Trauma-informed Community of Action

Brief evaluation of the community
and its use of the FutureNHS Platform

Academic Health Science Network
North East and North Cumbria

ThinkClarity

Acknowledgements

The brief evaluation documented in this report was commissioned by NHS England / Improvement through the NHS Northern Clinical Network and the Academic Health Science Network for the North East and North Cumbria. It was carried out by ThinkClarity using SenseMaker®, a software tool licensed by Cognitive-Edge.

We would like to acknowledge the contribution provided by Angela Kennedy, Angela Sweeney, Warren Larkin, and Nicola Armstrong who helped design the SenseMaker® questionnaire and other members of the Trauma-informed Community of Action Core Action Group who reviewed and approved the design. We are also grateful to Elaine Readhead & Darren Archer for arranging the contract and to Anne Richardson for her patience and persistence in encouraging members to respond to the survey.

SenseMaker® and ThinkClarity were recommended by Professor Gerald Midgley at Hull University.

The data was analysed and the report co-written by Eliza Ader of ThinkClarity.

Paul Ader
Director – *Think*Clarity
December 2020

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1. Executive Summary

This report provides the results of a brief evaluation of the development and current state of the virtual Trauma-informed Community of Action that was set up in early 2020 through the FutureNHS Collaboration Platform.

The community has grown continuously through 2020 from around 275 members at the end of May to over 500 in December.

When the survey was published in early June, all members were emailed to invite them to contribute. This was followed up by a request on the FuturesNHS Platform and by emails sent to all new joiners. In total, 90 members responded.

Analysis of the data collected in the survey identified eleven findings. Given the relatively low number of responses, these are necessarily indicative rather than strongly supported.

1. The strongest indicators of adoption of trauma-informed care are its inclusion in strategic plans, regulations and inspections, and its use in supporting and supervising staff.
2. The largest and most difficult barrier to the adoption of trauma-informed care is that services are currently too piecemeal for trauma survivors.
3. The purpose of the community is weighted more towards establishing trauma-informed care as universal practise than towards co-designing standards or building networks.
4. To be effective, the community needs to enable members to give and get support as well as collect and provide relevant information. Reflecting values is also needed but subsidiary.
5. The community of change is using all trauma-informed values to promote compassionate leadership.
6. The community of change is of value to people from clinical and non-clinical settings who engage with people with lived experience of trauma and adversity, as well as to those with this lived experience.
7. The community of change creates value by enabling co-production with shared learning as well as shared learning with reflection.
8. The value of the community of change may be challenged in organisations unless action is taken to limit superficial or over-use of the term trauma-informed care – particularly when it is used to make an existing/unchanged service sound better than it is.
9. Most respondents say that their relationship with the TiCA in 1-year will be stronger than it is today.
10. Only 45% of respondents had visited the FutureNHS website prior to completing the evaluation. However, most of those who had visited had a largely positive impression of it.
11. The FuturesNHS workspace should be used for case studies and ideas on practicing trauma-informed care, regular webinars, copies or links to documents and eLearning.

The report supports the findings outlined above with data and with anonymous examples of narratives provided by respondents where they agreed that these could be shared and published. A full copy of all of these narratives are included in Annex 2.

The Tableau packaged workbook used to visualise and analyse the data will be provided alongside this report.

2. Purpose and scope

The evaluation described in this report was commissioned by the NHS Northern Clinical Network and the Academic Health Sciences Network North East and Cumbria. It was set up with three interconnected aims:

1. To provide NHSE/I with an evaluation of the need for a community of practice and the way the funded activities are currently meeting those needs. It was set up to support the delivery of outcomes in sections 3.94 and 12 of the 2019 NHS Long-Term Plan. The community has always extended to wider applications of trauma informed care. The two sections in the LTP are copied in the sidebar.
2. To provide feedback on the way that the community is using the Future NHS Collaboration Platform.
3. To provide feedback that helps shape the community and ensure it meets the members needs and provides value.

> **3.94. New and integrated models of primary and community mental health care will support adults and older adults with severe mental illnesses**. A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. This includes maintaining and developing new services for people who have the most complex needs and proactive work to address racial disparities. Local areas will be supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks. By 2023/24, new models of care, underpinned by improved information sharing, will give 370,000 adults and older adults greater choice and control over their care, and support them to live well in their communities.
>
> **12. We will invest in additional support for the most vulnerable children and young people in, or at risk of being in, contact with the youth justice system**. The development of a high-harm, high risk, high vulnerability trauma-informed service will provide consultation, advice, assessment, treatment and transition into integrated services. This will provide support to and help to address the complex and challenging needs of vulnerable children and young people.

Figure 1 - Trauma-informed Care in the 2019 NHS Long-Term Plan

SenseMaker® was chosen as the method for this evaluation because of its ability to capture experience and aspirations for emergent practice and because it is a practical way to implement systems thinking. The methodology is described in Annex 1.

The scope of the work is framed in terms of the target population and focus:

1. The target population was intended to encompass as many existing and prospective members of the community as possible. The latter were largely people who attended one of the webinars provided by the TiCA.

2. The focus was on how respondents would like to influence the use of trauma-informed care and how they could help the community, or the community help them, to achieve this influence. This focus was enabled by asking each respondent to describe a real experience at the beginning of the survey (without providing any personally identifiable detail) in which this influence was or would have been helpful.

3. Background

3.1 Trauma informed care

In its current form in the Western world, trauma-informed care originated in work with American military veterans suffering from PTSD and has since been extended to civilian situations where people may have had traumatic experiences. It is important because it puts the patient's lived experience at the centre of the healing process and focuses on building support for the patient based on engaging with the complexity of that lived experience.

There is a growing understanding and awareness of trauma-informed care in the UK. It referred to twice in the 2019 NHS Long-Term Plan, in relation to providing TiC for at-risk youth and/or involved with the justice system, as well as being a part of new primary and community care for adults with severe mental illness. It is also mentioned in the 2019/20 – 2023/24 NHS Mental Health Implementation Plan in relation to adults with severe mental illness getting more control over their care, as well as in relation to support measures for rough sleepers. It has been argued that what is needed is a full cultural change regarding the impact of trauma on practise. This is the goal of the Trauma-informed Community of Action.

> "A Trauma Informed Approach is a system-wide approach to addressing the adversity that underlies much suffering and its impact on relationships. It is a system that is guided by knowledge of what is needed for healing from emotional and psychological wounds. It has relevance to everyone in the system through the promotion of safe, open trusting alliances. As such it works to create psychologically healthy and rewarding places of work that can adequately address the needs of people who come for help. It also focuses its efforts to prevent harm for people using the service, including that harm caused by services in their efforts to manage risk." (Kennedy, 2020, p4)
>
> *From: "Developing real world system capability in trauma informed care: learning from good practice."*

Figure 2 - Excerpt from report on National Trauma Summit in March 2019

3.2 FutureNHS Collaboration Platform

The Trauma-informed Community of Action opened a workspace on the FutureNHS Collaboration Platform in March 2020. FutureNHS was launched in 2016 to provide a collaboration tool for NHS professionals engaged in the health services New Care Models programme and is currently being redeveloped and extended so that it can be used by a much wider range of people. It allows forum discussions, distribution of information, and the hosting of events across a wide range of disciplines and workspaces; and it is especially focussed on groups working on new or transformative work.[1]

3.3 The Trauma-informed Community of Action (TiCA)

The TiCA emerged from the shared interest and advocacy of a core group of practitioners who provide care for people that have experienced trauma and/or who have themselves had direct or indirect experience of trauma in their own lives. The National Summit in March 2019 (referred to above) provided the impetus for the community to be established on a formal basis with start-up and maintenance funding from NHS England / Improvement.

[1] NHS to build 'online sharing and collaboration' platform for health and social care sector – Public Technology.net url

The Core Action Group (CAG) guiding the community preferred the term Community of Change rather than Community of Practice. This preference highlights the primary purpose of the community as advocates of change that will lead to the wide-spread recognition and adoption of trauma-informed care. The discussion below refers to communities of practice but can equally be applied to communities of change.

A community of practice is defined as a group of people (practitioners) who come together to engage in collective learning on or around a certain topic. Although the term was introduced by Jean Lave and Etienne Wenger in their 1991 book *Situated Learning: Legitimate Peripheral Participation* – the concept has a long heritage and has been linked to the learning relationship between apprentices and others in the medieval craft guilds. They are increasingly being adopted by organisations of all kinds in order to accommodate the move towards knowledge work, learning organisations, self-managed teams, increased connection and interaction and the requirement for continuous innovation. While they can vary significantly in their size, membership composition and modality of working, Wenger et al argue that to be effective and self-sustaining they need to comply with the principles listed below.

- **Design for evolution** – so that they continue to meet the interests of participants.
- **Open dialogue** – to enable sharing of perspectives from outside the community.
- **Encourage different levels of participation** – to meet the needs of core members, regular contributors, and occasional contributors who are largely peripheral observers.
- **Develop both public and private community spaces** – with private spaces for discussion and public spaces for blogs, conferences/webinars etc.
- **Focus on value** - and ensure discussion and activities are clearly linked to this value and explicitly discuss the value and productivity of their participation in the community.
- **Combine familiarity and excitement** – provide opportunity for radical or challenging discussion and the development of ideas alongside review and of more common concerns.
- **Create a rhythm for the community** – with a regular schedule of activities and/or focal points that bring participants together.

The activity-focused engagement of a community of practice can helpfully be contrasted with a community of interest. Whereas a community of practice is intended to allow active practitioners or people with lived experience to share tips and best practices, ask questions and provide support for each other; a community of interest is intended to allow people who have a shared interest in a topic but not necessarily experience or expertise to exchange information, ask questions, and express their opinions.

A community of practice can exist as long as the members believe they have something to contribute to it or gain from it. Having said this, many communities follow a life cycle similar to the one illustrated below. This is sourced from an InfoQ article by Emily Webber and, as shown in the caption, based on ideas discussed by Wenger, McDermott and Snyder.

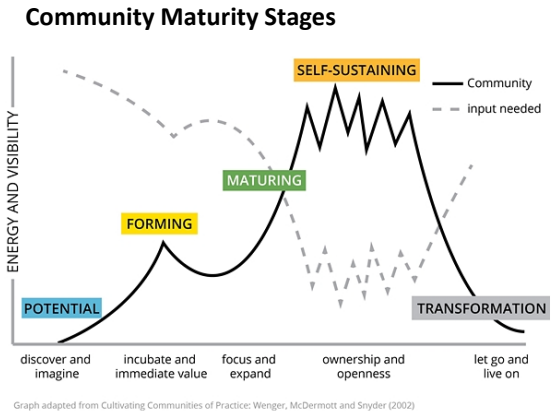
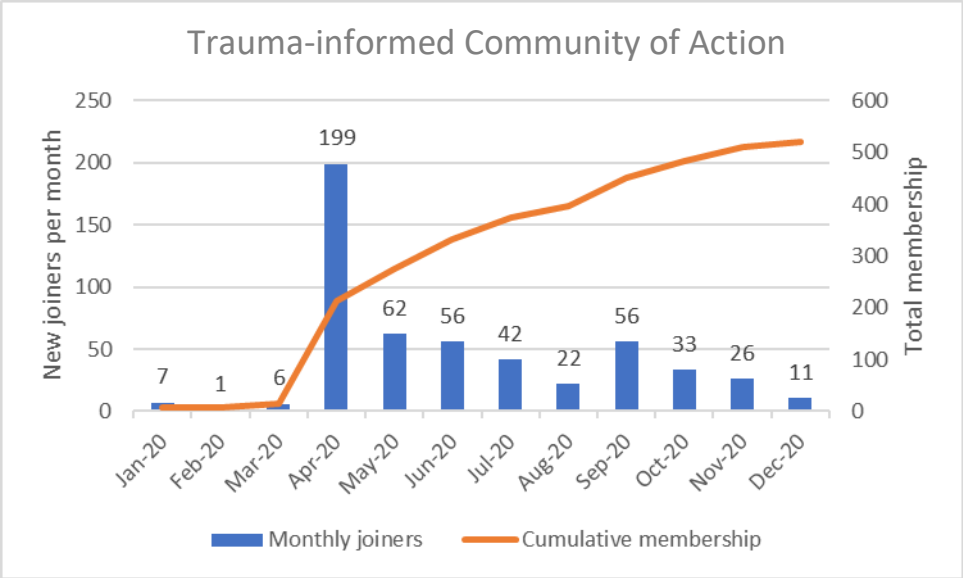


Figure 3 - Community Maturity Stages

Evidence collected during this evaluation points to the TiCA being in the maturing stage and making strong progress in line with the principles described above. This assertion is supported by the data included below on number of members, provision of webinars and number of documents previewed and downloaded from the community's workspace on NHS Futures.

3.4 TiCA - Data on membership and activity

The Trauma-informed Community of Action started with a large influx of members in April 2020 and has grown steadily since then. When this report was written in December 2020, the community had just over 520 members. The profile of new members is illustrated below. This is sourced from the FutureNHS Collaboration Platform.



Cumulative membership by month	
Jan-20	7
Feb-20	8
Mar-20	14
Apr-20	213
May-20	275
Jun-20	331
Jul-20	373
Aug-20	395
Sep-20	451
Oct-20	484
Nov-20	510
Dec-20	521

Figure 4 - TiCA: Number of new members and cumulative membership 2020

The profile of members by affiliation shows that while over 60% of members are connected with the NHS, a significant number of members are from elsewhere. This is broadly comparable with the profile of members who responded to the evaluation survey.

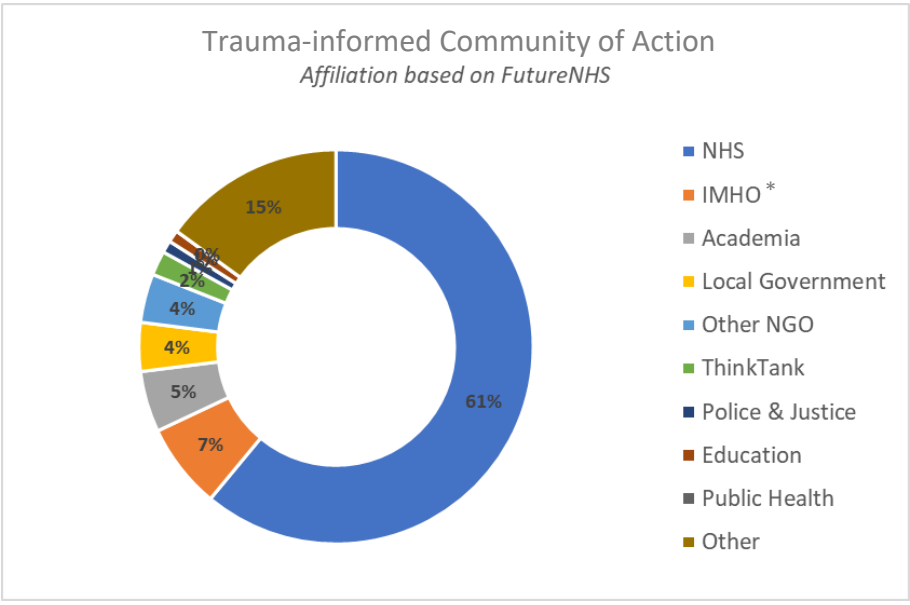


Figure 5 - Affiliation of TiCA Members

** IMHO is an abbreviation for 'Independent Mental Health Organisation'*

The profile of members by region shows that largest group are based in the area where key members of the Core Action Group are based.

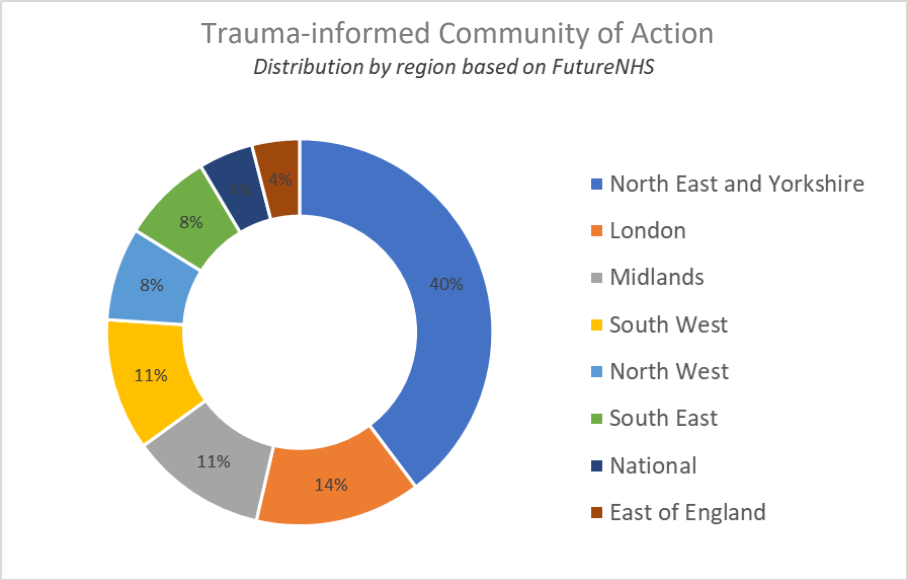


Figure 6 - Regional distribution of TiCA members

The community provided its first webinar on the FuturesNHS Platform at the start of September and has run a further 3 since then. Two more webinars are scheduled for the start of 2021. These are listed below for reference. We do not have access to the number of attendees at each webinar but understand that they were well attended.

Thurs 24-Sep-20	Older People and Trauma Informed Practice
Thurs 5-Nov-20	Embedding Trauma Informed Care in transformed models of community mental health services for people with a complex needs associated with those given a diagnosis of personality disorder
Thurs 17-Dec-20	Facilitating Lived Experience Leadership in Mental Health Services
Thurs 28-Jan-21	Trauma Informed Approaches to Working with Children and Young People
Thurs 25-Feb-21	Exploring Trauma Informed Approaches in Mental Health Inpatient Settings
Thurs 25-Mar-21	Research and evaluation of trauma informed approaches

Figure 7 - Names and dates of TiCA Webinars

The FutureNHS workspace also appears to be relatively well used for providing and accessing documents and other media. As shown in the following tables, 34 documents/items of media have been made available across 7 subject folders and, in total, these documents have been downloaded 405 times and previewed 943 times. This activity has been reasonably consistent during the year.

Subject Folder	Number of documents	Number of downloads	Number of previews
Childrens Services	5	59	83
COVID-19	7	52	78
Prisons	1	1	2
Trauma Informed Publications	2	146	190
Trauma Informed Resources	4	100	161
Trauma Informed Videos, Audio Recordings and Multimedia	4	25	383
Webinars	11	22	46
	34	**405**	**943**

Month in 2020	Number of downloads	Number of previews
Mar	2	7
Apr	66	86
May	36	57
Jun	44	56
Jul	58	97
Aug	17	58
Sep	64	174
Oct	29	187
Nov	62	142
Dec	27	78
	405	**943**

Figure 8 - Number of TiCA documents on FuturesNHS and number of downloads/previews

Members have also made use of some of the other features of the FuturesNHS Workspace. Just over 60 members have used it to post shared messages as part of a discussion. Most of these were in an introductory "Say hello, here" discussion; however, four other discussions listed below also included a number of messages.

- What research on trauma-informed approaches would you like to see?
- Developing TIC within an organisation - baseline audit tools?
- Physical healthcare and biological impact of trauma exposure.
- Trauma informed Care in Forensic Mental Health Services.

Blogs, forums and case-studies have not yet been set-up / used. We have also not been able to identify any instances where members have provided comments and/or engaged in discussions on shared documents.

4. Profile of respondents

The following bullet points highlight key data from the profile of the 90 respondents who completed the evaluation. Additional detail is shown in the data tables and map below.

- 76% gave their gender as women
- 87% gave their ethnic group as white
- 81% said they worked in a mental health service
- 26% said they worked in a hospital
- 24% said they worked in a community service
- 72% are connected with TiC as providers
- 26% are connected with TiC as a person with lived experience of trauma or adversity

Note that the questions on areas of work and connection with trauma-informed care invited respondents to select all options that applied – this means that the percentages add to more than 100.

		1. White	2. Asian / Asian British	3. Black / African / Caribbean / Black British	4. Other ethnic group	5. Mixed or multiple ethnic groups	**Total**
Number	1. Female	64		1	1	2	68
	2. Male	14	1		4	2	21
	3. Prefer not to say					1	1
% of Total	1. Female	71%		1%	1%	2%	76%
	2. Male	16%	1%		4%	2%	23%
	3. Prefer not to say					1%	1%
Number	**Total**	**78**	**1**	**1**	**5**	**5**	90
% of Total	**Total**	**87%**	**1%**	**1%**	**6%**	**6%**	100%

Figure 9 - Profile of respondents: gender and ethnic group

The respondents' area(s) of work have been grouped in the three categories shown in Figure 10. While the proportion of respondents working in a mental health service is expected, the 18% who do not work in either a mental health service or a hospital suggests that the community is gaining traction across multiple settings. This is further supported by the details in Figure 11 which shows the percentage of respondents selecting each of the options as one of their options.

	Number	% of Total
(1) Mental health service (MHS)	73	81%
(2) Hospital (and not MHS)	1	1%
(3) Other Setting	16	18%
Grand Total	**90**	**100%**

Figure 11 - Profile of respondents: Areas of work (grouped)

01. Mental health service	81%
02. Hospital	26%
03. Residential care	4%
04. Community service	24%
05. Social care	4%
06. Prison	2%
07. Primary care	9%
09. Charity	8%
10. Peer support	6%
11. University	8%
12. Other	20%

Figure 10 - Profile of respondents: Areas of work

Connection with TiC - Options chosen *Rows highlighted in yellow are repeats of earlier rows in a different sequence*	Analysis of combinations ***Number***	Chosen by ***% of respondents***
1. Person with lived experience of trauma and adversity		**26%**
On its own	2	
+ (2) Users of mental health services	1	
+ (2) User of mental health services, (3) Recipient of trauma-informed care,	1	
+ (2) User of mental health services, (4) Provider of trauma-informed care,	3	
+ (3) Recipient of trauma-informed care, (4) Provider of trauma-informed care,	1	
+ (4) Provider of trauma-informed care,	10	
+ (4) Provider of trauma-informed care, (5) Service manager or other managerial role,	5	
2. User of mental health services		**7%**
On its own	0	
+ (1) Person with lived experience of trauma and adversity	1	
+ (1) Person with lived experience of trauma and adversity, (3) Recipient of trauma-informed care,	1	
+ (1) Person with lived experience of trauma and adversity, (4) Provider of trauma-informed care,	3	
3. Recipient of trauma-informed care		**2%**
On its own	0	
+ (1) Person with lived experience of trauma and adversity, (2) Users of mental health services	1	
4. Provider of trauma-informed care		**72%**
On its own	38	
+ (1) Person with lived experience of trauma and adversity	10	
+ (1) Person with lived experience of trauma and adversity, (5) Service manager or other managerial role,	5	
+ (5) Service manager or other managerial role,	7	
5. Service manager or other managerial role		**24%**
On its own	10	
+ (1) Person with lived experience of trauma and adversity, (4) Provider of trauma-informed care	5	
+ (4) Provider of trauma-informed care	7	
6. Prefer not to say		**17%**

Figure 12 - Profile of respondents: Connection with Trauma-informed Care

Respondents were relatively widely distributed across England with single outliers in Scotland and Wales. This is illustrated on the map opposite.

It should be noted that to maintain anonymity, respondents were not asked to provide a specific location or the name of the organisation(s) where they worked or at which provided/used TiC services. There are also a few responses that appear to have been placed off the map – these have been left where they were placed.

