caregiver service experience* (e.g. feeling supported and valued); *family/caregiver voice* (e.g. opportunities to share experiences and feel heard); and their *own health and wellbeing* (e.g. less stress/more hope). Improvement in *family/caregiver engagement* (e.g. home-school links/partnerships) and *access to relevant support/services* (in-house or via signposting, referral etc.) to benefit service user outcomes were some of the common additional outcomes articulated.

Primary **outcomes for staff members** identified in NI empirical work included *improved staff knowledge* of TIP, trauma impact and thus an *enhanced understanding of service users' needs* as well as *enhanced practice skills*, and the ability/capacity to respond in a more helpful manner. For some, this meant helping staff to understand *what* they were doing and why, thus bringing 'purpose' and 'intentionality' to the service response. Additional staff outcomes reported were in relation to improvements to *staff health and wellbeing,* as well as *job satisfaction*. Thus, participants noted staff outcomes of improved team relationships; reduced vicarious trauma and staff sickness; and enhanced 'staff morale'; improved self-awareness, self-care and capacity to deal with job demands.

Finally, respondents across the study methods articulated **benefits related to the broader organisation** such as reduced staff sickness and vacancies; reduced potential for re-traumatisation of all within the system; reduced litigation; and importantly enhanced staff retention, an issue identified as critical in the current climate. In addition, TIA implementation was perceived to offer the potential to bring about enhanced partnership working between service settings and sectors, since many organisations provide services to the same individuals and families. Improved inter-agency collaboration was thought to offer the opportunity to improve service consistency and enhance the quality of service users' experience. This was noted, however, to remain an area of challenge in NI with reports of siloed and fragmented service provision, in spite of best intentions.

A common theme amongst study participants was the particular **relevance of trauma informed approaches to the NI context** given the history of political conflict. As a result of this unique context, the implementation of TIAs was referenced by some to elicit an opportunity to leverage political and societal momentum toward sustainable peace building. It was thus acknowledged across a number of the strategic focus groups in particular that TIA implementation, and the associated greater awareness of trauma impact, had provided a new opportunity to explicitly consider the impact of political conflict on service users (and staff), an area often reported previously as unvoiced.

Study participants noted that many of the 'positive impacts' thought to emerge with TIA implementation, would only become evident over time e.g. justice diversion. Such 'longer-term' outcomes were noted as important for **potential public sector cost savings** associated with early (or earlier) and more targeted intervention.

"The long-term economic cost to... the country in the context of the services that would have to come later. If you're fixing things earlier, your intervention is earlier then, it's going to make a difference."
(Cross-sector/Regional Focus Group)

Across survey submissions and focus group discussions, the urgent need to develop a robust evidence base for TIA implementation in different contexts was articulated, as a means of leveraging the additional resource thought to be required. The need for assistance to develop and implement an effective and coherent TIA research strategy at an organisational or service level, and to capture the full range of perceived benefits of TIA implementation over time, was also expressed.

Implementation Enablers, Barriers, and Challenges

In this section, we report on the enablers, barriers and challenges associated with TIA implementation, contrasting the findings from the international literature (REA findings) and those from the fieldwork undertaken in Northern Ireland (organisational/service survey, sector-specific focus groups and case study research). The combined findings are presented in Table 2. This section closes with an overview of participant perspectives on a future vision for advancement of TIA implementation in NI.

Enablers, Barriers and Challenges: The International Context (REA findings)

Enablers/facilitators and barriers to TIA implementation were identified in several of the included reviews. In the papers reviewed, authors used different ways to categorise such factors (e.g., intervention characteristics; inner/outer setting, etc.; Huo et al., 2023). In this REA, for ease of reference, we have adapted these different classifications (see full report) and have distinguished between barriers and enablers that relate to individual factors, organisational factors and external or wider context factors. Some papers also referred to 'challenges' as distinct from implementation barriers, but these frequently overlapped. As a result, we have brought the barriers and challenges together in the Table below.

