Mental Health Staff's Understandings of the Barriers and Facilitators to 'Trauma Informed Services'

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ABSTRACT

Background: The concept of trauma-informed services has been developed over the past twenty years and is growing in popularity. Trauma-informed approaches to service-delivery work on the understanding that a large proportion of the population have experienced trauma. There is substantial literature outlining the benefits of trauma-informed services to both clients and clinicians. Several authors and organisations have produced literature outlining how services can become trauma-informed. Much of the literature emphasises that trauma-informed changes must be led from the top-down. However, as not all services have made the 'shift' to become trauma-informed there are many staff who work to advocate for trauma-informed changes in, currently, trauma un-informed services. The barriers that they have encountered in advocating for trauma-informed services have not previously been studied.

Aims: This research explores the perceptions of staff who are advocating for trauma-informed changes. It aims to explore how these staff perceive trauma-informed services and their perceptions of the barriers and facilitators to their development.

Methods: Semi-structured interviews were carried out with fifteen mental-health staff working in NHS and non-NHS services. A range of services and professional orientations are represented in this study. Interviews were analysed using Thematic Analysis. A non-standardised questionnaire about the barriers to trauma-informed services was also completed by participants to provide supplementary descriptive information.

Results: Four main themes were generated, '*Defining qualities of trauma-informed services'*, '*Individual-level factors'*, '*System-level factors'* and '*Advice for change advocates'*. Sixteen sub-themes were categorised under these themes.

Conclusions: The themes extracted from interviews highlight the personal investment that participants have made in their efforts to develop trauma-informed services. The barriers and facilitators to trauma-informed services were often seen as interacting and overlapping. The work of these participants was facilitated by individual-level factors such as participants' persistence, passion for

the work and the inspiration gained from clients. Connections with allies both inside and outside of services were also perceived to be a facilitator. Managers were perceived as both barriers and facilitators but gaining management buy-in is suggested to be an important role of change-advocates. Additionally, sharing research with managers and colleagues was perceived to be a helpful strategy. Perceived barriers included the prevalence of the medical model, misunderstandings about what the trauma-informed model is and staff burnout. Participants shared advice and encouragement for individuals wishing to make trauma-informed changes to their services. This advice can be summarised by eight points: 1- Don’t give up, 2- Look after yourself, 3- Get management on board 4- Stay connected to allies, 5- Be patient, 6- Be tolerant of different opinions, 7- Make use of research, 8- Be strategic.

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1. INTRODUCTION

1.1. Chapter overview

In this chapter I introduce the concept of ‘trauma’ and several psychological models that explain ‘trauma responses’. I then present frameworks that can be used for working with trauma, consider how trauma can be diagnosed and how it might be conceptualised beyond diagnosis. I then outline what is understood from the literature about the prevalence of trauma in the population before introducing the concept of ‘trauma-informed services’.

I present the rationale for trauma-informed services and the core components that differentiate them from other services. I then discuss what is known thus far about the barriers and facilitators to their development as well as the limitations of this research. Finally, I critically review the available literature on staff who advocate for trauma-informed changes before presenting the rationale for this current study and the knowledge gap it aims to fill.

1.2. Literature search

Between September 2019 and January 2021 an exhaustive search of literature was completed in order to develop an understanding of the research and guidance related to trauma-informed services and their development. As well as developing a contextual understanding of the academic and research field, this review aimed to identify publications of relevance to the aims of this research.

I took a reflexive stance to the literature search, trying to set aside preconceptions about the subject area in order to allow new and unexpected meanings to emerge. ‘Bracketing’ is the practice of consciously working to identify and then set aside preconceptions about the data in order to minimise such influences (Chan et al., 2013; Strauss & Corbin, 1998). While it is not possible to obtain complete objectivity (Crotty & Crotty, 1998) I worked towards bracketing by practicing reflexivity and maintaining curiosity at every stage.

1.3. Introduction to trauma

In this dissertation, the word 'trauma' is used to refer to the experience of one or more life events which have a lasting psychological effect on an individual. Often trauma is described as either 'Type 1', following a single traumatic event, or 'Type 2' which includes prolonged exposure to traumatic experiences (Terr, 1991). In this dissertation the word 'trauma' will refer to both of these types of experiences and the lasting psychological effects that they have on individuals. An underlying assumption of this dissertation is that distress, also understood as 'mental health problems', is often, but not always, the result of traumatic experiences. This dissertation conceptualises trauma using psychological models, understanding trauma symptoms as responses to traumatic events/situations that were once adaptive, but which have since become maladaptive.

1.3.1. Psychological models of understanding trauma

Psychological causal models of trauma seek to explain how traumatic events can lead to lasting behavioural or psychological changes in individuals. These models consider the psychological effects that experiencing traumatic events can have on individuals and are often explained within the frameworks of traditional psychological models. Examples of psychological models from the cognitive and psychodynamic traditions are considered below as well as the dissociation model which considers the neural/biological impact of trauma.

1.3.1.1. The cognitive model

The cognitive model explains trauma responses as occurring following an event that conflicts with the individuals' pre-existing understanding of the way in which the world works (or 'cognitive schemas') (Beck, 1964). When an individual's thoughts, memories and images of trauma events do not align with their cognitive schemas, this can cause distress. As a means to understanding this experience a trauma survivor may replay the event they have stored in their memory. Each of these replays (or 'flashbacks') cause distress which individuals may respond to by withdrawing from, or avoiding, life experiences and emotions. Ehlers and Clark's (2000) cognitive-behavioural model of PTSD draws on these ideas and

identifies the ways in which memories, cognitions and behaviours prolong distress associated with traumatic events long after their passing.

1.3.1.2. The psychodynamic model

The psychodynamic attachment theory model of trauma understands trauma as a response to the activation of attachment systems in times of threat or distress. When dysfunctional attachment systems are activated it can become difficult to safely regulate emotions, although this can be mediated by social support. The Dynamic Maturational Model by Patricia Crittenden (DMM; Crittenden, 2000, 2006) draws on attachment theory to understand distress following traumatic experiences. This model understands trauma symptoms as defensive, relational responses. Crittenden suggests that templates for responses to traumatic events are written in early attachment relationships. These templates or 'functional formulation patterns' define the types of strategies that are employed in the face of traumatic events. A child's adaptive and self-protective patterns of response may correspond to their attachment style. However, when these adaptive responses are applied outside of threatening circumstances, they become dysfunctional or 'pathological'.

1.3.2. The dissociation model

The trauma model of dissociation specifically looks to explain one 'pathological' response to trauma, the 'compartmentalization of distress' (Holmes et al., 2005; Dalenberg et al., 2012). This model combines psychological theories about why dissociation occurs with neurobiological research on acquired neural abnormalities (Admon et al., 2013). This model suggests that in order to reduce the impact of traumatic events, individuals enter into an altered state of consciousness which is a psychobiologically adaptive way of managing overwhelming information (Loewenstein, 2018). These responses can occur to different degrees, from a largely 'normal' response which can be seen in non-clinically presenting populations, to pathological responses which can include symptoms listed in several disorders named by diagnostic manuals such as Dissociative Identity Disorder or Depersonalization (Dalenberg et al., 2012; Loewenstein, 2018).

1.3.3. Causal models and interventions

These causal models explain the emergence of trauma symptoms as, once-adaptive, psychological responses to experiences of traumatic events. Psychological causal models do not always necessarily align with specific interventions for trauma treatment, however several do. Additionally, not all psychological interventions are directly informed by the knowledge of the impact of trauma, alternatively they may focus on the reduction of problematic symptoms which are described in diagnostic manuals. For example, psychological interventions may treat obsessions and compulsions or depression which may have onset following traumatic experiences. These interventions would not be considered 'trauma-informed'. An alterative to understanding trauma presentations as expressions of once-adaptive coping mechanisms, is understanding trauma as having had a lasting physical or chemical effect on an individual. This is the approach taken by the 'medical model'.

1.4. Frameworks and approaches

There are several different frameworks for understanding how and why some individuals may present with mental health difficulties or distress. These frameworks influence the clients that are seen in services, the way that distress is understood and the types of intervention that are provided. In section *, several psychological causal models are considered. These models may fit loosely under a 'psychological' framework, as they understand trauma to be caused by psychological changes or differences. The frameworks considered below present alternative means to understand the effects of traumatic experiences. Psychological models and interventions may not fit exclusively into one framework, however the frameworks to understanding distress do play a large role in how services are offered to different populations.

1.4.1. The Medical Model

The medical model understands presentations of psychological distress using the same framework that is used to understand presentations of physical distress (Bracken et al., 2012). The medical model understands trauma responses as resulting from differences in brain structures, genetics, chemical or hormonal balances. The 'distress' or 'trauma' in this model is seen as existent within an individual who is identified as different from the normal population. Therefore,

within this model of understanding distress, trauma treatments are approached using physical/chemical interventions such as medication. Medical model assumptions can be seen in mental health services that rely on the use of diagnoses and medications in the 'treatment of trauma'. This reliance on the physical health framework to treat mental health has received substantial criticism for several reasons that are discussed throughout this chapter. The use of a medical model approach to working with mental distress is based on the assumption that diagnoses are a valid and helpful way of understanding the presentation of psychological distress. However, there has been a continual failure to identify to validate diagnostic categories and there is substantial overlap between these diagnostic categories that the medical model is reliant upon (Boyle, 1999; Burston, 2020; Kinderman et al., 2017; Kupfer, 2013; Kupfer & Regier, 2011). Despite this, diagnosis remains a popular way of understanding and approaching trauma presentations in mental health services.

1.4.2. The Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF) offers an alternative to diagnostic models (Johnstone et al., 2018) and a medical model framework for understanding distress. Its approach emphasises the importance of understanding experiences or 'adversities' rather than symptoms and corresponding diagnoses. The PTMF recognises the role of the operation and manifestation of *power* structures, *threats* caused by coercive power operations, and the *meanings* and discourses around power operations. Threat responses, or 'symptoms', are understood as adaptive survival strategies employed when facing power-threat-meaning processes. The PTMF describes seven 'provisional patterns' defined by personal experiences or 'adversities', an alternative to the diagnostic structures defined by 'symptoms' that would be used in the DSM or ICD. In an article by Johnstone et al., (2019) reflections on the PTMF are considered and the issue of 'trauma' is discussed. Johnstone et al. (2019) state that the PTMF's focus on trauma has been seen as both a benefit and drawback. In this article, the authors of the PTMF distance the model from the term 'trauma' because of its potential to be aligned with medicalising language.

1.4.3. The Trauma-Informed Approach

A trauma-informed approach can be seen as situated between the PTMF and the Medical Model. This psychological approach emphasises the importance of understanding trauma presentations as adaptive responses to adversity or traumatic events. This approach does not make specific claims as to the aetiology of trauma or privilege one psychological model (e.g. cognitive, psychodynamic or dissociative) over another. Instead this approach highlights the importance of ensuring that models and interventions incorporate the impact of adversity and trauma when formulating distress and therapeutic goals.

A trauma-informed approach recognises the widespread prevalence and impact of trauma in the population, focusing on acknowledging and addressing trauma whilst supporting service-users. SAMHSA's Guidance for a Trauma-Informed Approach (2014) conceptualises trauma by focusing on three factors: the *event*, the *experience* and its *effects*. In focusing on the trauma *event,* it suggests that significant traumatising events do not necessarily have to be life threatening. This can also include a series of events compounded over time (e.g., experiences of racism or poverty). SAMHSA's concept of trauma also emphasises individual interpretations of how events are *experienced*, highlighting that traumatic events involve a power imbalance and that individuals experience and ascribe meaning to the same event differently. Finally, SAMHSA's definition draws attention to the *effect* of the event on an individual, which can include relational, cognitive and physical effects in the short or long term. This conceptualisation of trauma is often utilised by advocates of trauma-informed services as it provides an intuitive and individualised way of understanding the impact of trauma. While this conceptualisation is not necessarily considered an alternative to diagnoses, it does provide a framework for identifying and working with trauma that is not reliant on diagnostic manuals.

1.5. Diagnosing Trauma

Diagnostic frameworks such as the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5; American Psychiatric Association, 2013) and International Statistical Classification of Diseases and Related Health Problems (ICD-11; World Health Organization, 2019) conceptualise trauma within the framework of

Post-Traumatic-Stress-Disorder (PTSD). The diagnosis of PTSD has attracted significant controversy since its introduction to the DSM-3 in 1980 by the American Psychiatric Association and with each revision of the DSM significant changes have been made (Pai et al., 2017). In the most recent edition of the DSM, revisions to the diagnosis have been controversial and raised debate regarding what constitutes trauma, the benefits or detriments of diagnosing PTSD and the heterogeneity of the diagnosis (Pai et al., 2017).

The utility of the DSM-5's diagnosis of PTSD as a way of understanding and describing trauma is often debated. Some practitioners argue that such frameworks are of limited use as diagnostic categories threaten to become too broad and inclusive (Sweeney et al., 2018). Others argue the contrary, that the diagnosis of PTSD is too narrow in its inclusion criteria and advocate for the inclusion of sub-categories such as 'Complex Post Traumatic Disorder' and 'Developmental Trauma Disorder' (van der Kolk, 2014). Here, the ICD-11 may be considered a better diagnostic tool as it includes the diagnosis of 'complex post-traumatic stress disorder' (CPTSD) which has a narrower diagnostic inclusion criterion.

Alternatively, it could be argued that the problem lies not with the diagnostic tools, but with the use of diagnoses. Patel (2011) argues that reliance on trauma diagnoses distracts from the reasons why trauma experiences occur. This distraction ultimately leads to disregarding and de-politicising issues such as gender oppression, violence or trauma. Patel (2011) describes how the diagnosis of PTSD has been used to portray torture as a psychological phenomenon, thereby concealing its political nature. Patel (2011) highlights the importance of looking more broadly at how the psychologisation of distress and trauma can be harmful and how a re-orienting of psychology to a human-rights based approach may provide a more ethical framework.

Many practitioners and researchers argue that trauma is best understood as a natural human response to adversity and that the broadening of PTSD diagnoses represents a move to the over-medicalisation of the human experience (Frances, 2013; McHugh & Treisman, 2007). This is also the perspective taken by the author of this research. There is extensive evidence showing the relationship

between exposure to aversive experiences and expressions of distress. Exposure to many of these adversities may be considered ‘traumatic’ but does not necessarily result in a PTSD diagnosis. The effects of trauma are also not necessarily encapsulated by a PTSD

In a move away from diagnostic categories and the focus on ‘PTSD’, alternative frameworks and models have been proposed that offer alternative ways of understanding and working with trauma.

1.6. Prevalence of trauma

Understanding the prevalence of trauma in the general population is a complex process. The results of prevalence studies vary in how they measure trauma. Some prevalence research reports on rates of diagnoses in the population. Kilpatrick et al. (2013) found that in a national sample of 2,953 adults in the USA, that 8.3% of adults had experienced PTSD in their lifetimes, 4.7% in the previous year and 3.8% in the previous six months.Comparative studies that have used similar methods show slight variations in reported prevalence (Karatzias et al., 2017; Kessler et al., 2010).

While prevalence studies are helpful in formulating a picture of the number of diagnoses within one population, they must not be misinterpreted as indications of the distress levels or numbers of adverse experiences within a population. While some individuals may not meet the criteria for a PTSD diagnosis, they may have been significantly affected by their exposure. Therapeutic support and other resiliency factors may also reduce the current impact of trauma presentation. However, individuals who have historically experienced trauma are vulnerable to re-traumatisation (Örmon & Hörberg, 2017). Additionally, in equating the rates of PTSD diagnoses in a population to the rates of trauma experienced within a population, these studies disregard the effects of trauma that are not described by PTSD. For example, the physical, financial or social effects of traumatic experiences.

The Adverse Childhood Experience (ACE) study (Anda et al., 2006) was a largescale public health study conducted in the USA in the 1990’s by the Centre

for Disease Control and Prevention (CDC) which highlighted the prevalence of exposure to traumatic events (ACEs) in the population and its association with physical health problems. The original ACE study identifies seven ACE's and reports on the prevalence in a large population (N=13,1494) of adults who had completed a medical evaluation in the USA (Felitti et al., 1998). Anda et al. (2006) report that more than 50% of respondents had experienced at least one ACE and 25%, at least two. While the ACE study provided data that has been extremely impactful to the study of the effects of trauma globally, it also holds several significant limitations. The ACE study is limited in the demographic variation which it studied, in that it largely examined the experiences of white, middle-class, adults patients. Despite this, the study is often used to describe broad populations which is does not represent. Additionally, the categories and descriptions of 'ACE's' that were captured by this study are narrow and may have resulted in an underrepresentation of the adversities experienced within populations. In particular, the adversities originally included do not include the impacts of social factors such as poverty or racism.

While the original ACE study is limited in its participant demographic variation and selection of ACE categories, it has been replicated around the world with studies using broader demographic variability (Almuneef et al., 2014; Bellis et al., 2014; Ramiro et al., 2010). Studies that have broadened the list of the original 'ACE's' have found that adverse experiences often co-occur with social disadvantages such as being from a minoritised ethnic background, experiences of poverty or lower levels of education (Goldstein et al., 2020). The relationship between trauma and social inequalities is explored later in this Chapter.

ACE studies, both the original and the studies that have elaborated on the original, shed light on the prevalence and impact of potentially traumatic events in childhood. However, they alone do not provide a perspective on the prevalence of trauma. Adult adversities are less often acknowledged and the impact of issues such as domestic violence, adult sexual assaults or experiences of torture can go unaccounted for by services that rely solely on ACE studies to understand prevalence of trauma exposure within populations. Stumbo et al. (2015) adapted the ACE items to consider adult experiences making several notable adaptations.

They found that exposure to adverse adult experiences was very high, with lifetime exposure rates of almost 94%. While ACEs showed poor predictive value to adult mental health problems, adult adverse experiences were more important predictors of mental health as well as physical health, quality of life, social functioning and recovery.

1.7. Impact of trauma

PTSD and CPTSD are mental health diagnoses in the ICD-11 and DSM-5, the onset of which are observed in response to experiences of trauma. However, as the ACE studies have shown, prevalence of trauma experiences within the population is higher than the prevalence of PTSD diagnoses. The difference in numbers between these two may be a consequence of narrow diagnostic categories, broad definitions of 'trauma' or of factors such as 'resilience' (Barker-Collo & Read, 2003; Goldstein et al., 2020; Haskett et al., 2006; Leitch, 2017). However, what is clear is that many people have experienced traumatic events in childhood and the impact of this goes far beyond a diagnosis of PTSD.

1.7.1. Impact of trauma on physical health

The relationship between trauma experiences and physical health is supported by ACE studies. Anda et al. (2010) found that outcomes in mental health, physical health, sexual and reproductive health, engagement in health-risk activities and premature death were all worsened with each additional reported ACE point. As previously discussed, Anda et al. (2010) was limited in its participant demographic and as such doubts have been cast as to the extent to which these conclusions can be applied to populations that are were represented in the original study. Additionally, it was not possible from this study to conclude that alternative factors were not responsible for the association.

Gilbert et al. (2015) reports on a more representative sample of adults across ten states in the U.S. and found a linear dose-response association between number of ACEs exposed to and the following health conditions after controlling for demographics: myocardial infarction, asthma, fair/poor health, frequent mental distress, coronary disease, stroke and diabetes. This dose-response relationship

between ACE exposure and physical health conditions are has been widely corroborated (Anda et al., 2006; Dube et al., 2003; Hughes et al., 2017). ACEs are also associated with life expectancy, as suggested by the work of Brown et al. (2009) who found that people exposed to six or more ACEs on average died 20 years before those not exposed.

1.7.2. Economic cost of trauma

The economic impact of widespread trauma includes many elements. Anda et al. (2004) analyse the relationship between ACEs, health outcomes, household dysfunction and work performance (including significant employment issues, financial problems and absenteeism). This study reports a strong dose-dependent relationship between work performance and ACE score. This relationship is mediated by interpersonal relationship problems, emotional distress, somatic symptoms and substance abuse (Anda et al., 2004). However, there are many indirect costs including costs to employers. In workforces with high rates of ACEs or personal traumas, unhelpful dynamics can play out damaging team relations and productivity (Lyth, 1990; Obholzer & Roberts, 2019; Rosemberg et al., 2018).

1.7.3. Trauma and mental health

People who access mental health services are more likely to have experienced trauma in childhood or adulthood (Kessler et al., 2010; Kezelman & Stavropoulos, 2012; Mauritz et al., 2013). A dose-response relationship has been found between trauma and psychosis (Shevlin et al., 2008), a higher prevalence of substance use disorders has been found in populations who experienced trauma (Mauritz et al., 2013) as well as a relationship between trauma and self-harm presentations (Cleare et al., 2018). There is also a strong relationship between childhood adversity, depression and anxiety (Rodman et al., 2019).

The Traumagenic-Neurodevelopmental model (Read et al., 2001) integrates biological and psychological research in understanding the mechanisms that connect trauma and psychosis. This well-established model explains the relationship by suggesting that trauma survivors are neurologically ‘primed’ to repeat behavioural patterns that originated as adaptive responses to early trauma. This model makes use of research that shows similar structural

neurological differences in the brains of children that have experienced trauma as well as the brains of adults who have diagnoses of psychotic disorders. The relevant neurological differences are located in the hypothalamic-adrenal-pituitary (HPA) axis, the hippocampus, the frontal/prefrontal-cortex and the dopamine system.

1.7.4. Relationship between trauma and social inequalities

Poverty is often considered an under explored significant predictor of trauma or distress (Johnstone, 2011; Metzler et al., 2017; Read, 2010; Read & Mayne, 2017). Many studies suggest there is inadequate research into the impact of historical or intergenerational traumas (Shevlin et al., 2008; Sweeney et al., 2016). Metzler et al. (2017) describe research exploring the cyclical intergenerational effect of poverty concluding that there is likely an intergenerational effect of ACEs placing people from minoritised ethnicities at a particular disadvantage. Mohan et al. (2006) found that Black mental health service-users are over-represented in inpatient services, more likely to be younger and to have experienced detention under the Mental Health Act (Mental Health Act, 1983, 2015). It has been suggested that social inequalities are likely a root cause of mental health distress and that this accounts for the subsequent correlational relationship between mental health distress and trauma (Johnstone, 2011; Johnstone et al., 2019). This raises a concern, as previously discussed, that by concentrating on 'trauma', the focus is taken away from perpetrators of violence or distress (Patel, 2011). Speaking about 'trauma' rather than *experiences* can sanitize experiences which have historically been kept secret, repressed, or ignored (Boyle, 2006).

1.7.5. A trauma-informed approach to mental health

There is a large body of evidence supporting the relationship between trauma and mental health. This relationship is widely accepted by the general public. Read et al. (2006) examine international data on beliefs about the causality of schizophrenia and find that internationally, the public prefer psychosocial explanations over bio-genetic explanations of schizophrenia. In one study, 94% of Australians expressed the belief that day-to-day stressors or financial difficulties were a likely cause of schizophrenia as opposed to only 59% who

agreed that bio-genetic explanations were causal (Jorm et al., 1997). Despite the evidential and public support of psycho-social models of understanding distress, mental health needs are increasingly being addressed using biological treatments and prescribing rates of antidepressants and antipsychotics are consistently rising (Cao et al., 2021; Mars et al., 2017). In his chapter on 'Toxic Psychology', Newnes (2011) examines how a medical framework has been adopted by clinical psychologists in treating mental distress. Newnes considers the coercive consequences of the medical model such as the use of diagnoses to section individuals under the Mental Health Act (Mental Health Act, 1983, 2015) and subsequent use of physical and medical restraints in inpatient services.

Trauma-informed approaches to service delivery are often seen as a preferred alternative to these traditional models as they emphasise a person-centred, validating and collaborative approach for both staff and clients. This dissertation is written from the perspective that a 'trauma-informed' approach is an appropriate and important way of providing services and support to individuals in distress. This assumption is framed within a psychological model of understanding trauma as an adaptive response that can be activated in individuals who have experienced threatening or distressing situations in the past for which they did not have the resources or support to cope. Sustainable and validating interventions for individuals who have experienced trauma are best provided in the context of understanding an individual's life experiences and the adaptive coping mechanisms they have developed. In addition, services that appreciate the likelihood that many, most or all of their service-users have experienced traumatic events or adversities are better able to provide a compassionate environment for successful therapeutic interventions. When individuals access services which can provide for them in this way, they are more likely to be able to safely share and explore their traumatic histories.

1.8. Trauma-informed services

Harris and Fallot (2001) introduce the concept of trauma-informed services in their paper '*Using trauma theory to design service systems'*. This provided the first guide for professionals to implement a 'trauma-informed' service model.

As the popularity of this approach has grown, the concept of trauma-informed systems has spread far beyond mental health services. Schools (Grybush, 2020; Gubi et al., 2019; Joseph et al., 2020), forensic services (Maguire & Taylor, 2019; Piper & Berle, 2019), social services (Heppell & Rao, 2018) and physical health services (Hoysted et al., 2017, 2019) have taken up the call to become trauma-informed. This approach was first developed and popularised in North America, however it is now growing in popularity in the UK. Scotland has now invested substantial work into creating a trauma-informed workforce and National Health Service (Children and Families Directorate, Scottish Government, 2020). It is the first country to implement a National Trauma Training Programme.

1.8.1. The values of trauma-informed services

SAMHSA's (2014) six core values of trauma-informed care (safety, trustworthiness and transparency, peer support, collaboration and mutuality empowerment and choice, cultural/historical and gender issues) are often cited in the literature and used to define trauma-informed services. There are variations to these six values and some additional elements that are not mentioned by SAMHSA (2014). Values cited by other sources are presented in Appendix A. Values from several important sources are considered below. These provide an insight into the way that trauma-informed services differ from other services

Understanding of trauma- Trauma-informed services require staff to be trained to understand how trauma presents as well as how to enquire about trauma (Harris & Fallot, 2001). Bassuk et al. (2016) created an instrument (the TICOMETER) to measure the extent to which a service is trauma-informed, the first domain on this instrument is '*Build trauma-informed knowledge and skills'*. The TICOMETER is a unique tool that may be useful for future research, however this research was conducted on a limited sample (largely homeless shelters in the U.S.A.). Harris and Fallot (2001) suggest that to ensure an understanding of trauma is sustained within services hiring practices should be reviewed so that trauma knowledge is not lost as the workforce changes over time. They also advise reviewing policies and procedures in order to embed trauma-informed approaches and increase sensitivity in the system.

Therapeutic relationships- In a literature review of 'trauma-informed care principles', Wilson et al. (2017) identified 'therapeutic relationships' as a common theme. This overlaps with other principles e.g. 'resist re-traumatisation', 'trustworthiness and transparency', 'relational collaboration' (Elliott et al., 2005; *SAMHSA*, 2014; Sweeney et al., 2016). Elliot et al. (2005) also found that relational collaboration is essential and that trauma-specific work can only be successful in the context of good therapeutic relationships. Chandler (2008) found that staff experience of their relationship with clients is central in a successful trauma-informed service transition.

Physical environment- The importance of a physical environment that helps clients and practitioners feel safe is often mentioned as a key tenet to successful trauma-informed care (Menschner & Maul, 2016; Sweeney et al., 2016) Borckdart et al. (2011) report on an acute inpatient hospital making trauma-informed changes. This service offered new trauma-informed care training, changes to policies, physical changes to the environment and collaborative care-plan practices. They saw a significant reduction (82.3%) in seclusion and restraint practices. Borckdart et al. (2011) largely put this down to physical environment changes and suggest that these changes reminded staff of the training they had received and the commitments they had made to change.

Resisting re-traumatisation- In their proposal for the 'Sanctuary Model', a trauma-informed system of care, Bloom and Farragher (2011) suggest that individuals who have experienced trauma are liable to becoming victims of repetitive traumatic cycles. In order to break these cycles, staff must be willing to observe their instinctual responses to enter into harmful re-traumatising cycles. Sweeney et al. (2018) explains that mental health services are especially likely to cause re-traumatisation as they use power-over practices such as involuntary detention under the Mental Health Act, physical and chemical restraints. Trauma-informed services actively work to prevent re-traumatisation by reducing these practices and supporting staff to be led by clients' perspectives and experiences rather than their diagnostic labels (Elliott et al., 2005).

Reducing vicarious trauma- Vicarious traumatisation occurs when individuals experience trauma as a result of working and empathising with clients who have experienced trauma (McCann & Pearlman, 1990). Vicarious traumatisation bears conceptual similarity to burnout, secondary traumatic stress, countertransference experiences and compassion fatigue (Bride et al., 2007; McCann & Pearlman, 1990). Bloom (2010) describes that mental health services must both serve client's conscious goals by maintaining a balance between providing empathetic support and protecting staff from vicarious trauma. This is particularly relevant in the context of the COVID-19. Aafjes-van Doorn et al. (2020) surveyed 339 therapists offering remote sessions during the COVID19 pandemic and found that 15% of therapists experienced high levels of vicarious trauma. Although this is a unique and relevant study, the demographic variability is limited to largely White Clinical Psychologists and it is not possible to conclude whether the effects experienced were resultant from vicarious trauma or exposure to primary traumatic stress.

Appreciating histories and contexts- Trauma-informed services must be competent in supporting cultural, social, genetic or historical traumas. They must move past biases, provide culturally responsive care, make use of the healing value of cultural connections and ensure policies are responsive to individual needs (SAMHSA, 2014). Elliott et al. (2005) suggest that this may mean healing takes place within clients' own contexts and involve support networks and community resources. While there is a wealth of evidence that highlights the relationship between cultural/social/historical traumas within certain communities and mental health distress, this principle is not always uniquely identified in studies of trauma-informed services (Harris & Fallot, 2001; Menschner & Maul, 2016; Wilson et al., 2017; Bassuk et al., 2017). It seems that while an appreciation of histories is often a rationale for the provision of trauma-informed services, it is not always deemed an essential principle for their delivery. This is not an issue unique to trauma-informed services and mental health services often fail to adequately integrate issues of race and ethnicity into service delivery planning stages (Patel & Fatimilehin, 1999 p.70).

Collaboration- An essential component of trauma-informed services is that they promote service-user collaboration at all levels of service delivery (Harris & Fallot, 2001). SAMHSA (2014) describe that an important aspect of collaboration is the levelling of power between staff and clients with organisations recognising that clients should be involved at all levels.

Trustworthiness and transparency- Trauma experiences are often defined by a breach in trust. Trauma-informed services work to establish relationships with clients that are trusting and transparent (SAMHSA, 2014). This allows individuals to feel able to engage with services in a way that can promote therapeutic healing.

Pathways to trauma specific support- Trauma-informed services must be equipped to guide clients into seeking trauma specific support as required. This is especially important if previous contact with mental health services resulted in re-traumatisation (Harper et al., 2008). SAMHSA (2014) makes it clear that access to trauma specific services, while essential, is insufficient to support all trauma survivors, and trauma-informed approaches must be applied to all service areas.

1.9. <u>The implementation of trauma-informed services</u>

There is no established regulating body which decides whether a service can call itself trauma-informed or definitively describes the steps that should be taken for a service to become trauma-informed. As such, there is variation between services that describe themselves as trauma-informed. Additionally, there is an overlap between 'trauma-informed principles' and other good practice approaches which a service may already have established. For example, the NHS Five Year Forward Plan (Mental Health Taskforce, 2016; NHS England, 2016) list '*shared decision-making*' and '*positive care experiences'* as targets. These are also core values of trauma-informed services. However, in the production of trauma-informed 'guides for implementation' researchers have emphasised that services cannot '*be'* trauma-informed without going through a process of '*becoming'* trauma-informed (Harris & Fallot, 2001). Sweeney et al. (2018) describe this process as 'a paradigm shift', which involves a shift in ideology and relational experiences.