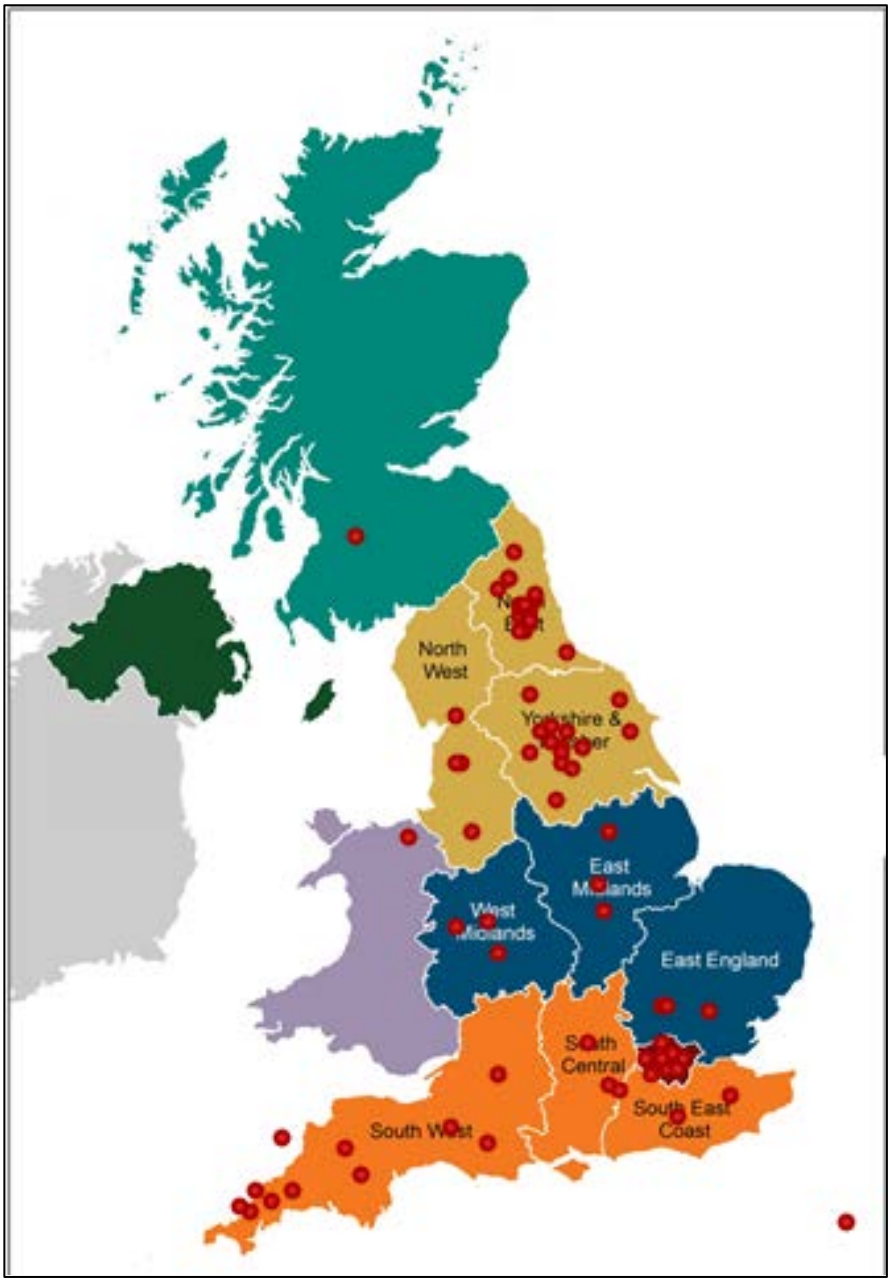


Figure 13 – Profile of respondents: Regional distribution

5. Findings & Discussion

This results and discussion of the evaluation is set out in the following sections:

- Indicators of adoption and barriers to adoption of trauma-informed care.
- Purpose and effect of the community of change.
- Value of the community of change.
- Engagement with the community of change and FutureNHS Platform.

5.1 Indicators of adoption and barriers to adoption of trauma-informed care

Finding 1: The strongest indicators of adoption of trauma-informed care are its inclusion in strategic plans, regulations and inspections, and its use in supporting and supervising staff.

The respondents were asked to use the experience they had described to answer the question "The Trauma-informed Community of Action is making a difference if …" by selecting three of the options listed below that they thought provided the most important evidence of adoption. The three indicators highlighted in yellow the following list were selected by the largest number of respondents and those highlighted in grey were chosen least frequently.

1. Training in trauma and adversity is becoming commonplace through organisations
2. There is greater emphasis on trauma-informed support and supervision of staff
3. A consensus statement of, and practice standards on, Trauma-informed Care is being adopted by many organisations and groups
4. Members have space & opportunity to discuss the value and productivity of the community
5. The national community includes thriving local communities that have built alliances across multiple disciplines and organisations
6. A significant percentage of active members of the community have lived experience of trauma and adversity
7. The community is taking specific steps to listen to marginalized voices and to people with diverse backgrounds and experiences
8. Trauma-informed care is reflected in strategic plans across the system and regulators are using its principles in inspections
9. The community has provided direct support for transformational change of local MH services for people with complex needs

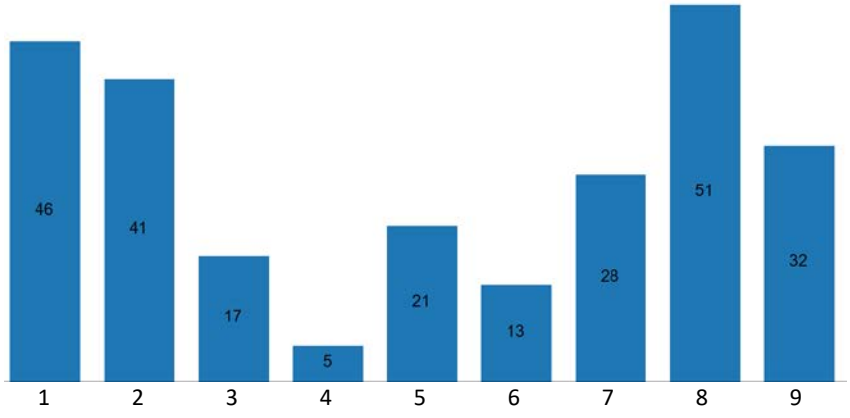
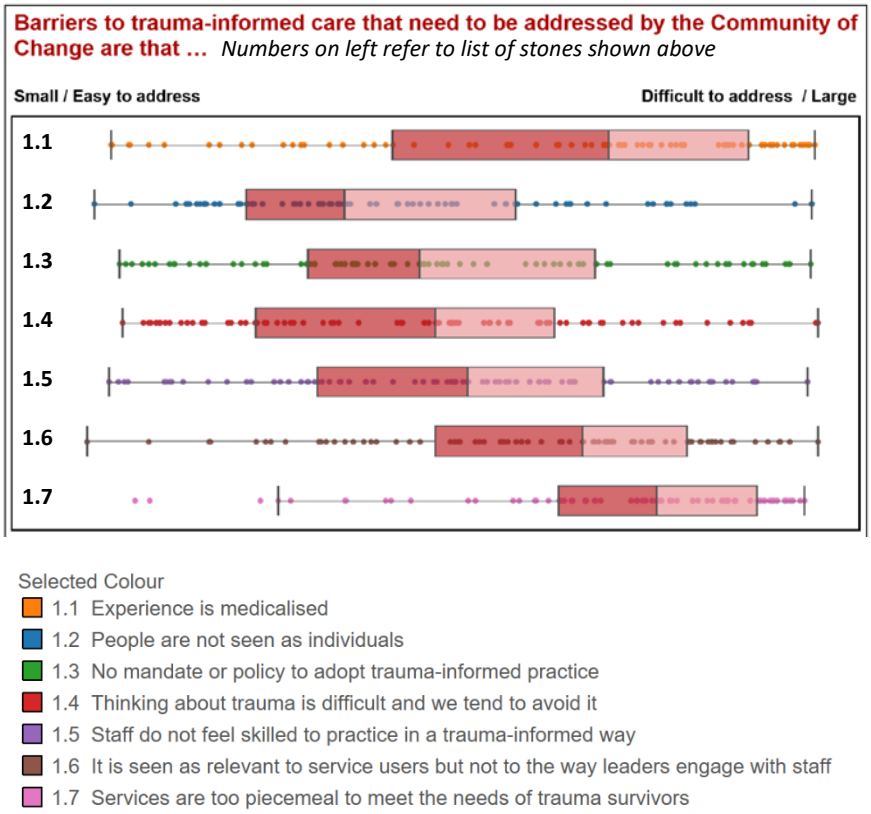


Figure 14 - Indicators of Adoption

Finding 2: The largest and most difficult barrier to the adoption of trauma-informed care is that services are currently too piecemeal for trauma survivors.

Having first identified indicators of adoption, the respondents were asked to assess the relative size and difficulty of addressing a number of barriers that need to be addressed by the community of change. This second question was presented as a canvas on which respondents were asked to place up to seven 'stones' representing a range of different barriers. The results of this question are illustrated in Figure 15 as a series of separate box & whiskers charts, with one row per stone.



How to read a Box & Whisker Chart:

- The ends of the two-tone coloured box are the upper and lower quartiles, so the box spans the inter-quartile range.
- The median (or middle value) is where the box changes colour
- The whiskers are the two lines outside the box. These extend to 1.5 x the inter-quartile range.

Figure 15 - Size and difficulty of addressing barriers to trauma-informed care (Box & Whiskers)

The data associated with the barriers are included below. *The row labels are truncated to save space and the column headings are the five quintiles.*

		1. Left	2. CL	3. Centre	4. CR	5. Right	Grand T..
Number	Total	48	67	66	77	67	85
% of T..	Total	56%	79%	78%	91%	79%	100%
% of Total	1.1 Experience is medicalised	10%	14%	12%	28%	36%	100%
	1.2 People are not seen as individuals	20%	36%	21%	17%	7%	100%
	1.3 No mandate or policy to adopt tra..	16%	29%	19%	19%	18%	100%
	1.4 Thinking about trauma is difficult ..	19%	23%	28%	22%	9%	100%
	1.5 Staff do not feel skilled to practice..	12%	23%	24%	23%	17%	100%
	1.6 It is seen as relevant to service u..	5%	15%	23%	30%	27%	100%
	1.7 Services are too piecemeal to me..	5%	6%	9%	36%	43%	100%

Figure 16 - Size and difficulty of addressing barriers to trauma-informed care (data)

The charts and data show that, in the view of respondents, the largest and most difficult barrier to address is **1.7 Services are too piecemeal to meet the needs of trauma survivors.** This is followed by **1.1 Experience is medicalised** and then by **1.6 It is seen as relevant to service users but not to the way leaders engage with staff**; however, both 1.1 and 1.6 have a larger interquartile range indicating that there is a higher degree of variance in these responses than in 1.7.

Looking more closely at *1.7 Services are too piecemeal to meet the needs of trauma survivors*, there are small number of potentially interesting outliers on the left-hand end of the row. These are response IDs 10, 36, 40, 63, 65 & 77. The narratives for these responses (see Annex 3) do not indicate why these respondents' views differed from those of most of the other respondents. This is not surprising because, as described in the methodology in Annex 1, the signification is based on the wider experience accessed through the narrative rather than of the actual narrative itself. Further analysis in Tableau of the answers these respondents provided to other questions also provide no particular explanation of their views. If the CAG believe that this merits further investigation, it could be revisited in an online TiCA meeting/webinar in which participants are shown the patterns and asked to suggest reasons why some of the barriers may be small/easy to address and other barriers may be large/difficult to address. Some of the participants at this meeting may have been respondents – but even if they were not, the 2nd order sense-making of the patterns provided through this process may identify actionable insight.

There are a number of inferential links between the indicators identified by respondents as providing most evidence of adoption of trauma-informed care and the largest/most difficult barriers. These are noted below.

Indicator of Adoption		**Barrier**
1. Training in trauma and adversity is becoming commonplace through organisations	←→	1. Experience is medicalised
2. There is greater emphasis on trauma-informed support and supervision of staff	←→	6. It is seen as relevant to service users but not to the way leaders engage with staff
8. Trauma-informed care is reflected in strategic plans across the system and regulators are using its principles in inspections	←→	7. Services are too piecemeal to meet the needs of trauma survivors

5.2 Purpose and effect of the community of change

Findings from the data collected in the three triads listed below can be grouped into a theme on the purpose and effect of the community of change. Data from these triads are summarised by zone as illustrated in Figure 17.

- Triad 1: The purpose of the Trauma-informed Community of Action is to…
- Triad 2: To be effective, the Trauma-informed Community of Action needs to…
- Triad 5: The Trauma-informed Community of Action promotes compassionate leadership by encouraging members to…

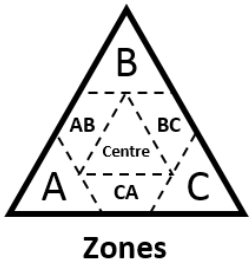


Figure 17 - Illustration of zones in a triad

Finding 3: The purpose of the community is weighted more towards establishing trauma-informed care as universal practise than towards co-designing standards or building networks.

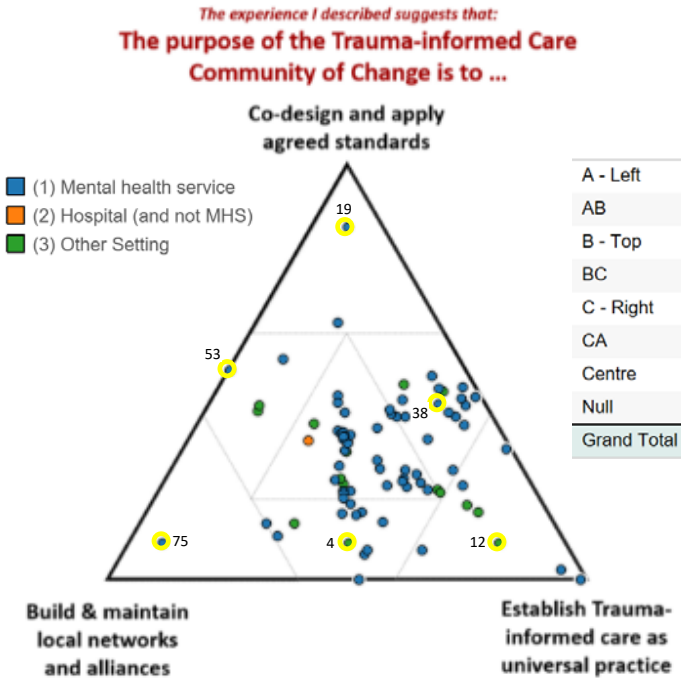


Figure 18 - Results from Triad 1 on Purpose of TiCA

	(1) Mental health service		(3) Other Setting		Grand Total	
	Number	%	Number	%	Number	%
A - Left	1	1%			1	1%
AB	2	3%	2	13%	4	4%
B - Top	2	3%			2	2%
BC	16	22%	4	25%	20	22%
C - Right	5	7%	3	19%	8	9%
CA	10	14%	2	13%	12	13%
Centre	36	49%	5	31%	42	47%
Null	1	1%			1	1%
Grand Total	73	100%	16	100%	90	100%

Note: Data table excludes "Hospital (and not MHS)" group because this only has one member in the centre zone. This data item is included in the row total.

Narratives have been included below for the random selection of responses in different zones highlighted in yellow. The numbers shown for these responses are their IDs.

While almost half (47) of the respondents put their mark in the centre zone, detailed analysis of the Tableau workbook shows that only 17 of these placed it right at the centre of this zone. 10 respondents placed their mark towards the middle of the base of the centre zone and 12 placed it towards the right-hand corner of the centre zone. These data items together with those placed in zones BC, C and CA suggests a strong weighting towards Establishing TiC as universal practice. It is also notable, although not surprising, that respondents in the "Other Settings" areas of work are proportionately more supportive of establishing TiC as universal practice than co-designing and applying agreed standards.

It is possible that Triad 1 reflects a progression from establishing TiC as universal practice to co-designing and applying agreed standards to building and maintaining local alliances and networks. If this is the case, then use of this triad at a future date might see a shift in patterns towards zone A.

Six of the responses in Figure 18 have been highlighted and labelled with their ID. These have been selected at random from the different zones and are intended to provide a link between the results in this triad and narratives in Annex 3. The Tableau packaged workbook available with this report provides direct links for all responses. The narratives for responses 4 and 75 are included below for the purpose of illustration.

Response ID 4:

Area of work: (9) Charity, (10) Peer Support, (12) Other, Provider to all of above and more

Connection with TiC: (1) Person with lived experience of trauma and adversity, (2) User of mental health services, (3) Recipient of trauma-informed care, (Other) Trainer in trauma-informed care and related topics

The parts of trauma-informed care that I most want to influence are ...

> I want to help practitioners and others understand that trauma-informed care is a much bigger concept than providing trauma-specific services. I am particularly interested in influencing health and care so that the needs of all those with complex dissociative conditions, particularly but not exclusively D.I.D. are fully recognised and addressed.

This is informed by the following experience ...

> I have been involved in the training of a wide range of practitioners, managers, commissioners, informal carers and people with lived experience. The training I deliver focuses on the most complex trauma-related dissociative conditions within a trauma-informed care environment. Many participants feedback that before the training they had not recognised current or past clients/patients who experienced such challenges, but after the training they felt they had learned new ways of working which would benefit this group.

Response ID 75:

Area of work: (1) Mental health service

Connection with TiC: Psychotherapist dealing with patients who have been traumatised in the past.

The parts of trauma-informed care that I most want to influence are ...

> How trauma informed care ideas interact with other established psychotherapies.

This is informed by the following experience ...

> I saw a discussion regarding a patient with a history of trauma, who had previously had some form of trauma-linked conversation with a staff member, and that this was being used as a reason for the patient to be not considered for further therapies such as CBT / psychodynamic therapy.

Finding 4: To be effective, the community needs to enable members to give and get support as well as collect and provide relevant information. Reflecting values is also needed but subsidiary.

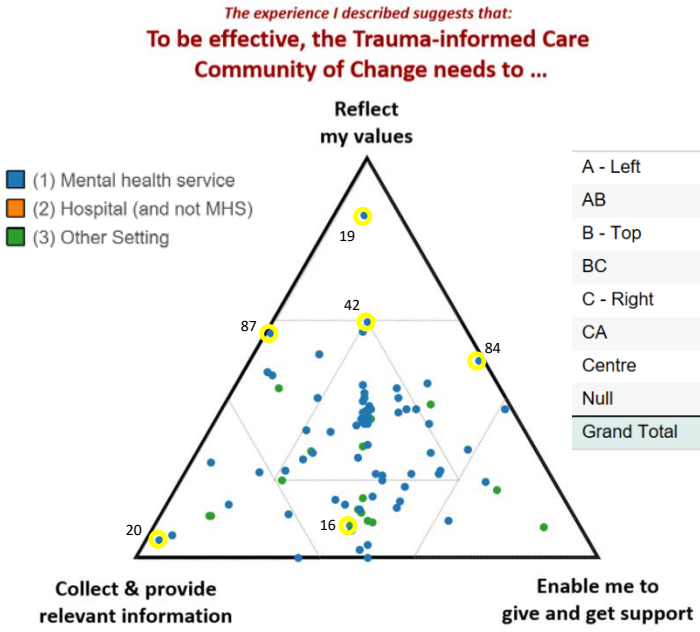


Figure 19 - Results from Triad 2 on Effectiveness of TiCA

	(1) Mental health service		(3) Other Setting		Grand Total	
	Number	%	Number	%	Number	%
A - Left	7	10%	2	13%	9	10%
AB	5	7%	1	6%	6	7%
B - Top	2	3%			2	2%
BC	4	5%	1	6%	5	6%
C - Right	3	4%	2	13%	5	6%
CA	12	16%	7	44%	19	21%
Centre	39	53%	3	19%	43	48%
Null	1	1%			1	1%
Grand Total	73	100%	16	100%	90	100%

Note: Data table excludes "Hospital (and not MHS)" group because this only has one member in the centre zone. This data item is included in the row total.

Narratives have been included below for the random selection of responses in different zones highlighted in yellow. The numbers shown for these responses are their IDs.

While the largest group of respondents placed their mark in the centre zone, indicating that all three of the signification anchors are of similar importance, only half of these marks were placed in the centre of centre zone. This indicates that half of the respondents who chose the centre zone nonetheless had a preference towards one or two of the anchors. Visual inspection of the patterns around the edges of the centre zone and in the adjacent zones suggests that there were two alternative preferences:

- Towards giving and getting support combined with either collection/providing relevant information or with reflecting the respondent's values.
- Towards collecting/providing information without a need to give or get support.

The attraction of collecting and providing information is linked, inferentially, to results from other questions as noted below.

- Triad 4 (see Figure 23 on page 26) in which responses are weighted towards co-production and a mix of co-production and shared learning.
- Stone 3 on canvas 2 (see Figure 29 on page 31) in which the majority of respondents agreed or strongly agreed that the FuturesNHS workspace "Provided interesting & useful materials."
- Stone 5 on canvas 3 (see Figure 30 on page 32) in which almost all respondents felt that the community needs to provide case studies and ideas on practicing trauma-informed care.

Six of the responses in Figure 19 have been highlighted and labelled with their ID. These have been selected at random from the different zones and are intended to provide a link between the results in this triad and

narratives in Annex 3. The Tableau packaged workbook available with this report provides direct links for all responses. The narratives for responses 16 and 42 are included below for the purpose of illustration.

Response ID: 16

Area of work: (3) Residential Care, (12) Other, Private Trauma Centre

Connection with TiC: (1) Person with lived experience of trauma and adversity, (4) Provider of trauma-informed care, Clinical Director

The parts of trauma-informed care that I most want to influence are ...

Broadening the range of effective therapies beyond CBT

This is informed by the following experience ...

I had an extremely frustrating experience of working in NHS CAMHS and adult services where it was clear that the permitted therapeutic approaches were entirely ineffective in aiding trauma survivors.

I think the NHS lag behind private & voluntary organisations and there should be space for dialogue and collaboration with these sectors. All too often the NHS assumes dominance and stifle practice by being overly prescriptive and seeking to standardise care

Response ID: 42

Area of work: (1) Mental health service, (2) Hospital, (4) Community service

Connection with TiC: (4) Provider of trauma-informed care

The parts of trauma-informed care that I most want to influence are ...

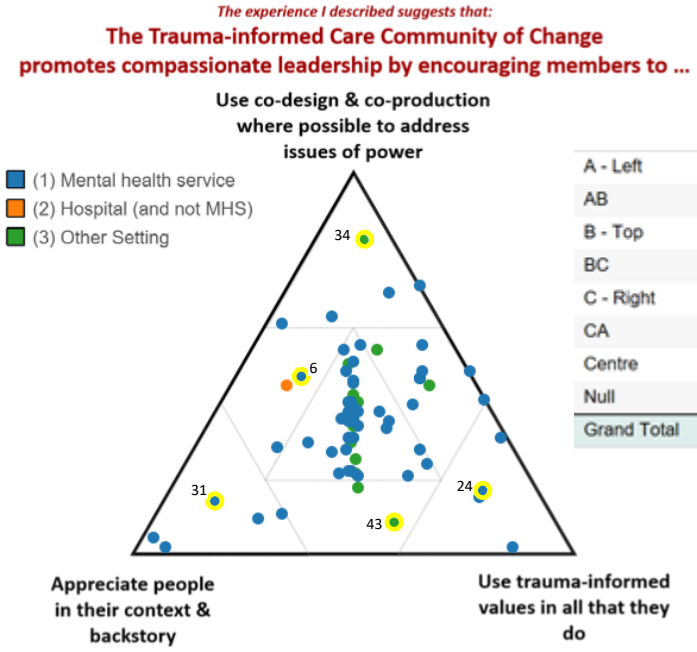
Lead and communicate about being trauma-informed; Train both clinical and non-clinical staff; Build a trauma-informed workforce

This is informed by the following experience ...