Individual factors identified in the literature reviewed tended to focus primarily on staff characteristics and attitudes and the way they engaged or disengaged from TIA implementation. Negative staff/service provider attitudes, staff resistance or poor (as well as uneven) staff engagement and commitment were found to be barriers to effective TIA implementation (Bargeman et al., 2022; Huo et al., 2023; Lewis et al., 2023; Mahon, 2022; Wassink-de Stigter et al., 2022), while staff buy-in (Phung, 2022) and openness to change were seen as enablers (Huo et. al., 2023; Wassink-de Stigter et al., 2022). Staff resistance to change was often linked to a poor understanding of trauma, and perceptions of TIC as costly, not relevant or ineffective. It was found that such factors could be addressed by adequate training (Bargeman et al., 2022).

Table 2. TIA enablers, barriers and challenges [1] REA only; [2] NI fieldwork only; [3] Both REA and NI

	Factors	Enablers	Barriers/Challenges
INDIVIDUAL	**Staff engagement**	• Staff buy-in & openness to change[3] • Staff involvement from outset[2]	Staff resistance to change & poor staff engagement[3]
	Staff perceptions of TIA	High/growing level of awareness of perceived relevance of TIA among staff[3]	Lack of perceived relevance of TIA among staff (or seen as latest 'fad')[3]
	Staff confidence/ vision	Collective sense of purpose[2]	Staff fears and misconceptions[3]
	Staff relationships & staff trauma	Positive and supportive relationships among staff – 'close-knit' teams[2]	'Traumatised' workforce – staff with personal traumatic experience & vicarious trauma[2]
ORGANISATIONAL	**Leadership buy-in**	High levels of commitment & support from senior organisational leadership[3] / Leadership drive[2]	Lack of leadership buy-in/commitment[3]
	Implementation structures	• Dedicated staff and implementation structures, e.g., champions, etc.[2] • Defined roles and responsibilities[2]	• Absence of implementation plan, structures & dedicated staff[2] • Staff turnover & burn out[2]
	Organisational culture of collaboration	• Culture of intra & inter-agency collaboration[3] • Cross-sector collaboration – a joined up approach[2] • Implementation of TIAs in other agencies serving same population[3]	• Lack of collaboration between teams[3] • Fragmentation of service delivery/ tendency to work in silos[2]
	Staff support	Culture of ongoing staff support and open communication/ supportive management[3]	Unsupportive culture with high pressure environment & staff time constraints[3]
	Staff training	Relevant, context-specific, ongoing staff training and development[3]	Insufficient or lack of adequate staff training / no training budget[3]
	Resourcing	Allocation of adequate financial/staffing resources[3]	Inadequate/insufficient financial resources allocated[3]
	Policies and Procedures	• Clear policies and procedures reviewed/adapted to TI principles[3]; • Alignment of TIAs with existing strategic plans/ policies[3]	• Policies & regulation incompatible with TIAs[3] • Inadequate/absence of consistent & clear policies/procedures[3] • Perception of TIAs as 'low priority' & 'not core business'[2]
	Staff & service user involvement	Meaningful staff and service user involvement[3]	Lack of staff and service user engagement & involvement[3]
	Monitoring and evaluation	Established mechanisms to regularly collect, review & communicate data on context-specific outcomes[3]	Lack of data collection & evaluation on relevant outcomes[3]
	Time	Sustained involvement in the change process overtime[3]	Lack of sustained involvement in change process[3]
	Size & Complexity	• Smaller size of organisation[2] • Willingness to start somewhere & cascade the learning[2]	• Large size & complexity of organisation[2] • Bureaucracy & hierarchical structures / 'red tape'[2]

[1] REA only; [2] NI fieldwork only; [3] Both REA and NI

	Factors	Enablers	Barriers/Challenges
EXTERNAL/WIDER CONTEXT	**Conceptualisation**	• Development of a shared/ common TI language & conceptualisation[3] • TIAs understood as whole-system culture change – relevant to all organisations[2]	• Lack of conceptual clarity & consensus about TIAs; difficulty in distinguishing TIAs from current best practice[3] • TIAs perceived as not relevant for non-frontline organisations and adult services[2]
	Evidence & Knowledge Exchange	• Growing body of empirical research evidencing positive impact & cost savings of TIAs[3] • TI development knowledge exchange opportunities & training framework[2] • Support from SBNI TIP project[2]	• Lack of empirical research/data on the effectiveness and cost savings of TIAs[3] • Fragmented and inconsistent development across different services[2]
	Legislative, commissioning & regulatory environment	• Legislative, commissioning and regulatory environment where TIA implementation is facilitated/ encouraged/ mandated[3] • Trauma informed commissioning[2]	Legislative, commissioning and regulatory environment hostile to TIA implementation[3]
	Institutional legacy	Policies developed to address institutional legacies[3]	Institutional policy legacies across all systems at odds with TIA implementation[3]
	COVID impact	• Heightened focus on need to support staff wellbeing[2]; • Extended use of digital technologies (to facilitate shared learning between teams in large national/ regional organisations)[2]	• Increased staff fatigue, turnover and service user need complexity[2] • Interruption of TI initiatives/loss of momentum[2]
	Political Context	Governmental and Departmental support for TIA implementation[2]	• Lack of a NI Assembly & Executive[2] • Public sector re-organisation[2]
	Economic Context	Potential for cost savings[2]	• Limited resources in current economic climate[2] • Short-term funding limitations in V/C sector[2]