1.9.1. Implementation guides

Helpful guides have been produced outlining important implementation domains to trauma-informed practice (collated in Appendix B). The original paper by Harris and Fallot (2001) describes five basic requirements for creating trauma-informed systems of care. Subsequent guidance has become more specific. SAMHSA's (2014) implementation domains were used as a framework by the NHS Education for Scotland (Homes & Grandison, 2021).

Implementation guides are helpful to services considering where changes will have to occur as they largely map on to the 'core values' of trauma-informed services. In comparing the guides, there are four key elements that are consistently deemed to be of importance:

1- *Trauma trained staff*- Staff must understand the prevalence and consequences of trauma as well as being aware of how trauma dynamics can enter into all areas of a system.
2- *Commitment to change*- Services must be committed to making changes. Changes must occur at all levels including at leadership and service delivery levels.
3- *Cross-sector collaboration*- this point highlights the importance of whole services or organisations being trauma-informed, not solely mental health services. Trauma-informed services include training and changes to policies in all areas of a service so that staff at every point can recognise and appropriately understand trauma.
4- *Evaluation*- the impact of trauma-informed changes should be evaluated regularly to reconsider their effectiveness. This also helps to support staff belief in and fidelity to trauma-informed changes.

In considering these elements, if a service intends to become trauma-informed it will require substantial work and investment.

1.10. Barriers to Trauma-informed Services

Implementation science literature suggests that barriers to service change can arise at multiple levels including within markets, organisations, staff groups or clients (Ferlie & Shortell, 2001). Within the trauma-informed care literature,

barriers have been explored at all of these levels. Sweeney et al. (2016; 2018) consider external environmental reasons for why services do not become trauma-informed from a UK context. These barriers consider broader environmental, epistemological or political considerations. The barriers at the individual organisation implementation level are often considered by research papers that evaluate the effectiveness of services that worked to become trauma-informed (Bartlett et al., 2016; Blair et al., 2017; Borckardt et al., 2011; Conners-Burrow et al., 2013). At the staff level, research tends to focus on staff attitudes as barriers to the implementation of trauma-informed care (Berkhout, 2018; Robey et al., 2020; Stevens et al., 2019; Young et al., 2019). Attitudes related to trauma-informed care have been considered as a barrier by Baker et al. (2018) who present the validation of the Attitudes Related to Trauma-Informed Care Scale (ARTIC), a measure of staff attitudes. Research into barriers from the perspective of service-users is currently limited (Purtle, 2020).

Appendix C presents a list of the barriers identified in the trauma-informed literature by several authors. The barriers that are most prevalent in the trauma-informed research, guidance and grey literature have been summarised below and categorised into two levels. First, broad environmental/historical barriers that prevent investment in trauma-informed care. Second, barriers to implementing trauma-informed changes that exist within the workforce. There is overlap between these levels and barriers.

1.10.1. Broad environmental/historical barriers:

Horror and denial- Sweeney et al. (2016) suggest that there is a self-protective resistance within services to accepting the prevalence of trauma experiences. Accepting the impact and prevalence of social inequalities and institutionalised injustices can leave practitioners feeling hopeless and in opposition to powerful groups upon which they may be dependent (Jackson, 2002; McCorkle & Peacock, 2005).

Continuous change and competing initiatives- There are continuous pressures placed on services for change and improvement. Wolf et al. (2014) completed focus groups and interviews across several social service agencies in New York and found that most organisations implemented principles of trauma-informed

care but did not label them as such. One explanation that Wolf et al. (2014) give for this is that the principles of trauma-informed care are aligned with the tenets of social work (e.g. self-determination, empowerment and social justice). While Wolf et al. (2014) provide an interesting insight into the competing initiatives in U.S. services, their study sample is limited to only fourteen services. Additionally, their conclusions may not be generalisable to U.K. mental health services.

Diagnostic manuals - Watt (2017) suggests that a trauma-informed approach to service delivery is not compatible with the current service models that are dependent on diagnostic manuals such as the DSM. Watt identifies several issues, including that trauma histories are less commonly or easily shared between services when a client moves and that diagnoses are more easily understood. Watt (2017) writes from an American perspective and highlights that as healthcare providers in the USA are reliant on insurance carriers, and these carriers require diagnoses to provide financial support. A health service model that moves away from diagnoses is currently incompatible with this system, however it may be more compatible with the U.K. system.

Biomedical causal models- Sweeney et al. (2018) consider the impact of the dominance of the biomedical model as a barrier. The biomedical model is often the dominant focus of training for health professionals and there is generally a lack of exposure to alternatives. Courtois and Gold (2009) highlight that there is insufficient training on traumatic stress in the undergraduate programmes of most health professions which has led to a training gap. Staff who have not been trained in traumatic stress will lack the confidence to enquire about it and be less aware of its prevalence.

Trauma and family blaming ideas- Sweeney et al. (2016) suggest that the popularity of a biomedical model of understanding mental health diagnoses indicates a resistance to the idea that trauma explanations are ‘family blaming’. Such resistances are historically linked to criticisms against the psychodynamic tradition. They are also related to the argument that enquiring about abuse, often seen as a central component of trauma-informed services, could prompt the creation of false memories. This discourse is particularly relevant to the dissociation model of trauma which implies that individuals who dissociate are

prone to fantasy constructions (Loftus and Ketcham, 1994; Dalenberg et. al, 2012). Sampson & Read (2017) report that staff concerns about prompting 'false memories' is a barrier to enquiring about abuse histories. The 'false memory debate' often arises despite the work that has been done to dismantle this problematic idea (Edwards et al., 2007; Farrants, 1998; Gleaves et al., 2007; Read et al., 2003).

Momentum- It may be the case that a 'critical mass' has not yet developed and the concept of trauma-informed services has not gained sufficient popularity and that services remain unwilling to invest in this model or paradigm shift (Sweeney et al., 2016). This is particularly relevant to the U.K. where currently trauma-informed approaches are less common than in North America.

Youth bias- Purtle and Lewis (2017) map the prevalence of trauma-informed ideas within American public policy. They found that policies disproportionately focused on young people (73.2%). If trauma-informed services are seen as primarily helpful for child services this may be a barrier to adult services deciding to invest in change.

1.10.2. Workforce implementation barriers

Lack of supervision and training- Regular supervision and training for all staff are often considered essential elements of trauma-informed services (Bloom, 2010; Sweeney et al., 2016, 2018). They require funding and staff capacity which are often in short supply (Sweeney et al., 2018).

Power imbalances- A culture in which service-users and their views have not historically been valued is a barrier to a trauma-informed approach. Services are likely to require additional training and support in integrating service-users views into planning. Sweeney et al. (2018) see services that employ 'power-over' approaches or are too 'risk-averse' as discouraging staff engagement. This is also emphasised by Elliot et al. (2005) who identify 'Relational Collaboration' including staff being aware of inherent power imbalances as one of ten principles that define trauma-informed services. However, they also consider that addressing this inherent power differential is a challenging goal. Ashcraft and Anthony (2008) completed a 58-month retrospective analysis of the effects following the implementation of trauma-informed training and found that staff

behaviours driven by ‘power-over’ dynamics can still persist in services regardless of previous training. While this paper is often referenced in reviews of trauma-informed practice, Ashcraft and Anthony (2008) examine changes in restraint and seclusion practices specifically and it may be that this conclusion is not generalisable to trauma-informed training specifically.

High staff turnover- Harris and Fallot (2001) recommend that services integrate trauma-informed thinking into their recruitment practices and ensure that all new recruits are trained in trauma-informed approaches. This practice is time and resource costly especially if a service has high staff turnover.

Organisational stress- Bloom and Farragher (2011) consider factors such as ‘parallel processes’ from the psychodynamic tradition as barriers to the implementation of trauma-informed changes. As staff come to acknowledge their client’s trauma as well as their own they may become hyper-aroused and the environment may become crisis-oriented making regulating practices such as self-reflection and supervision difficult.

Staff feeling de-skilled- Staff training in trauma is a basic requirement. Palfrey et al. (2019) evaluate the changes following a trauma-informed care workshop with mental health practitioners (nursing, medical and allied health professionals). This study found that despite training, staff felt that they did not have enough experience or expertise for work in trauma. While this finding is important to consider as a potential barrier of trauma informed services, Palfrey et al.’s conclusions are dependent on the results of self-report measures and as such participants’ *actual* knowledge or changes in practice cannot be known. Additionally, this study looked specifically at the experiences of CAMHS staff which limits generalisability and adds to the, previously discussed, youth bias in the literature.

Conceptual confusion- Trauma-informed approaches can be confused with trauma-specific work which may leave staff feeling de-skilled or unwilling to engage as they are not trained in trauma-specific work. Prevalent in the trauma-informed literature is a focus on services reducing restraint or seclusion practices (Ashcraft & Anthony, 2008; Azeem et al., 2011; Barton et al., 2009; Borckardt et al., 2011). Muskett (2014) explores this and suggests that services can often

become fixated on this as an outcome and lose sight of other components of trauma-informed services. This is a theme replicated in the trauma-informed literature and meta-analyses.

Low staff morale- Stevens et al. (2019) found that staff who described themselves as being 'open-minded' also perceived themselves as better at providing trauma-informed care. Bosk et al. (2020) also found that higher levels of staff rejection sensitivity was associated with less support of trauma-informed care and that this in turn was related to staff feeling more ready to leave their organisation. While both of these studies contribute to the literature by expanding research beyond a focus on youth services, neither study is exploratory as both ask staff their views on a limited list of barriers pre-determined by the study authors. This is a limitation of several studies in the trauma-informed literature as they often make conclusions as to the barriers experienced by staff based on their agreement with a list of barriers that have been pre-determined by the authors or by existent measures (e.g. the ARTIC scale (Baker et al. (2016).

Staff not enquiring about trauma- Sampson & Read, (2017) found in a review of 60 international studies that only 0-22% of service-users had been asked about abuse histories. Young et al. (2001) found the two most relevant reasons why staff reportedly did not enquire were a concern about upsetting clients and staff prioritising other tasks. Other reasons included clients having a diagnosis of schizophrenia, beliefs about the biological origin or distress and fears of inducing 'false memories'. Young et al. (2001) emphasise the importance of supporting staff to overcome these barriers as service-users are more likely to underreport trauma experiences. Additionally, this information is essential in developing accurate psychological formulations (Finch et al., 2020; Sharif et al., 2021). For clients, the experience of being asked about abuse histories in a mental health assessment can be therapeutic as it implicitly connects life histories to symptom presentations (Fowler, 2000; Read et al., 2005). However, it must be emphasised that enquiring about trauma experiences must be done in the context of a therapeutic relationship and staff must know how to respond appropriately to disclosures (Young et al., 2019).

Staff burnout- Trauma-informed approaches require staff to be exposed to client stories about trauma as well as encouraging staff to consider their own personal traumas and how they may affect their work. It has been assumed that this exposure to trauma stories will increase staff burnout, however research shows the relationship is more complicated. Baker et al. (2018) found, in a quantitative study that staff vicarious traumatisation scores were increased after trauma-informed training. However, their qualitative study revealed that staff did not report increased vicarious traumatisation. This relationship is explained as representing an increased awareness in the effects of trauma on staff which lead to higher vicarious traumatisation scores. Similar findings are reported by Damian et al. (2017) who report on the impact of trauma-informed care training provided to a group of government workers.

1.11. Facilitators to Trauma-Informed Services

The facilitators to trauma-informed services are less often reported than barriers. In guidance documents they are often integrated into the core values or implementation domains of trauma-informed services. Appendix D presents a list of the facilitators discussed in several significant papers. The facilitators listed below are those most prevalent in the literature and have not already been considered in 'Values' or 'Implementation guides'.

Education/training- Implementation science literature emphasises the importance of shared knowledge as a first step in making any service change. Williams and Smith (2017) surveyed staff one year after training in trauma-informed care and found that knowledge about trauma-informed care held by managers had a positive impact on their trauma-informed practice. Increasing staff knowledge and belief in the model is important in encouraging staff behavioural change. Fraser et al. (2014), Hopper et al. (2010) and Sundborg (2019; 2017) suggest that effective change-makers must first achieve buy-in and commitment from staff which can happen through training.

Trauma champions- Robey et al. (2020) and Muskett (2014) highlight the importance of services allocating leaders to drive trauma-informed agendas to achieve successful implementation. This is a recommendation made by Harris

and Fallot (2001) who suggest that this role is clearly defined and can help a team to remain focused on trauma issues.

Executive support- This is a facilitator that is noted in almost all research papers that review barriers and facilitators (Donohoe, 2010). Kirst et al. (2017) note that this is important to establish the resources needed for trauma-informed changes and to keep the issue of trauma on the agenda.

Inclusion of all staff- To ensure the success of trauma-informed changes, whole staff groups, from reception to front-line staff should be involved in changes and training. Kirst et al. (2017) suggest that training should stem beyond one organisation and into partner organisations to ensure that continuity and trauma-informed values are maintained throughout the clients experience of services.

Attitude changes- Baker et al. (2016) developed the Attitudes Related to Trauma-informed care (ARTIC) Scale and emphasise that staff attitudes towards trauma-informed care are an important driver to behavioural changes and the success of trauma-informed approaches. Lowenthal (2020) found in a scoping review of trauma-informed implementation literature that changes to knowledge, attitudes, behaviour and practice have modest effects on behavioural change and often barriers can prevent them from being maintained over time.

Therapeutic relationship- In their review of the literature Muskett (2014) found that in the 13 papers they considered, each one stressed the importance of emotionally-supportive care by staff. In evaluating the psychometric properties of a tool that measures consumer perceptions of care (applied in this example to trauma-informed care), Clark et al. (2008) found that interpersonal processes are fundamental to service-users experiences of care and that the therapeutic relationship is the most significant predictor of satisfaction. Kirst et al. (2017) also found this to be integral and highlights that in the context of histories of victimisation and trauma, safe relationships are essential.

1.12. The efficacy of trauma-informed services

The majority of studies that present evidence of the efficacy of trauma-informed mental health services have been completed in the U.S.A. and utilize pre-post study designs (Purtle, 2020; Sweeney et al., 2016). These studies generally

measure the effects of trauma-informed training or the implementation of specific trauma-informed treatment changes.

Several literature reviews summarising the results of efficacy studies can be found in the literature. Sweeney et al. (2016) present a review of eight studies presenting evidence of the efficacy of trauma-informed mental health services. This was not a systematic review and the search strategy was simplistic, however their conclusions based on this review were that beneficial effects noted included reductions in seclusion, reduced PTSD symptoms and improved engagement with therapeutic interventions. Social outcomes such as reductions in substance misuse, use of homeless shelters, or offending rates were not affected by interventions. Wilson et al. (2017) and Muskett (2014) present reviews of literature related to trauma-informed changes in inpatient services and share similarly positive outcomes specific to therapeutic interventions. Notable positive outcomes presented by these reviews include reductions in power-over practices such as restraints and seclusion which likely lead to re-traumatisation (Azeem et al., 2011; Barton et al., 2009; Borckardt et al., 2011), improved long term treatment effects (Gatz et al., 2007), reductions in PTSD symptoms (Messina et al., 2014) and changed staff perspectives indicating a cultural shift (Chandler, 2008; Green et al., 2016).

A recent and more inclusive systematic review that included school and medical services was completed by Purtle (2020) and considered the results of 23 studies. Of these studies, Purtle (2020) finds that 12 report significant improvements in knowledge, attitudes and behaviours of staff and 5 found statistically significant improvements in client outcomes. However, Purtle (2020) highlights that the strength of this review is limited by the literature being largely made up of short-term single group pre/post studies of organizations intervention effects that make use of unsophisticated analytic approaches and inconsistent assessment instruments.

Sweeney et al. (2016) note that because of the variation in intervention types, the exact change element responsible for positive outcomes cannot be identified. Purtle (2020) similarly argues that such is the problem with the mass of research into trauma-informed services that present single group pre-test/post-test that

broad conclusions about efficacy cannot be drawn. Purtle (2020) calls for further research into changes in staff outcomes, including staff knowledge and attitudes following trauma-informed interventions.

1.13. Literature concerning staff experiences of implementing trauma-informed changes

This chapter has reviewed the large body of research and academic literature contributing to the knowledge base of the barriers and facilitators to trauma-informed services. It presents several guides to implementing trauma-informed changes as well as research and articles offering advice on how changes can be made in light of barriers and facilitators. What this literature does not consider is *who* can make trauma-informed changes. Many of the changes suggested would only be possible from a managerial/executive level, e.g. incorporating trauma-informed principles into recruitment (Harris & Fallot, 2001). Much of the literature provides ideas for service managers and others holding positions of authority. However, not all managers are supportive of trauma-informed approaches and changes cannot always occur from the top-down. Staff who work within these services may still wish to implement changes or take steps to assist their service to become more trauma-informed.

Harris and Fallot (2001) describe staff who take on additional roles in helping their services focus on trauma-informed issues as ‘trauma-informed champions’. ‘Champions’ will be well informed about the prevalence and impact of trauma and will work to ensure that trauma-informed thinking remains on the agenda. While Harris and Fallot (2001) suggest that champions be allocated after a service has decided it will become trauma-informed, SAMHSA (2014) suggest that champions can be supportive in initiating service change processes. Robey et al. (2020) distinguish between these two roles by naming separately ‘appointed internal implementation leaders’ and ‘champions’. There is very little exploration of ‘champions’ and their value in the trauma-informed literature. There is also little research into the experiences of ‘implementation leaders’ of trauma-informed ideas within services (whether they are labelled as ‘champions’ or not). The research described in this dissertation captures the perspectives of staff

described as ‘trauma-informed change advocates’ who are working individually to make changes to their services.

A systematic review of the literature found only four studies that have explored staff experiences of making trauma-informed changes to services and their views on the barriers and facilitators.

1.13.1. Search strategy

Between September 2019 and January 2021, I completed an exhaustive search of the literature. Initial searches used EBSCO, an international online database resource and narrow search parameters such as “trauma-informed” AND “service” AND “mental healthcare” AND “barrier”. The reference lists from retrieved papers were manually searched for papers of relevance which were then cross-checked against initial search results. If papers of relevance were not found in search results this was noted in order to improve search parameters. Subsequently, parameters were broadened to ensure no relevant publications were missed. The more inclusive search used the international search databases: PsychINFO, PsycArticles, SCOPUS, Web of Science and Science Direct.

The following search terms were used:

(“trauma-informed care“ OR “trauma informed care“ AND “trauma-informed approach“ OR “trauma informed approach“ AND “trauma-informed service“ OR “trauma informed service“ AND “trauma-informed practice“ OR “trauma informed practice“) AND “mental health”

This search yielded 1,090 unique results. The abstracts and titles of these 1,090 results were read and filtered for relevance to the research aims. Where titles/abstracts did not provide sufficient information, full papers were accessed and appraised. It is possible that, despite all efforts, this review has missed some important literature due to discrepancies in terminology. 60 papers were found which considered the process, barriers and facilitators of developing trauma-informed mental health services. Only four publications specifically considered

these issues from the perspective of mental health staff. Further details, including the reasons for exclusions of the other 56 papers are mapped in Appendix E.

These 56 papers of relevance were considered as contextual information, and many are referenced in this chapter. The four papers of direct relevance, focusing on the experiences of 'trauma-informed change advocates' have been reviewed in detail below.

1.13.2. Kirst, Aery, Matheson and Stergiopoulos (2017)

This Canadian study interviewed 13 service providers/research experts and six service-users about their views on trauma-informed practices in substance misuse and mental health services. The researchers aimed to identify the critical components that support the implementation of trauma-informed services by asking staff about barriers and facilitators. These staff were involved in the development of trauma-informed services and held leadership positions as either executive directors or managers. Some participants worked in trauma-specific services and others in services that were deemed to practice trauma-informed care in mental health and addiction services.

Kirst et al. (2017) analysed interviews using thematic analysis and found the following themes:

- Facilitators
    - Organisational support and leadership
    - Inter-sectoral service integration
    - Staff awareness of trauma
    - Building a safe environment
    - Quality of the consumer-provider relationship
- Barriers
    - Provider reluctance to address trauma
    - Lack of accessible services
    - Time consuming, under-resourced work
- Areas of improvement
    - Increased trauma awareness across services

- Inter-agency work
- Improved training across staff
- Service-user involvement

Kirst et al. (2017) address a research gap by highlighting the views of service providers regarding the barriers and facilitators to the implementation and development of trauma-informed services. Results suggest that the guidance and literature reviewed in this chapter accurately represent the barriers and facilitators encountered by Kirst et al.'s participants. All of the barriers and facilitators highlighted by Kirst et al. (2017) have been addressed in the literature review.

In particular, Kirst et al. (2017) highlight the importance of organisational support and leadership. As the participants were all in leadership positions this is interesting. Kirst et al. (2017) suggest that this is important in retaining a focus on the organisation's commitment to be trauma-informed and ensuring that it does not fall off the service agenda. The issue of how to initially place trauma-informed care on the agenda has not been explored. In addition, the suggestions for areas of improvement all appear to be targeted at the managerial level from where it is easier to effect change. No suggestions are given with regards how to 'advocate' for a trauma-informed approach.

One limitation of this research that Kirst et al. (2017) highlight is that views about trauma-informed and trauma-specific services were explored concurrently. This makes it difficult to be certain that the themes which were extracted from interviews apply specifically to trauma-informed service development. A strength of this research is that participants represented a range of services from across Canada. This variation increases the generalisability of the study somewhat. However, this generalisability may be constrained to North America where trauma-informed ideas have gained popularity quickly.

1.13.3. Chandler (2008)

Chandler (2008) presents the experiences of staff in an inpatient service that had transitioned from a traditional medical model service to a trauma-informed one. The unit describes saw a substantial reduction in the use of restraints over the transition period. Transition involved a focus on trauma-informed skills training and education. Chandler interviewed ten mental health staff who had worked on

the unit for over 12 years who shared their perspectives on the service before and after the transition.

Chandler (2008) analysed interviews and found that the overarching theme in the narratives of these staff was of the transfer of control between patients and staff. Four sub-themes were identified:

> *'Changing Perspectives'*- staff were supported in changing the way that they understood service-user presentations. This shift is largely attributed to a manager in the team who was a strong advocate of trauma-informed changes and was able to model the trauma-informed approach and provide a space for staff to explore it.
>
> '*Collaborative patient-staff relationships'*- addressed a shift in the pronounced hierarchy amongst both staff and social-workers as a result of trauma-informed training.
>
> '*Implementing safety measures'*- this sub-theme made reference to acknowledging restraint procedures as re-traumatising. Positive changes included asking service-users about trauma histories and making physical changes to the unit to promote self-soothing for dysregulation.
>
> *'Implementing individualised evidence-based educational resources*' -while this category largely focused on skill-building, Chandler shares a perspective from a participant who suggests that guidance and templates for work with particular diagnoses was involved in supporting this trauma-informed development.

These sub-themes are largely consistent with the 'values' of trauma-informed services provided in the literature. Chandler concludes that staff describe trauma-informed changes as '*creating a culture of safety*' and that this change had required a 'paradigm shift'. This shift is described as happening top-down from leadership to staff and emphasises the importance of incremental change. This paper adds to the knowledge base by describing the views of mental health staff on what a 'trauma-informed service' is and capturing something of their experiences of the transition. However, this paper does not explicitly reference the barriers or facilitators that these staff encountered. In addition, the staff

interviewed were not described as trauma-informed 'champions', advocates or leaders, they were staff who had experienced the changes but not led them. Chandler does, however, note in the sub-theme '*changing perspectives'* the importance of a trauma-informed advocate or role-model. The experiences of this advocate are not explored.

1.13.4. Robey, Margolies, Sutherland, Rupp, Black, Hill and Baker (2020)

Robey et al. (2020) report on the results of two studies, Study 1 is relevant to this review. In Study 1, Robey et al. (2020) completed a secondary analysis of data collected by Baker et al. (2016). Baker and colleagues analysed responses to a questionnaire that asked staff to rate the level of trauma-informed care implementation within their organisation, their attitudes towards trauma-informed approaches and the extent to which their organisation had been successful in making changes. The researchers received 760 responses from participants who worked in human services, community-based mental health services or healthcare. On the basis of this research, Baker et al. (2016) developed the 'Attitudes Related to Trauma-informed Care (ARTIC) Scale' which can be used to assess how trauma-informed a service is. Findings by Baker et al. (2016) suggest that the scale has strong psychometric properties with strong internal consistency and test-retest reliability. The researchers suggest that the scale can be used as a helpful evaluation tool in pre/post trauma-informed intervention studies.

Robey et al. (2020) further analyse the data of Baker et al. (2016) by dividing participants, based on their ARTIC results, into either 'high implementing organisations' or 'low implementing organisations'. Data from these two groups was mapped against the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009). This framework is used to identify the importance of several domains to the successful implementation of a service wide intervention. The CFIR uses the following five domains:

- *Intervention characteristics*- attributes or values of the intervention
- *Outer setting*- wide contextual factors such as political contexts

- *Inner setting*- characteristics of the organisation
- *Characteristics of individuals*- staff differences and demographics
- *Process*- how the intervention has been rolled-out

Robey and colleagues identified how items on the CFIR were referred to as barriers or facilitators by staff in either high or low implementing services. The results found that the '*inner setting'*, '*characteristics of individuals'* and '*process'* domains were the most commonly rated on the CFIR. This suggests that the barriers and facilitators to trauma-informed services most often fall within these categories and that the categories '*outer setting'* and '*intervention characteristics'* are of less importance.

This study captures the views of a large number of staff (n= 760) at all levels of services, not only managers or leaders. Robey et al. (2020) emphasise that trauma-informed change must happen from the ground-up to be effective and sustainable as it is 'on the ground' staff who drive trauma-informed care. They also conclude that the personal attributes of the staff who make changes are central to the success of trauma-informed services, this is based on the importance of the '*characteristics of individuals'* domain. This is a notable finding as individual characteristics are not explored as a barrier or facilitator in the research literature.

The benefit of this study is that it captures a large sample of staff who work in services across the US. In the literature, the views of staff 'on the ground' are underrepresented and this research has worked to fill that gap. However, Robey et al. (2020) acknowledge that the sample, while large, may not be representative of many staff working in services implementing trauma-informed changes as in their sample a high number of participants were already familiar with the model. 62% of participants shared that they were quite to very familiar with trauma-informed care and 57% had received formal training in the model. It is possible that the findings from this particular research cannot be generalised to mental health staff in UK services.

1.13.5. Sweeney, Clement, Filson and Kennedy (2016)

This paper describes trauma-informed approaches and their application to UK mental health services. While it is not a research paper that analyses and summarises the views of multiple staff-members, one of the authors (Angela Kennedy) played a key role in making trauma-informed changes to a large NHS mental health service in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). This paper presents Angela Kennedy's experiences as a case-study, identifying several barriers that may explain why the implementation of trauma-informed approaches has been slow in the UK. These barriers are presented in Appendix C and several have already been discussed in this chapter.

In the presentation of the TEWV NHS Foundation Trust case study, Kennedy refers to several facilitators that were important to the success of the intervention. While they are presented as facilitators, these factors can be seen as helpful pieces of strategic advice for staff wishing to pursue trauma-informed changes in their service. The facilitators summarised are:

1- Sell the idea to someone in a senior position and focus on ways that the proposed trauma-informed intervention can meet service objectives (e.g., reducing inefficiencies).
2- Adapt the trauma-informed approach so that it fits with existent service methodologies (e.g., presenting it as a trauma-informed 'pathway')
3- Prioritise empowering staff and embedding trauma-informed ideas as opposed to adding tasks such as data-collection or monitoring staff attitudes or activities.
4- Empathic engagement with all staff is important so that they feel able to develop trauma-informed skills which they can use with clients and subsequently witness the therapeutic benefits of.

These facilitators offer a unique perspective on the ways in which individuals may go about strategically pursuing trauma-informed changes.

This paper and the case-study presented are important to consider as they constitute the only detailed perspective of a UK mental health service transitioning to become trauma-informed. In this paper, Sweeney et al. (2016) particularly emphasise the importance of a 'critical mass' developing so that trauma-informed approaches can be better modelled and shared. While this

paper is unique in the material that it presents, it is still largely focused on a top-down approach to trauma-informed changes. In addition, while it may be a helpful guide for staff looking to make similar changes, it does only present the perspective of one staff member in one trust and the barriers/facilitators cannot be generalised.

1.14. Rationale for current research

Trauma-informed changes are often implemented in services using a top-down approach. Much of the literature and guidance in the area is based on this assumption and is targeted at service leads. Kirst et al. (2017) explores the experiences of service leads and their perceptions of the barriers and facilitators to trauma-informed services This is likely to be helpful to service leads who are already supportive of these changes, however this is not the case for all organisations. Generally, the perspectives of staff 'on the ground' making trauma-informed changes are underrepresented (Purtle, 2020). Chandler (2008) presents the perspectives of staff from one organisation who experienced a service changing from a traditional model to a trauma-informed one. However, in this example the changes were decided upon and implemented using a top-down approach. While trauma-informed changes have gained significant popularity in North America, the UK has been slow to implement such changes (Sweeney et al, 2016). Sweeney et al. (2016) explore specific UK barriers and present a case study.

As the approach grows in popularity in the UK, more staff are working using 'trauma-informed principles' and shifting to understand distress from a social, rather than biomedical model. These staff-level shifts appear to be occurring at a faster rate than UK service-wide shifts, which has resulted in the development of a group of staff who are enthusiastic about trauma-informed changes but unsupported in their services. Little is known regarding the experiences of staff who have attempted to implement trauma-informed changes. The work of Robey et al. (2020) appears to suggest that the individual characteristics of these staff is of importance. Sweeney et al. (2016) make several suggestions about the key steps that are important in implementing culture shifts and discuss the potential

barriers that may be encountered. However, the actual experiences of staff in the UK who have attempted to make these 'culture shifts' from the bottom-up have not been explored. These staff likely have a wealth of knowledge that can be of assistance or inspiration to others. In particular, these staff have knowledge about the challenges that they have encountered and the ways in which they have managed them challenges as well as the factors that have been pivotal in supporting their goals.

1.15. Research Aims

By exploring the experiences of staff who have attempted to make bottom-up trauma-informed changes in their services, this research has several aims:

Aim one: present the perceptions of mental health staff who have attempted to make trauma-informed changes in their services

Aim two: explore how these staff perceive trauma-informed services and the value they see in this service model

Aim three: identify the perceived barriers and facilitators to trauma-informed services that these staff perceive to have encountered

Aim four: share learnings and advice from these staff members in order to assist others wishing to make trauma-informed changes

1.16. Research questions

The above research aims will be addressed by focusing on the following two research questions:

1. What do participants perceive to be a trauma-informed service?
2. What are the perceived barriers and facilitators to trauma-informed services?

2. METHODOLOGY

2.1. Overview of chapter

This chapter outlines the methodology and method used in this research study. I will first outline the ethical considerations and usefulness of this research. I will then consider the epistemological position of this research and reflect on the effect of my role as a researcher on the data I collect and the conclusions I draw. I will outline the procedure of the study including information about how it was designed, the participants and the process of data collection. Finally, I will report how analysis was conducted and the conclusions drawn.

2.2. Ethical considerations

Ethical approval for this study was sought and granted by the University of East London (Appendix F). Amendments to the ethics application were approved in March, 2021 to change the title of the thesis (Appendix G). Ethical considerations were guided by the BPS best practice guidance for research during Covid-19 as well as existing codes of ethics and guidance on research (British Psychological Society, 2014; The British Psychological Society, Ethics Committee, 2020)

2.2.1. Confidentiality and Anonymity

At the recruitment stage, participants were asked about their professional backgrounds and experiences in using ‘trauma-informed approaches’. The purpose of this was to ensure a diverse range of experiences were represented in the interview data. This aligned with the assumption that diverse experiences may lead to diverse perceptions which could be captured in the research. Following interviews and transcriptions, this information was anonymised to a basic level so all that remained was a broad list of professions and a list of service types. Potential participants were informed that their personal data would be kept confidential and their responses anonymous. This was of particular importance in this research as there was an expectation that participants would

be speaking about their places of work and potentially challenging themes could arise.