When I introduced the terminology 'Attachment seeking behaviours' in describing a girl's behaviours in her formulation as opposed to 'Attention seeking behaviours' with explanation (as part of Trauma Informed Care movement) in the MDT team discussion email exchanges, people responded to this with their 'aha' and some described how 'wording' change the attitude towards them from 'blaming culture' to 'curiosity' although not easy. When I introduced our pilot TIC project for non-clinical staff members, our inpatient school lead came back to report that she found the implementation of 'Safety cross' as a tool for reflection as well as a measurement very effective to take close look at individual staff members' experience from Trauma informed care perspective and she feels this enabled her to act early and appropriately in order to provide care to staff as well as young people.

The narrative for response ID 87 highlighted in Figure 19 is notable for suggesting that the values-based view of moving away from hierarchical and patriarchal modes of communication is an effective way of forming trauma-informed allyships with other professionals. This respondent feels that the TiCA should consider this issue in its future decisions and design protocols.

Finding 5: The community of change is using all trauma-informed values to promote compassionate leadership.



	(1) Mental health service		(3) Other Setting		Grand Total	
	Number	%	Number	%	Number	%
A - Left	5	7%			5	6%
AB	3	4%			4	4%
B - Top	3	4%	1	6%	4	4%
BC	6	8%	2	13%	8	9%
C - Right	5	7%			5	6%
CA	2	3%	2	13%	4	4%
Centre	47	64%	11	69%	58	64%
Null	2	3%			2	2%
Grand Total	73	100%	16	100%	90	100%

Figure 20 - Results from Triad 5 on Compassionate Leadership

Note: Data table excludes "Hospital (and not MHS)" group because this only has one member in the centre zone. This data item is included in the row total.

Narratives have been included below for the random selection of responses in different zones highlighted in yellow. The numbers shown for these responses are their IDs.

The majority of respondents (64%) placed their mark in the centre zone of the Triad 5 shown above in Figure 20. This suggests that the respondents already see the TiCA as using all of the values of trauma-informed care to promote compassionate leadership. The patterns of responses in the centre zone suggest that there may be a slight weighting towards the use of co-design & co-production, where possible, to address issues of power. However, this is counter-balanced by the broad distribution of responses in the zones adjacent to the centre.

The results here need to be considered alongside the barrier discussed earlier for stone 6 on canvas 1 (It [trauma-informed care] is seen as relevant to service users but not to the way leaders engage with staff (see Figure 15 on page **Error! Bookmark not defined.**). Taking these two results together suggests that while the use of trauma-informed values to enable compassionate leadership may be true in some organisations, it is likely to be aspirational in others.

Six of the responses in Figure 20 have been highlighted and labelled with their ID. These have been selected at random from the different zones and are intended to provide a link between the results in this triad and

narratives in Annex 3. The Tableau packaged workbook available with this report provides direct links for all responses. The narratives for responses 34 and 43 are included below for the purpose of illustration.

Response ID: 34

Area of work: (12) Other, Public health

Connection with TiC: (5) Service manager or other managerial role

The parts of trauma-informed care that I most want to influence are ...

> I am keen to see that all colleagues in the healthcare system around the patient care pathways are trauma informed and have received appropriate training

This is informed by the following experience ...

> I'm thinking about mental health and wellbeing pathways including primary care teams, accident and emergency psychiatric liaison VCE sector working with social prescribers who may be meeting people/patients in the course of their work and may overlook that there is a trauma dimension to their interactions that could facilitate or prevent better care and outcomes.

Response ID: 43

Area of work: (12) Other, Public Health Nursing

Connection with TiC: (5) Service manager or other managerial role

The parts of trauma-informed care that I most want to influence are ...

> I am particularly interested in how we work with schools to widen commitment to taking a TI whole school approach

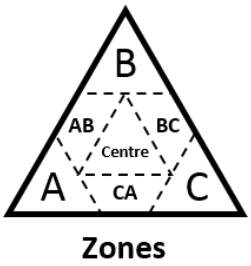
This is informed by the following experience ...

> I have seen teachers shouting and berating young people without knowledge of their emotional backstory. Equally I have seen teachers welcoming students with warmth and interest in their lives.

5.3 Value of the community of change

Findings from the data collected in the two triads and the dyad listed below can be grouped into a theme on the value of the community of change. Data from the triads are summarised by zone as illustrated below.

- Triad 3: the Trauma-informed Community of Action is valuable to…
- Triad 4: the Trauma-informed Community of Action creates value by enabling…
- Dyad: the challenge faced by the community of change in the organisation or group where I work or am supported …



Zones

Finding 6: The TiCA is of value to people from clinical and non-clinical settings who engage with people with lived experience of trauma and adversity as well as to those with this lived experience.

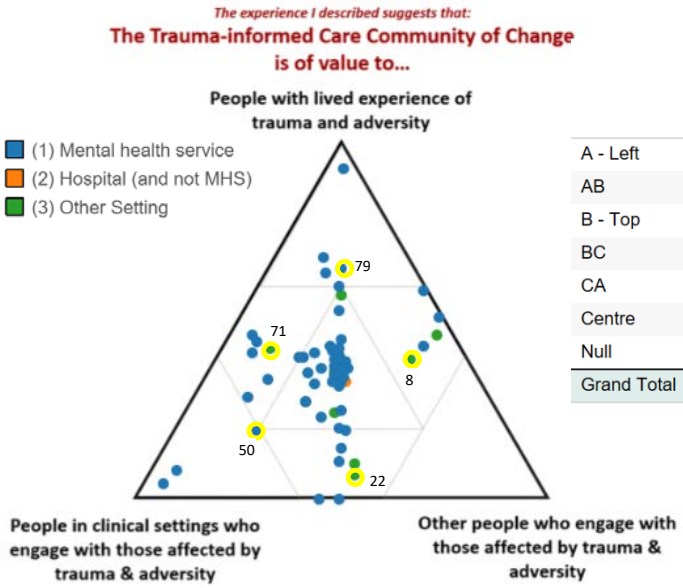


Figure 21 – Results from Triad 3 on to whom TiCA is of value

	(1) Mental health service		(3) Other Setting		Grand Total	
	Number	%	Number	%	Number	%
A - Left	3	4%			3	3%
AB	6	8%	1	6%	7	8%
B - Top	5	7%			5	6%
BC	3	4%	2	13%	5	6%
CA	5	7%	2	13%	7	8%
Centre	50	68%	11	69%	62	69%
Null	1	1%			1	1%
Grand Total	73	100%	16	100%	90	100%

Note: Data table excludes "Hospital (and not MHS)" group because this only has one member in the centre zone. This data item is included in the row total.

Narratives have been included below for the random selection of responses in different zones highlighted in yellow. The numbers shown for these responses are their IDs.

Almost 70% of respondents placed their mark in the centre zone indicating that the TiCA is of value to people from clinical and non-clinical settings who engage with people with lived experience of trauma and adversity as well as to those with this lived experience. However, the pattern within the centre zone, the cluster of responses in zone AB, and the absence of any responses in zone C shows a clear weighting towards people from clinical settings. However, this may be a consequence of the profile of respondents, most of whom are engaged in a clinical setting.

Five of the responses in Figure 21 have been highlighted and labelled with their ID. These have been selected at random from the different zones and are intended to provide a link between the results in this triad and

narratives in Annex 3. The Tableau packaged workbook available with this report provides direct links for all responses. The narratives for responses 8 and 71 are included below for the purpose of illustration.

Response ID: 8

Area of work: (6) Prison, (9) Charity, (11) University,

Connection with TiC: (4) Provider of trauma-informed care

The parts of trauma-informed care that I most want to influence are ...

> A Key focus and passion that has driven me for a number of years is to discover and grow hope in delivering compassionate interventions to restore wholeness to broken lives in the criminal justice system

This is informed by the following experience ...

> I have discovered over time that there appears to be a number of key blinds spots delivering informed trauma care in the criminal justice system these include lack of evidence base in this specific area. A clear ethical framework appropriates to this area network where practitioners can be supported and practice pooled
>
> This evaluation provides a significant opportunity to move forward with trauma informed care. If it is to be more than rhetoric. ideally it needs to be built creatively to shape practice and values.

Response ID: 71

Area of work: (9) Charity,

Connection with TiC: (4) Provider of trauma-informed care, (5) Service manager or other managerial role

The parts of trauma-informed care that I most want to influence are ...

> I would like to take trauma informed care out of the medical model framework and advocate for a more holistic approach that incorporates childhood (accumulative) trauma in the healing process if appropriate

This is informed by the following experience ...

> I am an integrative EMDR psychotherapist who worked with a young person who was traumatized after an attack. The client showed the classic symptoms of flash backs, panic attacks, not leaving home, avoiding crowds, sweaty hands, heart racing. We started our work with a timeline of trauma throughout his life. The client indicated no previous trauma. Throughout the EMDR process it became clear that the client had been brought up in a dysfunctional household. The client began to memorize a violent and aggressive household to which he/she adapted. Violence was normalized. It was paramount that in order to process the current trauma we needed to process the childhood adaptive patterns which he applied to his current trauma. The adaptive patterns did not work anymore and the client needed to be taught new behaviour. I believe this holistic approach is necessary for real trauma healing. This holistic approach needs long term therapy. The aforementioned client is now living a trauma symptom free life.

Filtering the results for Triad 3 by three of the multi-select options for the respondents' connection to TiC shows a slight difference in the patterns. See Figure 22 below. When looking at these three patterns, keep in mind that there are too few responses to allow for full use of filtering and disaggregation and that many of the respondents chose 2 or all three 3 of these options.

Response ID 36 has been highlighted above as an example. This respondent who works as a provider of trauma-informed care and has experience of trauma and adversity says that a client of his is stuck between his approach (which is trauma-informed) and the approach of the rest of the team (who are not) and that therefore making trauma-informed approaches more widely accessible through the Community of Change would be beneficial.

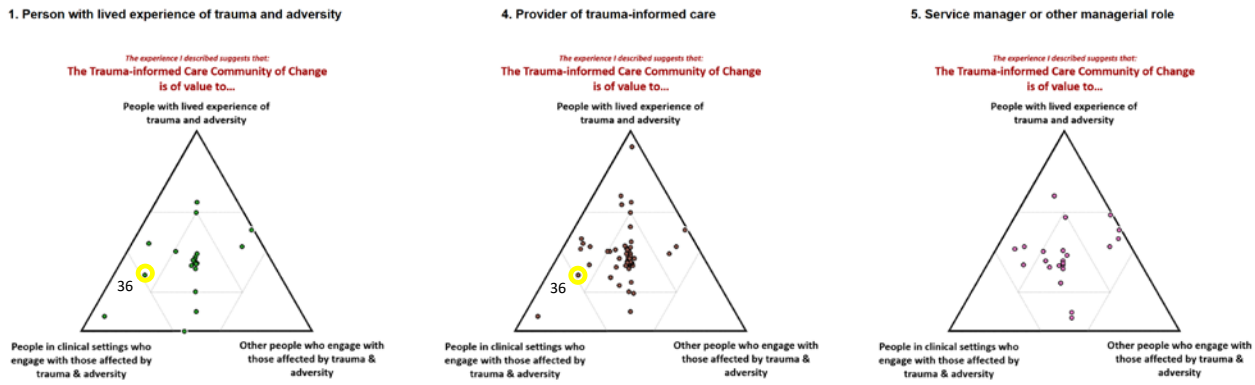


Figure 22 - Results for Triad 3 filtered by connection with TiC

Finding 7: The community of change creates value by enabling co-production with shared learning and shared learning with reflection.

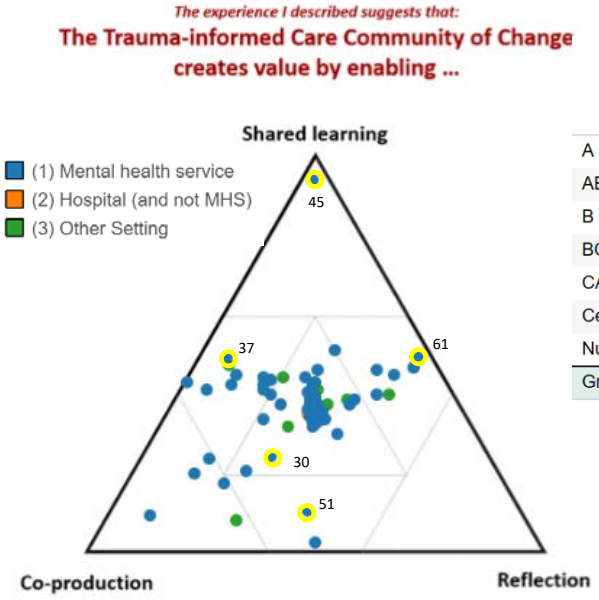


Figure 23 - Results from Triad 4 on the way in which TiCA creates value

	(1) Mental health service		(3) Other Setting		Grand Total	
	Number	%	Number	%	Number	%
A - Left	4	5%	1	6%	5	6%
AB	9	12%	1	6%	10	11%
B - Top	1	1%			1	1%
BC	6	8%	2	13%	8	9%
CA	2	3%			2	2%
Centre	49	67%	12	75%	62	69%
Null	2	3%			2	2%
Grand Total	73	100%	16	100%	90	100%

Note: Data table excludes "Hospital (and not MHS)" group because this only has one member in the centre zone. This data item is included in the row total.

Narratives have been included below for the random selection of responses in different zones highlighted in yellow. The numbers shown for these responses are their IDs.

In trauma-informed care, there is an emphasis on the values of sharing, co-production, and reflection – the three corners of triad 4. As shown above in Figure 23, almost 70% of respondents placed their mark in the centre zone and, of these, almost all of them were in the middle of the centre zone.

Looking at the patterns outside the middle of the centre zone, there appears to be a slight weighting towards co-production either on its own or with shared learning. It is interesting to note that with the exception of response ID 45 at the top of zone B, none of the respondents choose shared learning or reflection on their own. This suggests that these values need to be ancillary to co-production.

The small cluster in zone BC between shared learning and reflection is also of interest and suggests that the community of change creates value for some respondents by giving them the space to learn and to reflect on that learning without needing to participate in co-production. The illustration in Figure 24 below suggests that these respondents are mostly people who are currently aware of TiCA and who are not expecting to have a stronger relationship in a year from now. See circled area. This data is described in section 6.4.

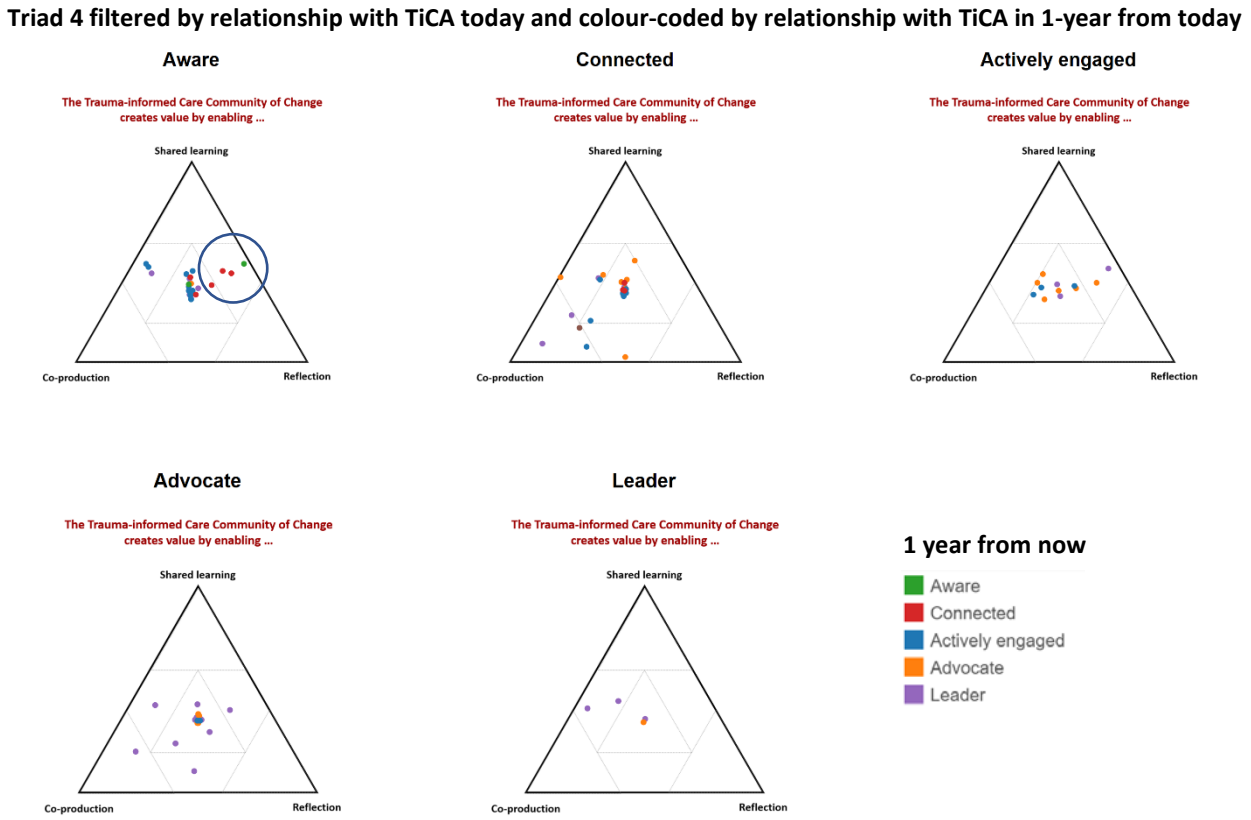


Figure 24 - Results from Triad 4 filtered by relationship with TiCA

Five of the responses in Figure 23 have been highlighted and labelled with their ID. These have been selected at random from the different zones and are intended to provide a link between the results in this triad and narratives in Annex 3. The Tableau packaged workbook available with this report provides direct links for all responses. The narratives for responses 30 and 45 are included below for the purpose of illustration.

Response ID 34 (referenced in Finding 2 on page 17) may also be relevant here because it points out that value of shared learning is underpinned by the fact that there are often a number of specialists from different teams working with one individual. Response ID is adjacent to response ID 37 on Triad 4 illustrated in Figure 23.

Response ID: 30

Area of work: (1) Mental health service

Connection with TiC: (4) Provider of trauma-informed care

The parts of trauma-informed care that I most want to influence are ...

> TIC is relevant to everything. The areas that I most want to influence are:- care for patients and their carers and families, care for staff, and care for organisations and communities

This is informed by the following experience ...

> It is difficult to keep the example anonymous. I regularly work with communities and patients of additional disabilities. A majority of them have experienced both historic abuses and ongoing discrimination from accessing services. Often they feel that the service providers are not aware of their needs or ready to meet their needs. As a result of the barriers, they might feel further traumatized during their contact with services. For example, the information might not be accessible or comprehensible; the contact methods could be inappropriate and staff might be seen as lack of awareness or sensitivity. My observation here is the importance of the appreciation of individuals' culture, communication and language and how services can prepare themselves to address patients and their carers/families with multiple difficulties and disadvantages and to embrace the values of diversity, inclusiveness and empowerment whilst showing their kindness and compassion. The challenges on achieving common language and terminologies can be extended to inter-agency working especially dealing with safeguarding and public protection.

Response ID: 45

Area of work: (1) Mental health service, (2) Hospital, (12) Other, Inpatient adults learning disabilities and Autism in a hospital setting and also on mental health wards

Connection with TiC: N/A

The parts of trauma-informed care that I most want to influence are ...

> To be able to gain more knowledge and tools that could be effective for patients that I support but also be able to pass the knowledge and information onto my colleagues, as I believe that staff who are informed about trauma can develop more empathy for patients who have experienced different types of trauma and it would be build the therapeutic relationship between staff and patients

This is informed by the following experience ...

> I have supported people over the years who have experienced trauma from domestic violence, attachment issues which does cause issues for individuals to trust others and build therapeutic and positive relationships with others including staff, family members and friends, and bereavement

Finding 8: The value of the TiCA may be challenged in organisations unless action is taken to limit over-use of the term trauma-informed care.

Respondents were asked to place a mark on the dyad/line in Figure 25 below to show whether, in their experience, the term trauma-informed care is a new name for something that is already happening or, conversely, is being used too broadly with the effect that it is losing its meaning.

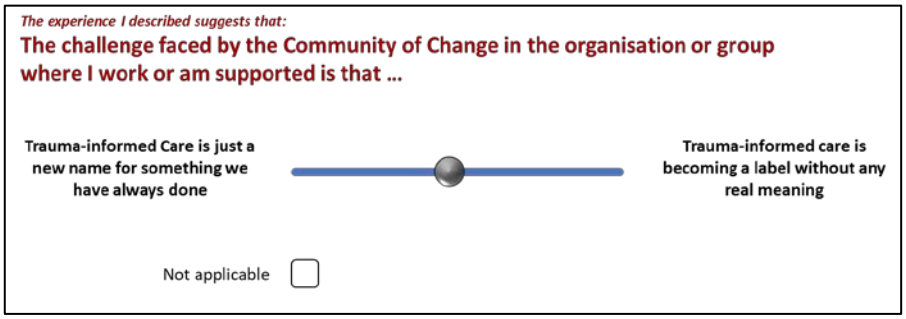
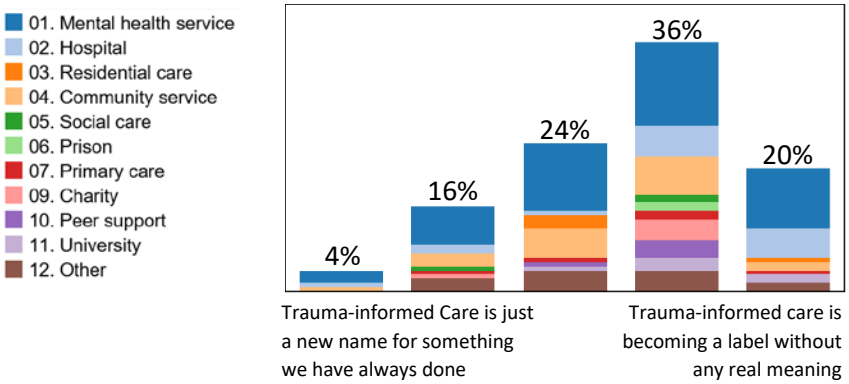


Figure 25 - Dyad question on use of the term "Trauma-informed Care"

The results in Figure 26 show that the largest group of respondents are in the centre-right quintile. This suggests that there may still an opportunity for the TiCA to establish a clear distinction between trauma-informed care as a specific approach and its use as a generic term.



01. Mental health ser..	5%	15%	26%	32%	23%
02. Hospital	6%	11%	6%	39%	39%
03. Residential care			75%		25%
04. Community service	5%	14%	32%	41%	9%
05. Social care		33%		67%	
06. Prison				100%	
07. Primary care		20%	20%	40%	20%
09. Charity		17%		83%	
10. Peer support			20%	80%	
11. University			17%	50%	33%
12. Other		20%	33%	33%	13%
Total	**4%**	**16%**	**24%**	**36%**	**20%**

Figure 26 - Results from Dyad question on use of the term "Trauma-informed Care"

5.4 Engagement with the TiCA and the FutureNHS Platform

Findings from the data collected in the dyad and the two stones canvases listed below can be grouped into a theme on the respondents' engagement with the TiCA and the FutureNHS Platform.