While perceived relevance of TIC was found to be a facilitating factor (Huo et al., 2023), staff reluctance to engage was found to be related to the perceived lack of relevance of TIC to the setting and target population (Bargeman et al., 2022). Thus, staff sometimes perceived that either TIC principles were not suitable for their organisation or that TIC delivery was not possible due to the diversity of service users (Huo et al., 2023). Staff confidence, staff fears and misconceptions, as well as worries about their own inadequacies were identified as barriers (O'Dwyer et al., 2021). Staff fear 'to offend' service users was also reported as a barrier to trauma screening (Oral et al., 2020). These fears were attributed to staff's discomfort with their own trauma history and their desire to avoid secondary trauma, compassion fatigue and burn out. It was found that these issues could be addressed through some of the organisational factors specified below, i.e., ongoing workforce training, development and support initiatives (e.g., Bargeman et al., 2022; Bunting et al., 2019).

Multiple **organisational factors** were identified as affecting TIA implementation. These were perceived as either barriers or enablers in the included reviews, dependent upon their presence or absence. Some of these were related to the TIA implementation domains mentioned in earlier sections, such as training, workforce support, service user and staff involvement or collaboration across the agency. These are incorporated in the summary table above.

Leadership buy-in was a key implementation facilitator and change driver highlighted in many of the reviews. This element consisted of high levels of involvement, commitment, accountability and support from senior organisational leadership. **Changes in policies and procedures** also featured as key organisational enablers noted within a range of reviews. In contrast, a lack of consistent and clear policies and procedures across all levels (Bargeman et al., 2022; Mahon, 2022; O'Dwyer et al., 2021) or policies that were too rigid or not compatible with TIA (Huo et al., 2023) were found to be significant barriers to TIA implementation. In addition, it was argued that any fragmentation between interventions and procedures could elicit staff perceptions of having to constantly adopt new innovations, detrimentally impacting staff buy-in (Wassink-de Stigter et al., 2022). On the other hand, clear policies and procedures at all levels (Bargeman et al., 2022), and the alignment and integration of TIA with existing strategic plans, programmes, interventions, policies and improvement plans (Huo et al., 2023; Wassink-de Stigter et al., 2022) were found to be important implementation facilitators. Such policies (in a range of healthcare, justice and child welfare settings) included promoting flexibility in care protocols and offering service users more choice and control over their care plans (Huo et al., 2023).

In terms of **resourcing**, while inadequate/insufficient financial resources allocated was considered a barrier to TIA implementation (Bargeman et al., 2022; Huo et al., 2023; Lewis et al., 2023; Lowenthal, 2020; Mahon, 2022; Wassink-de Stigter et al., 2022), the allocation of adequate financial/staffing resources to promote implementation was seen as a key organisational enabler (Huo et al., 2023).

An unsupportive **organisational culture** within a high-pressure environment (Lewis et al., 2023), coupled with competing priorities and staff time constraints (e.g., Bunting et al., 2019; Huo et al., 2023; Lowenthal, 2020; Mahon, 2022) were found to act as strong barriers to change. In contrast, a culture of staff support, open communication, and evidence-based practice (Huo et al., 2023; Lewis et al., 2023; Wassink-de Stigter et al., 2022), involving provision of ongoing mentoring, modelling and expert consultation (Huo et al., 2023) or ongoing staff support (Lowenthal, 2020) enabled change.