Several potential participants contacted me to ask further details about confidentiality and anonymity. I reassured participants that if they had doubts about confidentiality and the potential professional repercussions of their taking part that they would be under no obligation to participate. Some participants felt conflicted between a sense of 'duty' to contribute to the progression of trauma-informed research and concerns about professional repercussions. My responses balanced this conflict by stating that I would anonymise the data to a level that they were completely satisfied whilst also offering reassurance that the research would progress without their input and they did not need to feel any 'duty' pressure. Two potential participants withdrew their interest on the basis of these concerns.

Recordings were only listened to by me and I transcribed all of the interviews. Upon transcription all identifying information was removed to protect anonymity. Transcripts were accessible only to myself and my supervisor. All data was stored securely, as outlined in the approved Data Management Plan (Appendix H).

2.3. Epistemology and Ontology

Ontological assumptions and epistemological positions influence all aspects of research, from selection of the research question through to the conclusions drawn from the research (Willig & Rogers, 2017). Ontology asks the question '*what is there to know?*' and epistemology asks '*how can we know?*' (Willig & Rogers, 2017). This research is conducted from a realist ontology and a critical realist epistemology. A realist ontology assumes that there is a 'reality' that we strive to know through research. A critical realist epistemology assumes that there is a reality, but one that we can never fully know. A single 'truth' or 'reality' can never be discovered as the tools that we use to collect and understand data about reality are inherently limited by subjectivity. The tools that we use to examine reality are affected by many different things including personal experiences and historical or cultural contexts.

2.3.1. Critical realism and contextualising findings

In taking a critical realist approach to research I am aware of the limitations of my 'tools' and have taken steps to understand these limitations and how they impact on the conclusions that can be drawn from the data collected. These steps have been guided by Harper and Thompson (2011). First, I must compare my findings to the findings produced by other tools. I consider the data that I collect within the context of other data related to the subject matter. I have done this through examining the existent literature in the Introduction Chapter. Second, I must examine and evaluate my 'tools' so that I can understand their flaws and biases. This has been done by practicing epistemological and personal reflexivity throughout the research process. I have summarised this process in the next two sections. Finally, it is important for any conclusions drawn from the data to be appropriately contextually situated so that conclusions are not mis-applied. For this reason, in my Discussion Chapter I have considered how my findings sit contextually within the research literature.

2.4. Reflexivity

Reflexivity is the process of critically evaluating how one's personal experiences and views shape research (Harper & Thompson, 2011, p. 6). Epistemological reflexivity helps the researcher to understand the assumptions that they hold about knowledge and how this relates to the subject matter. Personal reflexivity can help researchers consider how their experiences or circumstances frame their view of research.

2.4.1. Epistemological reflexivity

This research aims to examine how participants conceptualise trauma-informed services and the barriers and facilitators to their development. It adopts a critical realist approach in the assumption that a reality does exist and that we are striving to access it even though data cannot provide us with direct access to it (Willig, 2013, p. 13).

Both research questions make several realist ontological assumptions. Firstly, I assume that there is such a thing as a 'trauma-informed service' which participants can experience, conceptualise and have perceptions of. This is not a description of just one service but is more akin to a service model which can be applied to different service types but in its application each service can be recognisable as trauma-informed. I am making the assumption that participants also believe that there is such a thing as a 'trauma-informed service' and that they share an understanding of what I am referring to when they take part in the research. Similar assumptions are made about barriers and facilitators to these services.

I also make critical realist assumptions. I assume that the data I collect from staff cannot truly encapsulate their perceptions, as I use my inherently biased interpretative tools to collect and view it, and that their conceptualisations are skewed by their interpretative tools. I assume that we do not all hold the same perceptions of 'trauma-informed services', 'barriers' or 'facilitators'.

2.5. Personal reflexivity

2.5.1. Trauma-informed services

I hold several assumptions with regards to what trauma-informed services are and of their benefits. My assumption that trauma-informed services are beneficial has come from my clinical experience and theoretical interest in the literature. Prior to beginning the doctorate in Clinical Psychology, I worked as a research assistant for a project funded to implement trauma-informed approaches in schools. While initially I was sceptical about the impact this would have, by the end of the project I observed the great benefits derived from the intervention. This experience has left me with the 'pre-understanding' (Burnham, 1993) that trauma-informed approaches are beneficial.

It is important to acknowledge that in the process of completing this current research I have also been working in mental health services. This research has developed as I have worked in an IAPT service, a specialist NHS child/adolescent trauma service and a third-sector CAMH trauma-specific service. In each of these services I have informally discussed my research topic with colleagues and my views on trauma-informed services have been shaped by

these conversations. I have felt encouraged by colleagues who held views about the benefits of trauma-informed practices. However, I was also disheartened to hear that so many have felt that it would either not be possible or would pose too much of a risk to them to advocate for their services making trauma-informed changes. This experience has framed my approach to the research and my own views about the barriers to trauma-informed services. I have come to appreciate the importance of having both managerial and peer support when proposing trauma-informed service changes. If this support is not achieved at the beginning it can be impossible to continue advocating for this approach. I am aware that the experiences of the participants I have interviewed may be quite different to that of many staff members who would like to make trauma-informed service changes but do not see them as achievable.

2.5.2. Leadership and power

This research implicitly condones the concept of trauma-informed services. Any research suggestions about how mental health services should be provided must be examined with careful curiosity as mental health research has a dangerous history of exerting power over the populations it serves. Personal relationships between individuals in leadership positions and related subject-areas should be studied and carefully reflected upon.

I am a White British woman in my twenties, completing this research for a professional doctoral training in Clinical Psychology. I am aware that in many spaces I occupy a position of power and privilege. This experience has shaped my worldview and the experiences and ideas that I have been exposed to. Throughout my life I have occupied positions where it has been extremely important to critically examine leadership and power structures. I was born in Brazil and spent my childhood there before moving to the UK. Growing up in a country so divided with such a complex historical relationship to power, has instilled in me the importance of actively deconstructing ideas about leadership and challenging power structures. Having pursued a career in Clinical Psychology, I have often felt disappointed by the many barriers preventing changes that will benefit clients. My relationship with power and leadership dynamics have biased my approach to this research in several ways. I

understand organisations as extremely complex systems, often reluctant to accept change. I recognise that these barriers are extremely difficult to shift or overcome. Services often suggest that changes can be proposed through formal channels such as submitting proposals to senior leadership teams or applying for funding bids. However, it is my understanding that if these changes are not aligned with existent service structures that they will be rejected, or impassable barriers will be erected. When participants in this research made reference to barriers I initially thought of these as problematic, unmoving obstacles but participants often understood this differently. I also often assume that change needs to happen with approval from the top-down but have been inspired by many of the participants in this study who are quietly effecting significant change from the bottom-up.

2.6. Design

This study makes use of a qualitative design to explore mental health staff's perceptions of 'trauma-informed services' and of their perceptions of the barriers and facilitators to these services. A qualitative design was chosen as it aligns with the exploratory nature of the question (Willig, 2013). The research questions do not pose hypotheses or speculate about results. Rather, they aim to explore how participants form perceptions about trauma-informed services from their experiences. The aim of qualitative approaches, and this research, is to generate new knowledge, suggest theories or questions (Henwood & Pidgeon, 1992). This research aims to capture the individual subjective experiences of participants, identify recurring patterns of experience and shed light on a shared conceptual issue.

2.6.1. Designing interview and questionnaire

Frith & Gleeson (2012, p. 85) explain that qualitative research questions in psychotherapy are often formed in preliminary research. Early in the research timeline I attended a local conference about 'Trauma-informed Care' organised by my research supervisor, Dr John Read. At this conference, attendees

considered the barriers and facilitators they perceived to have had experienced in their attempts to change their services. I took copious notes on the topic. Attending the conference, my notes, and a review of the literature formed the basis of the interview questions and the questionnaire (Appendixes I & J).

2.7. Data collection

2.7.1. Recruitment Strategy

Recruitment was completed through a professional network using purposive sampling (Etikan et al., 2015). The aim was to identify a group of professionals with experiences of attempting to transform their services into trauma-informed services. It was important for professionals with a range of experiences to be identified to ensure breadth of professional perspectives.

A group of individuals who had attended a conference about 'Trauma-informed Care' were sent an email by the conference organiser (my primary research supervisor) outlining the research and requesting that if they were interested to make email contact with me. Three-hundred and fifty people were sent this email and twenty-five responded. When expressions of interest were made by email I requested that potential participants send me a brief summary of their experiences so as to ensure that their input would be relevant. I asked for information regarding their professional backgrounds and whether they had experience in pursuing trauma-informed changes in their services.

Through this process it was discovered that several participants did not meet the inclusion criteria. Two potential participants had conversations with me regarding anonymity/confidentiality and did not proceed with the interviews. Several potential participants did not respond to contact following this initial email exchange. The maximum number of participants was capped at twenty. Fifteen participants took part in interviews. It was felt that sufficient variation in experience was represented in this group of participants.

2.7.2. Participant inclusion criteria

Participants were mental health staff who had experience of working in mental health services and had made attempts to make trauma-informed changes to services. Participants ranged in their professional backgrounds and their levels and types of service involvement. Fourteen participants were from the UK and one participant was from Ireland. All participants had previously signed up for a conference at the University of East London about 'trauma-informed care' and had shared their email addresses at this conference to stay connected and up to date about news and events.

2.7.3. Participant demographics

Fifteen participants took part in interviews and completed questionnaire responses. Their professional backgrounds included:

5- Clinical Psychologists

3- Therapeutic Practitioner (EMDR/EFT/MBT practitioners)

2- Counselling Psychologists

2- Social workers trained in mental health models

2- Mental Health Nurses

2- Mental Health Ambassador

1- Forensic Psychologist

Several participants were trained in more than one profession which is reflected in the numbers above. Of these participants, two were in managerial positions and they reflected on the experiences of being managers as well as on their experiences prior to taking on managerial positions. One participant was a therapeutic practitioner who also advocated for trauma-informed changes in their role as a 'service-user representative' in their trust.

Most participants described their perceptions of working to make trauma-informed changes in more than one place of work. All of these perceptions were considered in interviews. The types of services represented by these professionals included:

5- NHS Community Mental Health Team

4- NHS Adult Inpatient Services

3- NHS CAMHS Services

2- NHS Community CAMHS Services

2- Prison Service Mental Health Team

2- Third-Sector Trauma Specific Project

2- Third-Sector Community Mental Health Organisation

1- NHS Early Intervention Psychosis Team

1- NHS CAMHS Inpatient Service

1- Third-Sector Recovery Team

1- Local Authority Care Home

1- Third-Sector Child and Adolescent Service

2.8. Procedures

2.8.1. Interview Procedures

Participants were emailed a copy of the participant information sheet (Appendix K) and consent form (Appendix L). Interviews were completed and recorded via Microsoft TEAMS.

Interviews were semi-structured and guided by an interview schedule made up of ten questions based on the research aims (Appendix I). At the end of interviews, participants were asked to complete a questionnaire (Appendix J). Interviews took between 30-50 minutes. I reminded participants that they would be able to contact me within the following three weeks if they wished to have their data removed from the study. After each interview, participants were sent debrief letters (Appendix M).

2.8.2. Questionnaire procedures

After the interview, participants were asked to complete a questionnaire. I shared my screen with the questionnaire on it and participants gave their responses which I highlighted for them on the screen so that they could check it.

The questionnaire consists of a list of barriers that have either been identified in the literature (Menschner & Maul, 2016; SAMHSA, 2014; Sweeney et al., 2016, 2018) or at the 'Trauma-informed Care' conference. Table 1 below shows an example of one question in the format that the questionnaire was presented.

Table 1

Example of 'Barriers Questionnaire' question

	Yes	No	Highly Irrelevant	Irrelevant	Neither relevant or irrelevant	Relevant	Highly Relevant
A fear of staff experiencing vicarious traumatisation	Y	N	1	2	3	4	5

Participants first responded to the yes/no question of whether they perceived to have encountered this barrier in their own experience. They then rated on a Likert scale how relevant they perceived the barrier to be in the development of trauma-informed services generally.

The rationale for including the questionnaire was that this would provide an opportunity to collect information on participants perceptions of barriers that they may not have initially considered in the interview. In order to ensure the interview data could remain inductive, the questionnaire was completed after the interviews had finished. The questionnaires provided an insight into participants perceptions on the barriers that are present in the trauma-informed literature as well as barriers identified by their colleagues (who attended the conference). The aim of this was not to establish a consensus on the 'truth', but to understand the relative commonality of different perceived barriers.

2.8.3. Transcription

The audio recordings of interviews were transcribed verbatim so as to honour the true perceptions of participants using guidance from Banister et al. (2011). The research did not focus on discursive patterns or rhetorical devices and therefore higher levels of transcription were not used (Jefferson, 2004). All interviews were

transcribed by me and were checked several times for accuracy. This process helped me to familiarise myself with the data.

2.9. Analysis

Thematic analysis was used to analyse the interview data. Thematic analysis can be used to address questions about subjective conceptualisations as well as subjective experiences (Willig, 2013). Other qualitative methods were considered and discounted. Foucauldian Discourse analysis was not selected as it does not epistemologically align with the critical realist research assumption that there is a reality within which trauma-informed services exist and are experienced beyond their discursive constructions (Potter & Hepburn, 2005). Interpretative Phenomenological Analysis takes an idiographic approach and integrates an analysis of the participant experiences within the interview. The current research question does not necessitate an analysis of the meaning underlying participants accounts of experiences, rather it explores subjective accounts and perceptions at 'face value' (Willig, 2013). Grounded theory was not selected as the research questions aimed to produce data that makes suggestions about the realities of mental health services, as opposed to producing theories to understand these realities (Tweed & Charmaz, 2011).

2.9.1. Thematic Analysis

Braun and Clarke's (2006) guidelines for good thematic analysis were used to inform the steps of analysis. Themes were identified at the latent level as I considered underlying assumptions and conceptualisations within participants responses (Boyatzis, 1998; Braun & Clarke, 2006). An inductive approach was taken as themes were content driven, extracted from the data and, as far as possible, were not led by my preconceptions or interview questions (Braun & Clarke, 2021; Willig, 2013). Analysis aimed to capture and identify recurring patterns and important themes amongst participants. Not all recurrent codes constituted themes and not every theme was spoken about by all participants.

However, each data item was given equal attention and themes were generated when a substantial number of participants contributed to them.

It is important to acknowledge that themes are extracted from the data by the researcher, they are not 'naturally occurring'. A critical realist epistemology emphasises that the researchers' biases will always influence theme identification. In recent papers, Braun and Clarke (2019) express concern that their original guide (Braun & Clarke, 2006) could be used procedurally without sufficient reflexivity. They emphasise the actively subjective position that researchers must take in the analytic process. This is in line with critical realist research values. Braun and Clarke (2019) advocate for being explicit and deliberate in the application of method and in using reflexive practice to unpack assumptions and positionings. I have tried, wherever possible, to do this and have kept a reflexive journal throughout data collection and analysis (Appendix N). However, I do acknowledge that it is not possible for my theoretical and clinical experiences to be completely set aside in this process.

2.9.2. Familiarising self with data

Initial notes and ideas for codes were made during the data collection stage. These were then expanded upon during transcription. Transcriptions were checked for accuracy and notes were taken. Once all the data were collected the transcripts were checked before beginning the coding process (Banister et al., 2011).

2.9.3. Generating initial codes

I used the software NVivo to generate initial codes on transcripts (Appendix O). A few sentences prior and following code segments were retained to maintain the meaning of the text (Boyatzis, 1998).Throughout this process I kept in mind my research questions and attempted to keep my codes as broad as possible, in some cases noting several potential codes to one text segment.

2.9.4. Theme construction

I then reviewed all of the codes and corresponding text segments together. I looked for meaningful patterns amongst the codes and considered how they connected. I used paper mind-maps and printed cut-out transcript segments to

facilitate this without losing the contextual meaning of each segment (Appendix P). I sorted the codes into different broad categories with loose theme definitions. I considered many different possible descriptions of themes and how each code and text segment fit into these themes and whether they could be conceptualised in a different way (Braun & Clarke, 2006, pp. 89-90).

2.9.5. Reviewing themes

Level 1 - Text extracts for each theme were re-read and reviewed in the context of the theme definition. I paid particular attention to ensure that the themes were strongly linked to the data, distinct from one another and meaningful rather than simple data categorisations or summaries (Patton, 1990). At this stage attempts were made to identify problematic themes (Braun & Clarke, 2006 p. 91). Codes with insufficient data to support them were re-considered. Several different candidate thematic maps were created throughout this process (Appendix Q).

Level 2 - The whole data set of the interviews was re-read in order to verify whether the final candidate thematic map was a sufficient representation of the data.

2.9.6. Defining and naming themes

Themes were considered for their ‘essence’ and the distinct stories that they told about the data (Braun & Clarke, 2006; Patton, 1990). The scope and content of each theme was considered, and a brief description of each theme was produced.

2.9.7. Inter-rater reliability check

Following their naming and defining, themes and brief descriptions of themes were reviewed by my supervisor and an inter-rater reliability check was completed (details in the Results Chapter).

It is important to acknowledge that this inter-rater reliability check was completed *following* the creation of themes and in the process of producing the report. This is important to note as Braun and Clarke (2020) highlight that inter-rater reliability checks used as measures of coding quality can undermine epistemological assumptions as they represent a neopositivist approach to identifying ‘objectivities’. In this research, the reliability ‘check’ was supplementary and

helped to establish whether the themes that I had produced and seen as distinct and meaningful would be seen in this way by an independent reader. It was not used to establish whether or not the themes could be considered objective or unbiased. This process allowed for an extra reflexive process as I re-examined my personal biases and considered the quotes from a different perspective. The purpose of the inter-rater reliability check was not to come close to a 'correct' interpretation of quotes or to create a 'codebook' or framework for understanding as this is not aligned with the epistemological constructivism to which critical realism is aligned (Putnam, 1999; Braun and Clarke, 2020).

2.9.8. Producing a report

Following the inter-rater reliability check and the subsequent changes made the report was produced. A summary of the data is outlined in the results chapter including a review of the themes and sub-themes, identified alongside several data extracts for the reader to consider whether themes are reflective of the data (Braun & Clarke, 2006).

3. RESULTS

3.1. Introduction to chapter

The themes presented in this chapter have been developed through engagement with and analysis of the interviews. Themes have been developed with the aim of accurately representing the data set and the 'essence' of what participants shared in interviews. Research questions will be answered by making reference to the themes that have been extracted from interviews. Data from participants' answers to the 'Barriers Questionnaire' is also presented as complementary descriptive data.

3.2. Thematic analysis

Details of the analytic process have been provided in the Methods Chapter with illustrative examples in Appendixes O, P & Q.

3.3. Inter-rater reliability check

Initially, three over-arching themes, with thirteen sub-themes were identified. These initial themes and sub-themes were used in an intercoder reliability check. The names and definitions of each of the original 13 subthemes were sent to my supervisor, along with several quote examples from each theme, without identifying which theme they belonged to. My supervisor was invited to allocate each quote to a theme and these responses were then compared to the themes I had allocated for each quote.

The two raters agreed on 23 out of 26 theme allocations, an interrater agreement of 88.5%. A Cohen's *kappa* statistic, which allows for probable agreement by chance, was calculated to be 0.875. Cohen suggests that scores of between 0.81 and 1.0 represent 'almost perfect agreement' (Cohen, 1960; McHugh, 2012). As previously discussed, the aim of this exercise was not to establish the objectivity of themes. It was used as supplementary information in a reflexive activity as a means to examine personal biases. For this reason, the 'almost perfect'

agreement was not seen as an indication that themes were appropriate and the ‘disagreements’ were considered and reflected on with care.

The three disagreements were discussed in order to gain an understanding of potential issues with the themes or their definitions. Table 2 shows each quote which was disagreed upon, the reason for the disagreement and the action taken as a result of re-considering how these quotes may be seen from different perspectives. In addition to the changes made following disagreements, it was decided that several additional sub-themes should be added to capture the ‘advice’ that participants shared. These changes made to themes are outlined in Appendix R.

Table 2.

Inter-coder reliability theme check

SC rating	JR rating	Quote	Reason for disagreement	Actions taken
Sustainable changes	Value base (& Sustainable changes)	*"Whereas actually if somebody has constantly not got their needs met, constantly being judged and invalidated they will keep coming back. So for financial sense it's the idea of we're not meeting peoples needs properly but also - just in terms of that common humanity."*	Subtheme 'V*alue base'* is not clearly defined enough to exclude this quote.	'*Value base'* redefined
Staff support	Supervision & reflective practice	*"But people need to feel safe. You can't be in a service that will threaten you if you get something wrong or make it like a very defendable kind of practice kind of setup. It needs to be that everyone is learning, and in the team in the service- that everyone is able to think together and not just policy wise like genuinely there is that kind of environment and I think that that does come from places that respect teams and reflective supervision and all of that."*	Code *'Supervision and Reflective Practice'* and *'Staff support'* too similar.	Subthemes merged

Trauma-specific or trauma-informed	Management	*"Probably the main barrier we encountered early on was that people- a lot of senior people within the service would say things like, oh, we'll just be inundated with referrals if we start doing this kind of work, you know. So that's the kind of sense I think in another kind of a service level that we're kind of making huge amounts of work for ourselves."*	There is not enough context in this quote for it to be clear that it is talking about trauma specific services'.	All quotes re-considered for sufficient context. '*Trauma-specific or trauma-informed'* redefined

3.4. Final themes

The final result is sixteen subthemes categorised into four broad themes, which can be seen below in Table 3.

Table 3

Final themes and subthemes

Theme	Subtheme
Theme 1: Defining qualities of trauma informed services	**1. Understanding distress as trauma** - trauma-informed services conceptualise distress as originating from trauma experiences
	2. Meaningful engagement with clients- trauma informed work is about engaging with clients in a meaningful way.
	3. Long-term impact on clients - trauma-informed services provide changes to peoples lives that can be sustained, they are not a 'quick fix'.
	4. Issues with defining trauma-informed services- trauma-informed services are difficult to define and often can be mistaken for trauma-specific services, this is a barrier
Theme 2: Individual-level factors	**5. Persistence-** making trauma-informed changes requires persistence as well as patience.
	6. Passion for work- participants spoke about feeling passionate about 'trauma-informed' work and occasionally referenced their personal values in this theme.
	7. Inspired by clients- it is inspiration from clients that have kept these participants fighting for trauma-informed changes.
	8. Connections with allies- remaining connected with others who also wish to make trauma-informed changes is important in this process.

	9. Burnout- burnout can be caused by not working in a 'trauma-informed' way as well as by battling against systems to make 'trauma informed' changes.
Theme 3: System-level factors	**10. Supervision and reflective practice-** staff need to have supervision that is reflective and safe in order to provide trauma-informed care.
	11. Management- important to get buy-in from managers to make trauma-informed changes
	12. Medical model- trauma-informed care is seen as different to the medical model and it is difficult to go against this dominant and established model.
Theme 4: Advice for Change Advocates	**13. Be patient-** changes can happen slowly, this should be accepted as a part of the process.
	14. Be tolerant- allow for differences in opinion and space for exploration with colleagues.
	15. Make use of research- the trauma-informed evidence-base can be a helpful tool in advocating for change.
	16. Be strategic- consider carefully how changes can be made and support for your ideas can be gained.

In the following presentation of themes I describe the important and defining elements of each theme and how it captures something of the essence of the interviews. I hope to engage the reader with the content of the interviews and share sensitively and meaningfully what participants shared. While I have presented each theme and subtheme as distinct, they overlapped and interacted.

In the presentation of quotes that follow, participants names and other identifiable details have been omitted. Minor changes have been made to improve readability including the removal of 'filler' words (e.g. 'kind of'). Some words have been omitted to shorten quotes, without altering the meaning, this has been made clear

with (….). Where context has been necessary for the reader to understand the quote this has been made clear with [*context*]. For a full account of all the quotes used in each subtheme please see Appendix S.

3.5. Theme one: Defining qualities of trauma-informed services

In the interview, all participants were asked 'what would a trauma-informed service look like' (or similar). The quotes that are used in this theme are not solely from answers to this question as participants spoke about the defining qualities or attributes of trauma-informed services throughout interviews.

3.5.1. Subtheme one: Understanding distress as trauma

Ten participants spoke about trauma-informed services understanding expressions of clients' distress as originating in traumatic experiences. This was often referred to alongside an explanation of how other services are different. Participants also suggested that services which 'understood distress as trauma' enquired about trauma experiences. This was felt to be a difference between trauma-informed and other services.

> *"…and that was felt to be really important, that lens that we look at people through, you know the old expression; What happened to you not what's wrong with you? To help them make sense of things like dissociating"*
>
> Participant F

> *"They were saying '*no one's ever asked me that' *- kind of fundamental things about their lives which would help you understand their behaviour or why they might be at that point in life. And I think that really struck me- basic assessment questions not being asked-* 'what's happened to you*?'"*
>
> Participant A

Two participants expressed the importance of this understanding being present in every contact, including with non-clinical members of staff:

> *"Well, right from the start- everything from the moment the client walks in*

the door, there's a compassionate recognition of intergenerational adversity and the effect that had on emotion regulation. So there's an acceptance that this brain that's just walked in the door - because of the experience of trauma (…) I can see the pattern of what's going to happen – I hold compassionate awareness."

Participant A

"So it would be about the receptionist (…) meeting and greeting, and the nurses perspectives when they're considering the way that someone's difficulties are understood. So if somebody is withdrawn or they're stroppy that's understood in the context of- not their diagnosis of PD- but that persons experiences "

Participant K

Four participants spoke about their experiences with colleagues who did not 'understand distress as trauma'. These were spoken about as encounters in trauma-uninformed services or as barriers to trauma-informed changes.

*"When I worked in the secure hospital, the idea that I would even try and suggest to a nurse that someone might be responding with the self-harm because of the traumatic history they have and something had just happened within their relationship- it was madness. It was '*no they're mad*' rather than hang on let's slow down- think about why they might be distressed. No understanding of the development of the mental health difficulties."*

Participant B

3.5.2. Subtheme two: Meaningful engagement with clients

Eleven participants distinguished between trauma-informed services and other services by how they engage with clients in a meaningful way. Participants focused on the client's experience in this subtheme, explaining that trauma-

informed services provide an opportunity to meaningfully engage with clients, providing validation and empowerment:

> *“If we really listen and really help people reconnect with their values, reconnect with what’s meaningful in their life- then they will have a recovery that is meaningful for them.”*
>
> Participant A

> *“If we can involve these people in their own care and give them some kind of empowerment over that (...) it just makes so much sense to make them feel that their own stories aren’t being lost amongst a system of just psychiatric labels”*
>
> Participant O

For three participants engaging with clients and their trauma was spoken about as a significant emotional expenditure, or a painful experience:

> *"It's really painful. It’s a lot easier to not to know the trauma and just see that it’s someone not engaging or that it’s someone that’s just got mental health difficulties or whatever”*
>
> Participant E

3.5.3. Subtheme three: Long-term impact on clients

Eight participants spoke about trauma-informed services having a positive long-term impact on clients.

> *“By having access to a system of trauma-informed care (…) in some cases might help prevent people from turning into a lifetime user mental health services because the interventions that are being offered [otherwise] maybe are not appropriate to their needs”*
>
> Participant J

For some participants this meant moving people out of services more quickly. For others this meant services should not be focusing on ‘quick fixes’ but investing more resources initially for a better long-term result for clients.

> *“If it’s an approach that can help people get moved on from hospital faster, if it’s a tool that can be used to help people stay out of hospital, ideally full stop, but even if it’s for people to stay out of hospital for longer, broadly, the economic associations of that- make total sense.”*
>
> Participant O

> *"We help them in a way that’s sustainable and doesn’t impact on their physical health, now I think that’s different, I do think that’s different to other services. We’re not into quick symptom reduction and move people on."*
>
> Participant F

3.5.4. Subtheme four: Issues with defining trauma-informed services

Seven participants spoke about frustrations with the lack of definition of trauma-informed services. For some participants this was perceived as a barrier and they described their difficulty in advocating for a trauma-informed change when there is no single shared understanding of what this means. Three participants spoke specifically about the confusion lying in the difference between trauma-informed and ‘trauma-specific’ services.

> *"I think one of the main barriers that we came across, especially initially was that there isn't a clear model of trauma-informed care that you can propose to your service. You almost have to kind of build it from the ground up.”*
>
> Participant I

Participant H describes this as a barrier to gaining the support of staff who are not specifically trained in mental health.

> *“Sometimes the message that I would get back when I try to introduce trauma-informed thinking into the supervision space was,* ‘well, that’s not

our job. We're not mental health trained. I'm not able to talk to someone about their trauma' *and so there was this equation of trauma-informed care equals trauma-treatment"*

Participant H

Participant L describes this as a barrier because managers felt that a trauma-informed approach would equate to a higher number of referrals for trauma work.

"there's a lot of misconceptions about what it actually means, and it feels that we've got to get round that hurdle first. But it doesn't mean that you've got to do lots of trauma work. It means you've just got to hold it in mind and be receptive and open and be thoughtful."

Participant L

3.6. Theme two: Individual level factors

In this second theme, participants spoke about barriers, facilitators and motivating factors which existed at the individual level and directly affected them. Participants had some level of control over these factors and often made reference to the impact that these issues had on them personally.

3.6.1. Subtheme five: Persistence

Seven participants spoke about their work in pursuing trauma-informed services as being a personal battle that they must persevere with despite the toll it was taking on them. This theme was referred to by participants spontaneously as well as in response to a question about what advice they would give to a colleague wishing to make trauma-informed changes.

"Persistence – dogged persistence."

Participant L

“You need to be really resilient and you’re not going to have success every time, but you just keep trying. So I think it is that persistence that it is worth it.”

Participant K

“To be persistent.”

Participant J

Two participants spoke about very difficult situations that showed their persistence in overcoming barriers. Participant L spoke about extreme resistance to trauma-informed ideas from medical professionals, which ultimately resulted in an investigation. Participant G spoke about consulting with their union to get support in making trauma-informed changes that had been agreed by service leads in theory but prevented from happening in practice.

*"A *service* last year- I went and talked to them about running a piece of work with (...) their lids went up so high just having the conversation about it they actually reported me to their local medical committee and I had to go through a full investigation."*

Participant L

"...unfortunately it had to get a little bit tricky and I had to say look, I'm speaking to the Union. I'm not progressing with my research [measuring trauma-informed changes to their service], *but it's not really about my research, this is about changing the service. That's my main goal- the research has been a tool that I've been able to use to change it- so it did get a little bit tricky."*

Participant G

3.6.2. Subtheme six: Passion for the work

Eight participants spoke about their personal feelings and values as motivating factors to pursuing trauma-informed service changes. In this subtheme, trauma-informed services were positioned as an ‘ethical’ approach.

“I’ve really struggled to sort of fit into models where trauma is ignored (…) I want to make a difference. I want to work in in a way whereby there’s lot of meaning and purpose for clients and for myself, where there’s growth.”

Participant B

"I’ve always cared about what I do. I really care about the work I do, I have forever. I get a lot- it takes a lot out of me."

Participant F

Seven of these participants spoke about leaving jobs because they were not trauma-informed and implied that they did not align with their values:

"Not doing it- would just be- I’d just possibly have to leave the job if they started old way of working- it is just too challenging. It’s just too unethical for me."