- Dyad 2: Relationship with the Trauma-informed Community of Action today and in 1-year…
- Stones 2: Impression of the NHSFutures workspace …
- Stones 3: The FutureNHS workspace used by the TiCA needs to provide…

Finding 9: Most respondents say that their relationship with the TiCA in 1-year will be stronger than it is today.

The growth of the TiCA since it opened its FutureNHS workspace in March 2020 appears to be underpinned by a high proportion of members who are keen to develop a stronger relationship with the community over the next year. This is shown in the charts in Figure 27 and Figure 28. The first of these charts shows the change looking forward from today, the second looking back from a projection of one year in the future.

In summary, the number of members who are actively engaged will increase from 13% to 28% (12 to 25), advocates will remain broadly the same at around 24% and leaders will increase significantly from 4% to 30% (4 to 27). While these are encouraging results, they need to be used with care because the 90 members who chose to respond to the survey may be disproportionately interested in taking an active / leadership role; also, anonymous survey questions such as this one where there is an answer which is seen as 'right' are often 'gifted' i.e. people say what they think the organisation running the survey wants to hear.[2] The reliability of responses to this question can be tested by monitoring the actual level of engagement over the next 3-9 months.

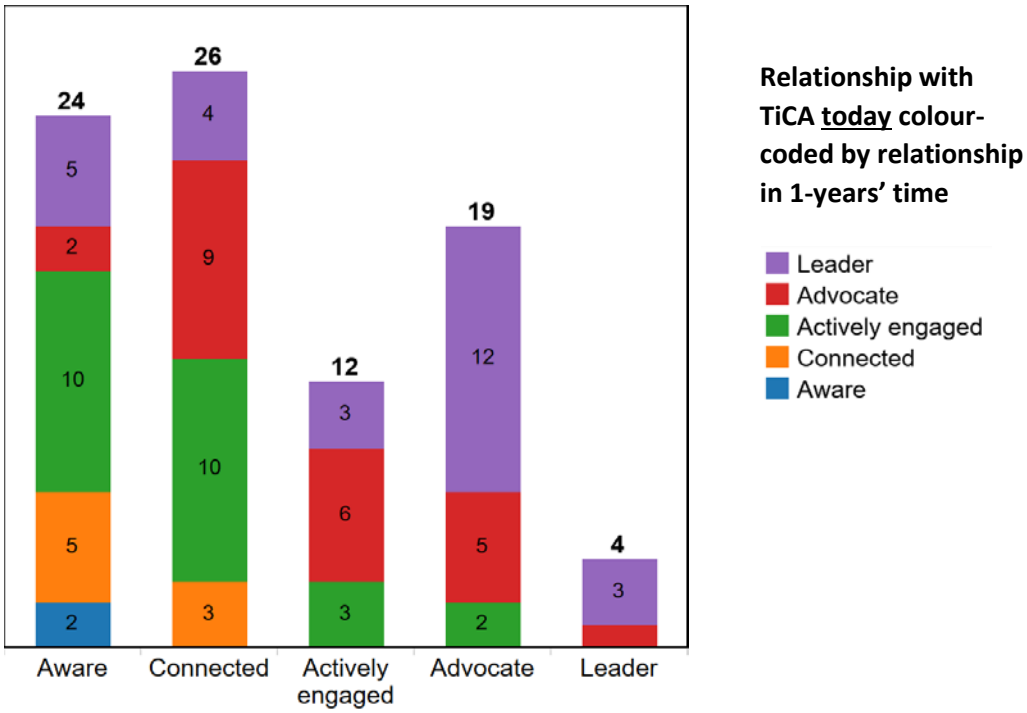


Figure 27 - Relationship with TiCA today

[2] Note: sense-making triads, dyads and stones-canvases are designed carefully to avoid gifting and gaming.

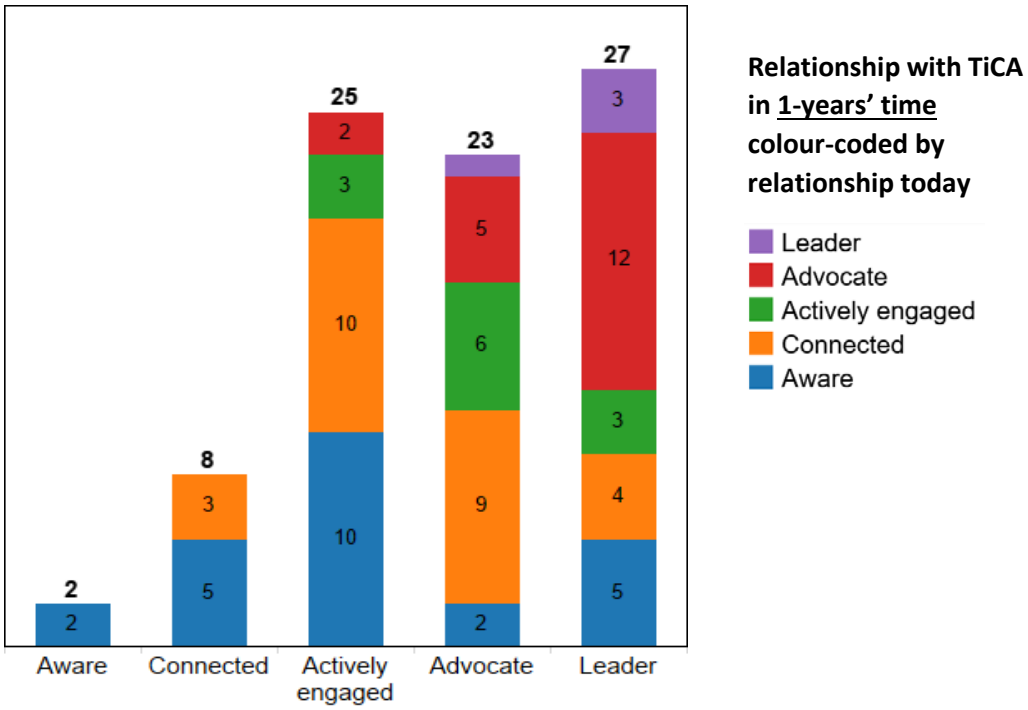


Figure 28 - Relationship with TiCA 1-year from today

Finding 10: Only 45% of respondents had visited the FutureNHS website prior to completing the evaluation. However, most of those who had visited had a largely positive impression of it.

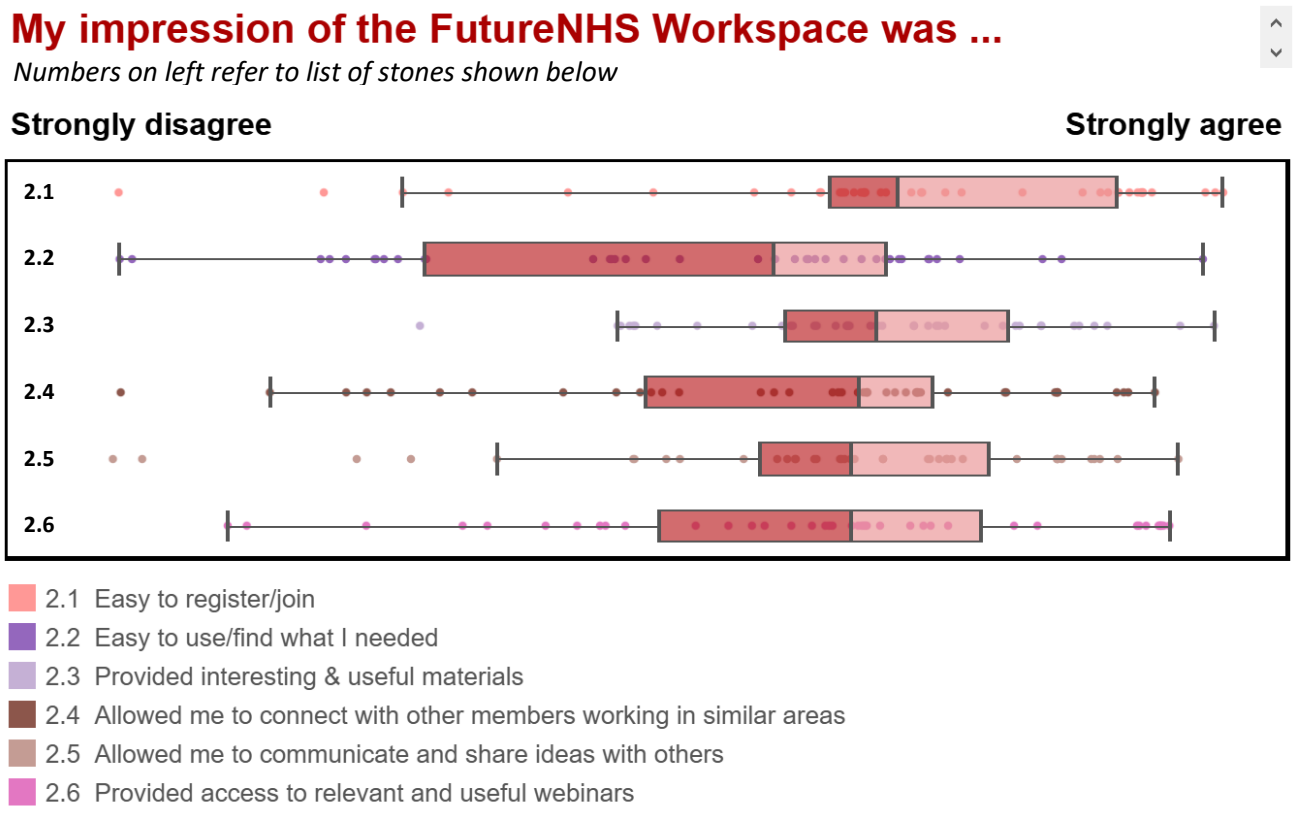
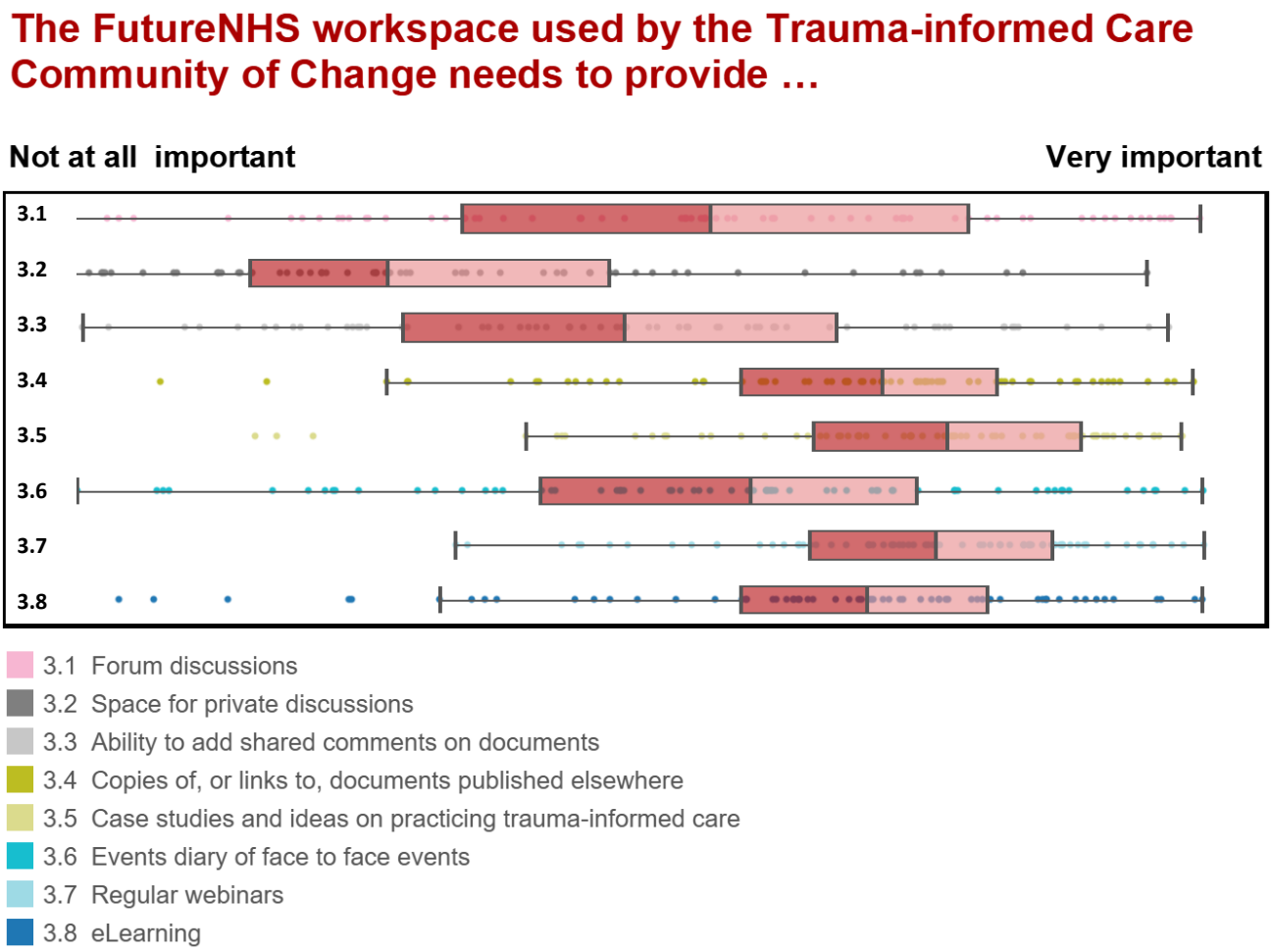


Figure 29 - Results from Stones Canvas 2 - Impression of FuturesNHS Platform

The only attribute that respondents disagreed with was the ease of finding/using what they needed. This may become more challenging as more users start using the platform and the number of documents/materials continues to increase.

Finding 11: The FuturesNHS workspace should be used for case studies and ideas on practicing trauma-informed care, regular webinars, copies or links to documents and eLearning



		1. Left	2. CL	3. Centre	4. CR	5. Right	Grand T..
Number	Total	28	51	54	65	58	69
% of T..	Total	41%	74%	78%	94%	84%	100%
% of Total	3.1 Forum discussions	8%	23%	24%	21%	24%	100%
	3.2 Space for private discussions	24%	39%	21%	11%	5%	100%
	3.3 Ability to add shared comments o..	8%	23%	31%	23%	14%	100%
	3.4 Copies of, or links to, documents ..	3%	6%	16%	48%	28%	100%
	3.5 Case studies and ideas on practi..		4%	15%	38%	43%	100%
	3.6 Events diary of face to face events	6%	15%	27%	32%	20%	100%
	3.7 Regular webinars		3%	13%	38%	46%	100%
	3.8 eLearning	6%	8%	11%	48%	28%	100%

Figure 30 - Results from Stones Canvas 3 - What the FuturesNHS Platform needs to provide

69 of the respondents placed one or more of the stones on the canvas shown above in Figure 30 to illustrate the relative importance of different features of the FuturesNHS Platform; the remaining 21 respondents selected “none of these” indicating, perhaps, that they did not see a need for a collaborative platform or, more likely, had not yet looked at the platform.

The respondents who answered this question identified the following four features as most important for them. This list is shown in order of priority.

- 3.5 Case studies and ideas on practicing trauma-informed care
- 3.7 Regular webinars
- 3.4 Copies of, or links to, documents published elsewhere
- 3.8 eLearning

The next two features identified by respondents, 3.1 Forum discussions and 3.6 Events diary of face-to-face events are relatively important but have a wider distribution of responses.

Feature 3.3, the Ability to add shared comments on documents, is balanced between the two ends of the canvas with an even distribution of responses. This is interesting because, as far as we can determine, members have not yet added shared comments to any of the documents on the website – although doing so would be a good indicator of shared learning and co-production.

Feature 3.2, the ability for members to send private messages to each other, is the only one that all respondents consider less rather than more important. The site administrator is not able to see the number of private messages that members have sent to each other so we do not know the extent to which this feature has been used; we assume, however that it has not been used very often. The author’s experience in other online communities of practice is that private messages are used alongside shared discussions to follow through on particular details and/or establish new a 1:1 connection that can be used to share learning and give and get support. It may therefore be worthwhile continuing to keep this feature under review to see if it is used more widely in the future.

6. Conclusions

This evaluation report was conducted with three aims in mind: to provide NHSE/I with an evaluation of the need for a community of practice and the way the funded activities are currently meeting those needs; to show how the TiCA is using the FuturesNHS collaboration platform; and to show how members feel the TiCA could be shaped to give them the most value and support widespread adoption of trauma-informed care. The evaluation used SenseMaker®, a narrative research tool that supports emergent design and analysis, to collect responses from 90 members of the community. The data was analysed in Tableau.

In general, the evidence presented in this report shows that the attitudes of the respondents to the TiCA is positive. The community has grown significantly in the 9 months since its launch in March 2020 and currently has more than 500 members from across the country. The research shows that a majority of respondents want to take an increasingly active role in the TiCA over the next year. The profile of respondents is weighted towards people engaged in mental health services in the NHS; while this is expected, trauma-informed care is important across multiple disciplines and settings. As such, the TiCA might benefit from a clearer analysis of its members. This could be started by adding fields to the FutureNHS database to provide categories based on discipline and setting. New members could be asked to select the relevant categories when they ask to join the community and, if permitted by GDPR, existing data on FutureNHS be used to tag current members.

The report sets out eleven findings (see Executive Summary) grouped into four sections:

- **Section 1: Indicators of adoption to and barriers to adoption of trauma-informed care.** The findings in this section will help the TiCA prioritise action to support continued adoption of trauma-informed care and to help members overcome specific barriers in their organisations. One of the key indicators, the inclusion of trauma-informed care in strategic plans, regulatory frameworks and inspections, could guide the co-production of material to be shared and the content of webinars and eLearning. Taken together, all the indicators and barriers provide a useful baseline for any further evaluation that may be carried out over the next few years.

- **Section 2: Purpose and effect of the community of change**. Findings in this section will enable the Core Action Group to shape and guide the TiCA's future so that it continues to engage and interest members in a way that meets their needs. These results may also highlight areas of difference that need to be addressed and groups of members who may need particular support to remain in the mainstream. This is important because, otherwise, the trauma-informed care and TiCA may be diluted to become 'everything to everyone'. This focus on alignment is helped by the findings that most of the respondents use the TiCA for collecting and sharing information and are willing and able to adhere to the principles of trauma-informed care.

- **Section 3: Value of the community of change**. The findings in this section illustrates that the value of the TiCA is currently focused on clinicians and, to a lesser degree, non-clinicians who support people with lived experience of trauma and adversity. The relatively low weighting of primary value to people with lived experience is likely to be due to the profile of respondents because almost everyone with lived experience of trauma and adversity was also a provider of trauma-informed care. The TiCA may want to revisit/reuse this question after the categorisation of members suggested earlier allows them to engage specifically with more people who have lived experience but are not providers and/or when the membership includes more people in this group. Overall, the emphasis amongst the respondents on the value of co-production and opportunities for co-production of knowledge supports the rationale for the TiCA as providing a space where trauma-informed professionals from a wide range of settings can come together to learn from each other.

- **Section 4: Engagement with TiCA and the FuturesNHS Platform**. As highlighted above, respondents indicated that their level of engagement within the TiCA will increase during 2021. Respondents who had visited the platform also had a positive impression of it and its contents and suggest that the most helpful content is case studies, ideas, webinars, copies of documents, and eLearning.

While the evaluation is based on a relatively small number of responses it provides some interesting future directions for the TiCA. If the results are indicative of future development and the TiCA continues to be supported by NHSE/I and guided by an active and informed Core Action Group, then it seems likely that trauma-informed care will achieve widespread adoption and provide value to people with lived experience of trauma and adversity and to the practitioners that support them.

Annex 1 – Methodology

A1.1 Introduction

The evaluation was carried out using SenseMaker® an online research method[3] that allows respondents to describe a lived experience and then signify, or make sense of, what the experience means to them in their own context. This process of self-signification allows qualitative micro-narratives to be collected from a large number of respondents and mapped/explored in a quantitative framework.

Individual micro-narratives may appear incomplete and/or ambiguous and should be read with their associated signification and compared with narratives that other respondents have signified in a similar way. As such, the primary purpose of the narratives is to provide a basis for signification of a respondent's deeper and often unarticulated lived experience and to provide explanatory power for patterns in signification data collected from all respondents.

The approach relies on the collection of a sufficient number of responses to form reliable patterns in the signification data. While we are not aware of any statistical method for determining the minimum number of responses needed to explore patterns, we use a practitioner's rule of thumb that any filtered group or cohort within the data must include at least 50 responses. When starting this evaluation, we assumed that the level of interest and engagement of members in creating and supporting the community would translate into a high-response rate and enable the collection of at least 150 and up to 200 responses. This represented around 75% of members in June 2020 and would have allowed a reasonable level of filtering to identify and explore patterns. In the event, we were only able to collect 90 responses.

With 90 responses, we have focused on top-level patterns and have not been able to filter/disaggregate the data to compare patterns for different cohorts.

The data collected from respondents was analysed and explored in Tableau – a widely used visualisation tool. A copy of the Tableau packaged workbook is available from the TiCA for further exploration. The workbook needs to be opened in a licensed copy of Tableau Desktop or in a free copy of Tableau Reader.

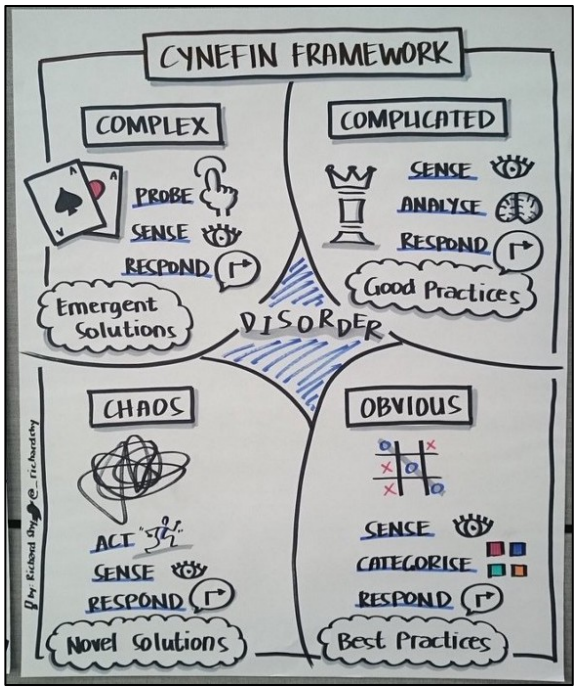


Figure 31 - Cynefin Framework

A1.2 Complexity & the Cynefin Framework

SenseMaker® is intended to be used for exploratory research in contexts where issues, decisions and actions are shaped by human complexity.[4] In these contexts, behaviour is based on co-evolution of the relationships and interactions between people (and other 'agents') and the boundaries that constrain (and/or enable) their

[3] SenseMaker® Online is licensed for use by Cognitive-Edge who hold a U.S. patent for "Computer-aided methods and systems for pattern-based cognition from fragmented material"

[4] Human complexity is also referred to as anthro-complexity and excludes the type of complex relationships and patterns associated, for example, with the movement of ants or the murmuration of starlings.

choices.[5] While it may be possible to 'see' one or more possible next steps in these contexts, there are too many 'unknown unknowns' to create a predictable relationship between cause and effect. Solutions therefore need to (be allowed/encouraged to) emerge from the way in which the relevant systems are disposed to evolve and, importantly, by taking small 'safe-to-fail' actions that catalyse change.

Complexity is one of five core domains in the widely cited 'Cynefin Framework'. A low-tech illustration of this framework is shown opposite[6]

SenseMaker® should be used to discover what is not yet known rather than to confirm or explain what is already known. The latter is the province of research tools such as conventional surveys, focus groups, risk analysis and options appraisal in the complicated domain and metrics, measurement and control in the obvious domain.