Insufficient or lack of adequate **staff training** (Bargeman et al., 2022; Maguire & Taylor, 2019; O'Dwyer et al., 2021; Wassink-de Stigter et al., 2022) was found to be a barrier to implementation, whereas relevant and ongoing staff training and development (e.g. Avery et al., 2021; Phung, 2002) was perceived as a key organisational enabler.

Including service users in diverse aspects of the implementation process was also seen as an important organisational enabler, while a lack of engagement of service users a noted barrier (Huo et al., 2023; Phung, 2022). **Service user involvement** included a range of strategies, such as seeking regular

service user feedback (the most common strategy mentioned); involving service users in the delivery of training programmes; having service users in leadership positions and/or implementation teams; and involving them in the design of initiatives or interventions (Huo et al., 2023). It was noted that in order to engage service users, adequate resources and flexibility had to be embedded into the service/initiative, e.g., paying for involvement or giving service users choice and control over schedules (Huo et al., 2023).

A **'culture of collaboration'** was found to be an important enabling factor for TIA implementation (Huo et al., 2023; Lowenthal, 2020; Wassink-de Stigter et al., 2022), especially when administrative support to coordinate and monitor the collaboration was properly funded. On the other hand, a lack of collaboration between teams was seen as an organisational barrier to effective implementation (Huo et al., 2023).

An additional key organisational enabler reported in several studies in different reviews was the establishment of mechanisms to regularly collect and review data on uptake and outcomes (Huo et al., 2023), thus **monitoring and evaluating progress and outcome data** (Wassink-de Stigter et al., 2022). This meant that successes could be celebrated, building staff confidence and motivation (Wassink-de Stigter et al., 2022). On the other hand, a lack of data collection and evaluation was identified as an organisational barrier to successful TIA implementation and sustainability (Huo et al., 2023).

Factors relating to the wider or external context in which organisations or services are embedded, surfaced as significantly impacting upon successful TIA implementation (Mahon, 2022). In this regard, the *lack of TIA definitional clarity* was highlighted as a barrier by Bargeman et al. (2022), who argued that this conceptual confusion led to great variability in how a TIA is interpreted, adopted and implemented in various settings and organisations. Implementation disparities can, however, be addressed by developing a shared understanding and accountability within services (O'Dwyer et al., 2021). Absence of consensus on concept terminology was noted in several papers reviewed as making assessment, analysis and evaluation of the empirical TIA evidence in different settings considerably more challenging (Phung, 2022), negatively influencing the acceptance of TIA ideas (Bargeman et al., 2022). On the other hand, the development of a shared language and understanding of TIAs (Lowenthal, 2020) has been argued to facilitate implementation.

Bargeman et al. (2022)'s review also emphasised the *importance of* **empirical evidence** about the efficacy of TIAs, as either an enabler or a barrier to implementation respectively, dependent upon its existence or lack thereof. They argue that the lack of empirical research on TIA effectiveness is currently hindering its operationalisation. Despite limitations, however, it was noted that a growing body of research is starting to offer relevant insight and evidencing positive impact, acting as a primary enabler of TIA implementation (Bargeman et al., 2022).

Institutional policy legacies across all service systems (health, child welfare, education, justice and social services) have also been identified as significant barriers to progress (Bargeman et al., 2022). These include: the legacy and tendency of the health system to pathologise symptoms and provide care based on diagnostic criteria; the legacy of standard operating procedures in child welfare; the legacy of educational policy and pedagogy to narrowly define the scope of a teacher's role in the classroom; the legacy in the justice system of punitive (rather than restorative) justice and correction facilities' procedures; and the legacy of social services as siloed programmes, where TIA implementation was not always seen as relevant. For instance, it is argued that a trauma-informed approach to youth mental health can sometimes clash with the conventional approach based on the DSM diagnostic system. When that happens, practice is thought to revert to conventional biomedical approaches (Lowenthal, 2020). In the context of psychiatric inpatient units, some argued that it was useful to reflect on the dominance of the biomedical model, in order to foster TIA implementation (O'Dwyer et al., 2021).

According to Bargeman et al. (2022), **"addressing the impacts of policy legacies across systems of care as they relate to the operationalization of TIC will be critical moving forward"** (p. 810).