Participant G

“I would not spend my energy as a professional in a service I didn’t believe in- so I came out- to do the things I’m interested in. I started to study more about ACES and understanding- then I came back and then left again recently for the same reason because I felt that we weren’t going anywhere.”

Participant D

“I would refuse to work anywhere like that again.”

Participant E

Participant E went on to contextualise this, saying that a ‘trauma-informed approach’ is more than an interest and that they connect with it on a personal and emotional level:

“it’s just a real– I was about to say interest, it’s not - I think it’s fundamental to do this work - it terrifies me when people don’t get how this is important.”

Participant E

3.6.3. Subtheme seven: Inspired by clients

Six participants spoke about the inspiration that they had gained from their clients. For some participants this was a motivational, facilitative factor in their pursuit of trauma-informed services, for others it was the original reason why they became interested in this field.

> *"Connecting with people is what keeps you going- and just I learn all the time. I learn more from letting people talk about their mental health than I could from any brilliant conference"*

Participant C

Participants shared the answers below in response to the question '*What has sustained your motivation?*'. These quotes highlight that participant experiences with clients have helped sustain their motivation in pursuing trauma-informed changes.

> *"I think it's the clients that I work with. There is such strength and they are so inspirational and I think every client that I meet- I grow so much as well, [really] yeah, and it's just, I guess it's about kind of meaning and purpose? That's why I get up in the morning, and I guess that's where my drive comes from and my own kind of growth too."*

Participant B

> *"Earlier on today, we had the post delivered by somebody who used to be in this service who's now getting on with her life. And you think, that's why I do this- this person, she had a lot going on with her then she was there quite proudly handing the post and I recognized her and thought '*Gosh… it's you'*, and she was smiling."*

Participant F

3.6.4. Subtheme eight: Connections with allies

Twelve participants referred to the importance of remaining connected to other people who are advocates of trauma-informed services. These connections helped to sustain motivation. They were also spoken of as facilitators to the development of trauma-informed services.

> *“I think you need to take care of yourself and find some allies.”*
>
> Participant A

Different views were shared about why allies and teams are important. Participants I and E shared that this prevents burnout and helps maintain appropriate boundaries. This was described as an important part of trauma-informed work:

> *"First thing I would say is to find like-minded colleagues because I think just having conversations with some of my colleagues who are similarly minded certainly helped me to persevere."*
>
> Participant I

> *“I really can’t do it without a team. I think, that’s important for lack of burnout in my experience, but also important for keeping boundaries, because actually part of being trauma-informed is not giving everything to everyone.”*
>
> Participant E

Three participants spoke about feeling isolated without allies:

> *“It becomes very isolating when you’re trying to advocate for a different perspective. So I think, yeah, definitely don’t do it on your own. Get some support collectively.”*
>
> Participant B

Participant D spoke about allies being helpful in spreading the trauma-informed message and applied the metaphor of allies planting seeds of knowledge to make a trauma-informed forest of ideas.

> *"…but do join strength with other people who are planting the seeds as well because then we see- it is the forest. I do think this is so, so important."*
>
> Participant D

3.6.5. Subtheme nine: Burnout

This subtheme is concerned with the impact of staff feeling overstretched to the point that they feel unable to continue with their work. Participants spoke about the possibility of 'burnout' as well as offering advice about how to avoid it. Nine participants referred to this issue, five specifically using the term 'burnout'. Burnout was spoken about as caused by a continued pursuit of trauma-informed changes without seeing results:

> *"I think staying in a place where you're banging your head against a brick wall- even if you know that it needs it* [your efforts to implement change]*, but it goes against your values- you can end up with burnout."*
>
> Participant A

> *"For me personally it's about trying to keep a balance between keeping my motivation but not becoming so all-consumed in it that I'm just going to burn-out because it's a systemic problem and it's a system that's not going to change overnight no matter how hard I fight."*
>
> Participant O

It was also spoken about as a result of working with trauma:

> *"Staff have to be looked after as well otherwise it's not a trauma-informed service in my view. Everyone should be looked after. Because it brings up a lot of stuff – the work we do in itself is traumatic a lot of the time."*

Participant D

"...recognition of the effects of trauma on the brains of the families that are coming in. And then, the triggering effect of that on the wellbeing of the staff really all those staff needed sabbaticals."

Participant L

3.7. Theme three: System level factors

In this theme, participants spoke about barriers and facilitators found at the system-level in services. These were factors that the participants themselves could not directly change or shift, however they were important factors to the success of their change implementation.

3.7.1. Subtheme ten: Supervision and reflective practice

Twelve participants shared ideas about what kind of supervision or reflective practice is important in trauma-informed services. These ideas included individual clinical supervision, team supervision and the promotion of reflective spaces or reflective thinking in general.

"There are many things that are required when comes to being trauma-informed (...) staff support, self care and team care, clinical supervision so there is a nurturing, safe space to hold the person during this process (...) the staff has to be looked after as well otherwise it's not at trauma-informed service in my view."

Participant D

Several participants highlighted problems with the claim that supervision is essential to trauma-informed services. Reflective supervision cannot necessarily be provided to all staff, so the claim that this is an essential component of trauma-informed services is a barrier. Participants explained that not all professions traditionally receive reflective supervision.

“I guess in psychology we’ve got quite an embedded structure around supervision, but nursing colleagues it tends to be a lot more managerial”

Participant O

One participant suggested that supervision is not necessary and can even be unhelpful.

“I mean, who is it that put down the law that supervision is an important element of trauma-informed services? (…) we've had a lot of trouble with supervision because you've got to have supervisors who are trauma-informed”

Participant L

In interviews where ‘supervision’ was considered a barrier, participants shared views about ‘reflective practice’ as important to trauma-informed services:

“I think even within the service I’m in now trying to get reflective practice is like getting blood from a stone. So I run a reflective practice in my team, but I’d prefer to be someone who partook in it. Yeah, I just run it anyway, ‘cause it’s useful space.”

Participant A

"...there seems to be a lot of rote learning and not enough reflection, and people haven’t stopped and paused and reflected in thought about the possibility that adversity is having a physiological effect on child development"

Participant L

3.7.2. Subtheme eleven: Management buy-in

Ten participants spoke about management buy-in as either an important facilitator or barrier, dependent on whether it had been achieved.

"…get buy-in from people, whether it's people at the top or higher than you, (...) going to be so crucial, (…) actually getting support from people higher up in the system can affect some change. Without that we wouldn't have gotten support for the funding bid, as much as I hate to admit it, without certain peoples names on the funding bid saying 'this is a good idea' would we have got the money? Possibly not. Possibly a much smaller amount."

Participant O

"It's the management- they don't allow change- management want things to stay as they are."

Participant F

Five participants described having positive experiences with managers and shared examples of how managers had been supportive:

"...and having a manager on board who made it mandatory for everybody to attend these meetings was important."

Participant J

*"I think there's already a foundation for trying to you know, include trauma-informed ideas within the way the *service* runs. I think that comes from the leadership who've done more than anything that psychologists or healthcare professionals have done. "*

Participant H

3.7.3. Subtheme twelve: Medical model

Twelve participants referenced the medical model or language related to the medical model, such as 'psychiatric diagnoses' or 'symptom reduction'. Participants spoke about there being a difference between their own understandings of distress and the medical model.

"So that's how I see my role, as trying to bring in a more trauma-informed,

adversity-informed understanding of psychosis as opposed to thinking of it as a brain disease or something medical."

Participant J

“I started seeing the same trend- trauma, trauma, trauma and - I just couldn't understand why people were saying it was a chemical imbalance and not really looking at the trauma aspect, because clearly that was the underlying issue for every single one of them."

Participant N

Several participants explained that it can be difficult to get colleagues to shift from medical model understandings of distress:

“One of the big things I came in with from my experience in the secure hospitals, is the damage that on occasion a diagnosis of personality disorder can bring about in the clinical responses to those difficulties that present under that diagnosis- how it can reduce peoples thinking.”

Participant E

"I suppose it’s trying to sort of get the team to acknowledge- not dismiss- what they were saying and not just medicate them because they were difficult to control."

Participant A

Three participants spoke about the prevalence of the medical model in management and leadership. These participants referred to this in the context of considering barriers to making trauma-informed changes.

“I think another barrier is just the ideological kind of differences that exist in services. Especially in CAMHS- it’s still quite dominated by kind of a consultant-led medical model of service provision.”

Participant I

“Medics have a very strong voice(…) they'll think ‘what medication does that patient need?*’ It was all about medication. Yeah, even if there’s been a disclosure of trauma. It’ll be about symptom reduction."*

Participant F

“One of the very concrete barriers is about the numbers of psychologists versus the number of nurses and doctors- I think we’ve got a lot of brilliant nurses who are very therapeutic in their mindset, but there’s still a lot who are sort of very aligned with the medical model in terms of their way of working, and often some are quite hierarchical, with always seeing the doctors as right”

Participant K

3.8. Theme four: Advice for Change Advocates

This final theme is centred around the advice that participants shared in interviews about how to develop trauma-informed services. Participants offered suggestions based on both their successes and their failures in implementing changes.

3.8.1. Subtheme thirteen: Be patient

Seven participants spoke about the time it takes for changes to be made or attitudes shifted. Some participants spoke from a place of experience about how long it had taken for them to see shifts, others expressed that they were aware of how long it would likely take them.

"I used to give talks about all this stuff and I didn’t ever get a good reception, but now people are really interested in it, so you know, I just think it’s been a process over time, it just seems to have taken an extraordinary length of time"

Participant L

*"'"*it's a marathon, not a sprint' *comes to mind… the outcome will be worth it in the end. You know, even if it takes 20 years to bring this in fully it's totally worth it, because there is no alternative in my view."*

Participant G

Two participants spoke about the importance of taking the time to make changes slowly so they can be sustained.

"I think my way of working anyway is to develop relationships with people over a longer term and trying to kind of pick the right times to introduce new ideas"

Participant H

Participant P spoke about their patience wearing thin as their service was taking too long to make trauma-informed changes.

" I'm losing patience with them… why is it so slow?!(...) it's just frustratingly slow, it's just taking them so long and they're just beginning this [trauma] training with staff where they've got little questionnaires and videos and it's all very good, but it's not enough. I want them to have big signs at the entrance to the hospital and I want them to be more dynamic about it and it's just not... I found it a bit sad actually."

Participant P

3.8.2. Subtheme fourteen: Be tolerant

In this subtheme the issue of differences of opinion is considered. Participants spoke about managing differences in opinion. Six participants spoke about tolerating differences in opinion and there was generally an emphasis on the importance of not alienating colleagues with differing opinions. Participants advised that it is helpful to tolerate differences and allow for exploration of trauma-informed ideas.

"…developing conversations with people without being too preachy or

teaching. Or that you're trying to tell people what to do. I think it's just about opening up a dialogue."

Participant J

"If you're trying to introduce these principles to an environment… or set of professionals who naturally aren't inclined to thinking the same way that you do as a psychologist... I think you're on to a loser if you go in and just try to start telling people how to do things differently or pulling people up on not being trauma-informed- there's something about being able to be quite political and diplomatic- know what battles you need to start and which you need to end."

Participant H

Participant F spoke from the position as a manager about tolerating the opinions of staff who were not trauma-informed but creating a safe space for their team to explore ideas.

*"I'm a manager, so I have to be really tolerant of the fact that they don't always know what they're talking about [*clinicians*]. They don't really engage in a conversation… you have to be very available and absolutely abide by the principles of confidentiality and create safety for your staff."*

Participant F

Two participants recounted stories about colleagues not being tolerant of their trauma-informed ideas and treating them unfairly as a result of this.

"I was the GP in the service that would be, you know, cast almost as the witch, I can remember being told by one GP at a meeting 'why don't you go and run a creche? Why you doing general practice?*' stuff like that... I mean - it was - it's taken a long time and it's only just coming- the GPs are coming on board in now with trauma-informed practice"*

Participant L

3.8.3. Subtheme fifteen: Make use of research

This subtheme was concerned with participant references to using relevant research to support their work. Eight participants spoke about using research to connect colleagues or managers with trauma-informed ideas. Participants found that the strong research base helped to legitimise their arguments for funding and resources being spent on trauma-informed training.

> *“I suppose one way is trying to build those personal relationships with the more senior and getting them on board and showing them the research.”*
>
> Participant A

> *"So when I came across the film ‘Resilience’ I watched it and then invited several colleagues, invited the service-users as well, to come to the to a launch(...) because for me from the beginning that was very important- getting the focus on research."*
>
> Participant D

A good knowledge of the research base also helped participants feel confident in what they were advocating for. Several specific resources or names were mentioned in this subtheme which participants found helpful to them in their work.

> *"Something that has been really helpful for me has actually been to make sure that I’m really quite informed about the research round kind of the role of trauma in kind of severe mental health problems, you know what trauma-informed care actually looks like. I think if you really know your stuff about the research, it’s easier to have those debates as they come up”*
>
> Participant I

> *"I’ve been really influenced by some of the stuff written by Karen Treisman, I don’t know if you’ve come across her (…), so I guess back to your point it’s about going back to your original motivation"*
>
> Participant O

"The helpful forces are… knowing that those people out there who really strongly advocated, that they have achieved some progress, and knowing that other places like Scotland have had- made a real difference with progressing it and the videos and research and things like that, so I think that's it. Well, I guess it's worldwide really, isn't it? But I think some countries I think Australia is done quite a lot of work on it as well."

Participant A

3.8.4. Subtheme sixteen: Strategic advice

This subtheme related to the advice that participants shared about the strategies they found helpful in making changes. Nine participants gave 'strategic' advice. This advice was about how to approach the implementation of trauma-informed change rather than advice for motivation or overcoming barriers.

Several participants spoke about the strategies that they used with colleagues or teams to bring them to appreciate the importance of trauma-informed approaches.

"just be very opportunistic so it's kind of not necessarily fighting a battle, but it's a bit, even though sometimes it is about it is little battles, but it's about you being clever, I suppose- push- push where it moves- to take your opportunities where you can to be savvy with what's changeable(...) with certain people- you just think I'm not going to… I'm not. I'm not up to it today or they're just not. I don't see why I have to be wounded by that experience and then some people it feels it really is worth it because it feels like a conversation where no one has to be right"

Participant K

"...it needs to be about empowering people in the team itself that it's about their responsibility just as much as it's about me being the qualified psychologist on the ward (...) *I think if anything for this to work it needs to be reliant on not just psychology to make it happen"*

Participant O

Three participants spoke about the strategy that they had used with colleagues 'showing' the benefits of the trauma-informed approach as opposed to simply telling them about it.

> *"one of the things I sometimes do is try to go for the hardest issue that's bothering the service, so the most disruptive client that everyone's given up on. Where the rhetoric around them is really unhelpful. Showing that doing things differently can have good effects when we're thinking about people slightly more holistically with a trauma hat on can actually get benefits"*
>
> Participant H

In addition to advice about colleagues, this subtheme also considers advice shared about strategic implementation of changes to services. This included suggestions about sustaining change in services following trauma-informed training.

> *"…we're trying to create a trauma working group comprising of our staff and service-users, to- the idea will be that once the staff are all trained up, whether it's fortnightly or monthly to talk about- these are the ideas that we have come away from the training day with, these are some of the things we could do, these are some of the changes we said we would make* (…) *to make sure we follow through with some of the actions* (…) *we don't want it to be reliant on the psychology team to hold this or carry this "*
>
> Participant O

3.9. Barriers Questionnaire

After each interview, participants were asked to answer a questionnaire about the barriers to trauma-informed services. This questionnaire is a non-standardised instrument and has been used on a small population, therefore it is not possible to generalise the results beyond the current sample. Participants were presented

with a list of 24 ‘Barriers’ and asked whether they had encountered the barrier in their work and how relevant they thought it was to trauma-informed change. Participants responses are collated in Table 4. On several questions, participants stated that they did not wish to provide an answer, for this reason not all responses add-up to 15.

In general, there is a high level of agreement across the questions. On three questions there was a complete consensus from participants that they had encountered the described barrier:

> Q10- *An organisational culture that conflicts with trauma-informed working methods*
>
> Q13- *Systemic issues that prevent long-term systemic changes (e.g., low staff morale or high staff turnover)*
>
> Q22- *Lack of understanding/education on trauma-informed methods*

On another three questions only one participant had not encountered the barrier:

> Q3- *Concerns about re-traumatising service-users by asking about trauma*.
>
> Q4- *Concerns about risks associated with new initiatives (risk averse).*
>
> Q5- *Continuous requests for change and upheaval making services wary of new initiatives.*

On two items only half or less participants shared that they had encountered the described barrier:

> Q9- *Assumption that few service-users will have experienced trauma and so the initiative is largely irrelevant.*
>
> Q19- *Fears of trauma-informed approaches being historically related to ‘family blaming’ ideas.*

Most items were considered relevant to participants, with 15 of the 24 items scoring above 4 on the 5-point scale. The items with the highest average ‘relevance rating’ were:

Q22- *Lack of understanding/education on trauma-informed methods.* (4.77)

Q17- *Reluctance to shift from biomedical causal models of understanding distress.* (4.75)

The only item to score below the midpoint was:

Q9- *Assumption that few service-users will have experienced trauma and so the initiative is largely irrelevant*. (2.92)

Table 4

Collated answers to 'Barriers Questionnaire'

		Encountered barrier?		Perceived relevance (mean)
Question number	**Barrier**	**Y**	**N**	**Average Rating 1-5 Likert scale** 1-Highly irrelevant 2- Irrelevant 3- Neither 4- Relevant 5- Highly relevant
22	Lack of understanding/education on trauma-informed methods	15	0	4.77
10	An organisational culture that conflicts with trauma-informed working methods	15	0	4.62
13	Systemic issues that prevent long term systemic changes (e.g., low staff morale or high staff turnover)	15	0	4.38
4	Concerns about risks associated with new initiatives (risk averse)	14	1	4.62
3	Concerns about re-traumatising service-users by asking about trauma	14	1	4.23

7	Trauma-informed approaches to service delivery have not yet gained enough momentum/popularity so are not a priority	13	2	4.46
21	Lack of managerial support for trauma-informed approaches	13	2	4.46
20	Not enough professionals are informed about this approach and prepared to act as leaders in this way of working.	13	2	4.23
5	Continuous requests for change and upheaval making services wary of new initiatives	13	1	4.17
6	Concerns regarding additional service expenditure making the prospect of systemic change untenable	13	2	4.15
23	Concerns about adding tasks for clinicians which will reduce time for clinical activities.	13	2	3.92
12	Difficulty in ensuring that mental health staff have access to regular, structured supervision.	12	2	4.67
8	Other initiatives/values to compete with or prioritise	12	3	3.92
11	Service feeling unable to provide changes required to be a trauma-informed service	12	3	3.92
17	Reluctance to shift from biomedical causal models of understanding distress	11	3	4.75
16	A focus on a biological (rather than social) view of distress which downplays the significance of trauma.	11	3	4.50
15	Undervaluing the importance of involving service-users in service development	11	4	4.15

2	A lack of resources available to deal with staff's vicarious traumatisation if it was experienced/identified	11	4	3.92
18	Strong representative of biomedical ideas at service-delivery levels of management	10	4	4.08
1	A fear of staff experiencing vicarious traumatisation	10	5	3.85
24	Concerns that the perceived additional volume of paperwork would reduce time for clinical activities, developing relationships and interacting with service-users.	10	5	3.67
14	Service being risk averse which discourages staff to engage with service-users as experts of experience	8	6	3.58
19	Fears of trauma-informed approaches being historically related to 'family blaming' ideas	7	7	3.33
9	Assumption that few service-users will have experienced trauma and so the initiative is largely irrelevant.	7	8	2.92

4. DISCUSSION, EVALUATION AND IMPLICATIONS

4.1. Overview of chapter

In this chapter I will consider how the following research questions have been answered:

- What do participants perceive to be a 'trauma-informed service'?
- What are the perceived barriers and facilitators to such services?

I will consider the results of this study and how they relate to the literature reviewed in the Introduction Chapter. I will critically evaluate this study and consider the clinical and research implications of its findings. Finally, I will conclude with a summary of the most important learnings from this research.

4.1.1. Revisiting the Aims of the Research

The primary aim of the project was to capture the views of mental health staff who had attempted to implement trauma-informed changes within their services. These mental health staff, my participants, have been referred to as 'trauma-informed change advocates'. This research also aimed to capture learnings and advice from participants which could be of use to other trauma-informed change advocates. In the Results Chapter, I presented a qualitative evaluation of the data collected by presenting themes that were extracted from the fifteen interviews. The Thematic Analysis produced four overarching and interacting themes with sixteen sub-themes. In this chapter I will consider these themes and sub-themes in answering my research questions.

4.2. Research Question one: What do participants perceive to be a trauma-informed service?

Firstly, this study aimed to understand how trauma-informed services were perceived by mental health staff wishing to transform their services.

4.2.1. A trauma-informed service model is difficult to define

In subtheme four '*Issues defining trauma-informed services'*, participants spoke about the difficulties they encountered in defining trauma-informed services. This was spoken about as a barrier. Participants considered that it was difficult to advocate for trauma-informed change in services as the concept required extensive explanation. Participants also spoke about several misconceptions about trauma-informed services, some of which are also described in the literature. Sweeney and Taggart (2018) outline six common misunderstandings related to trauma-informed approaches. Two of these issues were spoken about by participants in this sub-theme. First, that '*trauma-informed approaches claim that all mental health service-users have experienced trauma'* and second '*trauma-informed approaches treat people who have experienced trauma'*. Participants spoke about both of these misconceptions as issues.

As outlined in the Introduction Chapter, there is a large amount of literature that presents descriptions and definitions of trauma-informed services. Therefore, it seems unlikely that the reason why participants encountered this as a barrier is that there is insufficient research/guidance available. Perhaps it is, as Sweeney et al. (2016) suggest, that there is not yet a sufficient 'critical mass' of clinicians, services and researchers who are interested in trauma-informed approaches. Another possibility is that the guidance is largely produced in North America and may therefore be difficult to translate to UK service structures. A third possibility is that services are under less pressure in the UK to make this costly 'paradigm shift' as trauma-informed services are not yet considered the norm. Whether it is a 'critical mass' issue or a country-specific issue, the nationwide implementation of a trauma-informed approach in Scotland (Children and Families Directorate, Scottish Government, 2020) is likely to support an increase in popularity of trauma-informed approaches across the UK. As a result, these barriers may become less of an issue over the coming years.

4.2.2. An ethical service model

Despite the development of the subtheme '*Issues defining trauma-informed services'*, no participants expressed difficulty in defining trauma-informed services themselves. Interestingly, participants did not refer to the literature when asked the question '*what is a trauma-informed service'*. However, participants did

refer to their own personal values or experiences. They often elaborated more broadly about the ethics of working in a trauma-informed way. The question '*what* is a trauma-informed service' was often answered with references to '*why*' participants wished to work in trauma-informed services. Participants shared the view that this work aligned with their values and was the reason why they first entered into their professions. This conflation between 'what' and' why' in participants' answers is somewhat reflective of the conflation between 'implementation domains' (what) and 'values' (why) in the research literature.

There may be many reasons why participants defined trauma-informed services by drawing on value-based rationales for trauma-informed services. However, it is plausible that this is because their interest in trauma-informed approaches is not merely academic. They are personally invested and interested in these approaches which are closely intertwined with their value bases. In subtheme six, '*Passion for the w*ork', participants spoke about feeling motivated to advocate for trauma-informed services because they truly felt these were the better, or more ethical, alternatives to traditional services. In subtheme seven, '*Inspired by clients'*, they spoke of the way that clients had affected them and inspired them to pursue improvements in mental-health services. The personal investment that these participants were making in pursuing service changes was also notable and seen in subtheme five '*Persistence'* and subtheme nine '*Burnout'*. As there is little research that focuses on the views of trauma-informed 'champions' or change-advocates specifically, this relationship between the trauma-informed model and personal values or investment has not been explored. However, Robey et al. (2020) did find that the domain '*Characteristics of Individuals'* was related to the successful implementation of trauma-informed approaches and more important than '*intervention characteristics'*.

4.2.3. A meaningful service-user experience

Participants describe trauma-informed services as more ethical, more aligned to their own values and as improving the experiences of service-users. Theme one '*Defining qualities of trauma-informed services*' largely describes the experiences that participants believe service-users should have when they access services. This is prevalent in subthemes two '*Meaningful engagement with clients'* and

three, '*Sustainable changes for service-users*'. This finding is not unexpected, given that much of the literature refers to the importance of the therapeutic relationship (Muskett, 2014). Kirst et al. (2017) found this to be a facilitator of service change, however, it is often referred to in the literature as a value or defining element (Elliot, 2005; Sweeney et al, 2018; SAMHSA, 2014). It seems that for participants, a 'meaningful service-user experience' is a core and defining element of trauma-informed services.

While it is not possible to draw conclusions about the relative importance of factors that participants did not speak about, it is interesting to consider these and why they were not raised. Notably, participants did not speak about 'resisting re-traumatisation' which is often referenced in the literature as the rationale for and defining factor of trauma-informed services (Elliott et al., 2005). This finding may represent that for participants this is not a concern or relevant, alternatively the possibility that their current services are re-traumatising service-users may be difficult to face.

4.2.4. Understanding distress as originating from trauma

Unsurprisingly, a finding from this research is that trauma-informed change advocates define trauma-informed services as those that '*Understand distress as trauma'* (subtheme one). This theme can be seen as aligning with a 'psychological model' of understanding trauma, as discussed in the introduction chapter. Psychological models of trauma suggest that traumatic experiences can lead to lasting psychological distress which may present as mental health difficulties which could be identified and categorised using a diagnostic tool or manual. In this theme, participants referred to the relationship that they saw between mental health difficulties and experiences of trauma. Several participants spoke about the importance of educating staff in how trauma can present in clients, how to enquire about trauma and how to respond to disclosures. This is consistent with the trauma-informed literature (Harris & Fallot, 2000; Sweeney et al, 2016; Read et al, 2017; Lotzin et al, 2018). This was also spoken about in '*Make use of research'* (subtheme fifteen) in which participants said that sharing research and resources can help colleagues to understand the importance of trauma in distress presentations.

This theme referred to understanding distress as an expression of trauma, however it does not refer to which specific psychological causal models participants perceived to be of use in trauma-informed services. As discussed in the introduction chapter, trauma can be understood using several different psychological models, for example the cognitive model which references 'challenges to schemas' as a reason for traumatic experiences leading to lasting distress. These psychological models also often align with specific recommended psychological interventions. The literature and guidance on trauma-informed services do not necessarily align with any single psychological causal model of understanding trauma and several different models and interventions may be present within trauma-informed services. While participants did not refer to schemas, dissociation or attachment, which may suggest reference to a particular psychological model of trauma, many of them clarified that they did not use the medical model in conceptualising trauma. This emphasises that while there may not be a consensus on the preferred psychological causal model of trauma, trauma-informed services are considered to be based in psychological frameworks for understanding distress, as opposed to medical-model frameworks.

4.2.5. Not the medical model

Participants in this study explicitly spoke about the medical model as currently dominant in mental-health services. Several participants answered the question 'what is a trauma-informed service' by referencing the medical model, implying that a trauma-informed service is *not* a medical model service. This is highlighted by the sub-theme '*Medical model'* (subtheme twelve). It is also supported by participants answers to the 'Barriers Questionnaire' as the question which addressed the medical model '*Reluctance to shift from biomedical causal models of understanding distress'* (Q17) received the highest average relevance rating.

This finding suggests that participants perceive the trauma-informed approach to be directly opposed to the medical-model. Participants appeared to highlight this as one of the most important aspects of the trauma-informed approach. As discussed in the introduction, the trauma-informed approach is not the only

alternative to the medical-model for working with distress. It may be possible that this finding highlights that participants are more enthusiastic about a non-medical-model approach than the trauma-informed approach specifically. As this research did not ask participants about their perceptions of alternative frameworks, such as the PTMF, it is not possible to make assumptions as to how participants perceive other alternatives to the medical-model. It may be that trauma-informed advocates are equally likely to advocate for any psychological-approach above the medical model as opposed to the trauma-informed approach specifically.

There is a lack of consensus in the trauma-informed literature about how aligned the trauma-informed approach can be to the medical model. The literature often speaks of 'shifts' to a trauma-informed approach, or becoming 'more' trauma-informed, however the existent approach or model is rarely named. Several studies reference the trauma-informed approach as offering a way of supporting service-users without pathologising them, appreciating service-users' histories or contexts in understanding their distress (Elliott & Fallott, 2005). These discourses around 'pathologising' or 'contextualising' may implicitly reference the medical model, but even these vague references remain are minimal. In addition, several authors integrate medicalising language into descriptions of trauma-informed services or research (Wilson et al., 2017). For example, Leitch (2017) considers how a trauma-informed approach would be supported by neuroscientific concepts. Such references may be representative of the growing application of trauma-informed ideas in traditionally medical settings e.g., mental health nursing (Wilson et al., 2017). They may also be representative of North American bias in the trauma-informed literature as the American healthcare system is, to an extent, reliant on medical-model structures (Watt, 2017). Sweeney et al. (2016; 2018) write from a UK perspective and explicitly reference the dominance of the medical model as a barrier.

Participants spoke about the medical model as both a barrier and a defining element of trauma-informed services. The finding that participants define the trauma-informed approach contextually, as different to the medical-model is unique to this research. This may suggest that UK based 'change-advocates' are

more prepared to define the trauma-informed approach as different to the traditional medical-model than their American counterparts may, or it may be a feature of the participant sample.

4.2.6. Question one: Conclusions

In defining trauma-informed services, participants did not cite literature or research. Instead, they spoke about trauma-informed services providing a different and more ethical type of care for service-users. This was difficult to advocate for because colleagues and managers are either unaware of the trauma-informed approach or are not aware of how it might look in practice. Participants defined trauma-informed services as providing something different to medical-model approaches. However, they did not specifically name which causal models of trauma they referred to in their conceptualisations of trauma. While issues with defining trauma-informed services were considered, these were not conceptual issues but implementation issues. These findings are interesting as they highlight the importance of not just defining trauma-informed services conceptually but having examples of what trauma-informed services look like in practice. Additionally they highlight the importance, to these participants, of advocating for services that are not lead by medical-model frameworks for understanding distress.

4.3. Research Question two: What are the barriers and facilitators to developing trauma-informed services?

The barriers and facilitators to trauma-informed services were described largely across '*Individual-level factors'* (theme two) and '*System-level factors'* (theme three). Facilitators were also considered in '*Advice for change advocates'* (theme four). The information collated from responses to the 'Barriers Questionnaire' is also considered in this section as supportive information. A list of the barriers and facilitators represented by subthemes extracted from interviews is presented in table 5.

Table 5.

Barriers and Facilitators

Barriers	Facilitators
Burnout	Personal motivating factors e.g., persistence, passion for work, inspiration from clients
Management	Connections with allies
Medical model	Supervision and reflective practice
Issues with defining trauma-informed services	Using research
Supervision	Management

4.3.1. Facilitators

4.3.1.1. Individual level facilitators

Research and literature that explores the facilitators to trauma-informed services has largely focused on organisational or cultural facilitators (Kirst et al., 2017; Palfrey et al., 2019; Sweeney et al., 2016). Less attention has been given to the facilitative factors or qualities required of staff.

Participants in this research offered several pieces of advice for change-advocates at the individual level. This included '*Be persistent'* (subtheme five), '*Be patient'* (subtheme thirteen), and '*Be tolerant'* (subtheme fourteen). Participants were clear that their work to make trauma-informed changes is not necessarily easy or straightforward. The differences between these three subthemes highlights that participants have used several different strategies, sometimes pushing the trauma-informed message, other times waiting for changes to happen more slowly.

The personal factors that motivate staff who are interested in trauma-informed change are not explored in the literature. However, for the participants in this

research, these motivating factors are important facilitators. Motivational factors such as '*Passion for the work'* (subtheme six) and inspiration from clients (subtheme seven), were also referred to as facilitators.