A1.3 SenseMaker® signification framework

A SenseMaker® questionnaire is referred to as a signification framework and includes five types of question:

- **Prompting question**. Respondents are asked an open question that prompts them to describe an experience which is relevant to the issue or topic that is being explored. In the signification framework for this evaluation, we used two connected prompting questions. The first question asked the respondent to describe the parts of trauma-informed care that they most want to influence; and the second question asks them to describe a real experience that illustrates how they could help the TiCA, or the TiCA could help them, to have this influence. In line with ethical practice and GDPR, respondents are asked to ensure that they describe their experience in a way that does not include anything that could be used to identify any individual person. In most cases, respondents comply with this request; however, to be certain about this, we review all narratives and replace the names of any person, place or organisation with a relevant placeholder.
- **Triads** - these are triangles with a lead-in question and with a word or short phrase at each corner. The text at each corner is referred to as a signification anchor. Respondents place a mark inside the triangle in a place that balances and blends the relative importance of the three anchors. They place this mark while keeping in mind the experience they described in response to the prompting question. If the lead-in question and signification anchors have been crafted carefully then the process of placing the mark will create a novel response based on tacit sense-making of the anchors and how they apply in relation to each other. In all cases the anchors must not directly or indirectly refer to any attribute, value or concept that respondents would easily see as either right or wrong, acceptable or unacceptable. If this heuristic is not applied, the responses will almost always be gifted (where the answer is what respondents think is expected, desired or desirable) or gamed (where the answer will represent what respondents think will influence decisions/actions in a way that best servers their interests – regardless of their 'real' views).

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[5] Other agents can include, for example, myths, cultural/social/organisational norms. Boundaries generally constrain choices, however in some circumstances and for some agents they can provide new perspectives and possibilities that enable new choices and actions.

[6] The Cynefin Framework was originated by a group of people including David Snowden and published in the Harvard Business Review in November 2007. https://hbr.org/2007/11/a-leaders-framework-for-decision-making.

The Cynefin Framework shown used in this report has been updated: "Obvious" is now called "Clear", "Disorder" is now split between two types of confusion, and a sub-domain of liminal complexity has been added along the inner borders of the complex domain. The current 'standard' version of the framework is described clearly in a blog written by Chris Corrigan.

- **Dyads** – these are lines with a lead-in question and with a word or short phrase at each end. The text at each end is a signification anchor. Where possible and practicable these anchors are based on an unlabelled 'golden mean' (or hypothesis) in the centre of the line. In this case, the anchor at one end will represent the complete absence of the golden mean and the anchor at the other end, an excess of this golden mean. Constructed in this way, both anchors will appear to be negative. Respondents place a mark on the line in the place that balances the two anchors in relation to the experience they described.
- **Stones Canvases** – these are rectangles or squares with signification anchors along either two or four of the edges and up to 6 or 8 'stones' each labelled with a different word or phrase. The signification anchors, again a word or short phrase, are typically opposites of a particular attribute – for example, least important/most important or positive impact /negative impact. The labels on the stones are typically different members of a category, for example, barriers, needs or impressions. Respondents place relevant stones on the square or rectangle where they balance the two or four signification anchors and reflect any differences between the stones.
- **Multiple-choice questions** – these are conventional tick-box questions and are typically used to identify particular attributes of the experience described in response to the prompting question and/or provide information about the respondent. The purpose of these questions is to filter/disaggregate patterns in the signification patterns rather than to collect data on an independent basis. Where possible, these questions should request the respondent to choose a single option.

A1.4 Emergent design of the SenseMaker® signification framework

SenseMaker® signification frameworks can be 'designed' (or, more appropriately, crafted) in a number of different ways. The method used here was based on **emergent design**. This enables people who represent the respondents to choose the focal area that they believe will enable the most effective exploration and discovery and to identify signification anchors that are likely to surface patterns that will be useful. The process also has the benefit of allowing key stakeholders to make sense of the method without needing to listen to and learn conceptual details.

The emergent design process used in this evaluation is outlined below.

1. **Identify potential themes** from which SenseMaker signifiers could be developed. These were identified from the report of the National Trauma Workshop (referenced earlier) and reviewed and agreed with Angela Kennedy on behalf of the TiCA Core Action Group. These potential themes are illustrated below in Figure 32. (NB. The colours in this illustration are incidental).

2. **Individual Zoom meetings** with Angela Kennedy and three other members of the Core Action Group - Angela Sweeney, Warren Larkin, and Nicola Armstrong. The four participants had different connections with Trauma-informed care. In a different order to their names, these connections included: Independent Provider, Person with lived experience of Trauma, Academic and Independent Specialist. The participants, other than Angela Kennedy, were identified on an ad hoc basis rather than through a formal selection. Each Zoom meeting included the following steps. We facilitated this process but did not engage in substantive discussion or conversation with the participants about their decisions in steps (a) to (d).

    a. **Choose or suggest a theme**. Each participant was invited to choose one of the potential themes identified above or suggest an alternative theme based on a combination of the potential themes. Themes chosen by a previous participant were not available for selection.

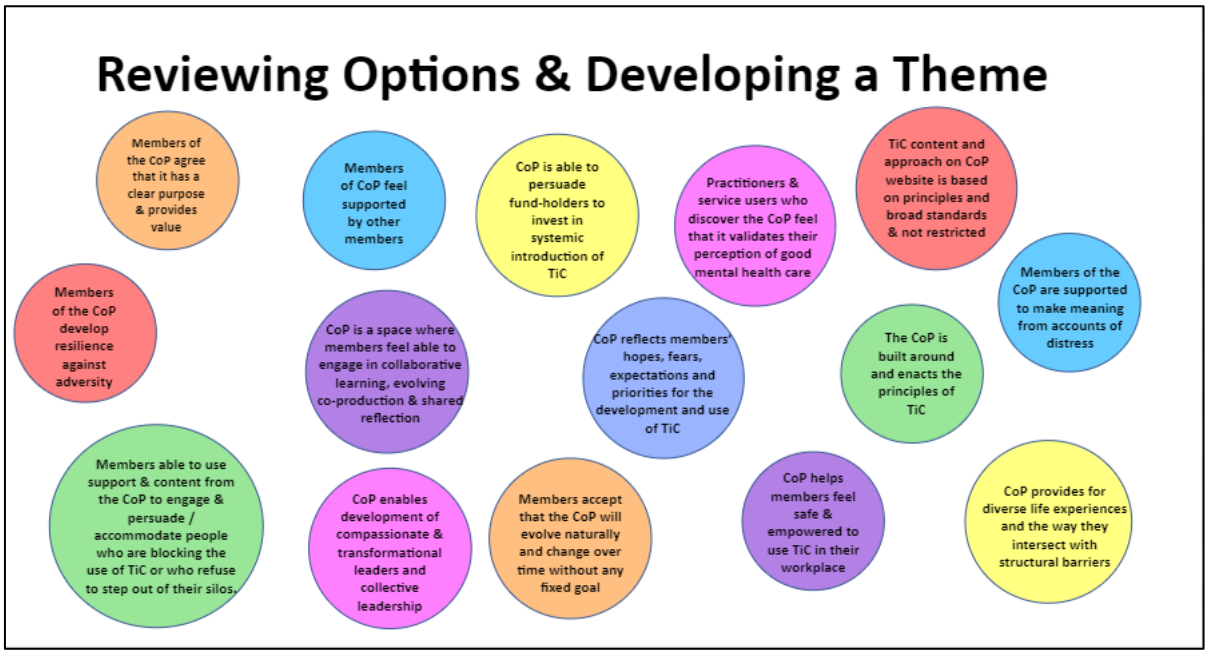


Figure 32 - Themes used in emergent design of SenseMaker signification framework

b. **Identify indicators**. Each participant was asked to list 10 words or short phrases that would, in their view, be heard, seen, felt or otherwise experienced if the theme or, more precisely a change associated with the theme, was 'happening'.

c. **Choose 1st signification anchor for a triad**. Each participant was asked to choose one of the 10 words or short phrases and place it as a signification anchor at a corner of a blank triangle – the decision on which one to select was left to the participant and based on an internal/tacit prioritisation.

d. **Choose 2nd and 3rd signification anchors for the triad**. Each participant was asked to return to their list of 10 words or short phrases and select a second and then, later, a third signification anchor. In both cases they were asked to ensure that they complied with the **four simple heuristics** listed below. If they needed to modify the listed words/phrases to comply with these heuristics they were allowed to do so.

   - The 2nd and 3rd anchor needed to have the same polarity as the previous anchor(s) – i.e., all positive or all negative.
   - The anchors needed to be chosen/worded in a way that avoided anything that would likely be seen as a 'right' or 'wrong' answer.
   - The anchors must not be mutually exclusive - i.e., all anchors needed to be able to be blended/combined with the other anchors.
   - The anchors must all be worded in a way that allowed some ambiguity – this was necessary to ensure that it would be seen as relevant to a wide range of experiences.

e. **Suggest a lead-in question for the triad** – Each participant was asked to suggest a lead-in question for the triad that reflected the initial theme, was open-ended (rather than aimed at securing a specific response) and connected smoothly with the three anchors.

f. **Review the language** – We worked with each participant to review the lead-in question and anchors so that, as far as possible, these used 'everyday language' that respondents would use in

day-to-day conversations – rather than in written documents or professional presentations. The lead-in question also needed to flow smoothly to each of the anchors when read out aloud.

3. **Preparation of draft signification framework** – The single triads provided by each participant were combined/extended to provide a draft framework with 8 triads, 2 dyads, 5 stones canvases, 5 multiple-choice questions and two tick-box questions on agreement to share/publish contributions. The draft framework was intentionally longer than it needed to be.

4. **Review and finalisation of signification framework** – The draft framework was reviewed with the Core Action Group at a Teams meeting on 20th May. Feedback was used to update and finalise the framework and shorten/focus it by removing 3 triads and 2 stones canvases. A copy of the final framework is included at Annex 2.

A1.5 Collection of Responses

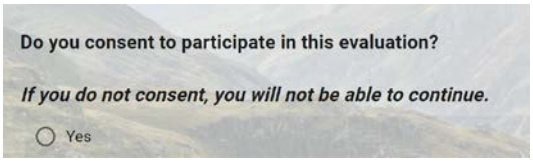
Anne Richardson emailed all members on 8th June (268 at the time) to invite them to complete the survey and provide a link for them to do so. The invitation started with "We need to know that this new community, facilitated by the NHS Futures platform is of value and how it could develop to best meet your needs"

A link to the survey was also posted on (and pinned to the top of) the community's workspace on the FutureNHS Platform and Anne Richardson emailed all new joiners to ask them to contribute. The survey was also mentioned during a number of the TiCA webinars.

The survey had an initial closing date of 19th June to attempt to encourage a quick response. This was extended to 19th July and then left open until mid-November. A copy of the invitation on the FuturesNHS Platform (and on the opening page of the survey) is included below.

In total 90 responses were collected. With an average of 385 members during the period from June to mid-November, the response rate is 23%. While this low response rate is somewhat disappointing for a new and active community, it is not entirely surprising given an industry standard rate of 29% for online surveys[7] and the extremely high workload and pressure resulting from the COVID-19 pandemic.

The first page of the survey asked respondents "Do you consent to participate in the evaluation". If they did not click the radio-button shown opposite, they could not continue with the survey.



The second page of the survey, illustrated in Figure 33, included an instruction "Please describe the example [in the answer to the second prompting question] without judgement and without including any details that could be used to identify you or anyone else". It also included questions that allowed each respondent to choose whether or not they wanted to share their narrative with the TiCA Core Action Group and, if this was okay, whether their narrative could be quoted in this report. Four respondents chose not to share their narrative and a further two chose to share their narrative but not to have it quoted here. These responses have been redacted in Annex 3 and replaced with a note on their status.

[7] Source: https://surveyanyplace.com/average-survey-response-rate/

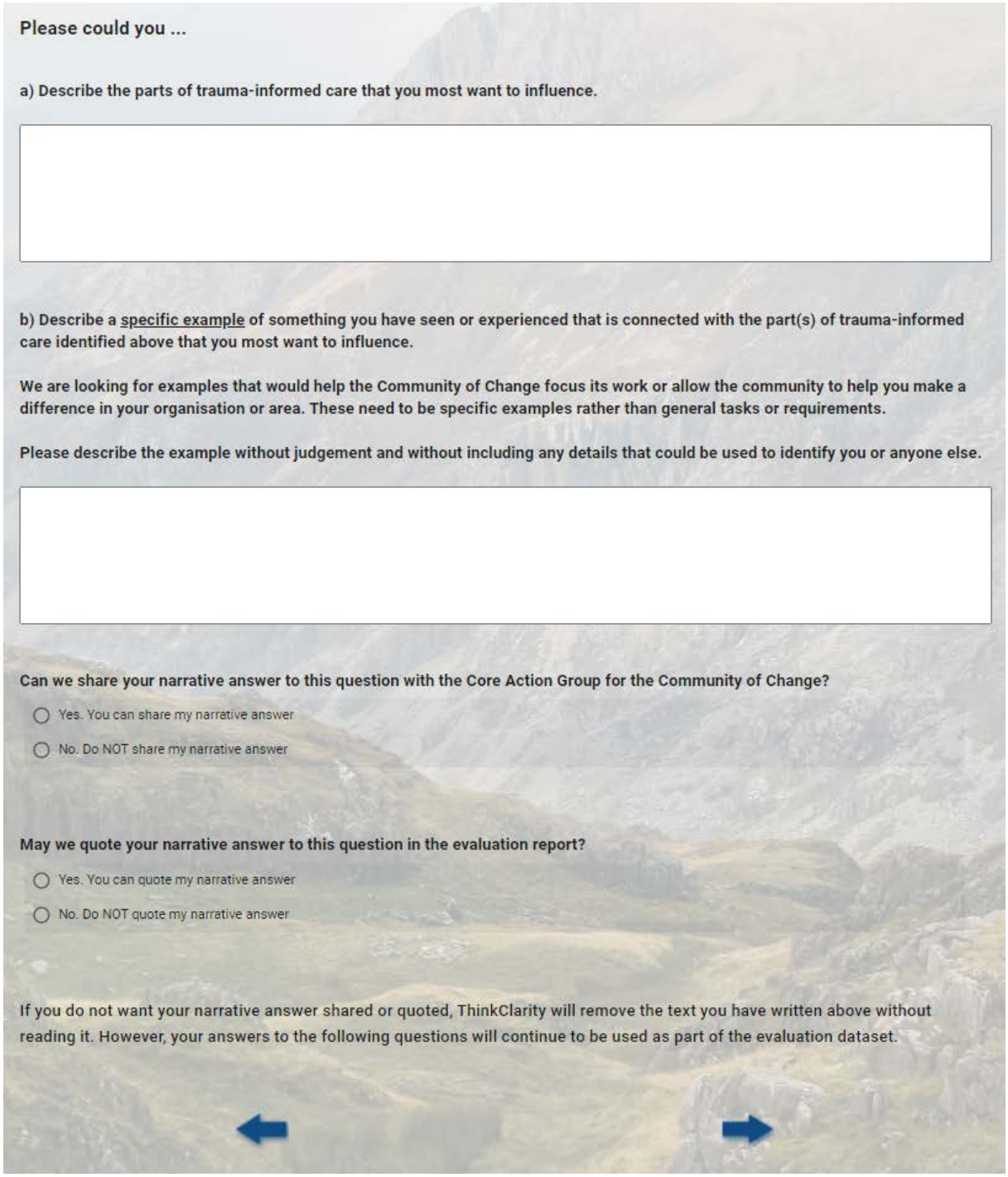


Figure 33 - Guidance on anonymity and request for agreement on sharing and quoting narrative

Annex 2 – SenseMaker® Signification Framework

The images included below are from the PowerPoint version of the framework

Thank you for joining and participating in the new and fast-growing

Trauma Informed Community of Change

I would appreciate it if you could complete this SenseMaker® survey to help shape our community so that it meets your needs and provides value.

The survey asks you to:

1. Describe how you would like to influence the use of Trauma-informed Care;
2. Describe a real experience that shows how you could help the community, *or the community could help you*, to influence the use of Trauma-informed Care; and
3. Answer a series of visual questions to signify what the experience you described means to you and to the community.

Note: If you are using Internet Explorer and have difficulty completing the survey, please open it on a different computer or a smart phone that uses a more up to date browser such as Microsoft Edge, Chrome or Firefox.

1. Please could you …

a) Describe the parts of trauma-informed care that you most want to influence.

b) Describe a real experience that shows how you could help the Community of Change – or how the Community of Change could help you – to influence the parts of trauma-informed care outlined above.
Do not include any details that can be used to identify you or anyone else.

Can we share your narrative answer to this question with the Core Action Group for the Community of Change? Yes ☐ No ☐

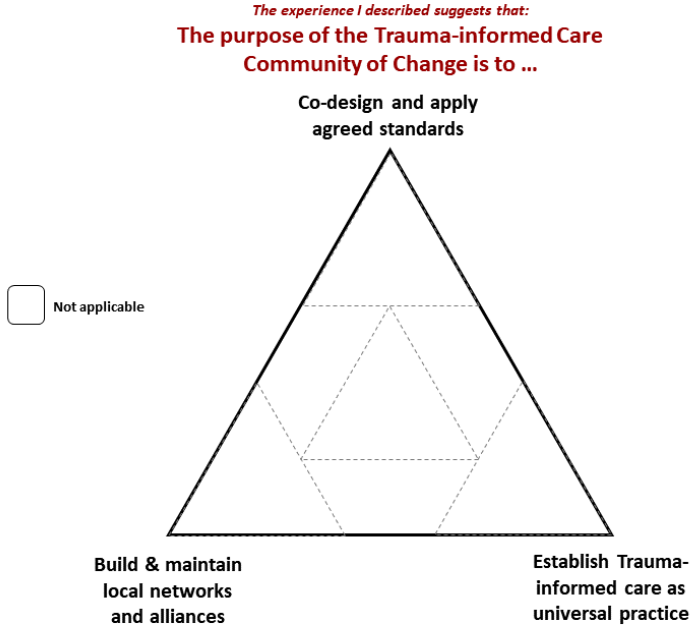
May we quote your narrative answer to this question in the evaluation report? Yes ☐ No ☐

If you do not want your narrative answer shared or quoted, ThinkClarity will redact your text without reading it. However, your answers to the following questions will continue to be used as part of the evaluation dataset.

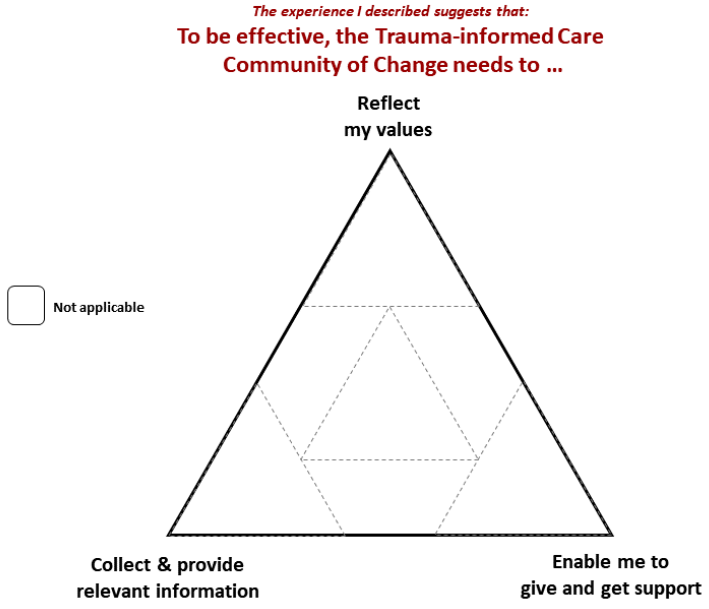
1

The message about Internet Explorer on the first page above was included following identification of an issue with Internet Explorer which, although still widely used, is a legacy product. Cognitive-Edge addressed this problem relatively soon after it was identified.

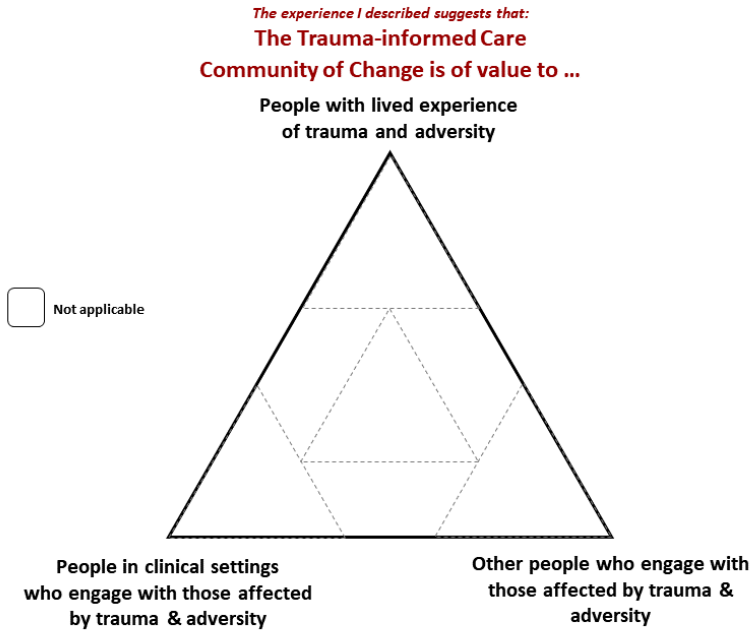
Q2: T1 - Purpose



Q3: T2 – To be effective



Q4.T3 - Scope



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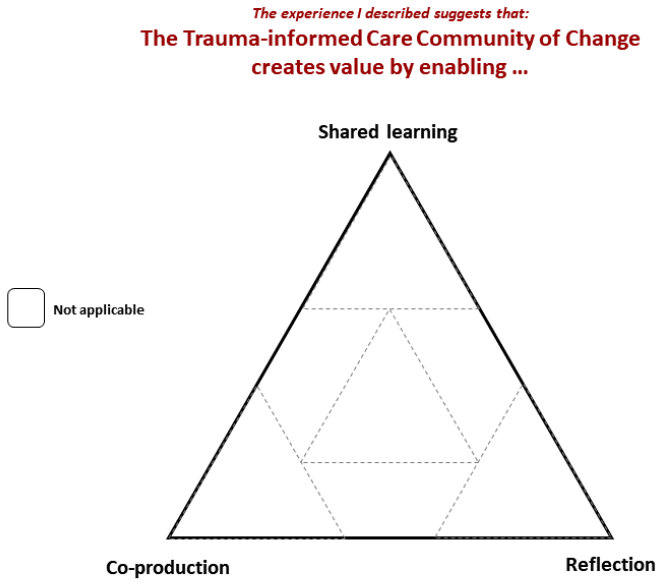
Q5: T4 – Enables



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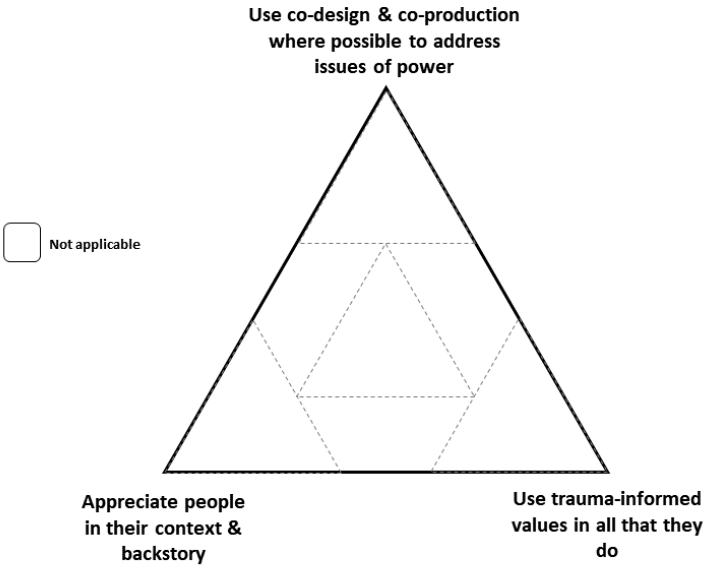
Q6: T5 – Compassionate Leadership

The experience I described suggests that:

The Trauma-informed Care Community of Change promotes compassionate leadership by encouraging members to …

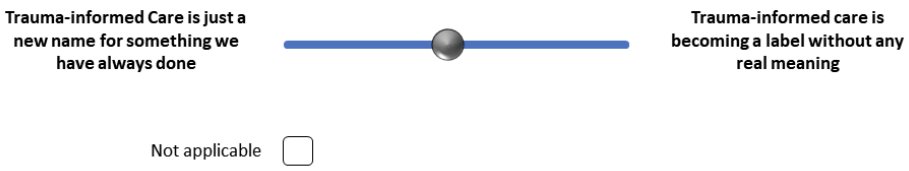


6

Q7: D1 - Context

The experience I described suggests that:

The challenge faced by the Community of Change in the organisation or group where I work or am supported is that …



7

Q8: SR1 - Engagement

The experience I described suggests that:

My relationship with the Trauma-informed Care Community of Change today

Please move the ball along the line to where it best reflects your current relationship with the Community of Change

I am not aware of it ☐

Aware | Connected | Actively engaged | Advocate | Leader

The experience I described suggests that:

The relationship I want to have with the Community of Change one year from today

Please move the ball along the line to where it best reflects what you want your relationship with the Community of Change to be.