Inter-agency cooperation was noted by Huo et al. (2023) as an important external enabler or barrier respectively. Authors noted that TIA implementation in one service acted as a precedent, generating some pressure for other organisations to do likewise. This review found that TIA implementation in agencies delivering care to the same service users was found to be crucial for implementation success in their own organisation. When this was not the case, TIA implementation could be "undermined by other agencies delivering care that reduced client trust and sense of safety with healthcare providers" (p. 10).

Implementation Enablers, Barriers and Challenges in Northern Ireland

Many of the enablers, barriers and challenges identified in the REA were reinforced in the findings from the NI fieldwork, although others appeared to be more particular to NI or perhaps elaborated in greater detail in this socially situated in-depth study (see Table 2). In this section, we detail those factors most frequently mentioned in the survey submissions, focus groups and case studies.

One of the enablers most frequently identified in the NI empirical work was **high-level leadership buy-in, support and commitment** to TIAs. This was also identified as a key barrier to implementation when not available. Such high-level leadership support (e.g. Directors, Assistant Directors, Chief Executives, Trustees, etc.) was considered instrumental to 'driving' TIA implementation and organisational change. In addition, key **implementation structures** (e.g., TIA strategic steering and implementation/ working groups) were also perceived as essential to action effective implementation. These enablers were found to be especially vital in large, multi-faceted organisations, such as HSC Trusts or large voluntary sector providers, to bring coherence across departments and progress change as a whole organisation. Effective leaders across the system were variously described as 'passionate', 'committed', 'empathic', 'active' or 'visionaries'.

"Having a Director [...] and an Assistant Director who are keen to drive this forward is hugely significant. The AD chairs this project and this will enable smaller projects... to become part of a more strategic whole which progresses the goal of becoming a trauma informed organisation."
(Survey submission - Frontline organisation, HSC, Statutory sector)

"... you do need to have the Director of HR on board, otherwise things aren't going to move forward. You need to have people that can make decisions and influence policies."
(Salvation Army UK, Senior Managers Focus Group)

However, supportive TIA leadership was not thought to be situated in senior management alone, but also recognised as needed *across* the system (i.e. horizontal leadership). The presence of **dedicated TIA roles** across the organisation (e.g., TIP 'champions') were frequently noted as essential to staff buy-in and implementation progress.

"I keep talking about those champions... it's having those champions sort of scattered in all around [the organisation], who are helping everyone to sort of join the dots and connect up, to help get that buy-in."
(Cross-sector/Regional Focus Group)

In contrast, lack of senior leadership buy-in or commitment was seen as a central barrier to implementation, which could lead to staff 'burnout' and 'cynicism' when not present. While a good deal of momentum was thought to have been generated by individual TIA champions, there were noted limitations when knowledge is located in individuals who inevitably at some point 'move on'.

The size of large multi-faceted voluntary sector organisations or HSC Trusts was noted to bring additional coordination challenges in light of different 'starting points' in terms of knowledge and expertise, as well as bureaucratic approval procedures.

"The size... and layers things need to go through in order to get approved and then for the changes to be rolled out and experienced by all."

(Survey submission - Frontline organisation, Multiple settings, V/C sector)

The meaningful **involvement of staff (and indeed service-users)** was another key enabling factor, considered by many to be at the heart of TIA implementation. A 'bottom-up' as well as 'top-down approach' was advised so that staff felt that it was not something being 'done' to them, but rather something that they were involved in creating. Leaders were thus encouraged to 'listen' to staff and 'live the culture of TIP'.

"From the initial onset, practitioners were involved, ground level workers were involved, and I think that was very important because it wasn't just sitting at a policy. (...) it was real and it was live for the people actually delivering the work."

(YJA Staff Focus Group)

"Listen to staff on the ground and support and try out their ideas for change... listen to service users' views... leadership living the culture of TIP from the top to the bottom"

(Survey submission - Frontline organisation, HSC, Statutory sector)

Staff buy-in was thought to be achieved by a combination of **universal, tailored and advanced workforce training and development opportunities** for staff. Joint training with staff from different parts of an organisation was thought to be particularly helpful, so that staff could learn with, and from, each other. In addition to training, other **regular support and reflection activities** (e.g., supervision, reflective practice, team meetings, communication and celebration activities) were considered critical to keeping the learning from initial trainings alive in people's everyday practice and relevant to their different roles and responsibilities.