An important facilitator and piece of advice was captured in the subtheme '*Connections with allies'* (subtheme eight). Participants here described several different types of connections with allies. This included having allies within their service who could help them advocate for trauma-informed change and having motivating allies they could connect with elsewhere. This subtheme also related to '*Make use of research'* (subtheme fifteen) as participants spoke about feeling encouraged to keep going by reading about the work of allies in the trauma-informed literature.

4.3.1.2. <u>System-level facilitators</u>

'*Management buy-in'* (subtheme eleven) was raised as both a barrier and facilitator by participants. Participants who had achieved management buy-in saw this as a facilitator, whilst those who had not, saw it as a barrier. This duality is also represented in the literature. In interviews with service providers, research experts and consumers, Kirst et al. (2017) also found that organisational support was spoken about as an important facilitator to trauma-informed services. Given that Kirst et al. (2017) present these views from service providers and consumers, and this research presents the views of client-facing staff, it is now possible to conclude that management is perceived to be important by all levels in services. It is notable that 12/15 participants experienced a '*Lack of managerial support for trauma-informed approaches*' (Q21) and a high proportion scored this as a 'highly relevant' factor.

'*Supervision and reflective practice'* (subtheme ten) were often spoken about in the context of managers as facilitators. Participants spoke about managers who supported them in securing reflective spaces and managers who prioritised staff wellbeing. While the provision of staff-wide reflective supervision was not always possible participants stressed that reflective practice could be achieved without formal supervision. Several participants raised the point that if 'supervision' is a requirement of trauma-informed services this is a barrier originating in the literature or definition of this model as it is not feasible to suggest that all staff are

provided with reflective supervision. Sweeney et al. (2018) state that minimal time for reflection, a consequence of an unsupportive organisational culture, can be a barrier to trauma-informed services. While 'supervision and reflective practice' was referenced in interviews as a facilitator rather than a barrier, in answering the questionnaire, 12/14 participants rated this as 'highly relevant' barrier that they had encountered.

4.3.2. Barriers

4.3.2.1. Barriers questionnaire

Several barriers that were not raised independently by participants were considered at the end of their interviews in answering the 'Barriers Questionnaire. In 21/24 of the barriers listed on the questionnaire, at least 10/15 participants answered 'Yes', that they had encountered the listed barrier. These high levels of agreement suggest that generally the barriers listed are relevant to the experiences of change-advocates. In particular, three barriers received a complete consensus and all participants shared that they had encountered these in their work:

> Q10- *An organisational culture that conflicts with trauma-informed working methods*
>
> Q13- *Systemic issues that prevent long-term systemic changes (e.g. low staff morale or high staff turnover)*
>
> Q22- *Lack of understanding/education on trauma-informed methods*

All of these barriers may be considered to exist at the system-level. They also bear similarities to several of the themes extracted from interviews. In particular the themes '*Make use of research'* (subtheme fifteen), '*Management'* (subtheme eleven) and '*Issues with defining trauma-informed services'* (subtheme four).

Question 22 stresses the importance of educating staff with regards to trauma-informed methods. As with many of these barriers and facilitators, this issue is slightly confused as there is a suggestion that trauma-informed services should provide this education (SAMHSA, 2014). However, participants in this research have indicated that this education is helpful before services are trauma-informed,

at the ‘advocating for change’ stage. This suggestion may indicate that an important part of the change-advocate role is in providing basic education as a means to gaining support for trauma-informed approaches.

Questions 10 and 13 highlight the significance of the shift required. In considering these answers alongside the theme ‘Management’ (subtheme eleven) this raises the question of how possible ‘bottom-up’ change is. Trauma-informed change advocates who do not hold management positions are unlikely to be able to shift ‘organisational cultures’ or affect issues such as high staff turnover. Therefore, it may be more appropriate that such barriers are rephrased as ‘limitations to the change-advocate role’, as some barriers are simply not passable without taking a management position.

Several notable observations can be drawn from the barriers that did not receive high scores on the questionnaire. In the introduction chapter, barriers from an environmental/historical context were discussed including a self-protective aversion to accepting the impact and prevalence of trauma (Q9) (Jackson, 2003; Sweeney et al, 2016) and ideas about trauma-informed approaches being related to family blaming ideas (Q19) (Sweeney et al, 2016). Neither of these barriers were extracted as themes from interviews with participants. However, as they are themes relevant in the literature, participants were asked about these when answering the questionnaire. These two barriers received the lowest level of agreement with only 7/15 participants stating that they had encountered them. Additionally, only one participant spoke in an interview about the idea of ‘family blaming ideas’ as a barrier. In response to the questionnaire, several participants shared their views that they had never considered this a barrier and regarded it with scepticism. Several participants shared that they disagreed with the idea that services did not acknowledge trauma and expressed that in their experience, services were certainly aware of the impact and prevalence of trauma.

The assertion that ‘services lacking a knowledge of trauma prevalence and impact’ is not a barrier, may appear to contradict the suggestion that trauma-informed changes must start with staff education about trauma. However, if services are generally aware of the impact and prevalence of trauma, the question of why services are not already trauma-informed must be asked.

4.3.2.2. System-level barriers

Several system-level barriers have already been addressed in this discussion including '*Management'* (subtheme eleven) and the '*Supervision and reflective practice*' (subtheme ten) as these were also considered as facilitators.

The '*Medical model'* (subtheme twelve) was often referenced by participants as a barrier in the context of power imbalances. Participants spoke about biomedical causal models of distress being favoured by team or service leads which made it difficult for alternative perspectives to be shared. It is notable that the questionnaire results show that while only 11/15 participants expressed that they had encountered 'Reluctance to shift from biomedical causal models of understanding distress' (Q17) as a barrier, which is within the mid-range of scores, this barrier received the second-highest 'relevance rating'. The mean score was 4.75 with 5 being 'highly relevant'. This may suggest that while not all participants encountered this as a barrier first-hand, they are aware of its importance. This is notable considering the majority of the trauma-informed literature does not make reference to the '*Medical model'*. Sweeney et al. (2016; 2018) suggest that this is a barrier which exists at the broader environmental level alongside political issues. It may be therefore, that for the participant sample this barrier is not of direct relevance to their work in advocating for trauma-informed changes.

4.3.2.3. Individual level barriers

Participants reported '*Burnout'* (subtheme nine) as a barrier. Different ideas were shared with regards to the relationship between burnout and trauma-informed services. These ideas can generally be divided into 'fears of vicarious traumatisation' and 'advocate burnout'.

The results presented by Baker et al. (2018) suggest that training in trauma-informed care can increase staff awareness of the impact that trauma work can have on staff which may result in inflated 'vicarious traumatisation' scores. If services are solely concerned about the reported rates of vicarious traumatisation this may be experienced as a barrier. Change-advocates in the current study suggested that trauma-informed services are aware of the possibility of vicarious

traumatisation and therefore support staff to manage its effects. A similar point is raised by Kirst et al. (2017) whose participants identified 'burnout' as a barrier, however emphasised that this can be minimised with staff support and training on how to manage stress. Therefore, although vicarious-traumatisation presents at the individual-level, it only becomes a 'barrier' to trauma-informed services when it is not handled appropriately at the system-level.

Burnout was also considered from the perspective of change-advocates specifically. Participants considered that burnout could be a consequence of continually advocating for trauma-informed change and seeing no progress. In addition, participants suggested that working in a way that is not trauma-informed or aligned with one's values can also lead to burnout. Unfortunately, this seems to suggest that if change-advocates work in a trauma-uninformed service they will be susceptible to burnout whether or not they expend their energies advocating for changes.

4.3.2.4. Question two: Conclusions

Participants spoke about barriers and facilitators at the individual level by referencing their own personal qualities, interactions and experiences. Participants were driven by their passion for the work and inspiration gained from clients. They encouraged other change-advocates to persist but be aware of the potential for burnout. They spoke about connecting with allies as helpful to prevent burnout becoming a barrier. They also recommended several strategies to do with approaching trauma-informed change with colleagues. In particular, participants spoke about being tolerant of differences in opinion to allow for colleagues to explore their ideas. They also recommended using the research to legitimise their trauma-informed arguments as well as using strategies to show colleagues the benefits of a trauma-informed approach. Participants also spoke about the benefits of using research to gain management buy-in which can be essential as there are several barriers which exist at the system-level and are difficult to shift. In particular, the prevalence of the medical model seemed to be a barrier that was difficult to imagine shifting.

4.4. Change processes and implementation science

While the current study has focused on services adapting to become 'trauma-informed', several findings and conclusions may also be applied to the broader literature on change-processes and their barriers/facilitators. Much of the implementation science literature for mental health services in the U.K. focuses on the implementation of evidence-based practice or of service-user involvement (Mancini et. al., 2015; Stevens, Shelley & Boden-Albala, 2020). Several of these studies identify barriers to implementation which are comparable to the results of the current research. Wakida et al. (2018) completed systematic review of the literature on barriers and facilitators to the integration of mental health services in primary health care. Wakida and colleagues found that 'management and/or leadership' was a barrier to change, which has also been found in the current research in the theme '*Management'* (subtheme eleven). They also highlighted barriers which were not raised as themes in the current study such as 'Financial Resources'. This discrepancy may be explained by the fact that the current study presents the perspectives of staff who are attempting to implement change who are not necessarily working at the service management level. Additionally, it is possible that several barriers identified in both Wakida et al. (2018) and the current research represent the same issue, however they are described in different ways. For example, 'financial resources' may be a barrier experienced by staff in managerial positions, however the participants in the current research may have identified this as an issue with 'management', perhaps as the management are not seen to prioritise spending on trauma-informed changes. The current study has not identified barriers perceived at the service-management level, however it has focused on barriers perceived by change advocates which appears to be a unique approach from the perspective of change-process literature.

While it is beyond the scope of this research to complete a full systematic review of the perceived barriers and facilitators within implementation science literature, several differences can be noted between the current study and this literature. It is clear that the implementation literature largely constitutes studies that focus on the barriers to services changing from the perspectives of service managers, as

opposed to barriers perceived by advocates for change. Michie et al. (2014) contribute a framework to identify barriers to the implementation of guidelines or of evidence-based practice (Mitchie et al., 2014), however this is also largely relevant at the service-management level as it focuses on staff motivation and capabilities. The current research instead focuses on strategic methods of making changes from within teams or advocating for service-wide changes. This is represented by the 'individual level' barriers and facilitators that have been discussed in this chapter.

The current research contributes to the implementation science literature in providing a perspective of the barriers and facilitators perceived by change-advocates. The 'individual level' barriers and facilitators are particularly unique as they highlight the personal efforts and sacrifices that are required of change-advocates which have not been accounted for in the literature. For example, 'Burnout', 'Personal motivating factors' and 'Connections with Allies' are not themes that have been identified in the change implementation literature. These findings contribute an insight into the personal efforts that are required of staff wishing to implement change. In introducing implementation science and the literature around it, Bauer et al. (2015) highlight that there already is a good amount of literature into barriers and facilitators within certain subject-areas, and that the next step is for literature to focus on testing optimal strategies for implementation. This may be an interesting angle for future research which follows on from the current study, to understand the perspectives from 'successful' change-advocates on how they managed to implement changes.

4.5. Advice for change advocates

All participants were asked about what advice they would give to other professionals wishing to develop trauma-informed services. Some of this advice has been represented in '*Advice for Change Advocates'* (theme four), and some has been integrated into other subthemes. A visual representation of how advice has been represented across subthemes can be seen in Appendix R.

The following eight headings summarise this advice from 'trauma-informed change advocates':

1. *Don't give up*
2. *Look after yourself*
3. *Get management on board*
4. *Stay connected to allies*
5. *Be patient*
6. *Be tolerant*
7. *Make use of research*
8. *Be strategic*

Specific pieces of advice and recommendations from participants has been collated and presented in Appendix T. Within the literature there are no comparable guidance documents that offer advice for trauma-informed change advocates.

Advice shared by participants in this research expresses the importance of self-care and persistence. This individual focus is supported by Robey et al. (2020) who highlights the importance of 'characteristics of individuals' who support trauma-informed changes.

Participants also shared that different approaches can be useful in different circumstances e.g. being tolerant of differences, patient about seeing changes and making use of research when attempting to shift colleague understandings of client presentations. A similar idea is presented as a facilitator by Sweeney et al. (2016) who share that 'empathetic engagement' is important so that staff feel able to develop skills and ideas about trauma-informed care. Additionally, Chandler (2008) found that 'changing perspectives' was supported by a change-advocate in the team. Participants expressed that it can be difficult and isolating to be the only one in a team or service that has a difference in opinion and that connections with allies can be helpful.

Participants expressed the importance of seeking support from management. The issue of pursuing management buy-in is interesting in considering that most trauma-informed research and service changes are implemented from the top-down. This research has attempted to explore trauma-informed changes

happening from the bottom-up. However, as this was clearly deemed an important factor for participants, it may be supposed that the efforts of change-advocates who are not in management positions are best directed at seeking managerial support. This finding is supported by Sweeney et al's (2016) described facilitators which suggest that efforts will be supported by selling the concept to senior leadership in organisations.

4.6. Recommendations for future practice

4.6.1. Clinical recommendations: Participants

Recommendations from participants are represented in the above section 'Advice for change advocates' as well as in Appendix T.

4.6.2. Clinical recommendations: Literature

Within Sweeney et al. (2016), Angela Kennedy presents her experience of developing a trauma-informed service as a case study. In this case study a list of facilitators are considered which address similar themes to those presented above. These have been presented in the Introduction Chapter. Kennedy makes several suggestions to do with adapting trauma-informed proposals to fit with existent service requirements so that they do not appear too challenging for staff or managers. For example, they suggest proposing a trauma-informed' approach within the service's existent methodology and ensuring that the new approach does not add clinical activities for staff. These ideas suggest the possibility that a trauma-informed shift is possible 'by stealth', without too much disruption to services. This suggestion aligns with the recommendation '*Be strategic'* (subtheme sixteen) and '*Be tolerant*' (subtheme fourteen).

The benefit of Sweeney et al.'s (2016) suggestions is that they are written from the perspective of someone who has had success in implementing a trauma-informed approach in the U.K.. However, in proposing that the trauma-informed approach is sold as a concept that is connected with a service's existent 'change process and aims' does appear to remove some of the emphasis from the idea of a trauma-informed service model as substantially different to a medical model service. Perhaps Sweeney et al. (2016) were able to overcome barrier

‘reluctance to shift from the medical model’ in making tentative proposals to change. However, one might suggest that having management and staff on-board is perhaps less helpful if they are not wholly aware of the significant culture shift required to become a ‘trauma informed service’.

4.6.3. Clinical implications: Researcher

The clinical implications and recommendations from the participants are extremely important, particularly for any future ‘trauma-informed change advocates’. Several additional implications have been noted below from my own perspective having considered the interviews and themes. This is advice specifically directed towards change-advocates:

- Management can support organisational changes to service structures which may facilitate a cultural shift. An important role of trauma-informed advocates is pursuing this buy-in. This can be supported by making use of the research which evidences the benefits of this approach as well as the guidance about how this approach can be implemented.
- The benefits of individual trauma-informed practices can be used to support arguments for service-wide trauma-informed changes. By witnessing the benefits of this practice, colleagues and managers are more likely to buy-in to trauma-informed ideas.
- Plan your approach to making trauma-informed changes.
    - Consider how this can made sustainable- what happens in a service with high staff-turnover? How can you ensure that you maintain a support-network of allies?
    - Consider the personal and emotional resources that advocating for a trauma-informed approach will require.
- Find ways to re-ignite and re-inspire yourself when you are feeling disconnected from your trauma-informed change plans.
    - Re-connect with colleagues who are also inspired by trauma-informed changes.
- Service changes do not happen quickly and a range of strategies will need to be employed to support change.

- Talk about the existent models used in your services and their underlying implications. The medical model is not sufficiently explicitly discussed in mental health services.

4.7. Recommendations for future research

4.7.1. Efficacy of bottom-up trauma-informed change

If staff are deciding whether it is worthwhile their investing time and energy into pursuing trauma-informed changes, it is important to understand how effective these bottom-up interventions can be. There may be a benefit from future research using a longitudinal design to measure the cost/benefits of bottom-up trauma-informed service change interventions. The ARTIC (Baker et al., 2016) may be used as a tool to evaluate changes in staff attitudes over a time period. The 'Consumer Perceptions of Care' questionnaire by Clark et al. (2008) would provide insight into service-users experiences of this change. Trauma-informed changes may also be measured by considering changes to practices such as restraints and seclusion (Clark et al., 2008; Azeem et al., 2011). In order to measure the costs to staff of this 'persistence' or 'burnout', either qualitative interviews or measures of quality of life/burnout would be helpful for example the Professional Quality of Life tool (ProQOL; Stamm, 2010).

4.7.2. Trauma-informed service examples

This research has highlighted that the prevalence and power of the medical model was often seen as a barrier. Participants described trauma-informed services as '*not the medical model'* and felt excited about knowing that an alternative model of mental health existed and was gaining support. However, participants also spoke about a difficulty in defining the trauma-informed model. This difficulty was specifically with regards to explaining how their services would look if they were trauma-informed. It may be helpful for research and guidance in future to focus on the concrete differences between medical-model services and trauma-informed services. Additionally, a series of examples of trauma-informed services to be collated along with reflections about the journey that each service

took would be important. This collection of examples would be helpful for change-advocates to share with colleagues and managers.

4.7.3. Trauma-informed change in the UK

The great majority of research and guidance related to trauma-informed change has originated from the US (Sweeney et al., 2016). This includes the large-scale studies into the barriers and facilitators to trauma-informed services (Robey et al., 2020). However, there are several important differences between UK and US mental-health services which make the implementation of trauma-informed approaches and the related barriers and facilitators quite different. In particular, the current research has highlighted that participants in this study viewed a trauma-informed approach as something different to the medical-model approach and that the prevalence of the medical-model can be a barrier to change. This perspective does not seem to be represented in the majority of trauma-informed literature.

If trauma-informed services are to be pursued in the UK, more research into the specific barriers to service change and the way that these barriers can be managed is of utmost importance. A large-scale, nationwide survey that collates perspectives on the barriers and facilitators to trauma-informed services would be important. This study should collect the perspectives of service managers, clinicians, change-advocates and service-users. This survey should also collect information about the attitudes towards trauma-informed services. Several researchers in the US have assessed the 'readiness for trauma-informed change' in their areas and found this to be helpful. Marvin and Robinson (2018) found that readiness to change was associated with favourable attitudes towards trauma-informed care. Farro et al. (2011) found that by assessing 'readiness', staff and leadership were mobilised to implement changes. Such a survey would not only collect information about attitudes towards trauma-informed services but it would also help to raise awareness of them which would be supportive of change-advocates work. The results of such a study would be helpful for service leads and commissioners to assess the need and readiness for trauma-informed change in services.

4.8. Critical Evaluation

Some critical evaluation of this study has already been completed in previous chapters regarding the design and methods. In this section I have used the principles outlined by Spencer and Ritchie (2012) to guide my critical evaluation of this study. I have also considered Nowell et. al's (2017) guidance on striving to meet the trustworthiness criteria in thematic analysis.

4.8.1. Contribution

Spencer and Ritchie (2012) consider that contribution refers to the value and relevance of research evidence to the areas of theory, policy and practice. The contribution of this research to the area of clinical practice has been considered with care from its beginning. The current study provides an insight into previously underrepresented perspectives which will be helpful to individuals who wish to develop their service into a trauma-informed service.

Within implementation science literature there is an emphasis on the importance of identifying barriers and how they can be overcome as a means to successful change implementation (Hakkennes & Dodd, 2008; Proctor et al., 2013; Tansella & Thornicroft, 2009). Bauer and Kirchner et. al. (2019) review the definition, history and scope of implementation science and assert that identifying uptake barriers and facilitators as well as considering strategies to overcome barriers is at the crux of successful implementation. The research presented in this dissertation addresses this issue for trauma-informed services as it provides a list of barriers, facilitators and advice for overcoming barriers which can support the implementation of trauma-informed changes.

4.8.2. Credibility

Credibility describes how well the research represents the views of participants (Tobin & Brgley, 2004). I worked towards achieving credibility through several activities that are described by Lioncoln and Gubaa (1985). This included prolonged engagement with the data, reading transcripts and recording thoughts and reflections at several different stages. Assurances as to the credibility of this research were also supported by participants' answers to the 'Barriers Questionnaire'. This supported credibility as, if answers to the questionnaire were

inconsistent to what I had understood from the interview, I was able to ask participants about these discrepancies. The majority of the barrier/facilitator themes that were derived from the interview data are related to questionnaire items rated as relevant by participants. The credibility of findings may have been further supported using a process of participant validation, having a participant consider the transcribed data and extracted themes. This was not completed and may be considered a limitation of the research methodology (Henwood and Pidgeon, 1992).

4.8.3. Rigour and Transparency

Nowell et al. (2017) write about trustworthiness and rigor with regards to thematic analysis. Rigour in quantitative analysis is often considered to be indicative of 'objectivity' which is problematic for qualitative research (Spencer and Ritchie, 2012). Most qualitative research assumes that a level of subjectivity will always be involved in research but the careful documentation of research decisions and processes, forming an 'audit trail' can support the defendability of research.

I have attempted to increase the rigour of this study by presenting the reader with a transparent account of my relationship to, and process of analysing, the data. In the Methods Chapter, I describe my analytic approach and reflexivity. In the Results Chapter, I share examples of quotes as well as my interpretations of their relationship to themes. A full list of quotes for each sub-theme has been provided in Appendix S for the reader to consider. In the Methods Chapter I also describe the process and results of an inter-coder reliability exercise. This process contributed to the rigour of the analysis process, allowing me to challenge several assumptions that I had about the data and to consider it in a different way.

4.8.4. Reflexivity

Reflexive notes were made throughout the research and analysis process (Appendix N). Early reflections about interviews and initial themes were compared to notes taken following transcriptions of interviews and later, initial coding of interviews. This allowed me to cross-reference ideas and make connections between different themes that arose throughout the process.

Following interviews, I noted my initial impressions. I considered my personal and emotional responses to the interview and what this may represent about the topic for the interviewee. A prospective reflexive review of how my experiences may have impacted on the data can be found in the Methods Chapter and a retrospective reflexive review of the data's effect on myself can be found later in this chapter.

4.9. Limitations

4.9.1. Sample limitations

One limitation of this research relates to the way that I recruited my participants. All participants had attended a conference on trauma-informed services. Many of them subsequently attended a local-conference in which the barriers to trauma-informed care were discussed. These experiences are likely to have influenced the views shared in interviews. This is particularly relevant to the 'Barriers Questionnaire' as several items of this questionnaire were created on the basis of views shared at the local conference.

Two potential-participants who identified with the description of 'mental health professional who has worked to implement trauma-informed changes' and attended the conference contacted me expressing an interest in taking part then later decided not to proceed. The reasons for not taking part, as I understand them, were related to concerns that their employers would not be happy if they found out. The precise reasons for this are unclear, however they represent an interesting limitation in relation to my participant sample. All of my participants were willing to talk with me about their experiences in encountering barriers in their services. This may be because they felt confident that their answers would be sufficiently anonymised. However, it may also be because they represent a group of mental health staff who do not mind being associated with trauma-informed ideas and the barriers to their implementation. This research is therefore perhaps not representative of the views of change-advocates who have been working to make trauma-informed changes without alerting their services to this change, the approach which appears to have been taken by Sweeney et al. (2016).

In addition, demographic information such as ethnicity, gender identity, number of years qualified and amount of time working towards trauma-informed changes was not collected. In retrospect this information may have been helpful in considering how participants were representative of mental health professionals in a range of services. The variation in participants' professional training backgrounds and experiences across different services is considered a strength of this research.

4.9.2. Epistemological inconsistency

The interview and the questionnaire data present two quite different explorations of participants' perceptions of trauma-informed services. While the interview presents inductive data and its Thematic Analysis is driven by the content of interviews, the questionnaire takes a deductive approach. This deductive approach is not aligned to the critical-realist position as it relies on the assumption that there is a reality that can be sought out through research. In interpreting the questionnaire I have made reference to the number of people who gave answers to each question. This is contradictory to the critical-realist approach, nonetheless, I do feel that this captured interesting results as it offered participants the opportunity to highlight the barriers that participants agreed with but had not initially raised in interviews. This has allowed me to reflect on the limitations of using interviews as a research method as it remains possible that there are barriers which participants perceive to be of great significance and yet have not remembered to mention within the allotted time. The same limitation can be seen in the use of the 'inter-rater reliability test', as has been considered in the Methods Chapter (section 2.9.7)

The questionnaire introduces a list of predetermined factors and asks for participant responses to these. While the questionnaire responses were seen as complementary to the results of the thematic analysis they provided independently interesting results. In answering the questionnaires, participants often responded with strong opinions about the barriers which were listed but not captured in interviews. These strong opinions are only represented by responses to the questionnaire and it was felt that some interesting information was lost as a result of this. In retrospect, I wondered whether the Delphi Method may have

been a better choice of method. The Delphi Method allows for a creative exploration of ideas which can facilitate the formation of a group judgement (Helmer, 1977; Adler & Ziglio, 1996). This method would have allowed participants to share their views on factors they may have forgotten to mention, or to clarify how their experiences are captured by the barriers compiled from the literature.

4.9.3. Underlying assumptions

This research is based on several underlying assumptions that I hold with regards to trauma-informed services. A number of these assumptions have been challenged through my involvement with this research and have highlighted several limitations of this study. Primarily, I have assumed that trauma-informed changes are worth pursuing and that participants would be in agreement about this. Participants challenged this assumption in a number of ways. One participant raised the issue with the term 'trauma' and highlighted that trauma-informed services cannot truly be different to the medical model if they use the word 'trauma'. Another participant highlighted that the trauma-informed literature and research is largely psychology biased, and it makes assumptions about the value of different ideas such as 'supervision'. These two criticisms of the trauma-informed model were not considered prior to the research in the formation of the interview schedule or questionnaire. As such, in interviews I asked 'why' participants think this approach is helpful without first asking 'if'. I also failed to consider that there may be other change-models participants see as helpful. One participant spoke about the benefits of the Power Threat Meaning Framework (PTMF; Johnstone et al., 2018). It may be the case that this participant sees this as a more helpful model than the trauma-informed one. The perceived limitations of the trauma-informed approach may have provided interesting information but were not considered in interviews.

4.9.4. Critiques of trauma-informed services

In addition to the critiques of trauma-informed services raised by participants, which have been discussed above, several critiques have been raised in the literature which are important to consider. An important critique of trauma-informed services lays with is its problematic emphasis on the term 'trauma'.

While this framework for understanding and working with distress can be seen as an alternative to medical-model services, the term ‘trauma’ cannot be completely divorced from diagnostic language and its relation to PTSD. This is a criticism which has been made by several key authors of the PTMF (Johnstone et al., 2019). The term ‘trauma’ is often understood as referring to single-event traumas which is not necessarily representative of all types of negative experiences which are of relevance to trauma-informed approaches.

Trauma-informed approaches make the implication that negative life experiences are the origins of distress which becomes understood as mental health difficulties. However, not all individuals who identify with mental health difficulties would not necessarily identify with ‘trauma’ as the origins of their difficulties. It may be that this is simply a semantic issue and related to the difficulty in defining trauma-informed services. However as discussed in the introduction, as trauma-informed services are difficult to define, there is great variation in the way that they are implemented. The aims and policies of trauma-informed services vary substantially and this may be related to how they conceptualise ‘trauma’. This variation can result in services which call themselves ‘trauma-informed’ neglecting to highlight the impact of systemically located traumas such as the impact of discrimination, deprivation or social-inequalities. As such, the term ‘trauma’ in trauma-informed services does appear to prioritise the importance of single-event traumas above others which may become lost in vague definitions.

One notable finding in this research is that change-advocates defined trauma-informed services as ‘Not the Medical Model’. This highlights another potential critique of the trauma-informed service model. As the ‘trauma-informed’ movement is rapidly growing in popularity and is often introduced as an alternative to traditional bio-medical frameworks, other alternatives to the medical model are often forgotten. The trauma-informed model highlights the importance of attending to individuals’ life experiences when understanding their distress presentations and accounting for this in each clinical contact. Although this is a different approach to the medical-model it is not necessarily unique and could also be understood as a psychological-model of service provision. Johnstone (2018) considers the growth of ‘psychological formulation’ as an alternative to

psychiatric diagnosis. Johnstone's description of a psychological formulation approach to service provision bears a great many similarities to the trauma-informed approach, to the extent that it is difficult to unpick the two. Psychological-formulation is an important process, intervention and tool of psychologists, however in the realms of service-delivery it is not nearly as popular as 'trauma-informed' approaches. The reason for this is unclear, however it is possible that the trauma-informed approach has gained such popularity as the use of the term 'trauma' aligns itself with the medical-model and the perceived credibility that comes with this.

4.9.5. Epistemology

It is essential, in any qualitative research to reflect on the underpinning epistemological and methodological assumptions (Holloway & Todres, 2003). This research has been conducted from a critical realist perspective which has allowed me to consider the material realities of participants whilst also attending to the context of their experiences. An important part of interviews therefore has been gathering contextual information about the realities of participants' experiences as a means to understanding their views on the barriers and facilitators to trauma-informed services. For example, each participant described the barriers to trauma-informed services and these barriers were understood as contextually relevant to each participant's experience. While each participant's context is different, many of the barriers and facilitators they perceived were described in similar ways. Noticing these similarities allowed for the construction of themes from the data and broader conclusions being drawn about the barriers and facilitators to trauma-informed services.

One criticism of critical realism is that research reflects interpretations by researchers rather than experiences of participants (Edwards, Ashmore & Potter, 1995). Through practicing reflexivity, I have worked to understand the impact that I have had on the research and I have worked to achieve transparency by sharing the process of analysis from initial coding to theme construction with the reader. I have worked to ensure that themes are grounded in participants' descriptions of their perceptions, opinions and experiences whilst considering the

realities within which they exist such as service constraints and the impact of the context of coronavirus pandemic on the UK and NHS services.

4.9.6. Thematic Analysis

Braun and Clarke (2019) emphasise that thematic analysis is not a linear process but a recursive one that develops over time. Themes do not 'reside' from the data and 'arise' without extraction, but it is important to acknowledge the theoretical position and role of the researcher. While I undertook steps to 'distance' myself from the data, often leaving breaks of several weeks between coding the same transcript twice so as to critically examine how my views about the content had changed, I acknowledge that it is not possible to fully 'un-know' information about a topic that may change one's views (Vaismoradi et al, 2016).

4.10. Reflective Review

Reflexivity is an important part of conducting ethical research (Attia & Edge, 2017), it also contributes to the credibility and reliability of research findings (Nowell et al, 2017). A prospective reflexive review has been shared in the methods chapter in which I considered the effect that my personal experiences had on the research. My underlying assumptions and the way that they affected the data have also been considered in the 'Limitations' section. In this section I will present a retrospective reflexive review, considering the impact that the research had on me.

4.10.1. Retrospective reflexivity

As this research has developed, as I executed interviews, analysed transcripts and written up the results, my relationship to the subject area has changed. I completed all of the interviews whilst working in trauma-specific services. The stories, perspectives and experiences that the interviewees shared with me had a profound effect on my development as a clinician. The participants spoke with such passion and emotion about the area that I often completed interviews feeling inspired by their energy and commitment. Many of these participants had made personal sacrifices in their determination to introduce trauma-informed changes to services in the best interests of their clients. Participants also told

stories of quiet determination and the impact that small conversations with colleagues can have in creating trauma-informed culture shifts. These participants have taught me about holding my personal values central to my work, remaining in touch with my motivations for entering this profession and about the powerful changes that can be made from the bottom-up in services.