I prefer not to say ☐

Aware | Connected | Actively engaged | Advocate | Leader

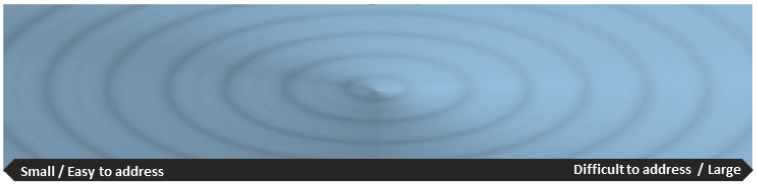
8

Q9.S1 - Barriers

The experience I described suggests that:

Barriers to trauma-informed care that need to be addressed by the Community of Change are that …

The numbered stones represent suggested barriers to the effective adoption of trauma-informed care. Place each numbered stone on the canvas in the position that shows how significant it is relative to the other barriers. The significance of a barrier is likely to be based on its size and/or how difficult it is to address. If you do not think a stone is a barrier, leave it in the tray.



Significance of Barrier

1. Experience is medicalised
2. People are not seen as individuals
3. No mandate or policy to adopt trauma-informed practice
4. Thinking about trauma is difficult and we tend to avoid it
5. Staff do not feel skilled to practice in a trauma-informed way
6. It is seen as relevant to service users but not to the way leaders engage with staff
7. Services are too piecemeal to meet the needs of trauma survivors

☐ None of these barriers are applicable

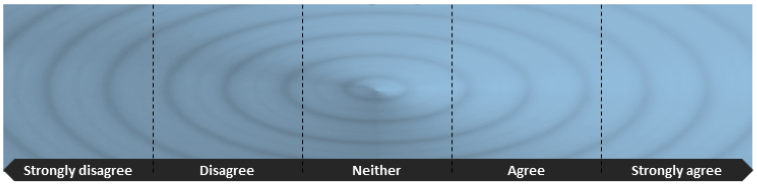
9

Q10: S2 - Impression

The experience I described suggests that:

When I visited the FutureNHS workspace used by the Trauma-informed Care Community of Change, my impression was that it (was) …

The numbered stones represent suggested attributes of the workspace. Place each numbered stone in one of the five boxes on the canvas to evaluate each attribute. Use the position of the stones in each box to indicate the strength of your response If you do not recall seeing the attribute or can't evaluate it, leave the associated stone in the tray.



Evaluation of FutureNHS workspace

1. Easy to register/join
2. Easy to use / find what I needed
3. Provided interesting & useful materials
4. Allowed me to connect with other members working in similar areas
5. Allowed me to communicate and share ideas with others
6. Provided access to relevant and useful webinars

☐ I have not yet visited the workspace

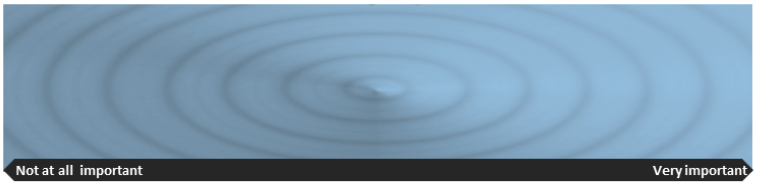
10

Q11: S3 - Importance

The experience I described suggests that:

The FutureNHS workspace used by the Trauma-informed Care Community of Change needs to provide …

The numbered stones represent what could be provided by the FutureNHS workspace used by the Community of Change. Place each numbered stone on the canvas to say how important it is that what is represents is provided. If you think that any of the suggestions are not relevant or are not required, leave the associated stone in the tray



Importance

1. Forum discussions
2. Space for private discussions
3. The ability to add shared comments on documents
4. Copies of, or links to, documents published elsewhere
5. Case studies and ideas on practicing trauma-informed care
6. Face to face events
7. Regular webinars
8. eLearning

☐ None of these

11

Q12: MCQ01

The experience I described suggests that:

The Trauma-informed Care Community of Change is making a difference if …

Select three of the following indicators that you think are most important in providing evidence that Trauma-informed care is being adopted.

- ☐ **1.01 Training in trauma and adversity is becoming commonplace through organisations**
- ☐ **1.02 There is greater emphasis on trauma-informed support and supervision of staff**
- ☐ **1.03 A consensus statement of, and practice standards on, Trauma-informed Care is being adopted by many organisations and groups**
- ☐ **1.04 Members have space & opportunity to discuss the value and productivity of the community**
- ☐ **1.05 The national community includes thriving local communities that have built alliances across multiple disciplines and organisations**
- ☐ **1.06 A significant percentage of active members of the community have lived experience of trauma and adversity**
- ☐ **1.07 The community is taking specific steps to listen to marginalized voices and to people with diverse backgrounds and experiences**
- ☐ **1.08 Trauma-informed care is reflected in strategic plans across the system and regulators are using its principles in inspections**
- ☐ **1.09 The community has provided direct support for transformational change of local MH services for people with complex needs**

12

Q13: MCQ02 – Gender
Q14: MCQ03 – Ethnic Group
Q15: SC05 – Where do you work/live

Gender

Select one

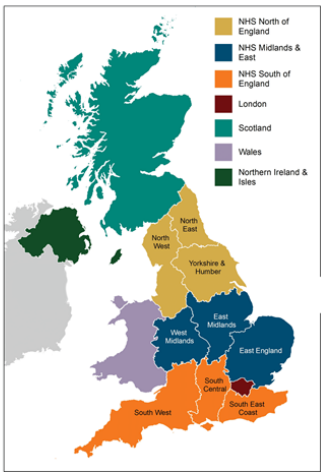
- ❑ Male
- ❑ Female
- ❑ Non binary
- ❑ Prefer not to say

Ethnic Group

Select one

- ❑ White
- ❑ Asian / Asian British
- ❑ Black / African / Caribbean / Black British
- ❑ Other ethnic group
- ❑ Mixed or multiple ethnic groups
- ❑ Prefer not to say

Where do you work / live?



13

Q16.MCQ4 – Area of Work
Q17.MCQ5 – Connection re TiC

Area of work
Select all that apply

- ❑ Mental health service
- ❑ Hospital
- ❑ Residential care
- ❑ Community service
- ❑ Social care
- ❑ Prison
- ❑ Primary care
- ❑ Emergency services
- ❑ Charity
- ❑ Peer support
- ❑ University
- ❑ Other (Please specify below)
- ❑ I prefer not to say

Connection with Trauma-informed Care
Select all that apply

- ❑ Person with lived experience of trauma and adversity
- ❑ User of mental health services
- ❑ Recipient of trauma-informed care
- ❑ Provider of trauma-informed care
- ❑ Service manager or other managerial role
- ❑ Prefer not to say

14

Q18: Text – Other

Optional: Additional Information
If you would like to provide additional information or give feedback on this evaluation, please type it below. Please remember not to say anything that can be used to identify you or any one else.

SAVE & SEND

15

Annex 3 – Narratives provided by respondents

Narratives that respondents did not want to share / have quoted in the report have been redacted (and replaced with a placeholder). We have also reviewed all the narratives and in the few instances where respondents have included the name of a person, place or organisation we have replaced the specific text with a relevant placeholder – these are shown in square brackets.

Each narrative is provided in two paragraphs. The first is the response to the question on the parts of trauma-informed care that the respondent most wants to influence. The second is their description of an experience that informed their decision on what they want to influence. Most respondents followed the guidance and answered the questions as asked. However, where this is not the case, the narrative still achieved its purpose of providing a way into the respondents' lived experience.

The questionnaire included a question at the end that allowed respondents to comment on the evaluation or anything else they considered relevant. These 'Endnotes' are included in the main table below if they are connected with trauma-informed care or the TiCA. Where they are connected to the evaluation, they have been moved to a separate section at the end of the table.

Where a narrative has been included in the main part of the report it is replaced here by a reference to the finding where it has been used. Also – where a narrative has been highlighted in one of the triads, this is annotated in the table so that the reader can cross-reference the zone in which it was marked.

The table below also includes data on the respondents' relationship with the TiCA to provide additional context. Other questions about the respondents have not been included because they are either too uniform to be informative or too complicated because they allowed selection of multiple options.

To see further connection between the narratives and its signification data, download the Tableau packaged workbook used for this analysis and open in a free copy of Tableau Reader. The packaged workbook and a link to Tableau Reader will be provided on community's FutureNHS workspace.

ID	Relationship with TiCA	Narrative & End Note
2	Today: Connected In 1 Yr: Connected	*[Narrative not to be shared]*
3	Today: Actively engaged In 1 Yr: Advocate	Making trauma informed care accessible to everyone - in relation to accessible training materials, psychoeducation and in relation to therapeutic approaches. The approach needs to fit the individual and be accessible to them - we need to therefore offer different 'ways in' for people. Sharing experiences of working with individuals with trauma histories - help to inform future practice in other areas of the country and within your own. Brings all this learning together and helps move things forward in all geographical areas at the same speed.
4 *Figure 18 (page 18)*	Today: Actively engaged In 1 Yr: Advocate	I want to help practitioners and others understand that trauma-informed care is a much bigger concept than providing trauma-specific services. I am particularly interested in influencing health and care so that the needs of all those with complex dissociative conditions, particularly but not exclusively D.I.D. are fully recognised and addressed.

ID	Relationship with TiCA	Narrative & End Note
		I have been involved in the training of a wide range of practitioners, managers, commissioners, informal carers and people with lived experience. The training I deliver focuses on the most complex trauma-related dissociative conditions within a trauma-informed care environment. Many participants feedback that before the training they had not recognised current or past clients/patients who experienced such challenges, but after the training they felt they had learned new ways of working which would benefit this group.
5	Today: Connected In 1 Yr: Advocate	Sservice user experience of being cared for staff experience of being contained/cared for and therefore able to care for others understanding of how trauma impacts on the development of self and relationships with other show trauma can affect people differently and how resilience and history of generational trauma can affect this develop understanding of how the system/organisation can act as both container and a vessel for re-traumatisation. A significant part of our work is supporting probation staff to work with people with complicated personal histories, with significant trauma evident throughout both childhood and into adulthood. We work with staff and individuals to develop a formulation which describes the history and impact on adult relationships and coping. We support staff to think about their own responses and try to develop understanding about how early life experiences can impact on the development of self and relationships with others. Through training a group supervision we try to explore ideas around the organisation and it's ability or inability to contain staff, who may come into the profession with their own lived experience of trauma and also then experience trauma through relationships with people who have offended. This can manifest through reading traumatic material, experiencing offence paralleling behaviour with people who have offended and also hearing stories from clients about their personal experiences. We try to support staff to recognise their own experiences and how they then understand the experience of others and also consider what they need from the organisation to be able to care for others. We need a community to support us to make in-roads in to the organisation with the aim of doing this work with senior leaders.
6 *Figure 20 (page 22)*	Today: Connected In 1 Yr: Connected	Inpatient care for clients who have experienced trauma in their childhood. I have witnessed clients who have been re-traumatised during their admission to acute inpatient units. This occurred by the use of physical restraint and depriving individuals from the sense of agency and autonomy. Such harm was not intended and the care team at the time had the best intentions and believed they were acting in the client's best interests. However due to the lack of experience and knowledge in the effects of childhood trauma and how certain aspects of past trauma can be replicated in an inpatient setting psychological harm was done. It might not be feasible to avoid all types of re-traumatising experiences but with being informed and aware of the effects of early trauma we can avoid the majority of psychological harm.

ID	Relationship with TiCA	Narrative & End Note
7	Today: Leader In 1 Yr: Leader	Leadership and buy in across the wider healthcare system but particularly in mental health. The Scottish ambition to be a trauma informed nation has investment from government. Significant buy in even from politicians who were at the launch. Clear outputs that are of high quality because of the investment and project management. it may not have changed that much front-line practice yet (or has it?) but it is starting from the right place and getting people from all sectors energised about the importance of this and integrating it into policy and practice of most impact.
8 *Figure 21 (page 24)*	Today: Actively engaged In 1 Yr: Advocate	A Key focus and passion that has driven me for a number of years is to discover and grow hope in delivering compassionate interventions to restore wholeness to broken lives in the criminal justice system. I have discovered over time that there appears to be a number of key blinds spots delivering informed trauma care in the criminal justice system these include a lack of evidence base in this specific area. A clear ethical framework appropriates to this area and a network where practitioners can be supported and practice-pooled This evaluation provides a significant opportunity to move forward with trauma informed care. If it is to be more than rhetoric, ideally it needs to be built creatively to shape practice and values
9	Today: Aware In 1 Yr: Actively engaged	The development of these skills in educational settings, local authority care and also across the wide range of services which work with young people. In a small health resource is commissioned to support staff working with looked after children in residential settings. Would like more information about Trauma Informed care.
10 Figure 15 (page 16)	Today: Advocate In 1 Yr: Advocate	The raising awareness of it and how many people it affects. Individuals in MH setting being secluded as they are considered bad not mad.
11	Today: Advocate In 1 Yr: Leader	Increase CAMHS staff awareness and understanding of trauma particularly developmental trauma and ensuring that their responses to young people who have experienced trauma are trauma-informed. During supervision noticing that staff sometimes lack understanding and therefore empathy for young people who are struggling with relationships or displaying behaviour that is difficult to manage due to past trauma. CAMHS staff uncertainty about accepting referrals for young people who have experienced developmental trauma because they do not display typical symptoms of PTSD or their difficulties are classed as 'behavioural'.

ID	Relationship with TiCA	Narrative & End Note
12	Today: Connected In 1 Yr: Actively engaged *Figure 18 (page 18)*	1. At this time of tremendous social upheaval and recognition of systemic racism and assaults on social justice I would like to see a focus on developing Trauma-Informed Communities with an emphasis on culture in villages, districts, and or regions. This means developing partnerships between police, health care, education, social services and community members through training and resource coordination that starts with understanding ACES and their connection to social challenges such as drug misuse, youth drop out rates, incarceration, suicide, homelessness, etc. See an article about Trauma-Informed Communities here: https://www.acesconnection.com/blog/strategies-to-combat-trauma-addressed-in-second-of-three-congressional-briefings2. Use of arts in building a bridge between trauma survivors and the communities in which they live (not just trauma survivors per se, but people with lived experiences of racism, discrimination, marginalization, oppression, and more). 3. Community dialogues between marginalized people and police officers about their respective ways of seeing their work and experiences. I have not been directly involved with Crisis Intervention Training (CIT) for police officers but have lived experience with police officers who have been trained in crisis de-escalation. To what extent these officers understood or did not the link between my crisis --including my aggressive stance and potential for past trauma, I do not know. All I know is that their recognition of my humanity, and willingness to engage with me saved my life -- if not physically, certainly spiritually. Later, I worked for an organization in [place] in the U.S. – [organization] -- that provided CIT training to police officers led by people in recovery. I propose utilizing Crisis Intervention Training as part of developing Trauma-Informed Communities. Please see CIT International for much more specific and detailed information. There is a wonderful resource that can be very helpful in working with community members to understand and address trauma. Go to ACES Connection Daily Digest for excellent graphics and articles including a past article on CIT training (www.acesconnection.com).
13	Today: Connected In 1 Yr: Actively engaged	Implementation within learning disabilities services, community and in patient. Currently I feel trauma is not at the forefront of people's minds when supporting people with learning disabilities, specifically within in patient services but also in relation to behaviours which challenge.
14	Today: Connected In 1 Yr: Actively engaged	*[Narrative not to be shared/quoted]*

ID	Relationship with TiCA	Narrative & End Note
15	Today: Actively engaged In 1 Yr: Advocate	To raise awareness of the impact of trauma and adversity on cognitive functioning due to direct and secondary impacts. To work towards incorporating this understanding into trauma informed care work so we can challenge perceived notions based on societal norms of how we experience and engage with the world. To challenge the notion of dysfunctional brains and fixed medical explanations in the neuroscience literature and to find ways to support those individuals who find it difficult to navigate the world due to their cognitive challenges. This is the story of an adult with a history of trauma, neglect and heavy alcohol use. They had not been considered for adult mental health services due to the alcohol use which was seen as the main presenting issue. Access to addiction services in their area meant committing to attending groups and accessing a twelve-step programme. They had continually failed to finish the programme but still attended the centre regularly but often intoxicated. The alcohol use had led to liver damage and associated alcohol related brain damage (ARBD). They had multiple acute hospital admissions and A&E presentations. One member of staff who had a good relationship with them had recognised the cognitive issues as a concern and requested an assessment through an unorthodox route as there were no pathways. The assessment highlighted cognitive impairments that impacted on memory and contributed to quite disorganised behaviour which fluctuated with the physical health issues. The service user was repeatedly asking for support to stay sober but recognised they were struggling to meet the requirements. They opened up about significant trauma issues in their past that were still very live for them but no one had asked about. The failure to complete the twelve-step problem was due to fear about losing connections in the centre as they had no one else significant in their life. They were accruing further neurological impairments with the liver problems as they couldn't manage the medication regime due to their cognitive problems and had been offered no support with this. They were refused access for an inpatient stay to address the brain injury because of the alcohol use. Highlighting the ARBD issues and pursuing a social care needs assessment helped them stabilise the liver condition and address some housing issues. They were then able to do some work around the trauma issues and alcohol use. Prior to that intervention they had not been expected to survive more than twelve months. This is a common scenario in addiction services where the trauma needs are not recognised and where at least 30% of people have ARBD. There is good evidence from progressive work in Liverpool that addressing the trauma, ARBD and social issues can lead to good outcomes for people yet in other areas they are denied access to healthcare and often die from the damage caused by the alcohol use following multiple hospital admissions or end up in care homes with extensive brain damage. There is still considerable negative judgement in services around alcohol abuse but little understanding of the causes of that alcohol use which are often due to childhood trauma and/or neglect. This scenario is also very common in adult mental health services where similar issues are not recognised and therefore not addressed.
16 *Figure 19 (page 20)*	Today: Aware In 1 Yr: Leader	Broadening the range of effective therapies beyond CBT I had an extremely frustrating experience of working in NHS CAMHS and adult services where it was clear that the permitted therapeutic approaches were entirely ineffective in aiding trauma survivors.

ID	Relationship with TiCA	Narrative & End Note
		I think the NHS lags behind private & voluntary organisations and there should be space for dialogue and collaboration with these sectors. All too often the NHS assumes dominance and stifle practice by being overly prescriptive and seeking to standardise care.
17	Today: Connected In 1 Yr: Advocate	I want to influence different things in different ways. Nationally I think we should go for a strategy that parallels what they have done in Scotland. Locally I want to move towards trauma informed and trauma responsive care in the hospital where I work and in the Trust as a whole. I think we should be elaborating what we mean by 'trauma' to include the impact of oppressive and micro-oppressive behaviour in areas such as racism, homophobia, sexism, ageism, ableism. I also want to impact on trauma informed ways of working in 'forensic' settings. I have been working on a TIC strategy in the Trust and hospital where I work and I have experienced the passion that it evokes in clinicians.I have experienced the impact of a range of trauma insensitive and non-responsive work settings and this has impacted on me as a practitioner and the people I work with in a number of ways.
18	Today: Advocate In 1 Yr: Advocate	Approaches and practises used A friend has recently returned from [region] where he had suffered from mental health issues. He was reported missing in [country], found 3 days later walking around bare foot and disorientated. He had suffered with mental health issues previously and attempted to take his life. When back in the UK, his condition deteriorated and was taken into hospital. He was detained under section 2, and released within 12 days, with a diagnosis and told he was better off staying at home.
19	Today: Connected In 1 Yr: Leader *Figure 18 (page 18)*	Organisational culture TIC I most want to influence is culture..... Recently I overheard a discussion between members of an MDT relating to a female service user who has survived horrendous trauma using language that dehumanises and focusses on the behaviour of the client rather than the underlying function and survival function. This leads to a negative attitude for clients and affects their care and needs to be challenged however training, recruitment, values, policy etc etc also needs to target this at the earliest point in staff members journeys.

ID	Relationship with TiCA	Narrative & End Note
20 *Figure 19 (page 20)*	Today: Advocate In 1 Yr: Leader	I would like to be able to use my lived experience to help influence attitudes of professionals towards people who have experienced trauma and may be displaying emotional dysregulation. From my own personal experience, I do not see this as a 'behavioural choice', and more of a response to a traumatic stimuli or re-traumatising events. Punitive responses and behavioural approaches have caused me re-traumatisation and I would like to see more of a focus on what is happening to trigger a behaviour or emotion rather than a blaming approach. I would like to help in the education of mental health professionals in trauma informed approaches and hopefully implementation of these practices when working with patients in urgent, acute and community settings. I am also extremely interested in research in trauma informed practices. I had my diagnosis changed from PTSD to EUPD by a consultant after one consultation. I was told my low mood was due to my personality and that all my problems were behavioural, due to my personality, and thus therefore my fault and that it was my own choice to end my life. This was a message that was repeated for 10 years. As a result of having an EUPD label, all past trauma was ignored. I noticed a change in approach towards me, staff became hostile and I was unable to access the trauma treatment I had been recommended. I was also unable to access any treatment for depression and anxiety. It resulted in a suicide attempt which left serious physical harm and lifelong disability. Despite a resulting Section following a long stay in a 'physical' hospital, I am still told the injuries were my choice. The approach services have taken has left me with more psychological problems, for example a major trigger for my flashbacks now is not having any choice in my treatment, as this was taken away from me by services, and has left me feeling I am going to die and cannot access any help (not dissimilar to an original trauma). My flashbacks have been seen as 'acting out' and as such punitive actions have been taken. Furthermore, if I ever tried to question my diagnosis (as I didn't feel it described my experience at all and quite simply, I didn't meet the criteria), I was simply told that that's what people with that diagnosis say - again making me feel I had no control and worsening my trauma symptoms. Even when my diagnosis was changed back to PTSD, it wasn't changed by my GP, crisis team or medical hospitals, which meant in a crisis I couldn't access the care I needed. I had care plans put into place that I had no involvement in and that I knew were harmful yet could not change - again increasing my fear and making my symptoms worse. I started to feel everyone hated me, stopped leaving the house, am ashamed of my personality, have lost all confidence and have panic attacks when I hear of, or am reminded of, EUPD diagnoses. I was first diagnosed with PTSD in 2001, I still have not been able to access trauma therapy in 2020.I truly believe that if a trauma informed approach had been used where my distress was looked into, rather than labelled, I may have had a chance of recovery. I feel if medical professionals could recognise distress as fear (in my case) in traumatised individuals, and that a flashback may not be what one sees on the movies and can present in different ways, such punitive responses wouldn't be used and there would be less re-traumatisation by services.