Such activities reinforced a supportive staff culture or whole-team approach, rather than staff members being left to 'sink or struggle' alone. Together such targeted routine activities were thought to lead to improvements in staff knowledge, skills and confidence, collegiate relationships and an enhanced relational intentionality in practice. In these ways, a TIA ethos was thought to 'seep into' the workforce culture and a collective vision engendered.

"In terms of the ethos of the school, to have the staff sit down and to think, you know... 'here's where we're at and this is where we want to be and we're all on board, we're all on the same train, going the same direction'."

(Fane street PS Staff Focus Group)

The barriers and challenges to achieving staff buy-in included **staff burn-out and turnover**, thought to be influenced by vicarious trauma in the workplace as well as staff members' personal history of adversity and trauma, commonly thought to have been exacerbated by the COVID pandemic and the NI political conflict. Such factors were thought to necessitate an enhanced focus on staff wellbeing, which was a noted area of implementation progress in NI but where significant work remained.

"We have potentially a traumatised workforce, so we have some of them who have been traumatised by their work, by the system they work in, or indeed because of their own personal histories or our societal history as well, and the Troubles, the conflict as well."

(SBNI Focus Group)

Other organisational factors commonly noted as a 'massive challenge' to TIA implementation included the perceived **absence of 'space and 'time'** in systems already considered over-stretched.

"...to implement this and make it meaningful... you need time and space to think about it, to understand it, to integrate it, to apply it, (...) you need a bit of space and time in order to be able to do that. And actually, when services are just running from pillar to post, that's a massive, massive challenge."

(HSC Trusts Focus Group)

"We don't have the time to do it regularly. That's the problem, (...) we just don't always have this space and time for reflective practice. But when we do, it's really enlightening because there's such a wealth of wisdom and knowledge within the team."
(Belfast Inclusion Staff Focus Group)

Staff workloads were frequently described as 'busy', 'unmanageable', and 'heavy' with noted 'staff fatigue'. In such circumstances, TIA implementation was considered **'low on the agenda'** or 'a luxury'.

"The services and the system has never been under such pressure and as a result, we're just..., you know, services are really running to standstill just to try and get their basic level of work done... I think time is probably the most precious commodity that we have now, and it's actually the very thing we have the least of."
(HSC Trusts Focus Group)

The fact that TIA implementation is **not considered 'core business'** to many organisations, in particular non-frontline and adult providers, was articulated as a key barrier in some settings. Participants spoke of the need to help organisations connect TIAs with existing priorities such as staff wellbeing and improved retention, and other aligned initiatives. Participants in safeguarding contexts spoke of their perception that organisational procedures could augur against TIA implementation, with a **lack of perceived relevance**.

"We've got a lot of work to do in the adult safeguarding world. Our role at the minute seems to be very policy-driven... very process-driven. (...) There isn't a lot of time to think about trauma."
(HSC Trusts Focus Group)

An additional concern commonly reported was that TIA implementation could be considered **tokenistic or a passing 'fad'**, rather than meaningful transformation in the best interests of service users:

"There is a danger that this could become a tick box thing, and people go 'well, what do we do now? what do we need to do to get our Gold Star for being trauma informed? and then we can move on'."
(HSC Trusts Focus Group)

Justice sector participants also commonly reported the challenge of bringing a trauma-informed focus on victim experience and public protection, while simultaneously embracing a 'children first' philosophy when working with young people involved with the justice system.

"We have to keep asking where is the victims in all this process? (...) the tensions are between the 'child first' approach... the victim's needs, but also public protection.... (...) obviously there's going to be a push, pull in connection to that."
(YJA Staff Focus Group)

The challenges of working in a more integrated, collaborative manner across agency and sector boundaries, despite the noted desire to do so, was repeated by participants in all elements of this study. There was a recognition that much knowledge was lost with **siloed-working** with the need to work better together clearly articulated:

"...moving forward... the important thing is just to keep it all joined together."
(HSC Trusts Focus Group)

In terms of external or wider context factors, study participants reported barriers and challenges particular to NI. These centred on the **political hiatus without a functioning Assembly** (at time of study fieldwork). In this 'political vacuum', it was considered difficult to gain momentum with policy-making 'paused'.