4.11. Dissemination

It is important to me that the findings of this study and the advice shared by participants are accessible to those who would most benefit from them. A summary of findings will be shared with participants in a format that is accessible and practically useful for them. It is hoped that participants will feel able to contribute to the dissemination of these findings by sharing this summary with colleagues and assisting them in connecting with allies.

With the support of my research supervisor, I hope to publish the findings of this research in a scientific journal. A practical summary document will also be sent to Clinical Directors of NHS Mental Health Trusts and organisations that advocate for trauma-informed ways of working (of which there are several across the U.K.). The research will also be submitted for consideration to conferences of relevance to the subject-area.

5. CONCLUSION

Trauma-informed approaches have been steadily gaining popularity in recent years, offering an alternative model of understanding and approaching distress to the traditional medical model (Sweeney et al, 2018). The research literature and guidance around trauma-informed services has largely been produced in the US and implies that changes must happen from the top-down, with management positions investing in trauma-informed change interventions and training. However, trauma-informed literature also suggests that a paradigm/culture shift at the level of client-facing staff is important for sustainable service changes (Harris & Fallot, 2001; Robey et al, 2020). In both these cases, client-facing staff are presented as passive participants in trauma-informed service change interventions. The perceptions of staff who have been involved in pursuing trauma-informed changes, either from managerial positions or from the 'bottom-up' are underexplored in the research literature. This study fills this gap, offering an exploration of the perceptions of mental health staff who have attempted to make trauma-informed changes in their services.

This study sheds light on the mental health staff who are motivated to develop their services on behalf of their clients. It highlights how passionately these staff feel about the need for trauma-informed changes to mental-health services. These participants have been motivated, not by theoretical learnings or research, but by the interactions that they have had with clients. Participants have expressed the empathy and connection that they feel for their clients in pursuit of a service model that will better, and more ethically, serve them.

Staff making changes from the bottom-up must consider with care whether the changes they propose will be possible or whether there will be insurmountable barriers that will impede trauma-informed changes. One important role for change-advocates is pursuing management buy-in to the trauma-informed approach. For participants, using research to educate colleagues and managers about trauma-informed approaches helped in this role. Participants considered the trauma-informed model as an alternative to the medical-model but spoke about the patience and tolerance that is required to pursuing this alternative.

Additional advice to change-advocates has been shared throughout this research and in the appendixes.

I hope that this research will be of interest, and of practical use, to others who wish to pursue trauma-informed changes to their services.

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APPENDICES

5.1. Appendix A- Values of trauma-informed services

Harris & Fallot (2001)	Elliot (2005)	SAMHSA (2014)	Sweeney et al. (2018)
1. Understanding trauma 2. Understanding the consumer survivor 3. Understanding services 4. Understanding the service relationship	1. Recognising the impact of violence and victimisation on development and coping strategies 2. Identify recovery from trauma as a primary goal 3. Employment of an empowerment model 4. Strive to maximise choice and control over recovery 5. Based on relational collaboration 6. Create and atmosphere that is respectful of survivors need for safety, respect and acceptance 7. Emphasise strengths and adaptations over symptoms 8. Minimise re-traumatisation 9. Culturally competent	1. Safety 2. Trustworthiness & Transparency 3. Peer Support 4. Collaboration and Mutuality 5. Empowerment, voice and choice 6. Cultural, historical and gender issues	1. Seeing through a trauma lens 2. Appreciation of invisible trauma and intersectionality 3. Sensitive discussions about trauma 4. Pathways to trauma-specific support 5. Preventing trauma in the mental health system 6. Trustworthiness and transparency 7. Collaboration and mutuality 8. Empowerment, choice and control 9. Safety 10. Survivor partnerships

	10. Service user input in designing/ evaluating services		

5.2. Appendix B- Implementation domains

Harris and Fallot (2001)	Ko et al. (2008)	Hummer et al. (2010)	SAMHSA (2014)	Menschner and Maul (2016)	Bassuck et al. (2017)
1. Administrative commitment to change 2. Universal screening 3. Training and education 4. Hiring practices 5. Review policies and procedures	1. Integrate practices across all service sectors. 2. Providers and policymakers to consider changes to practice. 3. Evaluate the impact of trauma-informed care. 4. Education and training for all child/family staff 5. Early and strategic provision of	1. Program procedures and settings 2. Formal service policies 3. Trauma screening, assessment and service planning 4. Administrative support for program-wide trauma-informed services	1. Governance and leadership 2. Policy 3. Physical environment 4. Engagement and involvement 5. Cross-sector collaboration 6. Screening assessment and treatment services 7. Training and workforce development 8. Progress monitoring and	Organizational ingredients 1. Leading and communicating about the transformation 2. Engaging patients in organizational planning 3. Training clinical as well as non-clinical staff 4. Creating a safe environment 5. Preventing secondary traumatic stress in staff 6. Hiring a trauma-informed workforce Clinical key ingredients 1. Involving patients in the treatment process 2. Screening for trauma	Domains in the TICOMETER to assess trauma-informed care 1. Build trauma-informed knowledge and skills 2. Establish trusting relationships 3. Respect service users 4. Foster trauma-informed service delivery

	trauma-informed care 6. Use appropriate trauma-specific assessment measures 7. Interdisciplinary collaboration	5. Staff trauma training and education 6. Human resources practices	quality assurance 9. Financing 10. Evaluation.	3. Training staff in trauma-specific treatment approaches 4. Engaging referral sources and partnering organizations	5. Promote trauma-informed policies and procedures

5.3. Appendix C- Barriers to trauma-informed services

Sweeney et al. (2016)	Kirst et al. (2016)	Sweeney et al. (2018)	Palfrey et al. (2019)	Robey et al. (2020)
1. Family blaming ideas 2. Resistance to addressing historical/ cultural trauma 3. Horror of embracing trauma 4. Continuous change and upheaval 5. Conceptual confusion 6. Competing initiatives 7. Access to supervision	1. Provider reluctance to address trauma 2. Lack of accessible services 3. Limited funding for programs/ services 4. Staff burnout	Related to working in the UK public sector: 1. Underfunding 2. Paperwork 3. Changes to public-services 4. Low morale and high staff-turnover Related to organisational cultures: 1. Cultures that fail to support TI working methods 2. Lack of supervision/training /support 3. Little reflection time 4. Apprehension regarding applying TIP to individual practice Dominance of biomedical models 1. Reluctance to change from biomedical models 2. Biomedical training	• Clinicians lack of perceived experience and confidence dealing with families affected by trauma • Clinicians feeling under equipped to assess or respond to distress • Staff not feeling that they have specialist skills • Biggest barrier- view that 'trauma' is a	Inner setting barriers • Staff turnover • Lack of leadership support • Resource limitations (e.g. time and money) Intervention characteristics barriers • Adaptability of construct • Competing priorities Process barriers • Lack of fidelity to intervention Individuals barriers • Unchanged staff attitudes • Negative staff beliefs about trauma-informed services • Personal staff attributes

8. Insufficient momentum		3. Lack of investment in non-biomedical services 4. Lack of exposure to social, historical, urban and cultural trauma 5. Historical underpinnings of psychology 6. Accepting the extent of trauma	specialist area and outside of scope of practice	• Self-efficacy Outer setting barriers • Needs of patients interfere with trauma-informed care implementation • Peer pressure

-

5.4. Appendix D- Facilitators

Sweeney et al. (2016)	Kirst et al. (2017)	Sweeney et al. (2018)	Palfrey et al. (2019)	Robey et al. (2020)
1. Senior support 2. Methodology for system change 3. Staff empowerment 4. Understanding organizational benefits	1. Organizational support 2. Community partnerships 3. Staff awareness of trauma 4. Safe environment 5. Peer support 6. Quality of consumer-provider relationships 7. Consumer and provider readiness to change 8. Staff supports	1. Trauma enquiry 2. Understanding coping adaptations 3. Moving beyond 'power over' relationships	• Strong leadership from management to support initiative • Ongoing consultations with clinicians about perspectives • Involving extensive networks and partnerships	Inner setting facilitators • Quality evidence for trauma-informed care • Thoughtful implementation process of trauma-informed care • Quality of trauma-informed care materials • Flexibility within trauma-informed care model Process facilitators • Careful planning • Formal titles of trauma-informed staff (e.g. TI leaders or champions) • Evidence of quality improvement shared with staff • Supportive and engaging trauma-informed care implementation Individual facilitators

				• Frontline clinicians belief in trauma-informed care • Previous staff experience and training • Identification with organization and self-efficacy Outer facilitators • Policies or funding that support trauma-informed care • Client focused care adaptations • Collaboration with other organisations

5.5. Appendix E- Literature search strategy

Selected databases: PsychINFO, PsycArticles, SCOPUS, Web of Science and Science Direct.

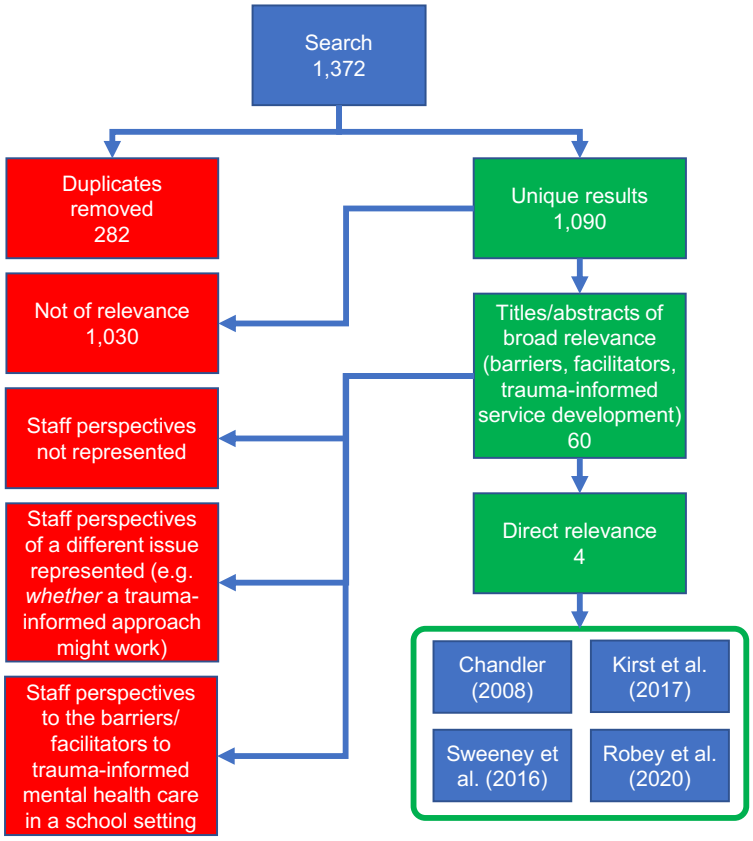
Search terms: *("trauma-informed care" OR "trauma informed care" AND "trauma-informed approach" OR "trauma informed approach" AND "trauma-informed service" OR "trauma informed service" AND "trauma-informed practice" OR "trauma informed practice") AND "mental health"*

Date: Publication search parameters spanned from 2000 to present day as Harris and Fallot (2001) are often credited with the conceptual origin of trauma-informed approaches to mental health services. An initial scan of abstracts/summaries of papers and books older than 2000 did not highlight any papers relevant to this research.

Figure E1, below, shows the reasons why publications were excluded from this review. Circled in green are the publications reviewed in the Introduction Chapter.

Figure E1

Literature exclusion diagram


Search
1,372
Duplicates removed
282
Unique results
1,090
Not of relevance
1,030
Titles/abstracts of broad relevance (barriers, facilitators, trauma-informed service development)
60
Staff perspectives not represented
Staff perspectives of a different issue represented (e.g. *whether* a trauma-informed approach might work)
Direct relevance
4
Staff perspectives to the barriers/ facilitators to trauma-informed mental health care in a school setting
Chandler (2008)
Kirst et al. (2017)
Sweeney et al. (2016)
Robey et al. (2020)

5.6. Appendix F- University Ethics Application form and Approval Decision

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: John Read **REVIEWER: Tim Lomas**

STUDENT: Sarah Clark

Title of proposed study:

Course: DClinPsy

DECISION *(Delete as necessary)*: Trauma Informed Services: Why and How?

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer)*:

- The current guidance from UEL is that due to the COVID-19 all research interactions need to take place online using Teams (rather than face-to-face, as is mentioned on p.4 and p.7). It's possible this guidance will be revised at some point this year (and the information letter can reflect that, and state on-campus interviews will be conducted if the guidance allows), but until then online should be the default.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Sarah Clark Student number: U1826609 Date: 13/05/2020

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

	HIGH
	MEDIUM
x	LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: Tim Lomas

Date: 13.5.20

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:
*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

5.7. Appendix G - Change of Thesis Title Request

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

1. A copy of the approval of your initial ethics application.

Name of applicant: Sarah Clark

Programme of study: Doctorate in Clinical Psychology

Name of supervisor: Prof John Read

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: What is a 'trauma informed' service?	The new title better explains my research subject.
New Title: Mental Health Staff's Understandings of the Barriers and Facilitators to 'Trauma Informed Services'	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name): Sarah Clark

Date: 08/03/2021

TO BE COMPLETED BY REVIEWER		
Title changes approved		
Comments		

Reviewer: Glen Rooney

Date: 22/03/2021

5.9. Appendix H - Data Management Plan

UEL Data Management Plan: Full

For review and feedback please send to: researchdata@uel.ac.uk

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Sarah Clark
PI/Researcher ID (e.g. ORCiD)	U1826609
PI/Researcher email	U1826609@uel.ac.uk
Research Title	What is a 'trauma informed service'?
Project ID	N/A
Research Duration	14 months (February 2020- September 2021)
Research Description	The research will explore the views of professionals who are currently working to implement 'trauma-informed' approaches in their services. The research aims to understand how this can be pursued in different service contexts, the barriers in the way of 'trauma-informed services' and the factors that are helpful in their development. The research aims to develop a shared understanding of what can be done by professionals to take steps towards having more 'trauma-informed services' in the UK. This research also aims to take the first step in developing a 'snapshot' questionnaire which can be used to gather an idea of what barriers are particularly important to professionals in specific services

Funder	N/A – part of professional doctorate
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	04/02/2020
Date of last update (of DMP)	21/04/2020
Related Policies	UEL's Research Data Management Policy UEL's Data Backup policy
Does this research follow on from previous research? If so, provide details	N/A
Data Collection	
What data will you collect or create?	Summary: ➢ 20 interview audio recordings ➢ 20 interview transcripts ➢ 20 completed questionnaires ➢ 20 consent forms ➢ 20 participants contact details ➢ Minimum of 20 'summaries of experience in trauma informed services' collected prior to participant selection and interview Interviews Approximately 20 interviews with professionals who have an interest in 'trauma-informed' work in the UK will be completed. All interviews will be audio-recorded and transcribed by the researcher. Audio recordings will be held on the Dictaphone before they will be transferred to a password protected computer and held as an .mp3 file. Data will be anonymised at the point of transcription and saved as .doc files. Each participant will be given a participant number (in interview chronological order) and all identifiable information (e.g. names, names of services, locations) will be anonymised in transcripts. Questionnaires As a part of interviews, staff will be asked to share their opinions on how relevant an identified 'barrier' to trauma informed services is in their opinion by completing questionnaire. This will be completed by paper then scanned into PDF format.

	Pre-interview data (consent forms, contact details, summaries of experience) Personal data will be collected on consent forms (names). As the research makes use of purposive snowball sampling, some details about each professional who expresses an interest in the interview will be collected prior to the interview to assess their suitability for interview. This will comprise of their names, answers to a few questions about their professional experiences in 'trauma informed services', and contact details so that interviews can be arranged (email addresses and phone numbers). This information will be held in a .doc formatted document and saved on the UEL H: drive separate to the interview audio files, transcripts and data for analysis.
How will the data be collected or created?	Interviews will be recorded on a Dictaphone. Participants responses to questionnaires will be completed by paper. Audio files of interviews will be transcribed on a computer as a word document.
Documentation and Metadata	
What documentation and metadata will accompany the data?	➢ Participant information sheets ➢ Consent forms ➢ Debrief sheets ➢ 'Barriers rating scale' questionnaire
Ethics and Intellectual Property	
How will you manage any ethical issues?	➢ Written consent will be obtained for all participant interviews ➢ Participants will be advised to their right to withdraw from the research study without a reason until two weeks following the interview at which time data analysis will commence. This will be made clear on the information sheets and consent forms. If a participant decides to withdraw from the study they will be informed that their contribution and data (any corresponding audio recordings or transcripts) will be removed and confidentiality destroyed ➢ In the case of emotional distress during or following the interview, contact details for relevant support organisations will be made available. If participants appear distressed during the interview they will be offered a break or an option to end the interview. ➢ Transcription will be undertaken only by the researcher to protect confidentiality of participants.

How will you manage copyright and Intellectual Property Rights issues?	None
Storage and Backup	
How will the data be stored and backed up during the research?	Interviews- **stored** Audio files and transcriptions will be saved on the UEL OneDrive as .mp3 and .docx files within 24 hours of the interview taking place. The UEL OneDrive can only be accessed using the researcher's personal username and password. Audio files will be moved to the H: Drive once transcription has taken place to ensure separation of personal identifiable data from anonymised data. Audio files and transcripts will only be opened by the researcher when in private or in supervision with DOS. Each audio and transcription file will be named with the participant number (attributed in chronological order) and date of interview e.g. 'Interview recording Participant 1 on 2nd February'. Questionnaires- **stored** Questionnaires will be filled out by paper and identifiable information will not be written on the hard copies. Each questionnaire will be labelled with the participant number only. Once completed, questionnaires will be scanned in PDF format and handled in the same way as the interview data (above). Interview and Questionnaire- **backup** Interview and Questionnaire data will be backed-up on the researcher's password protected USB stick. The password protected USB stick will be held in the researcher's private locked file cabinet. Pre-interview data (consent forms, contact details, summaries of experience)- **stored** Consent forms will be scanned in PDF format and uploaded onto the UEL H: drive. Paper versions will be shredded after they have been uploaded. Contact details and summaries of participants experiences will be saved in a .doc file and saved in the UEL H: drive. This information is retained so that if a participant wishes to withdraw their data it is possible to identify them with their data and delete the correct information. Pre interview data- **backup** Pre-interview data will be backed-up on the UEL OneDrive and saved in a separate location to the pseudonymised data (the UEL H: drive). All pre-interview data will be retained until the

	research is completed and passed at which point this data will be deleted. Identifiable information linked to Participant Numbers A n encrypted .doc document that lists the contact details of participants with their 'Participant Numbers' will be saved in the UEL H: drive. This is a different location to where the pseudonymised data is saved (Interview recordings, transcripts and questionnaires saved to password protected USB stick and UEL OneDrive). [recommend audio recordings, once transcribed are stored on the H: Drive in a separate encrypted folder as this is more secure than USB stick]
How will you manage access and security?	The researcher will transcribe all interviews (removing identifiable information in the process) and only the researcher, supervisor and examiners will have access to the transcripts. Audio files once transcribed will be stored on the researcher's H: Drive. Questionnaire data and transcripts will be saved to the UEL OneDrive which can only be accessed using the researcher's personal username and password. Data will be labelled with the Participant Number and date of interview.
Data Sharing	
How will you share the data?	Excerpts from anonymised transcripts will be shared with the research supervisor via UEL email. File names will be participant numbers e.g. Interview Transcript Participant 1. Answers to the 'barriers' questionnaire will be shared in the same way as interview extracts, they will be anonymised and renamed under the participant information number e.g. Questionnaire Response Participant 1. Extracts of transcripts will be provided in the final research and any subsequent publications. Identifiable information will not be included in these extracts.
Are any restrictions on data sharing required?	Anonymised transcripts will not be deposited via the UEL repository as they will contain sensitive information.
Selection and Preservation	

Which data are of long-term value and should be retained, shared, and/or preserved?	Audio recordings and electronic copies of consent forms will be kept until the thesis has been examined and passed. They will then be erased from UEL servers (One Drive and H: Drive). Pseudonymised transcripts will be held on the researcher's encrypted storage devise for three years following the completion of the research. It will be held for three years which will give enough time in case the data may need to be re-analysed for publication in a peer reviewed journal.
What is the long-term preservation plan for the data?	As above.
Responsibilities and Resources	
Who will be responsible for data management?	Sarah Clark
What resources will you require to deliver your plan?	Personal password protected laptop Encrypted storage device (USB) Access to UEL storage Dictaphone
Review	
Date: 21/04/2020	Reviewer name: Penny Jackson

5.10. Appendix I- Interview Schedule

INTERVIEW SCHEDULE

Order of events:

1. Introduction to researcher
2. Introduction to research including confirming that they have read participant information sheet. If they have not we will go through this together. Answering any questions they may have about the study.
3. Signing of consent forms.
4. Introduction to the interview (see blurb below in *italics*).
5. Debrief and any further questions to be answered.

Interview

Verbal instruction: This interview will be semi-structured which means that while I have a list of questions that I would like to know the answer to it will feel more like an informal chat. Some questions that I ask might make it sound like I haven't been listening to you as you have already answered them, but I am just asking in case you have anything to add to what you have already said.

1. Can you tell me a little about your experience and how it might relate to this topic?
2. Can you tell me what you think a 'trauma informed' service would look like?
3. Why do you think this approach is helpful?
4. What is your motivation for developing your service in this direction?
5. To what extent is your service trauma informed?
6. Have you seen your service change its ways of working to utilize 'trauma informed' principles in the context of the Covid19 pandemic? If so how?
7. Do you think TI principles might be helpful in the current climate? How?
8. What barriers have you come across?
    a. Have you moved beyond them?
    b. What has helped you to move beyond or around them?
9. What helps sustain your motivation?
10. What advice would you have for someone who was starting the same journey to developing a 'trauma informed' service as you have taken?
11. What would you have done differently if you had the knowledge you have today?
12. Having knowledge of the subject are there any questions that you expected me to ask and I haven't asked yet?

Verbal instruction: I'm interested in the barriers that professionals, such as yourself, have encountered in developing 'trauma informed' services. Within the literature there are ideas of barriers as well as facilitators that may have helped in the development of these services. I believe that this is helpful information to consider for professionals who are working towards 'trauma informed' services. I also believe that it would be helpful for professionals to have a questionnaire that they can fill out to help them consider which barriers they may need to navigate on their journeys.

I am going to ask you to fill out a questionnaire. This questionnaire has two intended purposes:

1. *It will help us understand which barriers you have experienced in your own work.*
2. *It will give us an idea of which barriers you consider to be of most relevance to the development of trauma informed services (which may not include your own) more generally.*

5.11. Appendix J- Questionnaire

QUESTIONNAIRE

I'm interested in the barriers that professionals, such as yourself, have encountered in developing 'trauma informed' services. Within the literature there are ideas of barriers as well as facilitators that may have helped in the development of these services. I have listed some of these below. I hope to understand whether these are barriers you have encountered and how relevant you think they are to the development of 'trauma informed' services.

There are two parts to each question:

1. Is this a barrier that you have encountered in your work? (Yes/No)
2. How relevant is this as a barrier to the development of trauma informed services? (Relevance Likert scale)

Vicarious trauma

	Yes	No	Highly Irrelevant	Irrelevant	Neither relevant or irrelevant	Relevant	Highly Relevant
A fear of staff experiencing vicarious traumatisation	Y	N	1	2	3	4	5
A lack of resources available to deal with staff's vicarious traumatisation if it was experienced/identified	Y	N	1	2	3	4	5
Concerns about re-traumatising service-users by asking about trauma	Y	N	1	2	3	4	5

Introduction of a new initiative

	Yes	No	Highly Irrelevant	Irrelevant	Neither relevant or irrelevant	Relevant	Highly Relevant
Concerns about risks associated with new initiatives (risk averse)	Y	N	1	2	3	4	5

Continuous requests for change and upheaval making services wary of new initiatives	Y	N	1	2	3	4	5
Concerns regarding additional service expenditure making the prospect of systemic change untenable	Y	N	1	2	3	4	5
'Trauma informed' approaches to service delivery have not yet gained enough momentum/popularity so are not a priority	Y	N	1	2	3	4	5
Other initiatives/values to compete with or prioritise (e.g. the 6 C's of nursing care)	Y	N	1	2	3	4	5
Assumption that few service-users will have experienced trauma and so the initiative is largely irrelevant.	Y	N	1	2	3	4	5

Organisational culture

	Yes	No	Highly Irrelevant	Irrelevant	Neither relevant or irrelevant	Relevant	Highly Relevant
An organisational culture that conflicts with trauma-informed working methods	Y	N	1	2	3	4	5
Service feeling unable to provide changes required to be a trauma informed service	Y	N	1	2	3	4	5
A difficulty in ensuring that mental health staff have access to regular, structured supervision (an important tenant of trauma informed services).	Y	N	1	2	3	4	5
Systemic issues that prevent long-term systemic changes (e.g. low staff morale or high staff turnover)	Y	N	1	2	3	4	5

Service being risk averse which discourages staff to engage with service users as experts of experience	Y	N	1	2	3	4	5
Undervaluing the importance of involving service-users in service development	Y	N	1	2	3	4	5

Epistemological differences

	Yes	No	Highly Irrelevant	Irrelevant	Neither relevant or irrelevant	Relevant	Highly Relevant
A focus on a biological (rather than social) view of distress which downplays the significance of trauma.	Y	N	1	2	3	4	5
Reluctance to shift from biomedical causal models of understanding distress	Y	N	1	2	3	4	5
Strong representative of biomedical ideas at service-delivery levels of management (e.g. management teams made up of largely medical professionals)	Y	N	1	2	3	4	5
Fears of 'trauma informed' approaches being historically related to 'family blaming' ideas	Y	N	1	2	3	4	5

Leadership

	Yes	No	Highly Irrelevant	Irrelevant	Neither relevant or irrelevant	Relevant	Highly Relevant
Not enough professionals are informed about this approach and prepared to act as leaders in this way of working.	Y	N	1	2	3	4	5

Lack of managerial support for 'trauma informed' approaches	Y	N	1	2	3	4	5
Lack of understanding/education on 'trauma informed' methods	Y	N	1	2	3	4	5
Concerns about adding tasks for clinicians which will reduce time for clinical activities.	Y	N	1	2	3	4	5
Concerns that the perceived additional volume of paperwork would reduce time for clinical activities, developing relationships and interacting with service users	Y	N	1	2	3	4	5

5.12. Appendix K- Participant Information Sheet

PARTICIPANT INFORMATION SHEET

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

My name is Sarah Clark. I am a Trainee Clinical Psychologist in the School of Psychology at the University of East London, studying for a Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into the development of Trauma Informed Services. I am interested in understanding the experiences of people who have worked to make their services 'Trauma Informed' or used 'Trauma Informed' principles in their service development. I hope to understand what factors have facilitated changes in this direction as well as what kinds of factors have hindered development. I hope an understanding of the barriers and facilitators to 'trauma informed services' as well as an understanding of the rationale for working within this model, will be helpful in some way to professionals who wish to follow suit in developing a 'trauma informed' practice.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am looking to understand the perceptions of people who have had experiences in attempting to implement 'Trauma-Informed Principles' in services they have worked

in. I am aware that you have experience of working in this area and it seems that your experiences may be of assistance in answering my research questions:

- What is a 'trauma informed service'?
- What are the perceived barriers and facilitators to developing trauma informed services?

You have been invited to participate in my research as your professional experience is likely to provide an interesting insight into my research topic. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to take part in an interview which will take approximately 30-40 minutes either in person on University of East London premises, or by video call (using the TEAMS video call system). This interview will be semi-structured and audio recorded. This interview is not an examination of your expertise in any way and is likely to feel like an informal chat, there is no need to prepare for it.

You will also be asked, as a part of the interview to fill out and give your opinion on a scale that I am developing that rates the significance of a series of barriers (to trauma informed services) that have been identified from the literature.

I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of the research topic

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made within three weeks of the data being collected (after which withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Sarah Clark
Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology, University of East London, Water Lane, London E15 4LZ
Email: u1826609@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor

Dr John Read
School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: J.Read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

5.14. Appendix L- Consent Form

CONSENT TO PARTICIPATE
Trauma Informed Services: Why and How?

Please initial to indicate in the boxes where you consent:

I consent that….	**Initial**
I have the read the information sheet relating to the above research study and have been given a copy to keep.	
The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information.	
I understand what is being proposed and the procedures in which I will be involved have been explained to me.	
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to identifying data.	
It has been explained to me what will happen once the research study has been completed.	
I hereby freely and fully consent to participate in the study which has been fully explained to me.	
Having given this consent I understand that I have the right to request that my data is withdrawn from the study up to **three weeks after my interview date**. After this time point the data will be anonymised and my data cannot be separated and withdrawn.	
I understand that if I am free to withdraw my data from the study at any time by emailing Sarah Clark. I also understand that withdrawing from the study will not disadvantage me in any way and I am not obliged to give a reason for withdrawing.	

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS) …SARAH CLARK …… ……

Researcher's Signature

……

Date: ……..

5.16. Appendix M- Participant Debrief Letter

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on the Development of Trauma Informed Services. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided:

- Any personal information or contact details which you provide (e.g. on your consent form) will be stored electronically on a secure server which is password protected as well as an encrypted USB drive. This information will be connected with your interview so that it is possible to identify which interview is yours should you wish to withdraw your participation. You have been given three weeks following your interview date to contact the researcher if you wish to withdraw the data you have provided.
- Interview audio recordings will be transferred to the encrypted USB drive and secure server within a week of the interview taking place.
- Any personal information or information that can lead to identification of yourself or your service will be anonymised at the point of transcription. Following transcription the interview recording will be deleted.
    - The anonymisation of personal will involve the deletion or, where appropriate, replacement of details such as names, places and identifying characteristics of individuals or their services.
- Data that is not anonymised will only be seen by the research team (Sarah Clark and Dr John Read).

- Anonymised data will be seen by the research team, university examination team, may be used in the dissemination of the research and will be accessible through the university data repository.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways please let me know and I can provide you with the contact details of an organisation local to you that may support you.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Sarah Clark
Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology, University of East London, Water Lane, London E15 4LZ
Email: u1826609@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor:

Dr John Read,
School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: J.Read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

5.17. Appendix N- Reflexive journal extracts

Below are adapted excerpts from the journal I used to document significant reflections or feelings I had during the analysis and write up processes.

Following an interview

I have now completed 10 of my interviews. The interview I have just completed was probably the most challenging so far. The participant raised several points regarding the subject area which were extremely important and interesting. The participant shared their views about trauma-informed ideas being helpful to services, however that a drawback to them is their 'psychology bias'. There are many recommendations within the trauma-informed service literature about the ways in which a service can be trauma-informed: by acknowledging trauma, supporting staff to think about the impact of trauma on them, preventing re-traumatisation. However, this participant raised the point that many of these recommendations and papers are written by Clinical Psychologists and assume that all professions hold the same values when working with trauma. In particular, the participant spoke about 'supervision' and said that it would not be possible, realistically, for supervision to be provided to all staff. There is not space or provision for supervision in many services. By saying that this is a basic requirement for a trauma-informed service we are excluding services or professions that will never provide supervision. They spoke in particular about nursing and about how, for nurses, the space would be better used as a quiet hour for 'self-care and reflection' by themselves rather than structured supervision. Structured supervision would possibly likely feel more like a task or assessment as nursing careers can be so hierarchical and competitive. This would not be the supportive time that many papers assume that it would be. I admit that I had also made these same assumptions. As a trainee clinical psychologist I highly value supervision and have been lucky to have experienced many supportive and reflective supervisors. This is not mirrored across professions so I can now see the limitations of this perspective. I am left wondering what other limitations of trauma-informed services I may have missed or under-appreciated and whether I should have also explored this explicitly and in detail with participants. A large proportion of my participants are psychologists

so my data is likely to be biased by that. I feel very glad to have had this alternative view shared with me and my biases challenged.