ID	Relationship with TiCA	Narrative & End Note
21	Today: Connected In 1 Yr: Actively engaged	Development of NICE guidance and pathways of care for Complex PTSD and Dissociative Disorder Teaching and training of psychiatrists and psychologists. 1. The development of NICE guidance and a specific NICE pathway of care for those experiencing Complex PTSD and severe dissociative disorders such as PTSD. NHSE has a strategy for lifelong care for survivors of sexual assault and abuse and yet all the money associated with this has gone into SARC centres (important of course) but without any real joined up thinking around treatment of the psychological sequelae. Contact has been made with the commissioners responsible for this but it was initially batted back and forth. More recently a positive response was received but considerable time and joined up working / responses needed to make this an effective piece of work.2. Linked in to 1. is canvassing and asking the RCPsych and BPS to make a position statement on the diagnosis of DID to stop the ongoing controversy within clinicians in the UK about the condition to the detriment of patients and support the focus on treatment pathways and approaches they might need. Again this required considerable time from clinicians and joined up working / responses across centres.
22 *Figure 21 (page 24)*	Today: Actively engaged In 1 Yr: Actively engaged	Understanding how we move from the collective experiences into changing systems. Most services are focused on pathway development and even today I am on a call where they are talking about the increase in male psychosis during Covid without a discussion on what the context may be. If we agree as we should through the platform that how someone got here is a key focus we need to work across the system that is focused on Department of Health Long term plan targets in particular IAPT numbers and treatment.
23	Today: Actively engaged In 1 Yr: Actively engaged	Resisting re-traumatisation - having processes/systems that aren't retraumatising (getting a young person to tell their story 10+ times). Trauma informed Transitions. Promoting Choice - having a menu style option for people to access what they want to work on promoting empowerment and collaboration - helping clients take ownership of their own journey - shared care records, evidence of shared decision making. Working with a younger person in the care system, having to tell his story to a new worker whether that be new social worker, new YOT worker, new support worker, new CAMHS worker and these people asking the same questions, that he eventually gets fed up and asks what's the point.
24 *Figure 20 (page 22)*	Today: Advocate In 1 Yr: Leader	TIC within community settings, particularly in relation to high risk, high harm, high vulnerability adolescent populations. Trauma-informed transitions from secure settings to community settings. A young person with significant experiences of developmental trauma received a 3-month secure accommodation order and was accommodated within a secure children's home, where he had the opportunity to begin to experience safety and stability, and to commence therapeutic relationships. However, no placement was identified in a timely manner - he left the SCH on the date his order expired to move to a placement that he had never visited,

ID	Relationship with TiCA	Narrative & End Note
		had no information regarding, and had never met any of the carers. This is a common occurrence within the children and young people's secure estate.
25	Today: Advocate In 1 Yr: Leader	Staff attitudes towards trauma and how this can be shown in practice and improve multi-agency practice. An example would be sharing knowledge around how someone could be behaving in a certain way due to past trauma experienced by that individual. Being able to formulate an approach prior to intervention rather than acting without preparation can make a huge impact on a person's health and wellbeing. Also improves engagement and understanding. In terms of change members with lived experience work within my area and their stories are impactful on organizational thinking.
26	Today: Advocate In 1 Yr: Leader	Clinicians and Non-clinical staff members. Young people and their carers. Both in community setting ([organisation]) and inpatient setting ([organisation]) Non-clinical staff members have also been a big encounter for young people or carers and they acted as a responsible adult in a critical moment for young people, as well as they were affected by witnessing a crisis. This survey may be better answered once I can join and experienced the group.
27	Today: Aware In 1 Yr: Actively engaged	Developing skills and confidence in non-clinical staff who work with many children and young people with low level mental health needs and who can be very effective in supporting their resilience. There will always be times when specialist clinical involvement may be required but areas such as whole organisation/school approaches are very effective in providing an environment that allows children and young people, their families and carers to manage the impact of trauma. School are notified of domestic abuse incidents in evenings/nights where the police and others attend. The children/young people often attend schools the day following the day. Sometimes these children need time out and someone to talk to before they can learn, others go into school class and then talk to someone about the issues they have seen or heard. One school has set aside accommodation where children can go for time out if they need it, where they can receive their lessons for a time if that is what they need and where their concerns and issues are heard and addressed. Working closely with the local CAMHS service they have found a big reduction in referrals, successful parent skills sessions have been held and senior staff in school have not been called in because of escalating behaviour.

ID	Relationship with TiCA	Narrative & End Note
28	Today: Aware In 1 Yr: Leader	Currently within my organisation, trauma-informed care is considered to be client based in directionality. The tensions between the demands of commissioners to the culture of 'every second filled' provision of service, acknowledges (perhaps in lip service, with words such as 'be mindful' when working with, those who have experienced extreme adversities), though offers no practical training / awareness of the necessity to focus on the impacts / wellbeing of clinicians. Having returned to the NHS recently, I was pleased to see that trauma-informed care was much more considered and part of daily formulations / huddles etc, however, there appears to be some confusion at the clinician ground level in their use of framing and language, examples of this are 'this is attachment, we're not commissioned for attachment' being over-laid on familial discord, ultimately complex trauma, well documented or framed within ACE's literature. There also appears to be some barriers at the 'evidence base' ideology level of provision which is much more complex. Oone recent example I have witnessed was that a CPWP apprehensive to work with someone due to trauma (it can appear to provoke a good deal of anxiety in treatments with little training towards considerations of frequency etc), a family therapist signposted a family due to it being framed as attachment issues. In example of staff, I have worked in a stretched service historically with one practitioner who had 167 people on a caseload, happily these are things which I don't see as frequently. Though have witnessed a colleague presenting as quite stressed due to workload and the complexity of two cases they were currently working with, whilst support was offered, it was also commented on that the clinician 'did not help himself though' without consideration of the impact that the work had been having for several months. My team has recently had 4 people hand their notice in, in three months, there appears to be little consideration to why skilled clinicians are leaving services and the systemic issues which motivate them to do so.
29	Today: n/a In 1 Yr: Aware	Reducing re-traumatization in inpatient contexts. Thinking about intergenerational trauma/chronic trauma caused by inequalities and discrimination Working in an inpatient context seeing how retraumatising the visible racial inequalities can be. How retraumatising mealtimes can be.
30	Today: Advocate In 1 Yr: Leader *Figure 23 (page 26)*	TIC is relevant to everything. The areas that I most want to influence are:- care for patients and their carers and families- care for staff - care for organisations and communities It is difficult to keep the example anonymous. I regularly work with communities and patients of additional disabilities. A majority of them have experienced both historic abuses and ongoing discrimination from accessing services. Often they feel that the service providers are not aware of their needs or ready to meet their needs. As a result of the barriers, they might feel further traumatized during their contact with services. For example, the information might not be accessible or comprehensible; the contact methods could be inappropriate and staff might be seen as lack of awareness or sensitivity. My observation here is the importance of the appreciation of individuals' culture, communication and language and how services can prepare themselves to address patients and their carers/families with multiple difficulties and disadvantages and to embrace the values of diversity,

ID	Relationship with TiCA	Narrative & End Note
		inclusiveness and empowerment whilst showing their kindness and compassion. The challenges on achieving common language and terminologies can be extended to inter-agency working especially dealing with safeguarding and public protection.
31 *Figure 20 (page 22)*	Today: Connected In 1 Yr: Actively engaged	My job is as an Old Age Psychiatrist working with care and nursing home residents (mostly dementia patients). I would like to be able to improve my own and others' understanding of the reasons for behaviour patterns and to apply the best forms of care (pharmacological and others) to relieve suffering that may be underlying challenging behaviour. An elderly married couple both admitted to a care home because he had a stroke and both suffered dementia although had managed at home for a while with wife as main carer and social services assistance. On entry to the CH she became resistive to allowing carers to help her husband, and progressively more aggressive towards them when they tried to prevent her walking her husband (who was unable to mobilise safely due to his stroke). Reducing her acetyl-cholinesterase inhibitor and treating with Memantine helped her to be less protective/possessive about him and accepting of assistance to him and herself. I am hoping that sympathetic management and behaviour support measures will allow them to continue to share a room and each other's company.
32	Today: Aware In 1 Yr: Advocate	I want to be part of developing trauma-informed organisations, particularly within the forensic sector: youth justice, the courts, police and prison settings. For a year I was seconded into the [justice organization] within [county & town]. I facilitated multi-agency formulation sessions to support professionals within social care and youth justice working with these vulnerable young people understand how trauma, abuse and their personal experiences influenced the development and continuation of offending behaviours.
33	Today: Advocate In 1 Yr: Leader	*[Narrative not to be shared/quoted]*
34 *Figure 20 (page 22)*	Today: Aware In 1 Yr: Actively engaged	I am keen to see that all colleagues in the healthcare system around the patient care pathways are trauma informed and have received appropriate training I'm thinking about mental health and wellbeing pathways including primary care teams, accident and emergency psychiatric liaison VCE sector working with social prescribers who may be meeting people/patients in the course of their work and may overlook that there is a trauma dimension to their interactions that could facilitate or prevent better care and outcomes.

ID	Relationship with TiCA	Narrative & End Note
35	Today: Advocate In 1 Yr: Leader	I want to make sure that children and young people who have experienced trauma or developmental trauma actually get a service rather than being viewed as not for CAMHS or too complex. I did a screening assessment and accepted into CAMHS a 9-year-old boy who had moved to live with relatives after witnessing his Mum attempting to take her own life. He had been expressing suicidal thoughts and talked of needing to keep busy all the time or with people so he did not get consumed by the dark thoughts. His Aunt too really needed support regarding what he was sharing with her and how to support him. He was offered an initial asst but then discharged as he was categorised as not having a mental health problem within the remit of CAMHS/ similarly a 17yr old girl whose family I know, who has been impacted by a bereavement of another young person and recently revealed a rape, presenting as self-harming out of control and taking drugs. Her parent spoke to me of feeling blamed by CAMHS for poor parenting utterly bewildered that CAMHS can only offer some short term DBT, she spoke of being afraid her daughter will die of misadventure and feeling really let down by the service. I work for CAMHS and I feel we are trauma informed but often if a child presents trauma at the time of asst they are then redirected to the third sector or worse still do not get any service. Pathways have become too narrow or are used to deny services. this is what I want to change.
36	Today: Advocate In 1 Yr: Leader *Figure 15 (page 16)*	I want to see TIC embedded into MDT client care plans - seeing that TIC is being used to understand the person, their relationship to services and how we deliver an intervention. Working as part of an MDT with a young woman who struggles with distressing psychosis and intrusive trauma memories, who uses illicit substances in an attempt to manage her distress. The client struggles to see the service as of value to her as she feels we do not understand her. Through using TIC principles I have sought to develop and strengthen her risk management plan and care plan to better take account of her trauma history; however the wider MDT have not bought into this work and are continuing to use the old plans which were not trauma informed.
37	Today: Aware In 1 Yr: Actively engaged *Figure 23 (page 26)*	I would like to influence the area of trauma-informed care that is related to working with Children, Families and Young People who have experienced trauma in their lives but who are not given the support that they need. This is often particularly acute around Looked-After and Adopted Children (or those at the edge of care) who have experienced significant early-life traumas but whose expressions of this trauma are not identified, acknowledged or treated. As much as I would like various agencies (including the criminal justice system, social care, and education) to adopt a trauma-informed view, I feel that the NHS should lead by example and that we should be flying the flag for trauma-informed support and systemic practice. When working with a young person (a 14-year-old girl), who lives in residential children's care, I found that she was passed through various services before she arrived at ours. This girl has been diagnosed with a number of different psychiatric disorders and is currently supported under the Children Act 1989. The view of this young girl is heavily informed by her behaviour and there is little in the way of trauma-informed practice that has been provided to her, by any agency around her. The girl's behaviour is

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		challenging and dangerous but there is an impasse between all of the services that surround her about acting in her interests and the support that is needed. The behaviours that she has engaged in are becoming riskier and it feels that there are limited opportunities for the system around her to view her difficulties as trauma-related.
38 *Figure 18 (page 18)*	Today: Connected In 1 Yr: Leader	Working within a perinatal service it has become apparent to me that the language used in maternity services needs an overhaul. Although mental health services still have a long way to go in terms of trauma informed care, it feels to me that maternity services and trauma informed care is in its infancy - therefore influencing a shared language of trauma informed care through training and closer working relationships is key to supporting change in this. One woman's story, that on reflection, is shared by so many across the women I have worked with since joining a perinatal mental health service. She describes her labour to me - failure to progress. Although in summary postnatally written as a 'normal labour' - nothing about her experience felt normal to her. Birth revisited - she found to be completely invalidating as the midwife explained to her why she had a normal labour. Second time pregnant - maternity HCA said to her that she was so glad her own daughter, after having an emergency caesarean the first time, decided to go natural the second time (by this stage this patient had chosen to have a caesarean given her experience first time round).Medical terminology can often be unhelpful and lacking a trauma informed approach, but I have been surprised to learn that during the most at risk time of a women's mental health it feels there has been such a lack of thought / or progress in trauma informed care as to the sharing of other people's personal or professionals accounts to patients and the motivations for sharing, as well as the recording and language used it continues to be harmful
39	Today: Aware In 1 Yr: Aware	What is trauma informed care no idea
40 *Figure 15 (page 16)*	Today: Advocate In 1 Yr: Leader	Increasing service co-production, collaboration and empowerment of service users. Formulation - Helping service users and staff to understand/interpret presentations through a trauma-lens. Trauma-informed Policy and procedure within the service Throughout my career I have often experienced a primarily medicalised framework for understanding and conceptualising patients' mental health difficulties. I would like to influence the shift in perspective. To change the narrative and people's understanding/conceptualisations of patients' distress. To shift the narrative that there is somehow a 'deficit' or 'disorder' with the individual to this is a 'survival strategy' which can be understood and adapted.
41	Today: Aware In 1 Yr: Connected	*[Narrative not be shared/quoted]*

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42 *Figure 19 (page 20)*	Today: Actively engaged In 1 Yr: Advocate	Lead and communicate about being trauma-informed. Train both clinical and non-clinical staff. Build a trauma-informed workforce When I introduced the terminology 'Attachment seeking behaviours' in describing a girl's behaviours in her formulation as opposed to 'Attention seeking behaviours' with explanation (as part of Trauma Informed Care movement) in the MDT team discussion email exchanges, people responded to this with their 'aha' and some described how 'wording' change the attitude towards them from 'blaming culture' to 'curiosity' although not easy. When I introduced our pilot TIC project for non-clinical staff members, our inpatient school lead came back to report that she found the implementation of 'Safety cross' as a tool for reflection as well as a measurement very effective to take close look at individual staff members' experience from Trauma informed care perspective and she feels this enabled her to act early and appropriately in order to provide care to staff as well as young people. Thanks for accepting me in.
43 *Figure 20 (page 22)*	Today: Connected In 1 Yr: Actively engaged	I am particularly interested in how we work with schools to widen commitment to taking a TI whole school approach. I have seen teachers shouting and berating young people without knowledge of their emotional backstory. Equally I have seen teachers welcoming students with warmth and interest in their lives.
44	Today: Connected In 1 Yr: Advocate	As a nurse I am always very passionate about helping nurses reframe some of the presentations we see that can be tricky and difficult to be around at times as a response to trauma and to emphasise how helpful and skilled they are in working with those presentations. To remind staff of their skills and reframe them as containing and compassionate skills and support them to develop new skills. I'm also interested in the work around management of violence and aggression and I work with some of the violence reduction managers in our trust to look at how trauma informed care is weaved into that. I think that least restrictive practice has influenced much of our trust but has led to too little containing environments and care for our patients and a lack of sense of safety at times for our staff. I deliver a 2-day trauma awareness training across [NHS Trust] and have just completed its initial evaluation of 400+ staff trained. Specific examples are staff who say prior to the training they are 'just there to contain and manage', 'I go home at night and cry', 'I was thinking of leaving my job before the training because I didn't care anymore', I have nightmares' 'I've lost my compassion', 'I feel de-skilled and have no confidence', 'I am undermined and de-valued' and so many more comments like that. Just having a basic awareness of TIC shifted those views and changed their practice and how they viewed themselves. Seeing staff use formulations, sensory interventions, distress signatures, collaborative personal statements and care plans is great and I want to be able to take that further to all staff but there has been little board investment to date. I want to be able to influence how this work is prioritised by our senior leaders.
45 *Figure 23 (page 26)*	Today: n/a In 1 Yr: Actively engaged	To be able to gain more knowledge and tools that could be effective for patients that I support but also be able to pass the knowledge and information onto my colleagues, as I believe that staff who are informed about trauma can develop more empathy for patients who have experienced

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		different types of trauma and it would be build the therapeutic relationship between staff and patients. I have supported people over the years who have experienced trauma from domestic violence, attachment issues which does cause issues for individuals to trust others and build therapeutic and positive relationships with others including staff, family members and friends, and bereavement.
46	Today: Aware In 1 Yr: Advocate	I don't know if I'm answering the question correctly, but I work as a Social Prescriber, and I would love my colleague Social Prescribers to be trained in trauma-informed care. I came across many patients that have lost trust in the system - in Primary Care or NHS - and I think it has a lot to do with us not being trauma informed - I work in a very deprived area in London, and many people I see struggle with being sent from pillar to post, and having to fill in forms. For example E-consultations are great for many people, but the more vulnerable people really struggle to bring up the patience to fill in another form, without feeling reassured that they are listened to / that appropriate action will follow.
47	Today: Connected In 1 Yr: Actively engaged	My own individual practice and that of my team. The practice of local care homes and how they are responding restrictively to the COVID-19 pandemic. I would like to support local care homes to take creative steps to allowing visitors into homes, or to think creatively about how they support people with dementia in the pandemic e.g. not just using isolation in own rooms but considering zoning, etc.
48	Today: Actively engaged In 1 Yr: Leader	How our community team acknowledges and works with impact of trauma on a day-to-day basis. This includes supporting professionals to be able to tolerate thinking about trauma, as well as working with the impact of trauma. I would also like to influence the wider organisation to consider trauma informed practices. I have previously worked in teams in which it has been easier for professionals to adopt a medicalised model of care and who found it very challenging to tolerate thinking about what someone might have been through in their lives. This led to stigmatising and judgmental language and at times discrimination towards service users. Understandably service users often felt misunderstood and unsafe in these teams.

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49	Today: Aware In 1 Yr: Connected	Would like to have a greater understanding of the impact of acute and long term trauma on individuals, and how this affects their presentation and ongoing mental health. Would like more strategies for helping individuals manage symptoms. Would like more on formulation skills, so that as a team we can understand clients' presentations and behaviours staff may find challenging in the context of trauma. Would like to learn more about intergenerational trauma and ways of breaking the cycle. Work in a perinatal service and we work to try and help mums and dads be the best parents they can be. Need to work to manage 'ghosts in the nursery', where parents have experienced trauma from difficult past experiences, and help them build positive relationships with their children. Also interested in understanding more about cultural factors and trauma- we work with a very diverse population.Have worked with a mum who was a refugee from an African country. She had experienced a lot of trauma having to move from her country of birth to live in a refugee camp in a different country. She had experience of rape and having a baby at a very young age without the support of parents- her mum abandoned her on the camp to return home. Baby subsequently became ill and as a result ended up with long term physical and learning disability. She came as a refugee to England alone with her disabled child and had no knowledge of where her parents were. We worked with her in her second pregnancy- she had experiences of dissociation due to fears that something would go wrong again and the same thing would happen when she had the baby. She needed a lot of support being a parent, and she remained very anxious something was going to go wrong. She experienced a lot of bodily symptoms of anxiety and symptoms of PTSD. She had experience of being abandoned as a child and little support in the UK. There were issues of working through an interpreter and working cross culturally. I would like more training working with refugees to understand their experiences in countries they flee from, in camps, surviving in a new country. Have many experiences of working with mums too, British born, who have experienced poor parenting through their own mums having mental health problems or drug and alcohol problems. They have experienced inconsistency and unpredictability in their own childhood. They do not have the support of a reliable parent now to help with their own childrearing as grandparents. In fact, they often have to help their mum when she gets into difficulties when her mental health deteriorates and this can trigger painful memories and feelings of panic and being overwhelmed. We work to try and prevent intergenerational transmission, but this can be challenging as our clients often struggle with regulating emotional distress, difficulties making good choices in relationships, difficulties mentalising their own children's feelings etc, all of which impact on them being good parents to their own children
50	Today: Aware In 1 Yr: Connected *Figure 21 (page 24)*	I have recently started working as an Occupational Therapist in a Specialist Community Forensic Team - I would like to learn more about trauma-informed care so that I can work in that way within the team. I have not yet completed any training in trauma-informed care (although I do have plans to) and I am looking to learn as much as I can to impact my work in the above team in a positive manner.

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51 *Figure 23 (page 26)*	Today: Advocate In 1 Yr: Leader	Staffs understanding of their own wellbeing and understanding the importance of TIC delivery to patient care in mental wellness. Member of staff in supervision stated that they have not experienced any trauma in their own life, when this was explored together we realised they thought Trauma had to be a particular event that was seen in their mind to be an acute event i.e. Rape, Abuse, war, bombing. Helping this member of staff identify what is Trauma, has helped them understand their own wellbeing and that of their patients
52	Today: Aware In 1 Yr: Actively engaged	In [county] we have a Suicide Prevention Service, it's through the referrals to this service that the development of a TIC lens has been most prioritised. The networks of people affected by a suicide is extensive and included multiple community sectors all of whom could benefit from training and ongoing reflective supervision and support. A recent suicide of a child age 16 highlighted the impacts on the wider community system, education system, and social network. Development of resources, maintenance of them, and how to make such resources available to the right people at the right time is a challenge. Very specifically I would like to develop strategic support training in education settings for TIC awareness, both with a prevention and postvention emphasis.
53 *Figure 18 (page 18)*	Today: Connected In 1 Yr: Advocate	The training of first contact practitioners (primary care) and teams' culture around TIC in 3rd sector. Leadership and integration of the TIC approach into 3rd sector systems and support. Practitioner not having the skills set to deal with Trauma when it has risen in a conversation around well-being. The practitioner being unconsciously traumatized by the event and educating or being influential around the education of how trauma is talk about in a work setting and between services.
54	Today: Connected In 1 Yr: Advocate	I would like to influence the concept that Mental Illness is NOT necessarily caused by Trauma however Trauma does impact and interfere on one's ability to accept and understand Mental Illness. Trauma and Mental Illness are often so entwined that it's difficult to tell them apart and only by further exploration at deeper levels can we separate the two and begin the healing process along a road of recovery. A service user has been a patient in private care for over 10 years. In that time she has been classed as one of the most difficult and risky patients in that care setting. Funding then stopped and the patient came to the NHS. By this point much damage had been done to that individual creating high dependency on medication and on services. Though unravelling the strands the individual has now moved to independent living in a community setting where she receives understanding and support from her mental health professionals. It is sometimes easier to give up and give that person a crutch to hobble about rather than giving them the massive amount of support needed to allow them to learn how to walk on their own.