"When you look at central government, particularly no Minister, no Executive, no funding, you know a lot of our policy development has paused. We do say we'll keep it warm, but actually it's paused because we don't have, we've been without a minister for nearly a year, without an Executive for longer. So it is really difficult."
(Cross-sector/Regional Focus Group)

Adequate resourcing and prioritisation challenges in a stringent economic climate were also noted. This was the case across the organisations represented in this study but appeared to be felt more acutely by representatives of the community and voluntary sector, given the reliance on short-term funding and the absence of trauma informed commissioning.

"For there to be authenticity to the TIP movement, there should be adequate resource (...) Workloads should be manageable and support and remuneration must equal demands of the job."

(Survey submission - Frontline project/service, HSC, Statutory sector)

Thus, the challenge for organisational leaders was to understand what could be achieved with the resources available, and where possible, what could be mainstreamed into routine service delivery. The **absence of a coherent research and outcomes strategy** to clearly evidence TIA benefits and the potential for cost-savings was identified as essential in this regard.

"Resourcing is going to be a massive challenge, so some of this is going to be about how we prioritise to make best use of the resources that we've got. We cannot do everything. So where do we make the most positive benefit?"

(Departments & Regulators Focus Group)

A further challenge connected with the wider environment commonly reported included the **impact of the COVID pandemic** when TIA implementation 'momentum' was lost to deal with the evolving emergency. While the negative ramifications of the pandemic were many, participants also highlighted the positive focus on staff wellbeing, which emerged at that time. Additional inhibiting features included the **challenges of recruitment and retention** across sectors and settings noted in recent independent reviews, as well as significant public sector reorganisation in recent years.

The **central resource** provided by the SBNI TIP project was cited by study participants across the different elements as an important enabler in the NI context to date, with the need for further centralised networking and context-specific implementation support articulated.

Future Vision and Priorities

According to many participants in this study, further advancement of TIA implementation in NI depends largely upon a governmental mandate to provide cross-departmental support to create a trauma-informed strategy for NI. This would include designated resources and trauma-informed commissioning to create sustainable change. To achieve such strategic commitment, an over-arching research strategy was considered vital to enable the development of a robust evidence base, including the potential for cost savings.

Further context-specific TIA implementation knowledge-exchange and networking initiatives were deemed essential to advance cross-sector TIA standardisation; promote collaboration; share transferable best practice and implementation learning; and thus bridge the theory-practice implementation gap. In addition, it was considered important that TIA training be embedded in all professional programmes in NI, with the proposed development of a national trauma-related training framework akin to developments in Scotland.