Following the inter-rater reliability check

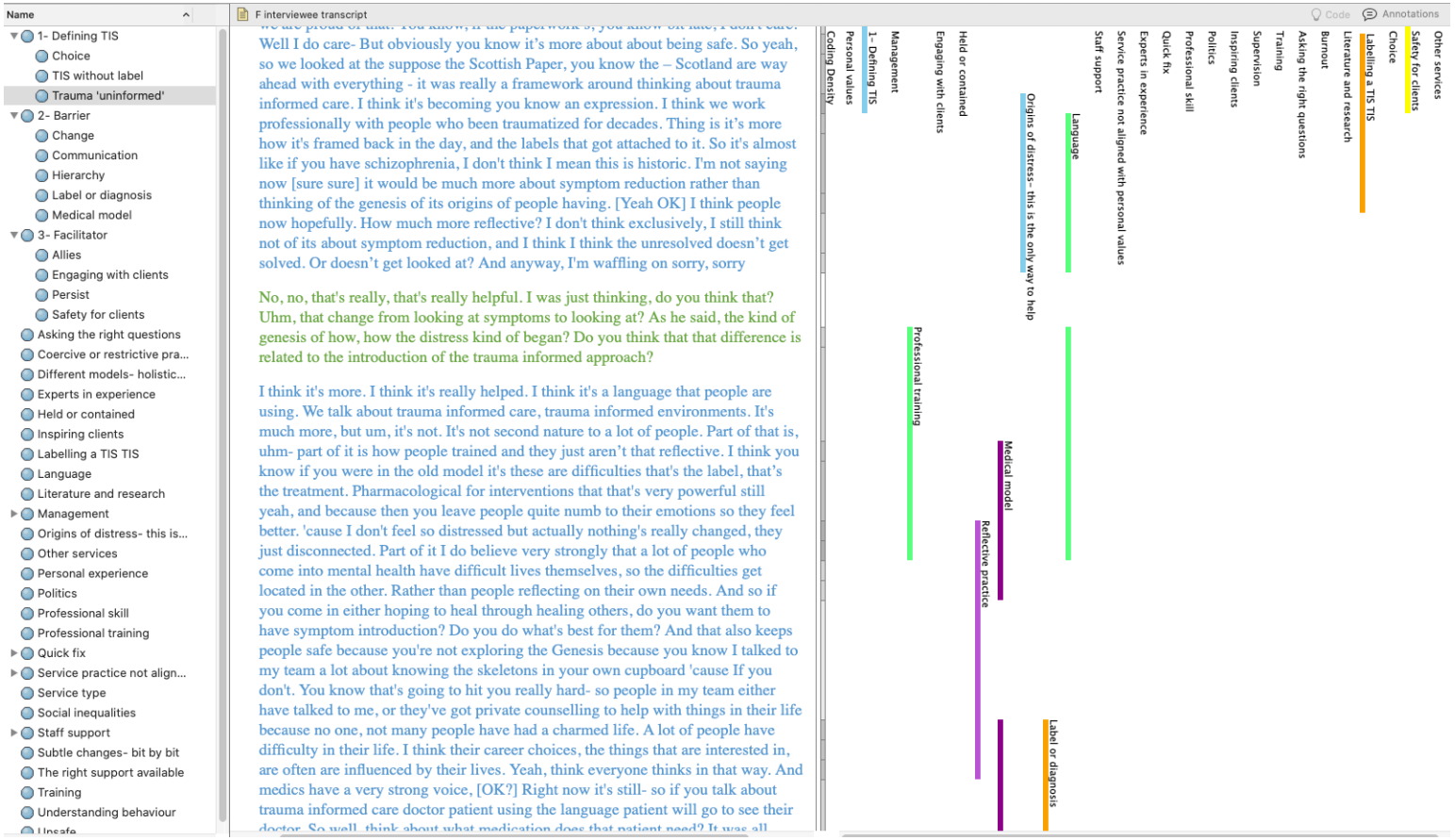
Prior to this meeting I felt certain about the themes that I had produced and described. However, I now doubt several of them- not only those which my supervisor and I disagreed over. I have read the criticisms of inter-rater reliability from Braun and Clarke (2020) and have been considering how this relates to the inter-rater reliability check that I have now completed. My rationale for completing a check is that it is a way of practicing an 'extra layer' of reflexivity, of pushing myself to examine my biases. However, of course, from a critical realist perspective I am aware that my biases are important and cannot be removed. However, I still hope that the readers of my report will be in agreement as to my theme selection and description. I believe that this meeting has allowed me to 'make conscious' and examine several biases I have about the subject area. In particular:

- *The medical model: Previously I was only using quotes which directly said 'medical model' for this category. I spoke about this with my supervisor and he asked why I had not included references to 'diagnosis', 'recovery' or 'medication'. I initially felt surprised at myself for not including these references as they are quite clearly representative of medicalising language. However, on reflection I wondered whether I was finding it difficult to imagine a service that truly did not use any of this language. The closest experience that I have had to such a service is in my current placement, a service which sees young people who have experienced sexual assault/abuse. However, in this service the trauma experience is at the forefront of all thinking and distress is clearly linked to trauma. It is difficult to imagine the removal of all references to the medical model in a service where the trauma experience is not as clear or is historical, such as in the IAPT service I worked at. I acknowledge that my lack of experience within generic mental health services has made it difficult for me to imagine a service that is truly trauma-informed and does not use*

references to the medical model. I will need to re-examine my quotes and transcripts to consider whether participants have been speaking about the medical model and I have not noticed this.

- *The 'advice' from participants- it felt hugely important to me that the advice from participants was shared in a way that is helpful to others wishing to make trauma-informed changes. From the beginning of the project I was envisioning this being a separate advice sheet which could be distributed through networks. My focus on this advice sheet being separate has stopped me from appreciating that the advice participants shared in interviews does actually constitute a separate theme. I will consider how this advice can be captured in my themes as well as in a separate document for dissemination.*

5.18. Appendix O- NVivo Coded transcript segment

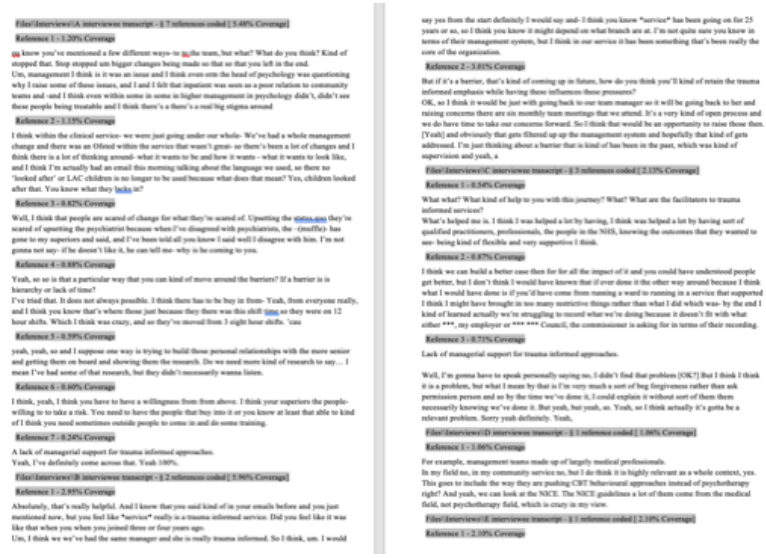


5.19. Appendix P- NVivo Codes and Nodes

Following initial code generation (Appendix N), transcripts were re-read and codes were re-considered. Several codes overlapped in their content and were merged (e.g. ‘Origins of Distress’ and ‘Understanding Trauma’). Care was taken to ensure that important information represented by codes was not lost by re-reading transcripts and quotes in context. After this first review, quote segments for each code were printed and allocated a colour code. Figure P1 shows a selection of quote segments to be printed:

Figure P1

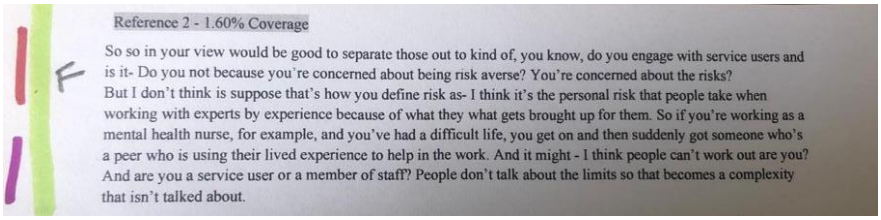
Example of quote segments under one code



Quote segments were then reviewed independently of their initial codes and re-coded with additional codes that it was felt they may correspond to. Figure P2 shows a quote segment with its initial colour code in green and additional colour codes tagged in red and purple.

Figure P2

Example of quote that has been re-assessed for codes of relevance

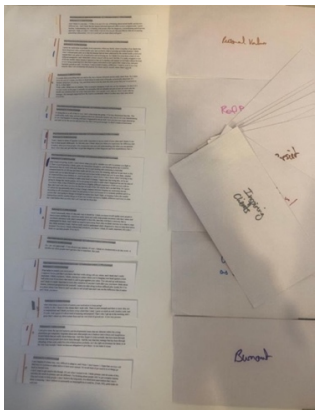

Reference 2 - 1.60% Coverage

So so in your view would be good to separate those out to kind of, you know, do you engage with service users and is it- Do you not because you're concerned about being risk averse? You're concerned about the risks? But I don't think is suppose that's how you define risk as- I think it's the personal risk that people take when working with experts by experience because of what they what gets brought up for them. So if you're working as a mental health nurse, for example, and you've had a difficult life, you get on and then suddenly got someone who's a peer who is using their lived experience to help in the work. And it might - I think people can't work out are you? And are you a service user or a member of staff? People don't talk about the limits so that becomes a complexity that isn't talked about.

This process highlighted the codes for which shared several quotes were shared (as colours were often seen together). Quotes were re-sorted (into envelopes of code selections) and read under their varying code categories. A photo of the re-sorting process is presented in Figure P3

Figure P3

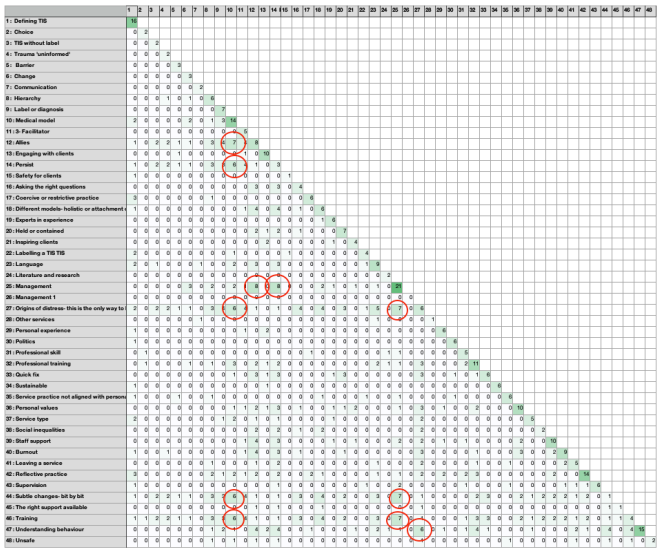
Re-sorting quotes and codes



This process of identifying overlapping quotes was also completed using Nvivo 'Node Matrix'. This produced a report in which codes with a high number of overlap were highlighted. This can be seen below in Figure P4 with 'high overlap' codes circled in red.

Figure P4

Nvivo 'Node Matrix'



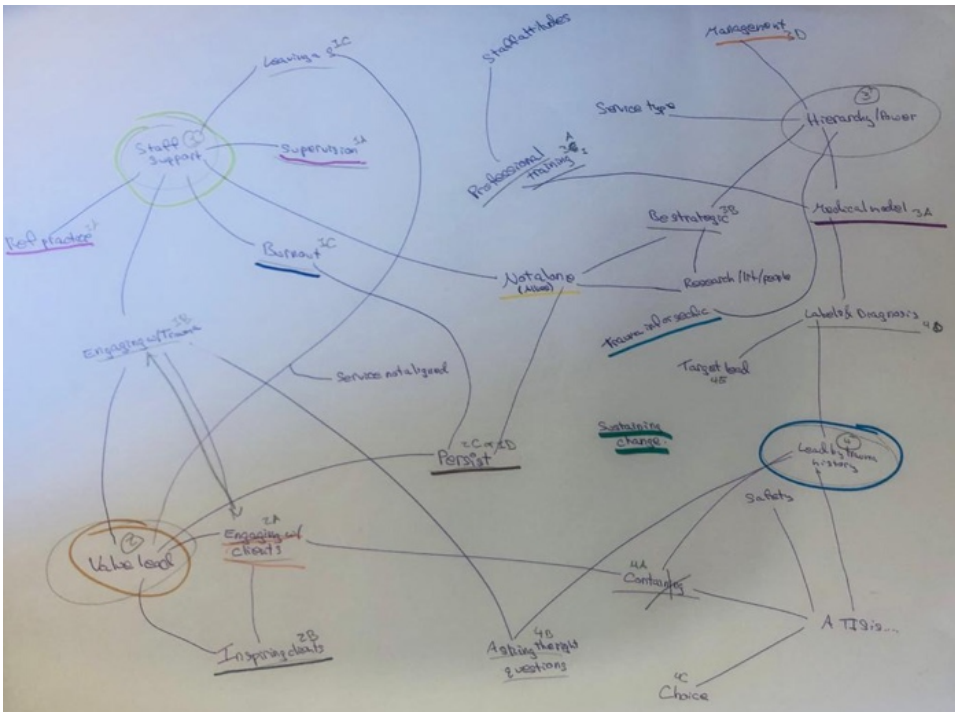
Once overlaps were noted, quotes were scrutinised for meanings that may have originally been missed. While this process highlighted codes that had a high number of overlapping quotes, a large overlap was not necessarily deemed a rationale for cutting or merging themes. The focus in this exercise was in ensuring that codes accurately represented what participants had said and that each code represented something unique. After this, quotes were considered as a group within each code and initial descriptions of each code were formed.

5.20. Appendix Q- Candidate thematic maps

Following initial descriptions of themes being created, several different candidate thematic maps were created. This process allowed me to consider how initial themes interconnected and what this may represent about them and the data.

Figure Q1

Example of candidate thematic map



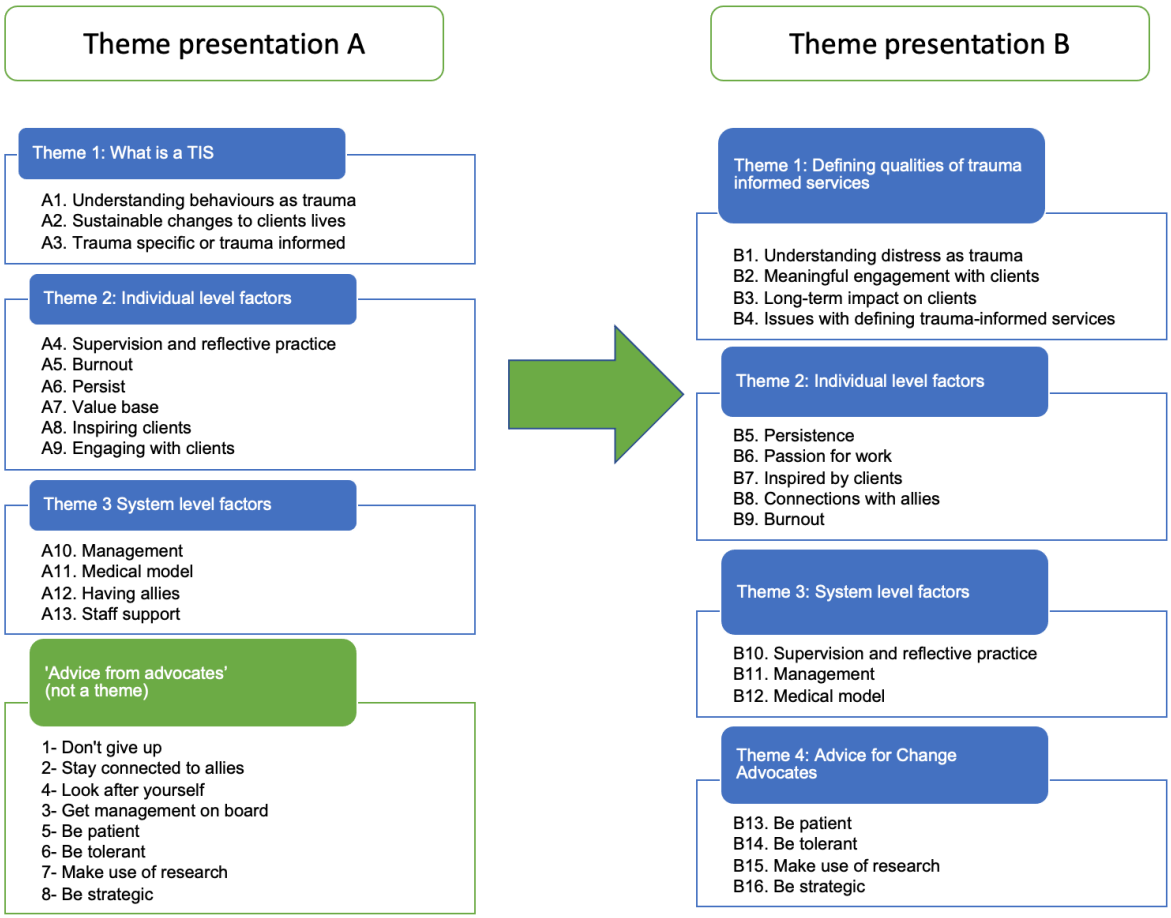
From this exercise I was able to see how sub-themes connected and could be grouped under different theme categories.

5.21. Appendix R- Theme construction process

'Theme presentation A' (which can be seen below in Figure R1) was used for the inter-rater reliability check described in the Methods Chapter. Following the check, in consideration of the raters disagreements, several changes and additions were made which resulted in the final map, *'Theme presentation B'*.

Figure R1

Changes made to thematic map following inter-rater reliability check and review meeting



As a result of disagreements highlighted in the inter-rater reliability meeting, the following changes were made:

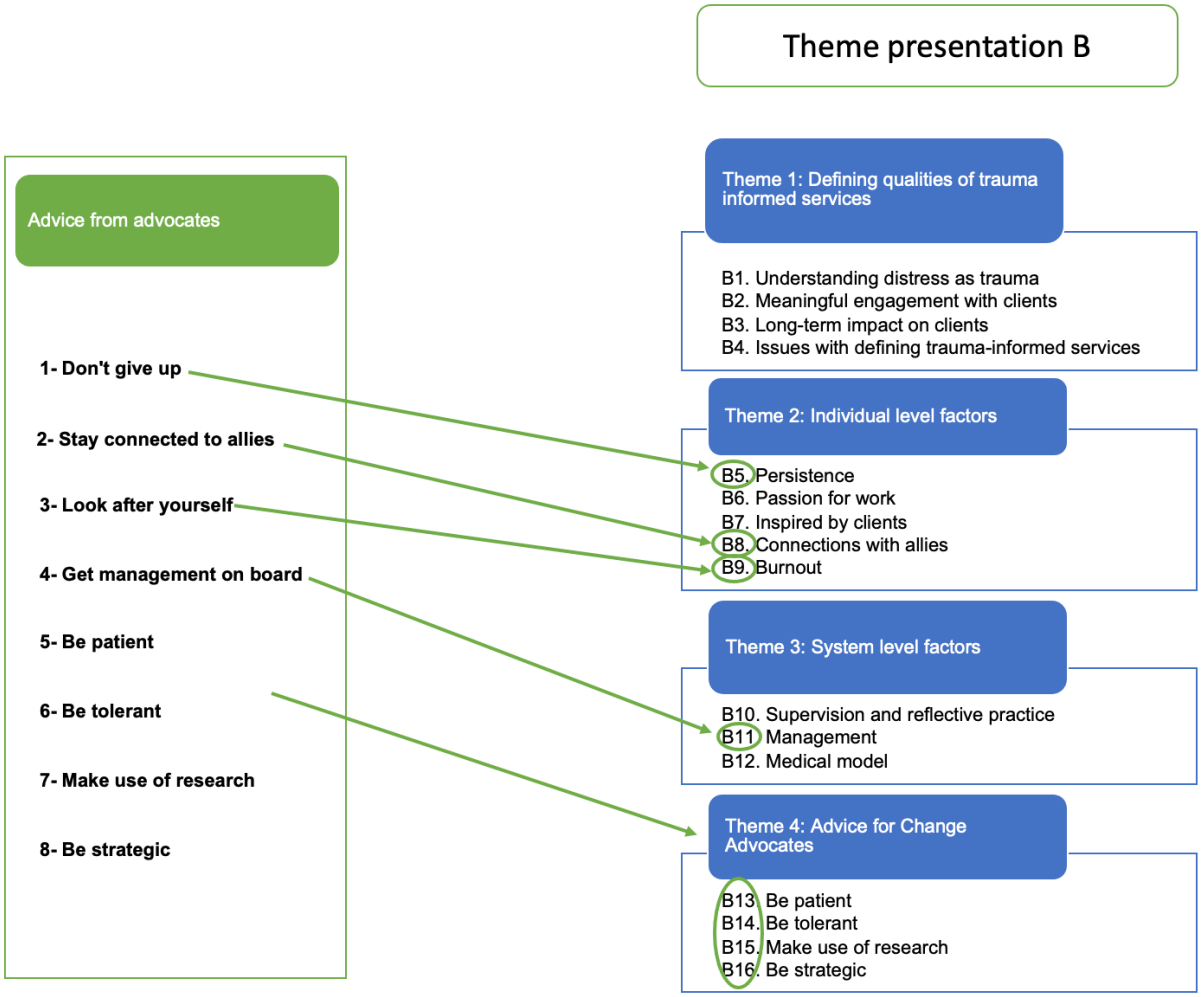
- Disagreement with regards to the code '*Value base'* (A7) and its definition. Re-defined this code as '*Passion for work'* (B6).

- Disagreement in codes '*Staff support'* (A13) and '*Supervision and Reflective Practice*' (A4) lead to inter-rater coding errors. In reviewing the quotes for each code it was noted that these could be merged into *'Supervision and Reflective Practice*' (B10)
- Disagreement with regards to the code '*Trauma Specific or Trauma-informed*'. Redefined this code as '*Issues with defining TIS*' (B4).

Prior to the inter-coder reliability meeting, a separate document '*Advice from advocates'* had been created. This was a collection of quotes which culminated in a list of 8 pieces of 'advice' from participants. It was decided that these collections of quotes were important information that constituted sub-themes in themselves. Four of these pieces of 'advice' were already described by sub-themes, however the other four constituted new sub-themes under '*Advice for Change Advocates'* (Theme four). Figure R2 below shows how the 'advice' is now represented in the final thematic presentation.

Figure R2

Construction of theme 'Advice for Change Advocates' (subtheme sixteen)


Theme presentation B
Advice from advocates
1- Don't give up
2- Stay connected to allies
3- Look after yourself
4- Get management on board
5- Be patient
6- Be tolerant
7- Make use of research
8- Be strategic
Theme 1: Defining qualities of trauma informed services
B1. Understanding distress as trauma
B2. Meaningful engagement with clients
B3. Long-term impact on clients
B4. Issues with defining trauma-informed services
Theme 2: Individual level factors
B5. Persistence
B6. Passion for work
B7. Inspired by clients
B8. Connections with allies
B9. Burnout
Theme 3: System level factors
B10. Supervision and reflective practice
B11 Management
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Theme 4: Advice for Change Advocates
B13. Be patient
B14. Be tolerant
B15. Make use of research
B16. Be strategic

5.22. Appendix S- Full quote per theme

5.23. Theme 1: Defining qualities of trauma-informed services

5.23.1. Subtheme 1: Understanding distress as Trauma

Interview	Subtheme 1: Understanding distress as trauma
F	*"…and that was felt to be really important that lens that we look at people through this thinking, you know the old expression; What happened to you not what's wrong with you?"*
A	*"They were saying well no one's ever asked me that, you know, kind of fundamental things about their lives which would help you understand their behaviour or why they might be at that point in life. And you know, I think that really struck me. But I would consider this kind of basic assessment questions not being asked- what's happened to you?"*
J	*"And I think that the trauma-informed approach offers a more compassionate, I guess healing, understanding way of dealing with people, than the diagnosis, overmedicating, pathologizing approach."*
I	*"I think CAMHS traditionally can be, (…) quite CBT orientated and the kind of CBT models that people might be using don't always seem to formulate trauma as a causal role in peoples presentations. So I think sometimes peoples presentations can look unusual if you don't consider you know, trauma and the effects and kind of neurological and cognitive development, intergenerational trauma."*

Interview	Subtheme 1: Understanding distress as trauma
E	*"…a lot of the diagnosis seemed to miss, at least in my experience, the trauma- or not really help the staff be 'trauma-informed' as we'd now call it, in their ways of understanding- and reduced it to quite a behavioural or kind of genetic understandings of difficulties."*
H	*"...and they forget it's kids normally that have been through traumas that most people have never been through. And the way that they manage that has been through offending. For a lot of them prison probably isn't the right environment for them, so at the very least morally I think we have an obligation to give them - to not make it worse."**
F	*"I think we've worked professionally with people who been traumatized for decades. Thing is- it's more how it's framed back in the day, and the labels that got attached to it. So it's almost like if you have schizophrenia- I mean this is historic, I'm not saying now [sure sure]- it would be much more about symptom reduction rather than thinking of the genesis of its origins of people having- I think people now are hopefully much more reflective? I don't think exclusively, I still think not of its about symptom reduction, and I think I think the unresolved doesn't get solved. Or doesn't get looked at? "*
K	*"So it would be about the receptionist at the- the person who's meeting and greeting, and the nurses - the way that someone's difficulties are understood. So if somebody is withdrawn or they're stroppy that's understood in the context of- not their diagnosis of PD- but that actually that person experienced this and that"*

Interview	Subtheme 1: Understanding distress as trauma
L	*"Well, right from the start- everything about it - everything from the moment the client walks in the door, there's a recognition - a compassionate recognition of intergenerational adversity and the effect that had on emotion regulation. So there's an acceptance that this brain that's just walked in the door - because of the experience of trauma(…) I can see the pattern of what's going to happen – I hold compassionate awareness."*
K	*"I was in a meeting with carers and the carers asked the psychiatrist 'why has this happened?' And she said 'dunno bad luck really' and I just [exasperated laugh and gesture]- what sort of answer is that?"* [in reference to first episode psychosis where trauma history is unacknowledged]
I	*"I think you will come up against a lot of people saying 'Yeah, but you're kind of saying that all young people who come into the service have trauma, which also is not true. No, we're not saying that all young people with mental health problems are traumatized, but ignoring the role of trauma in mental health is a bit like ignoring the role of smoking in lung cancer, we've got this huge this huge percentage and maybe not all people who develop lung cancer were smokers, but a lot of them are- you know not all young people who develop severe mental health problems have experienced trauma. But the vast majority of them have."*

Interview	Subtheme 1: Understanding distress as trauma
B	*“When I worked in the secure hospital, the idea that I would even try and suggest to a nurse that someone might be responding with the self-harm because of the traumatic history they have and something had just happened within their relationship- it was madness. It was ‘no they’re mad’ rather than hang on lets slow down- think about why they might be distressed. No responsibility for their own actions in it. No understanding of the development of the mental health difficulties.”*
A	*"They were saying well no one’s ever asked me that, you know, kind of fundamental things about their lives which would help you understand their behaviour or why they might be at that point in life. And you know, I think that really struck me. But I would consider this kind of basic assessment questions not being asked- what’s happened to you?"*

5.23.2. **Subtheme 2: Meaningful engagement with clients**

Interview	Subtheme 2: Meaningful engagement
C	*"…just listen to every single person who's in your service about what they need from it, why they're there, understand the behaviour and just hear people and involve them in the work you're doing with them"*
O	*"If we can involve these people in their own care and give them some kind of empowerment over that, I don't know it just makes so much sense to make them feel that their own stories aren't being lost amongst a system of just psychiatric labels"*
N	*"I became Manager and I thought right, you know I'm going to offer a differential service. I'm going to work very closely with the family, in a way that service users can relate to me- connect with me, trust me, open up about what they've been through and how their life has been."*
B	*"The building of the relationship which we would consider core. And perhaps the models being more secondary to that would be awareness of our own selves in particular, and how we manage kind of power dynamics in that relationship with the client."*

Interview	Subtheme 2: Meaningful engagement
K	*"Sometimes you think- gosh, if I if I had gone through that if I was telling my story and somebody was telling me that that's not true, I've made it up. It would make me go a bit mad. It would and I kind of think our system does that all the time. Yeah it invalidates. It says that's not relevant. Your ill- we're going to explain it like this."*
K	*"Actually, that's one of the things that I think a trauma-informed organization would be much more compassionate because there will be a sense of I understand why and I think when you come from that place of understanding and not judgment that's massive in terms of how you are able to offer some patient validation."*
O	*"I guess in our environment- yes ok, so we've got some nice plants in the ward and some nice cushions, but it's more, it needs to be deeper than that otherwise it's- well it's meaningless isn't it, it needs to be in how we relate to the clients that we work with and how we talk to them."*
A	*"And if we really listen and really help people reconnect with their values and you know reconnect with what's meaningful in their life, then they will have a recovery that is meaningful for them."*
F	*"It's really not about reducing symptoms, it's about helping them to be masters in their own world so we don't take things away from them, sit with them and help them with it? We can bear witness to it, we help them to help them."*

Interview	Subtheme 2: Meaningful engagement
H	*"To get in touch with the vulnerability that makes it- rather than it just being this kind of theoretical story of abuse trauma, neglect on paper- but actually now that you understand the effect it had on someone"*
E	*"It's really painful. It's a lot easier to not to know the trauma and just see that it's someone not engaging or that it's someone that just is - Just got mental health difficulties or whatever. It's hard to see that all of us, every human being is a part of all the experiences we've had. And when you actually sit down and read like can try and piece together and create a kind of formulation of why someone might be doing something, that's maybe quite difficult."*
E	*"I'm trying hard to be- 'cause it is hard [Yeah?]. It's painful to be trauma-informed! And I think that's the biggest takeaway I have."*
D	*"One is courage. I think it is another obstacle for trauma-informed services and it takes a lot of courage right? To deal with the trauma- it is not a simple process. And I do believe that a lot of the professionals and I'm not talking about only therapists here because I work with a lot of fields. Yeah, I do think a lot of the times we have our own triggers that are unresolved. So there are many things that it requires when comes to trauma-informed."*

Interview	Subtheme 2: Meaningful engagement
L	*"they will be much more able to reflect on this kind of stuff and hold the emotional pain of it because you have to get to the point- where you can - where you're working with trauma, you have to get to the point where you can hold mindfully the pain and trauma of that person without taking it into yourself. So you have to be very able to integrate yourself and but still at the same point, hold there, hold compassionately their pain."*

5.23.3. **Subtheme 3: Long-term impact on clients**

Interview	Subtheme 3: Long term impact on clients
J	*“By having access to a system of trauma-informed care, this is kind of more anecdotal (…) in some cases might help prevent people from maybe turning into a lifetime user mental health services because the interventions that are being offered, maybe are not appropriate to their needs”*
F	*"We help them in way that’s sustainable and doesn’t impact on their physical health, now I think that’s different , I do think that’s different to other services. We’re not into quick symptom reduction and move people on."*
C	*“I think it moves- I think people progress more quickly (…) it’s fairly demonstrable that if you take a trauma-informed approach across a community as far as you can, you actually get people healthy more quickly, they rely on services less. And they recover needing services less often in the future. And if you get it right, you can also teach people how to steer clear of services and not create a backlog.”*
A	*"You know, having years of therapy is, -the cost benefit is worthwhile, you know, I think given full-time rather this sort of rotating door to inpatient costs- I dread to think how much it costs, rather than actually giving them the help that’s required."*