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55	Today: Aware In 1 Yr: Leader	I would like people with trauma histories to be treated compassionately, within a whole person framework, that works with the person collaboratively to find ways to recovery. I would like to stop the medicalisation of trauma and medical treatments for emotional difficulties. One of the events I witnessed several years ago has stayed with me and still bothers me. A young man disclosed sexual abuse to me on an inpatient mental health ward. He was refusing medication and was forcibly injected with an antipsychotic in his gluteus maximus despite my attempts to look at alternatives with him and the treating team. The whole experience was extremely traumatic for the young man who felt huge shame and for me too. To retraumatise those who have existing traumatic experiences in my view is shameful. However, we continue to do this over and over again.
56	Today: Connected In 1 Yr: Leader	I'd like to support staff I work with to understand the importance of asking what has happened to you, what do we need to know about your life to understand how you are today? rather than this being an add on question at the end of a meeting- I want to see all staff within an MDT see the value of spending time collecting background history because this ensures we know about a person's trauma and can understand how they are interacting with us based on these experiences- I'd like to see all services for older people recognise that this is imperative in our work - otherwise we have a missed generation where there was multiple traumas experienced before the knowledge of how this affects our bodies and brains, and before the introduction of parenting support etc- I'd like services to be able to work across the inpatient and community mental health pathway in a way that best meets the needs of a person rather than due to service restrictions- An older person on our ward, who has been unintentionally traumatised by her experiences of services during her life, remains on an inpatient ward because no suitable placement can be found to meet her needs and manage the behaviours that challenge. - However, this continues to maintain her distress because she is away from her family and has no sense of stability or direction. Staff struggle to see the connection between her trauma, her current distress and the behaviours that challenge. - MH services and social services are failing this lady because her needs do not fit neatly into any placement or setting. If a specific care package could be set up within a home that is near enough to her needs, she could be discharged. But referral criteria is rigid, without options for understanding the person- I have witnessed this happen time and again in older people's services, especially for older people who have been in MH services for many years and now are falling between services (MH and social). But their distress is a product of how they have been treated and traumatised by historic psychiatric treatment and we need to take ownership of this.

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57	Today: Leader In 1 Yr: Advocate	Development of an organisational culture that takes account of the lives people have lived (staff and service users) in both the delivery of treatment and care (content - right thing for the right people at the right time) and how it does this (interpersonally sensitive and compassionate care, doing with rather than to people). This is likely to involve; training, supervision, resourcing balanced workforce, revisions to policy and procedures, co-production..... Importance of all tiers of management and leadership being compassionate in their support of the workforce, e.g. when delivering a presentation to our senior leadership team about why we might want to be sure we are a trauma informed organisation - significant light bulb moments from the audience, particularly the corporate directors and deputy directors appreciating why this is of relevance to them (interactions with one another, recruitment processes, cost savings associated with recovery work).
58	Today: Aware In 1 Yr: Actively engaged	The two arms of 1) keeping it central to all day-to-day interactions between staff and service users, and 2) ensuring that all service planning and development keep TIC central in their thinking, regardless of professional background or the type of service being delivered. The challenges faced in providing the trust trauma leaflet to all service users as they make initial contact with the team. In a service development event, a lot of discussion went into whether this was appropriate. The feedback from service users and experts by experience helped us decide that this was the right thing to do but we have yet to practically implement this service development. I think it mirrors previous fears around talking about suicide. It saddens me though that mental health staff do not feel confident enough or that they have been trained to talk with service users about trauma. I think more senior staff need to be on board with TIC principles in order to support staff on the front line do the work that they often would like to do but are not confident with.
59	Today: Actively engaged In 1 Yr: Actively engaged	I want our health providers to be curious about what has happened to people and to meet them where they are with a view to healing trauma. So working with health providers - training, coaching, developing models etc People who act violently in our services are often very distressed and that is because of early trauma. I would like to support our staff to work in safe ways with the distress and to influence our services so that they can heal and not 'manage'.
60	Today: Actively engaged In 1 Yr: Leader	*[Narrative not to be shared/quoted]*

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61 *Figure 23 (page 26)*	Today: n/a In 1 Yr: Aware	The understanding of psychosis as trauma and offering EMDR and other trauma therapies to clients with psychosis, to heal the psychosis. In team meetings, staff being unaware of the trauma that the client has experienced that has led to their becoming psychotic a relapse being attributed to non-compliance, without thinking about the event that might have triggered the underlying trauma the team thinking a recent traumatic event is irrelevant, and the psychosis is due to their illness, generics or non-compliance. This questionnaire was sent out to us at work ([NHS Trust]). I have never heard of the trauma informed community of care before and so I have answered as best I can. It would have been helpful to have more information about all of this before being asked to complete a questionable.
62	Today: Advocate In 1 Yr: Advocate	I work in the field of domestic abuse and sexual violence, the impact of which on its victims can be long lasting. A number of our clients have previously accessed health services and been given various diagnoses based on their presenting symptoms but without being asked what has happened to them that may have contributed to how they feel. I would like routine enquiry on childhood trauma and domestic abuse to form part of all routine primary care provision, in order for patients to receive a more informed level of care and support. Below is an extract from a spreadsheet of data we have been collating for commissioners which details suicide attempts and threats involving our clients. Male child under Crisis Care team with CAMHS. Various attempts at self-harming by cutting, self-strangulation, swallowing items which include batteries, magnets, liquids, blades, jumping from windows/cliffs, some of which resulted in hospital attendance. Only disclosed abuse to CAMHS after months of suicide attempts. A large number of domestic homicide review recommendations have included the need to include awareness of domestic and sexual abuse within healthcare professionals training, but despite this being quoted on numerous occasions, the ability to influence this area of learning has been non-existent, ideally this needs to change if we are truly able to address trauma.
63 *Figure 15 (page 16)*	Today: Aware In 1 Yr: Connected	To learn about and embed trauma informed care into older people's mental health and dementia services Lack of awareness of the role of trauma, or consideration of trauma by some professionals. This is especially relevant to people living with dementia who may not be able to tell people about their experiences and who may have lost their previous coping strategies.

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64	Today: Advocate In 1 Yr: Advocate	Assessment of people coming into mental health services, and how this then defines the pathway for an individual. Crucial as people who have experienced trauma may not appear to meet criteria for Step 4 services yet have experienced severe trauma - training needed and responsive service.A person with DID known to service assessed according to one presenting part who appeared to be in control and have no needs and yet the service was aware of severe and extreme trauma history of the person and yet offered only very short-term therapy which would be potentially harmful.
65	Today: Actively engaged In 1 Yr: Advocate *Figure 15 (page 16)*	Its ubiquity. I'd like to see an understanding of trauma and trauma-informed ways of working embedded as standard across all health and social services - and, ideally, even more widely. During a hospital admission for a physical health problem, my treatment triggered previous trauma. It was a distressing experience that could have been avoided if the staff on the ward had worked in a trauma-informed way.
66	Today: Connected In 1 Yr: n/a	*[Narrative not to be shared/quoted]*
67	Today: Aware In 1 Yr: Actively engaged	Understanding those with backgrounds of trauma and ensuring interventions provided meet the differing needs of those we support. Working with external agencies that have a very limited experience of trauma and how best to support those with this experience. Seeing interventions provided not viewing a person holistically and focussing on one aspect of the person without taking into consideration their experiences and how they have an impact.
68	Today: Advocate In 1 Yr: Advocate	I would like to be more involved with children's mental health services, particularly in relation to school and education. Developing a trauma and SEMH focused approach in school to make this a narrative norm in teaching and supporting young people. Rather than the current reactive systems. A school in my local area has developed a 4-week plan of SEMH and trauma intervention based on borough wide training. This approach will offer specific training to named staff who will then facilitate learning for the pupils and peer supervision for staff. The intention is to imbed this thinking into the school ethos and provide a trauma informed approach to all young people, particularly during the return to school following lockdown.

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69	Today: Aware In 1 Yr: Actively engaged	I want to continue supporting my team and myself to think more proactively and consistently about the complex role of trauma in our clients' history, development of their difficulties and ongoing current struggles. I want us to look at every aspect of our service through this lens and develop ways to improve the experience of people who have experienced trauma. I want us to do this in partnership wherever possible with people with lived experience. I want us to contribute more to the literature and evidence based about providing support and treatment for people with complex post-traumatic stress. I want to develop our work with parents, carers and loved ones to help them in developing a more trauma-informed understanding of their children's difficulties and their own where needed. Though we have given it some a lot of thought within our team of clinicians, I feel we need to give a lot more thought to how we share info about our service and approach the orientation to the service and our initial meeting (assessment). And really everything we do after that point as well! I am concerned that some of the people who either don't show or attend but struggle hugely to engage, or don't come back after their initial meetings with us might be doing so because we have not understood and supported them enough around their experiences of trauma. While we are mindful of trauma and work very explicitly with our clients around this and post-traumatic stress we have never had any training on trauma-informed approaches and we have not discussed our approaches with any experts by experience for guidance in this area specifically.
70	Today: Advocate In 1 Yr: Leader	The parts I would like to influence most at the impact on service users in making sure that care options are always appropriate for them not to tick the box of the service. I would also like to look at the impact of iatrogenic harm on not only service users but staff as well as this impacts on the risks of burnout. I have had to challenge service offers to people during the pandemic as it has been a case of services being asked to offer the minimum at the time of the pandemic and discharge people quickly. This Ii think is not TIC as it doesn't look at the impact the pandemic and lockdown has on people trauma response feelings.
71 *Figure 21 (page 24)*	Today: Connected In 1 Yr: Advocate	I would like to take trauma informed care out of the medical model framework and advocate for a more holistic approach that incorporates childhood (accumulative) trauma in the healing process if appropriate. I am an integrative EMDR psychotherapist who worked with a young person who was traumatized after an attack. The client showed the classic symptoms of flash backs, panic attacks, not leaving home, avoiding crowds, sweaty hands, heart racing. We started our work with a timeline of trauma throughout his life. The client indicated no previous trauma. Throughout the EMDR process it became clear that the client had been brought up in a dysfunctional household. The clients began to memorize a violent and aggressive household to which he/she adapted. Violence was normalized. It was paramount that in order to process the current trauma we needed to process the childhood adaptive patterns which he applied to his current trauma. The adaptive patterns did not work anymore and the client needed to be taught new behaviour. I believe this holistic approach is necessary for

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		real trauma healing. This holistic approach needs long term therapy. The aforementioned client is now living a trauma symptom free life.
72	Today: Aware In 1 Yr: Connected	Systemic under-representation of older people when considering trauma-informed care and advocating for awareness and application of these in direct work with older people. The role of historic trauma, or generally a person's background and past life, is often overlooked or less considered on dementia wards (by virtue of time constraints, paperwork and the dominant medical model). Funding or resources for specific pieces of trauma-informed work have been directed in my health-board towards children's services in the first instance, and then adult (with the belief this includes 'older adults' without considering the significant barriers for this population in accessing many adult services).
73	Today: Connected In 1 Yr: Connected	Assessment and recognition and education of therapists Over diagnosing with personality disorder and this being an obstacle for people accessing trauma treatment because they are seen as too unstable.
74	Today: Aware In 1 Yr: Leader	As an individual and organisation that specialises in Trauma informed care we want to contribute to workforce understanding of trauma informed approach, poor signage at hospitals so confusion when trying to find departments, staff calling you by your Christian name without asking, staff talking about you while you are present, being referred to as a bay number rather than by name, a complaints service that defends the hospital rather than admit poor practice.
75 *Figure 18 (page 18)*	Today: Aware In 1 Yr: Aware	How trauma informed care ideas interact with other established psychotherapies. I saw a discussion regarding a patient with a history of trauma, who had previously had some form of trauma-linked conversation with a staff member, and that this was being used as a reason for the patient to be not considered for further therapies such as CBT / psychodynamic therapy.
76	Today: n/a In 1 Yr: n/a	I am not clear what you mean by this. Again I am not at all clear what you are asking.
77 *Figure 15 (page 16)*	Today: Connected In 1 Yr: Advocate	Strategic use of the patient voice No front-line experience but committed to the patient voice as shared decision making and because it is the law (Montgomery case) Not sure about the comment that there is no policy/mandate to support TIC given that Shared Decision making is the Law (Montgomery 2015).

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78	Today: Advocate In 1 Yr: Actively engaged	Helping adults to understand behaviours of children in light of ACEs and how to support the child. I would like to be able to support parents in recognising their own ACEs and how these may influence their response to their own children or other people/situations. I worked with a child who had experienced and was continuing to experience trauma. Her behaviour in school was very difficult to manage and her teacher found it hard to understand why the child was behaving as she was (running from class, hurting other children, trying to control as much as she could to feel safe). I saw the teacher developing secondary trauma through her daily interactions with the child and this in turn reduced her ability to contain the child's emotions as she was trying to manage her own.
79	Today: Connected In 1 Yr: Advocate	After 25 years plus of working in frontline and specialist NHS mental health services with people with severe and enduring complex mental health problems I would guestimate 100 percent of service users I have worked with have survived both significant standalone trauma events (death, serious illness, accident, crime and abuse, DV) and/or multiple trauma events connected to or arising from early life trauma. I am good at establishing trust and negotiating safe boundaries and ways of working in this respect, and creating safe therapeutic space however on a practical level I would like to help service users understand how trauma may be continuing to affect them (psycho education) particularly with cognitive functioning (I call it trauma brain which generally service users find helpful) including memory, retrieving and transferring information to different environments and situations, recall of recent sessions and even remembering to refer to materials from previous sessions (particularly for those diagnosed with PTSD), executive function (organising, sequencing, planning) and coping with unforeseen events when plans to not go according to plans! I now work in a tier 4 CAMHS service after years of been a team leader in frontline services (Home treatment, liaison, inpatient and community primary and secondary care services). I have supported and supervised many staff, mostly CPN's, Social Workers, Occupational Therapists, junior medical staff and Support Workers. Most of these staff have little or no knowledge of trauma apart from a very basic understanding of it learnt in undergraduate studies. There is such poor investment in educating and properly training and equipping front line staff with the specialist skills required to support service users in this regard. Commonly the hard to engage label is applied to service users who are repeatedly retraumatised by their contact with the very services who should be supporting them. Dysregulated behaviour is often experienced as challenging, fear and anxiety are experienced as hostility and missed appointments and memory and organisational challenges for some trauma survivors are interpreted as poor engagement. Sadly, this has worsened over the last few years in London with the mass exodus of young enthusiastic staff and the over reliance on locum staff, many of whom are poorly equipped to deal with anything other than the most basic and acute mental health issues so investment is required. If you work in a psychological service generally there is more support and knowledge available than if you are a CPN, Social Worker or OT working in a service. So much depends on the skills available within the team and supervision. I would like to see massive investment in proper education and support available to staff working in frontline mental health services.

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80	Today: Actively engaged In 1 Yr: Leader	I work within Older Adults so these services are the main focus of my interest. We have provided staff wellbeing workshops on our Covid ward (mental health inpatient OA ward) these took a trauma informed approach and were well received. If we don't care for our staff how do we expect them to provide proper care for clients. In OA the medical model prevails which is disease orientated and trauma is not often considered unless a psychologist raises it. I would like to influence a change in this system.
81	Today: Aware In 1 Yr: Leader	I am interested in expanding trauma-informed care beyond the work of psychologists and psychotherapists and embedding it into the everyday interactions and environment of a psychiatric inpatient ward. In particular, I would like to explore what trauma-informed psychiatric nursing looks like, and how an understanding of trauma and evidence-based trauma-informed practice can become commonplace throughout the inpatient environment, particularly in CAMHS. A patient was admitted to the adolescent unit and during his admission was diagnosed with PTSD. He was an unaccompanied minor and asylum seeker, and had experienced parental abandonment, physical abuse, exploitation/slavery, trafficking, and street homelessness. Whilst he received psychological input, the majority of his care team (e.g., his primary nurse and other staff allocated to work with him on a day-to-day basis) were unsure of how to incorporate his experiences of trauma into conversation, care planning, and assessments. There was also some misunderstanding of his symptoms, with a few members of staff querying whether he was 'putting on' certain behaviours (sporadic shouting, disassociation, heightened startle reflex) as he didn't seem psychotic. There appeared to be a conflation of the hallucinations and responding behaviours that might be associated with PTSD flashbacks, and those arising from psychosis. Furthermore, it was clear that the ward environment was especially distressing for this patient. He became extremely anxious and distressed when there was noise or disturbance on the ward caused by other patients, and also found restrictions on the ward (locked doors, not allowed to leave freely) difficult to manage.
82	Today: Leader In 1 Yr: Leader	I would like the client experience to be improved so that the way services make sense of, and understand, what clients bring changes for the better. At the moment services tend to use diagnosis to describe and categorise. This means that we do not sufficiently seek to understand a client's presentation in the context of their life experience (i.e., what has happened to you rather than what is wrong with you). I would like to influence systems so that staff can feel confident to hold in mind trauma and take a compassionate, curious and reflective stance in their relationships with clients, rather than categorise first and then interpret all behaviours in the light of this categorisation. The judgements around the diagnosis of Personality Disorder are highly problematic.For whatever reason talking about being trauma informed continues to be conflated with trauma work. There is therefore an ongoing challenge to differentiate these two and encourage staff to think about what it means to be trauma informed. It has been difficult to introduce a system wide change (which is acknowledged as considerable) as a change which is endorsed whole heartedly by key leaders in the organisation. The way that psychosis is understood by the organisation (and indeed many trusts) is still overly dominated by an illness model which does not consider trauma to be causative in the context of psychosis. Introducing formulation as a way of

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		improving understanding can help but is too often see as an add on to the all-important diagnosis.
83	Today: Connected In 1 Yr: Advocate	At present, I am quite new to the TIC journey. I've been drawn here because I think the service user experience in my service (an adult CMHT) could be improved by TIC. I think this would be validating and informative and also contain and help staff to formulate their work and experiences. My hope would be that service users would be helped and not retraumatised by their experience with services, and I do not believe this is the case at the moment. A referral was received by CMHT for a young woman who had been sexually abused as a teenager and 'hadn't been the same since'. She was in trouble with the police and had been kicked out of home as she was angry a lot of the time and this was difficult for her family to contain. The response to the referral was primarily one where there appeared to be a disconnect, despite explicit mention in the referral letter, between this young woman's experiences as a teenager and her subsequent trauma responses and the system struggling to meet her needs. There was a suggestion already, based on my own interpretation of the language used in the notes by police and mental health first responders, that she was being portrayed as troublesome and difficult. It would not surprise me if she were to be given a label of a personality disorder, and this narrative to overshadow the trauma that led to this point and would be traumatising in itself. I think this can be particularly difficult when the person themselves does not make the links between what they have been through and their difficulties in the here and now, and I would hope that TIC would help someone understand this and support them to make changes.
84 *Figure 19 (page 20)*	Today: Advocate In 1 Yr: Actively engaged	Trauma-informed care has been accepted in principle but not in practice. As an organisation we focus very heavily on medication and comparatively very little on psychological provision. I do try to influence this when I can, but opportunities to do so are limited. As an example, Registered Nurses, the largest professional group in the Trust, in order to develop, are pushed to become Non-Medical Prescribers in order to become Advanced Practitioners, Associate Nurse Consultants or Nurse Consultants. There is no 'parity of esteem' between psychological therapy qualifications and prescribing.
85	Today: Aware In 1 Yr: Actively engaged	My current interests lie in maladaptive coping strategies for managing trauma. Working in a men's inpatient service I support those who use substances as a coping mechanism for past adverse experiences. Therefore, I want to support staff in understanding underlying causes of substance misuse so that they can view people in a more psychological way. Within my ward environment, I have observed staff refusing to engage with people who present with substance misuse as "they'll never change".

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86	Today: Connected In 1 Yr: Actively engaged	I would like to influence TIC becoming a fundamental element of all care provided to patients, there isn't a single area within the Trust that won't experience patients with trauma, therefore TIC needs to become a part of basic practice. Promoting TIC in the service I work within and trying to change culture from within, through practicing TIC in my own work. Raising awareness of TIC in other specialties outside of psychologically based services e.g. medical, occupational therapy, physiotherapy would be helpful as trauma can be missed or unintentionally dealt with in a manner which invalidates the patients experience or dismisses the impacts of trauma on their life. Within my service we see a lot of patients whose experience hasn't been validated or in some cases believed by medical professionals, for some people this in itself is traumatizing and for others it deprives them of the opportunity to talk about trauma they may have experienced. In terms of the area, I would like to influence it relates to the promotion of TIC as a basic standard of care for all patients and the promotion of TIC in non-psychologically based specialties e.g. medical, occupational therapy, physiotherapy.
87	Today: Leader In 1 Yr: Leader *Figure 19 (page 20)*	Formulation of difficulties for teams in the communities. Replacing diagnoses where possible around PD with understanding complex trauma. I want to get a TIC formulation implemented using the four Rs. I want to spread therapeutic approaches throughout community mental health services The MAIN part I am concerned about is that we don't have medical professionals on board with TIC, they prefer it to be alongside their traditional work. This is incredibly frustrating and leads to burn out. It seems to obvious and then we come up against a Trust which may appear compassionate but is still medically left I have found the most useful aspect has been allying myself in a non-professional away from hierarchies. Working with any other staff or service user who wants to be involved away from the constraints of more patriarchal systems. We have made training packages easier to deliver by other professionals and also service users.
88	Today: Connected In 1 Yr: Actively engaged	To change the way that the health services respond to people who have a diagnosis of personality disorder or have experienced trauma which is impacting on their mental health. Including myself and how i respond. I can think of several examples of individuals who present to A&E with suicidal thoughts or after serious self-harm, who are labelled as "wanting their needs met" and sent home to community services which are not coping (as in the services are not coping/not sufficient to meet the need).
89	Today: Aware In 1 Yr: Actively engaged	*[Narrative not to be shared or quoted]*
90	Today: Connected In 1 Yr: Leader	Care for people who have learning disabilities and autistic people. A lack of TIC awareness in care teams - social care providers. A lack of TI formulation development in services.

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91	Today: Connected In 1 Yr: Actively engaged	I most would like to influence the way services are delivered in mental health to be trauma informed. I work in acute care and feel there needs to be a greater commitment to practical applications of the all the evidence we have about the re-traumatisation of people who end up in mental health services. This would involve active inclusion of people with lived experience, psychologically informed environments and training for staff about trauma for them and the people they provide services for. This needs to be throughout the organisation and not a separate area of special interest.I have completed some relational based (cognitive analytic therapy) training with a staff team and also some workshops on vicarious trauma specifically regarding working on an acute ward. Both of these trainings were helpful in getting the nursing/HCA team to think about the impact of the work they do and the quality of their human interactions with people they support. I have also experienced the punitive nature of the organisation in relation to its own staff teams and services. There is unfortunately a very limited view at higher levels that is there is a serious incident in area A then increased scrutiny is required and that something must be done. There is no consideration from the top about psychological safety for the staff or service users or that attributing blame may be counter-productive. I would suggest that there are times the organisation itself contributes to the trauma experienced by staff and service users.

Four respondents included endnotes about the survey. These are included below.

- I found some of the visual rating images very difficult and am concerned I have not been able to express my views accurately using them. I know you can't please all of the people all of the time and appreciate the attempt to reach those who prefer visuals to text. On plus side it has given me the experience of exclusion that those who are more visual must feel when traditional text-based evaluations are asked for.
- I really hated having only three choices for the list of critical elements!!!!!!!!!
- Hi when completing this form, it was very difficult to highlight the stones and carry onto the area and took a long time to do due to this issue. I was also unable to do this for the area that I worked so I clicked onto prefer not to say as it was becoming frustrating. I work in the [*Region]*. I will also sign up to the community change web page this evening. Thank you
- I could not get the stone on the map to move, so I had to tick prefer not to say to be able to submit. But I work in [county].