Recommendations

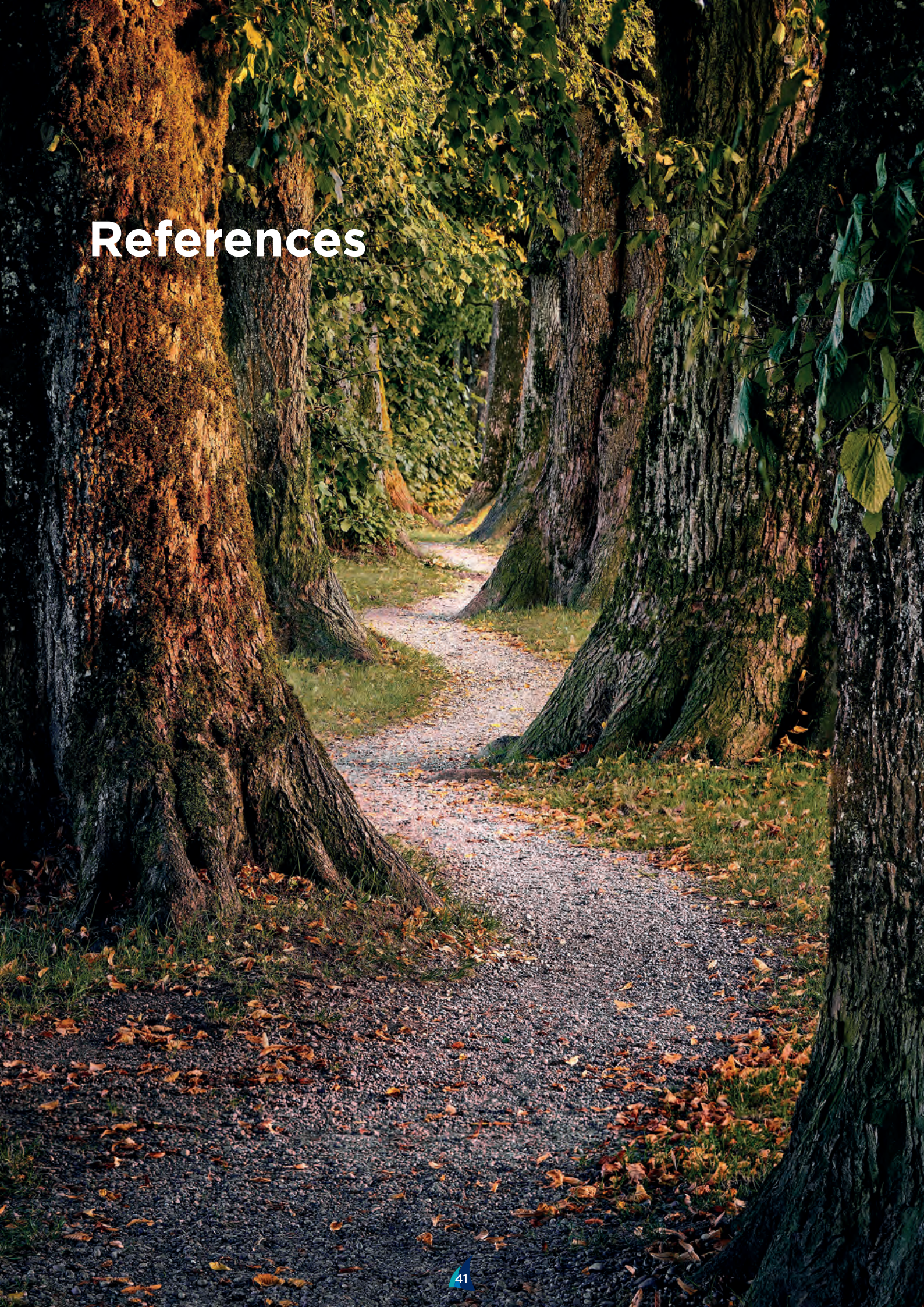
1. TIAs are a useful framework to hold together and drive forward a range of strategic priorities across child and adult services in health, social care, justice and education across statutory, community and voluntary sector provision. Such priorities include: early intervention and support to prevent and mitigate the lasting effects of adversity and trauma; enhanced service user, caregiver and community involvement; rights-based, nurturing, restorative and relationship based approaches to service delivery including the reduction of restrictive practices; school in the community/ community in school; staff wellbeing; quality improvement initiatives and outcomes-based approaches. As such, **TIAs have the potential to underpin current policy developments providing a consistent theoretical framework** (e.g. Mental Health Strategy 2021-31; Preventing Harm, Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use 2021-31; Strategic Framework to End Violence Against Women and Girls (in process); Children and Young People's Strategy 2020-30; Infant Mental Health Framework for NI).

2. A governmental mandate and **trauma-informed strategy for NI** is now needed to advance coherent and meaningful TIA implementation across sectors and settings. This should be accompanied by designated resources and trauma-informed commissioning requirements to create sustainable change.

3. There is a need for the development of a **regional inter-departmental research and outcomes strategy**, and independent evaluation to track TIA implementation progress and evidence outcomes. The development of such a research and outcomes strategy should be undertaken in consultation with organisations to ensure new and existing data collection tools and processes are consistent across NI, considered relevant to participating organisations, and capture the full range of perceived benefits of TIA implementation over time.

4. A **regional NI trauma informed resource hub or centre** would be of benefit to facilitate organisational leadership, networking, best practice resources and specialist interest groups and conferences. Such a hub would provide ongoing support for cross-sector, context-specific TIA implementation, and enable learning to be cascaded. Further clarification and support to organisations should also be provided to ensure a consistent understanding across NI of the underpinning principles of TIAs and their implementation in specific settings and sectors, including the relevance for adult services and strategic, governance and commissioning bodies.

5. **A regional training framework** should be developed (learning from the Scottish National Trauma Transformation Programme). This will ensure clear differentiation between trauma informed and trauma-focused service provision and enable organisations to progress workforce development and support strategies, aligned with TIA implementation and commensurate with their role and responsibilities.



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