Interview	Subtheme 3: Long term impact on clients
F	*"We don't have enough resources, so we do the best we can and the expectation is that people aren't staying with us for long periods of time. You have to recover and go. Yeah, you know if people have had the same difficulties- isn't just a quick fix it and move on. You know people need sustained support over a longer period of time, so part of it is how it's commissioned for people should work with a service that can actually work with people at their pace, not at our pace. That's not available at the moment."*
I	but it kind of seems to be at least historically has been in mental health- and just that it seems to work you know when I worked in the in the CMHT I mean it was still very, you know, it was still, um, long-term work, but at least it felt like maybe the work was targeting what needed to be worked on as opposed to be masking it with, you know anti psychotic medication or [yeah] so yeah, just all of those things really, I think they probably all fed into my interest in this work.
O	*"If it's an approach that can help people get moved on from hospital faster, if it's a tool that can be used to help people stay out of hospital, ideally full stop, but even if it's for people to stay out of hospital for longer, broadly, the economic associations of that- make total sense."*
P	*I just think that it could save itself so much money if they just they could revolutionize mental health if they would just admit that things aren't trauma-informed.*

Interview	Subtheme 3: Long term impact on clients
K	*“Whereas actually if somebody is constantly not got their needs met, constantly being judged and invalidated they will keep coming back. So for financial sense - we’re not meeting peoples needs properly but also in terms of that common humanity.”*

5.23.4. **Subtheme 4: Issues with defining trauma-informed services**

Interview	Subtheme 4: Issues with defining trauma-informed services
I	*"I think one of the main barriers that we came across, especially um, initially was that there isn't kind of a clear model of trauma-informed care that you can propose your service. You almost have to kind of build it from the ground up, which I suppose is you know is good in the sense that means you can make it really bespoke version of trauma-informed care that might suit your service's individual circumstances, but it does also mean that it feels like to implement a system of trauma-informed care needs a lot of work, and maybe in in the vast majority of services where that's not maybe in part of your job plan, so I guess it feels like you know it takes a lot of very motivated staff, who are willing to go above and beyond their kind of contracted roles to do."*
E	*"Every service has been working out how to be more aware of peoples trauma, including sometimes not calling it trauma. Because people don't always like 'trauma-informed' as a phrase"**
A	*"'cause that's what I keep pushing up to my seniors. We talk about trauma-informed- but what does that mean? What does it look like? You know, we can all talk about it? Or was it look like day to day?"*
C	*"…where as trauma informed fields are very medical model I think people's minds eye. You know people who don't know anything about it. I think we're here and all 'trauma informed' but what does that mean? "*

Interview	Subtheme 4: Issues with defining trauma-informed services
C	*"I really think we need to to create a accreditation of trauma informed practice, whether it's more about, I don't know whether it needs to go more in the direction of an accreditation in engaging lived experience or trauma informed, I think engaging lived experience makes it more accessible to non clinical settings because you can think more about you, know how it works."*
K	*"there's a lot of misconceptions about what it actually means, and it feels that we've got to get round that hurdle first. But it doesn't mean that you've got to do lots of trauma work. It means you've just got to hold it in mind and be receptive and open, and be thoughtful."*
H	*"Sometimes the message that I would get back when I try to introduce trauma informed thinking into the supervision space was, well, that's not our job. We're not mental health trained. I'm not, you know, I'm not able to talk to someone about their trauma, and so there was this equation of trauma informed care equals trauma treatment"*
I	*"I think you will come up against a lot of people saying 'Yeah, but you're kind of saying that all young people who come into the service have trauma, which also is not true. No, we're not saying that all young people with mental health problems are traumatized, but ignoring the role of trauma in mental health is a bit like ignoring the role of smoking in lung cancer, we've got this huge this huge percentage and maybe not all people who develop lung cancer were smokers, but a lot of them are- you know not all young people who develop severe mental health problems have experienced trauma. But the vast majority of them have."*

Interview	Subtheme 4: Issues with defining trauma-informed services
J	*"She felt that it was going to mean that everybody would or would start to identify trauma in their patients and refer them to psychologists to deal with the trauma and it would in a way - its like replacing the medical model with just another label. I was always quite frustrated with that because I felt it was a misrepresentation of what the trauma informed approach is about. And actually, it wasn't necessarily about- let's just refer everybody to psychology to fix it. It was much more about. Having having a shared understanding more widely in the team of what peoples difficulties you may have stemmed from to improve generally people you know peoples understanding and compassion, not not that, lets just refer to psychology to fix it. "*
I	*"A reality that needs to be accepted as people have a perception that if they you know in quotes, open up the trauma that- this feeling that- trauma informed care means kind of jumping into doing trauma based work with everyone."*

5.24. Theme 2: Individual level factors

5.24.1. Subtheme 5: Persistence

Interview	Subtheme 5: Persistence
L	*“Persistence – dogged persistence.”*
K	*“You need to be really resilient and you’re not going to have success every time, but you just keep trying. So I think it is that persistence that it is worth it.”*
J	*“To be persistent.”*
D	*"One is courage. Yes, I think this is another obstacle for trauma informed services- it takes a lot of courage."**
D	*"I think I would say don’t look to the side, just keep doing what you believe. When I say don’t look to the side I mean don’t let all against you, you know against it against the context, the managers who says no or the people who don’t get excited. If you believe in it, just keep going and find the people who believe in it also, to grow in strength and support each other because it is a very challenging journey. You know and you face all sorts of things. So I would definitely say- if that is what makes your heart beat and deep in yourself it makes sense- do not give up. Just keep it going."*

Interview	Subtheme 5: Persistence
I	*"First thing I would say is to find like-minded colleagues because I think just having conversations with some of my colleagues who are similarly minded certainly helped me to persevere."*
K	*"I would say that I definitely think there's something about keep going. Just, you know, be brazen, be able to take knockbacks 'cause you will get knock backs and and sometimes it can be quite emotionally wounding too- knockbacks."*
A	*"What advice would you have for someone who is taking the same path as you to developing a service to be trauma informed or pushing their service in that direction?" "Don't give up."*
J	*“I think it just helps to be really a bit a bit stubborn. A bit - a dog with a bone and just be very opportunistic so it’s kind of not necessarily fighting a battle, but it’s a bit- sometimes it is about little battles, but it’s also about you being clever, I suppose with- push where it moves- take your opportunities where you can to be savvy with what’s changeable.”*
L	*"I used to give talks regularly with GPs about all this stuff and I didn’t ever get a good reception, but now people are really interested in it, so you know, I just think it’s been a process over time, it seems to have taken an extraordinary length of time"*

Interview	Subtheme 5: Persistence
L	*"A *service* last year- I went and talked to them about running a piece of work with (...) their lids went up so high just having the conversation about it they actually reported me to their local medical committee and I had to go through a full investigation."*
G	*"...unfortunately it had to get a little bit tricky and I had to say look, I'm speaking to the Union. I'm not progressing with my research, but it's not really about my research, this is about changing the service. That's my main goal at the research has been a tool that I've been able to use to change it so it did get a little bit tricky. "*

5.24.2. **Subtheme 6: Passion for work**

Interview	Subtheme 6: Passion for work
A	*“it was so far against my values that I had to leave. I think just the amount of restraint and medication, the way I felt people were treated...”*
D	*“I would not spend my energy as a professional in a service I didn’t believe in- so I came out- to do the things I’m interested in. So I started to study more about ACES and understanding- then I came back and they left again recently for the same reason because I felt that we were not going anywhere.”*
E	*“I would refuse to work anywhere like that again.”*
G	*"Uh, not doing it- it would just be. I just possibly have to leave the job if they started old way of working- it is just too challenging. It’s just too unethical for me."*
K	*"Sometimes you know earlier on I I did question it thinking is this the environment for me- is this? Can I carry on? And I do have days where I think can I do this? This is so awful. I can’t bear it. It’s awful isn’t it but sometimes I just really can’t bear it. And the idea that you have to be in the system to change it and and that being I have to remind myself of that sometimes because you feel as though you- because you’re in it you will somehow be complicit in it. And all the toxicity and awfulness of it, and try and bear that is difficult sometimes."*

Interview	Subtheme 6: Passion for work
D	*"I'm totally, totally passionate about that, and that is why I left my job* [in trauma un-informed service]*, to do more of the work I believe in"*
E	*"it's just a real– I was about to say interest, it's not - I think it's fundamental to do this work - it terrifies me when people don't get how this is important."*
B	*"I've really struggled to sort of fit into models where trauma is ignored (…) I want to make a difference. I want to work in in a way whereby there's lot of meaning and purpose for clients and for myself, where there's growth."*
H	*"So there's something that feels wrong- I think morally about the way some of the- narratives around some of the clients (…) for a lot of them *** probably isn't the right environment for them, so at the very least morally I think we have an obligation to give them- to not make it worse."*
F	*"but you hear about people getting on with their lives and saying that was a moment in my life that made a difference. To be part of that- it's a privilege. I feel quite humbled by it 'cause it is- people tell you things that never told anyone else - how privileged is that, they've trusted you with such sensitive information. I still feel quite moved by that."*

Interview	Subtheme 6: Passion for work
K	*"So I think there's also personal reasons as well in terms of. Um? I guess it's hard to- Yeah, I think in terms of equality is just really important to me as a kind of core value and I think it's not fair to treat people differently. So, but also just- I think when you when you experience the difference that it makes when you treat people with compassion and care and understanding "*
B	*I guess my motivation is probably lived experience within my family where a member of my family has been diagnosed with a mental health issue and you know, kind of growing up in that situation. I think what I realized quite early on is that the traumas had not been addressed by the mental health system and instead there was quite a lot of medication and sectioning etc. So I think I've come from a kind of very different perspective. and I think that's always stayed with me and I feel like I've really struggled to sort of fit into models where trauma is ignored or that we're dealing with aspects of it [Yeah] without the kind of core being treated and how that kind of gets overlooked so and I guess that's kind of my own post traumatic growth as well. You know, I want to kind of make a difference. I want to work in in a way whereby there's lot of meaning and purpose for clients and for myself, where there's growth.*
F	*"I've always cared about what I do. I* really *care about the work I do, I have forever. I get a lot- I takes a lot out of me."*

5.24.3. **Subtheme 7: Inspired by clients**

Interview	Subtheme 7: Inspired by clients
F	*"Earlier on today, we had the post delivered by somebody who used to be in this service who's now getting on with her life. And you think, that's why I do this- this person, she had a lot going on with her then she was there quite proudly handing the post and I recognized her and thought 'God, it's you', and she was smiling."*
L	*"I get a lot of pleasure out of seeing a young person gradually- and it takes a long time- moving from being stuck at home, not able to get out or do anything to starting to integrate into society. And I mean obviously it takes a long time but - you form relationships with those young people that are really rather lovely."*
B	*" I think it's the clients that I work with. There is such strength and they are so inspirational and I think every client that I meet- I grow so much as well, [really] yeah, and it's just, I guess it's about kind of meaning and purpose? That's why I get up in the morning, and I guess that's where my drive comes from and my own kind of growth too."*
C	*"Connecting with people is what keeps you going- and just I learn all the time. I learn more from mental health by letting people talk about their mental health than I could from any brilliant conference"*

F	*"...way back when I was a general nurse, so before was mental health nurse I was a general nurse. And on the ward I remember people who had significant surgery and their distress at changing their bodies that wasn't really talked about. I remember it vividly with people who had a radical mastectomy and I went in to help her wash and she said don't look at my body. Don't look at my body - so upset and you know that was never - I never talked to her about- I tried, I was 19- I didn't know what to say. And so I've been very quickly become a mental health nurse. I thought- that makes sense to me"*
D	*"So is it comes from my passion from the resources that human beings have in themselves, it comes from my respect that people should know about this because then they can make their own decisions"*
H	*"So I think some of its relationships with the clients and then little things like I came back from leave today to find one of them has written me a letter. Just saying, even though he's basically *moving*... how much he's appreciated my relationship with him. Those moments that remind you why you do what you do."*

5.24.4. **Subtheme 8: Connections with allies**

Interview	Subtheme 8: Connections with allies
A	*“I think you need to take care of yourself as well, and find some allies.”*
I	*"First thing I would say is to find like-minded colleagues because I think just having conversations with some of my colleagues who are similarly minded certainly helped me to persevere."*
P	*Yeah, finding a few allies. Find a focus and someone to talk to about it. Because sometimes you just need someone to just yell and scream about it to. To keep you motivated.*
E	*"Having a team around me that want to do and try to do the same thing."*
H	*"...having the right team that buys into the same ambition- having back up to try to do something different and maybe that that might be quite risky or could invite professional conflict and that you have a backup supervisor or a lead or department or a team that you can fall back on to help in support."*
I	*"First thing I would say is to find like-minded colleagues because I think [OK], no, just having conversations with some of my colleagues who are similarly minded, I think just kind of help you - certainly helped me to persevere."*

Interview	Subtheme 8: Connections with allies
J	*"Find out who are your allies in and around you. Who's gonna help. Who's on the same wavelength? And start with that. Have some regular meetups to develop your ideas."*
K	*"To know that you're not alone with your quiet militancy is helpful- I think that's fantastic to know that- I think there's various kind of forums and things like that, I joined recently joined some, an NHS one that someone sent me a link to. So I think that idea that you can beaver away quietly on your own but you've got connections with other people who are beavering away."*
C	*"What's helped me is- having qualified practitioners, professionals, the people in the NHS knowing the outcomes that they wanted to see- being kind of flexible and very supportive I think. So always having a team that feels like a team."*
O	*"This project's been going on so long because there are so many parts to it- it can be easy to spread yourself very thin. To then end up trying to start a few things all at one time so nothing's ever done really really well. So, probably getting this, working group established a lot sooner in the process."*
E	*If something doesn't feel right very often, it might be because it's - it's something's not happening in finding that space to think about it with someone. If it's not in the service you working, whether it's in conferences or seminars or reading, finding that space to keep that space, to think of the person rather than just the difficulty they present is fundamental, and that will help build more kind of trauma informed individualized care.*

Interview	Subtheme 8: Connections with allies
G	*"I have some brilliant people in a steering group, some fantastic, skilled connections way more skilled than me in many ways who encouraged me along the way."*
D	*"…but do join strength with other people who are planting the seeds as well because then we see- it is the forest. I do think this is so, so important."*
E	*"What helps you to keep going?"* *"Having a team around me that want to do and try to do the same thing… [pause]"* *"Great, OK- is that the headliner then?"* *"Yeah, probably. I really can't do it without a team. I think, that's important for lack of burnout in my experience, but also important for keeping boundaries, because actually part of being trauma informed is not giving everything to everyone."*
K	*within our own trust we've we've got a small network so it's really helpful to- Just share ideas and not feel as though you are battling on alone, so I think I would say that I definitely think there's something about keep going. Just, you know, be brazen, be able to take knockbacks 'cause you will get knock backs and and sometimes it can be quite emotionally wounding too- knockbacks. I think that is definitely what Fiona Kennedy was describing was that almost kind of the idea of trauma gets acted out sometimes and actually some of the communications that you can get can be quite painful and they don't quite make sense as well, so I think it's really good in that way to have supports and to know that you can go and talk to someone about something that didn't go well or stuff that you don't quite know how to make sense of.*

Interview	Subtheme 8: Connections with allies
I	*"So I think maybe connecting even virtually with people who are similarly minded kind of helps you- helps prevent you kind of feeling like you just exist in this siloh and that you're this kind of mad person who just, you know, loves trauma and keeps banging on about it, you know. [yeah] I think I'm just a bit obsessed. I think realizing why the work is important, I think is, uh. I think finding ways to connect similarly minded people probably helps prevent burnout."*
B	*"What advice would you have for someone who was starting the journey to kind of develop or transform their service to be more trauma informed? "* *"I would say kind of think about it collectively. So to get support collectively to not be on your own with it all. Because I think that was something I was that was struggling with in the NHS. And I guess I had a different opinion? And it becomes very isolating when you're trying to advocate the different perspective. So I think, yeah, definitely don't do it on your own. Get some support collectively."*
K	*So I think within our own trust we've we've got a small network so it's really helpful to- Just share ideas and not feel as though you are battling on alone*
I	*(Quote above in 'burnout' also relevant here)*

5.24.5. **Subtheme 9: Burnout**

Interview	Subtheme 9: Burnout
I	*"I think realizing why the work is important, I think is- and I think finding ways to connect similarly minded people probably helps prevent burnout."*
A	*"I think the chaos that sometimes can be inside the system. Kind of permeates into everyone and then thinking stops, and you know, then it's just reverts back to old ways."**
A	*I think staying in a place where you're banging your head against a brick wall- even if you know that it needs it* [your efforts to implement trauma-informed change]*, but it goes against your values- you can end up with burnout*
P	*what advice would you have for somebody who's kind of starting the same journey as you? Oh God, I don't know, is it worthwhile? It depends on- trying to find allies is so important. Maybe I should look for a few more allies.*
O	*"So I guess it's about for me personally it's about trying to keep a balance between keeping my motivation but not becoming so all consumed in it that I'm just going to burn-out because it's a systemic problem and it's a system that's not going to change overnight no matter how hard I fight"*

Interview	Subtheme 9: Burnout
E	*“What do you think of trauma informed service would look like?”* *“Starting with the clinicians, ’cause I think if you don’t get that right, it leads to burnout and it’s not sustainable”*
E	*"I really can’t do it without a team, I think, and I think that that’s important for lack of burnout in my experience"*
G	*“…how you just sort of get chewed up and spat out by the service and I just feel like that’s just good enough”*
K	*within our own trust we've we've got a small network so it's really helpful to- Just share ideas and not feel as though you are battling on alone, so I think I would say that I definitely think there's something about keep going. Just, you know, be brazen, be able to take knockbacks 'cause you will get knock backs and and sometimes it can be quite emotionally wounding too- knockbacks. I think that is definitely what Fiona Kennedy was describing was that almost kind of the idea of trauma gets acted out sometimes and actually some of the communications that you can get can be quite painful and they don't quite make sense as well, so I think it's really good in that way to have supports and to know that you can go and talk to someone about something that didn't go well or stuff that you don't quite know how to make sense of.*

Interview	Subtheme 9: Burnout
K	*"Sometimes you know earlier on I did question it thinking is this the environment for me- is this? Can I carry on? And I do have days where I think can I do this? This is so awful. I can't bear it. It's awful isn't it but sometimes I just really can't bear it. And the idea that you have to be in the system to change it and and that being I have to remind myself of that sometimes because you feel as though you- because you're in it you will somehow be complicit in it. And all the toxicity and awfulness of it, and try and bear that is difficult sometimes."*
G	*"...between watching my colleagues and myself burnout repeatedly over the years and then watching this revolving door phenomena for the patients, I just didn't know what else I could do for the next 20 years of my career except when I came on this model, it seemed to kind of tick those boxes, so that's a huge motivation."*
D	*"But the staff has to be looked after as well otherwise it's not at trauma informed service in my view. Everyone should be looked after right? Because it brings up a lot of stuff - the work we do in itself is traumatic a lot of the time."*
L	*"...recognition of the effects of trauma on the brains of the families that are coming in. And then, the triggering effect of that on the wellbeing of the staff and really all those staff needed sabaticals."*

Interview	Subtheme 9: Burnout
O	*"if you're working in a trauma informed way or not, staff would still be exposed to peoples trauma, but actually, under trauma informed care model- the hope is that it would then be lessened because then the staff would be more conscious about thinking about themselves in relation to the work, rather than just carrying on being exposed to it regardless and then not looking after themselves so."*

5.25. Theme 3: System level factors

5.25.1. Subtheme 10: Supervision and reflective practice

Interview	Subtheme 10: Supervision and reflective practice
C	*“We introduced a psychotherapist to give monthly supervision to the team. That made a big difference.”*
F	*"I think you would need people who are trained in a whole variety of modalities of working with trauma, so not one size fits- I think you need a team that is well supervised and connected."*
H	*"What sustains you?"* *"I suppose some of it is having the right supervision…"*
D	*"There are many things are required when comes to being trauma informed (...) I want to add also staff support- self care and team care. Clinical supervision so again there is a nurturing, safe space to hold the person during this process. Because if it’s a client or a patient, you have the one to ones – the therapist or the group or whatever they are going to support through this process? But the staff has to be looked after as well otherwise it’s not at trauma informed service in my view. Everyone should be looked after right? Because it brings up a lot of stuff - the work we do in itself is traumatic a lot of the time. So I do think there is a huge lack of staff support, not the operational supervision, that kind of support - talking about support space for the staff to go through their own triggers."*

Interview	Subtheme 10: Supervision and reflective practice
O	*“I guess in psychology we’ve got quite a embedded structure around supervision, but nursing colleagues it tends to be a lot more like managerial like are you performing your work as you should be? Are you meeting the demands like rather than how you feeling about the work?”*
J	*“Good supervision needs to be in place for people, I think that’s something that actually is a barrier in our team. I think psychologists- we have a history and tradition of getting good clinical supervision, but I don’t think my colleagues have the same supervision. They’re all supervised, but it’s very tick boxy- it’s all about- you know it is not necessarily very reflective in the way we used to as psychologists. And actually we developed a staff wellbeing programme in my team. We developed a staff wellbeing programme and we ask people what would improve their wellbeing at work- Yeah, and then they - we gave them a few options and one of one things that came up was more reflective supervision”*
B	*"a barrier that has been relevant in the past, was* the type *of supervision- supervision was more internal and within the line management system, which kind of goes against the the kind of concept of having supervision that's independent, but we were able to take that forward- eventually it was addressed and it was taken quite seriously that we needed kind of trauma informed supervision as well and supervision that was much more neutral too.*
G	*"We, we don't have access to good quality one to one supervision at all for nurses that it's just not available and it never will be available- we were told. So that's a major barrier."*

Interview	Subtheme 10: Supervision and reflective practice
I	*"in a busy CMHT you know where you know nursing stuff don't probably don't have access to a high level of supervision anyway, and then to kind of asking to implement trauma informed supervision on top of that..."*
L	"I mean, who is it that put down the law that supervision is an important element of trauma Informed services? (…) we've had a lot of trouble with supervision because these - Because you've got to have supervisors who are trauma informed"
A	*"I think even within this service I'm in now trying to get reflective practices like blood from a stone. So I run a reflective practice in my team, but I prefer to be someone who partook in it. Yeah, I just run it anyway, 'cause it's useful space."*
E	*"What advice would you have for someone who was starting the same journey to kind of push your service to be trauma informed or more trauma informed?"* *"the promotion of reflective space in not just a reactive way, so debriefs after difficult situations happen, but also- those reflective spaces to check in as a team"*
L	*"...there seems to be a lot of rote learning and not enough reflection, and people haven't stopped and paused and reflected in thought about the possibility that adversity is having a physiological effect on child development"*
G	*"We've been told to have reflective practice, but it's not very well organized, and it's usually done by the line manager, so it has just come back in the last couple of months."*

5.25.2. **Subtheme 11: Management buy-in**

Interview	Subtheme 11: Management buy-in
F	*"I think how it's funded. Who is actually managing it and who are the managers. So that is it's not just words on the page, is actually is a principles that are adopted not just in how we work with the people use ourselves how we work with each other. How people work with me. How I work with my manager. My manager supported how the trust is coordinated, what is in place says trust cares about everybody."*
P	*" Because they think they're already doing it and they're not. The professionals, I think, think they already do this work and you're adding something they haven't time to do, and I think that I think there's just such huge resistance to it. I don't know if that happens and other trusts. But I think it's how it's lead from the top will influence how it how it's seen on the shop floor, right? "*
J	*"[manager] felt that it was going to mean that everybody would start to identify trauma in their patients and refer them to psychologists to deal with the trauma and it would in a way - its like replacing the medical model with just another label."*
G	*what advice would you have for someone who's just starting the same journey is here to develop a trauma informed service? Or? I mean you can kind of beyond that really, you know, trauma informed methods through several different services in different working groups.* *Uhm, I suppose you know that phrase. It's a marathon, not a sprint. Um, comes to mind, um, the buy-in is really important.*

Interview	Subtheme 11: Management buy-in
	You know from, I suppose it's great to have as many stakeholders, investors, stakeholders, academia, your service user. You know your all your different types of clinicians.
O	*"get buy in from people, whether it's people at the top or higher than you, to get buy in from a more senior- whether it's more organisational or managerial level, whatever it is, getting buy-in, from people whose voices are going to be more likely to be listened to is going to be so crucial, so if from them if there's buy in at the top it can filter through different levels of the system (...) but actually getting support from people higher up in the system can affect some change, you know, without that we wouldn't have gotten support for the funding bid, without certain, as much as I hate to admit it, without certain peoples names on the funding bid saying 'this is a good idea' would we have got the money? Possibly not. Possibly a much smaller amount."*
D	*"No doubt about it's a barrier, because then you have the prescribed way of working- when you have a prescribed way of working it is hard for you to be open to be able to do other things, even if you believe in these other things "*
B	*"some of our services are being now funded by the NHS. Um so- I guess maybe it's a potential barrier more than kind of current barrier, but I think in terms of um, there are much more measures that are coming into the process now, so there would be - kind of weekly measures at each session that need to be- due to [yeah, I see] and also the other aspect is that sessions are becoming more shorter now because there's much more emphasis on outcomes, so I think- so, although not current barrier, yeah, I really I'm so concerned about that aspect really"*

Interview	Subtheme 11: Management buy-in
H	*"having back up to try to do something different and maybe that that might be quite risky or could invite professional conflict and that you have a backup of the supervisor or a lead or department or a team that you can fall back on to help in support."*
G	*“What barriers have you come across?”* *“So the management buy-in was massive [*important to success*] and it wasn’t management at the highest level, it was just middle management”*
I	*"But probably the thing that stops it from being trauma informed is that it’s not a kind of a service level agreement about kind of the business of our work."*
I	*Well, I think it is important that that that your supervisors or leadership so that you know the leadership is on board with it in some way to support the development of it is quite hard doing on your own*
D	At the time that I saw in 2017 the film I was already with this company, so my manager was totally supportive.. She is amazing and she she is still very much involved with the whole idea so she was totally giving me- open door for me to do what I felt it was necessary. But they didn't feel the that there was the support the from the new managers from this new company

Interview	Subtheme 11: Management buy-in
F	*"It's the management- don't allow change, management want things to stay as they are."*
G	*"And so the barrier with the management buy in I had to. I actually had to a contact my my union up because I had to sort of explain to them look I'm doing this piece of research, you know, and they recognize the research part, the university piece- but there was just reluctance about change. It's basically organizational change is the big one, so unfortunately it had to get a little bit tricky and I had to start to say look, I'm speaking to the Union. I'm not progressing with my research, but it's not really about my research. This is about changing the service. That's my main goal at the research has been a tool that I've been able to use to change it so it did get a little bit tricky."*
A	*"Management I think is it was an issue and I think even the head of psychology was questioning why I raise some of these issues."*
J	*"Well, I think it is important that that that your supervisors or leadership is on board with it in some way to support the development of it- it is quite hard doing on your own."*
A	*"I think, yeah, I think you have to have a willingness from above. I think your superiors-must be willing to take a risk. You need to have the people that buy into it..."*

Interview	Subtheme 11: Management buy-in
H	*“I think there’s already a foundation for trying to you know, include trauma informed ideas within the way the *service* runs. I think that comes from the leadership provided by the *** who’ve done more than anything that psychologists healthcare professionals have done. So I think there’s a good baseline level of receptiveness rather than conflict. So what that means is that my service has been quite well received and there’s an interest in what we have to say and an interest in what we have to offer.”*
B	*"Did you feel like it was like that [trauma informed] when you when you joined three or four years ago?"* *"I think we we’ve had the same manager and she is really trauma informed. I would say yes from the start definitely "*
D	*"At the time that I saw in 2017 the film I was already with this company, so my manager was totally supportive.. She is amazing and she she is still very much involved with the whole idea so she was totally giving me- open door for me to do what I felt it was necessary. But they didn't feel the that there was the support the from the new managers from this new company"*
A	*"I suppose one way is trying to build those personal relationships with the more senior and getting them on board and showing them the research(…) I think you have to have a willingness from from above. I think your superiors- willing to to take a risk. You need to have the people that buy into it or you know at least that able to kind of I think you need sometimes outside people to come in and do some training. "*

Interview	Subtheme 11: Management buy-in
J	*"...and having a manager on board who made it mandatory for everybody to attend these meetings was important because there are other teams, I know where these forums are- If you if you want to attend, that's fine. If you don't, that's fine. And because we're all so busy- it wasn't often prioritised and you get the psychologist turning up with maybe two or three people or one person. Yeah, but because for us it was made mandatory. We had the whole team turning up. All the time. And I think that was useful. To get the manager for on board about the importance of this is it's very useful."*

5.25.3. **Subtheme 12: Medical Model**

Interview	Subtheme 12: Medical model
D	*"The NICE guidelines a lot of them come from the medical field, not psychotherapy field, which is crazy in my view."*
K	*" I think in our service concept where we're going, it is in the future much more trauma informed, but where it is at the moment is still pretty medicalizing of service users problems."*
J	*So that's how I see my role, as trying to bring in a more trauma informed, adversity informed understanding of psychosis as opposed to thinking of it as a brain disease or something too medical."*
N	*"I started seeing the same trend- trauma, trauma, trauma and - I just couldn't understand why people were saying it was a chemical imbalance and not really looking at the trauma aspect, because clearly that was the underlying issue for every single one of them."*
E	*"One of the big things I came in with from my experience in the secure hospitals, is the damage that on occasion diagnosis of personality disorder can bring about in the clinical responses to those difficulties that present under that diagnosis, but also how it can reduce peoples thinking."*
O	*"But equally we've been switched on to the fact that if we're trying to understand, I guess, what might be classically diagnosed as personality disorder, through a more trauma-informed lense, then how that could potentially undermine our*

Interview	Subtheme 12: Medical model
	psychiatry colleagues' ways of working or thinking etcetera, so yeah I think we anticipated that getting psychiatry buy in was going to be a barrier but in fact it turned out to not be as big of one as we feared"
B	*"We do not adhere to the medical model, although some of the kind of measures that we use might screen for, for example post traumatic stress. But we would not use the idea of disorder, that would more be used just to kind of as a way of tracking the course of the therapy and the improvements or the areas that are stuck on."*
A	*"I think we can't escape from medication necessarily…"*
A	*"I suppose it's trying to sort of get the team to acknowledge not dismiss what they were saying and not just medicate them because they were difficult to control."*
A	*"they're run by psychiatrist and it's very medically model driven (...) thinking about sort of formulation you know with the team sort of trauma informed formulation and to some degree it hit - they did want to listen to what I had to say, but then ultimately there was such a pressure to push patients through that just like medication, then just became the quick fix."*
I	*"I think another barrier is just the ideological kind of differences that exist in services, you know. I mean, especially in camhs is still quite dominated, at least locally, by kind of a consultant lead medical model of service provision. And so I*

Interview	Subtheme 12: Medical model
	think quite senior people who exist within within our service have very different views about, you know, the kind of what they see as being the appropriate service model to be using, and some people would be very, very diagnostically lead"
K	*"One of the very concrete barriers is about the numbers of psychologists versus the number of nurses and doctors- I think we've got a lot of brilliant nurses who are very therapeutic in their mindset, but there's still a lot who are sort of very aligned with the medical model in terms of their way of working, and often some are quite hierarchical, with seeing the doctors being right"*
A	*"people are scared of change, they're scared of upsetting the status quo they're scared of upsetting the psychiatrist"*
G	*"Plus, you know, I suppose it's such a massive change were very medical model in ***. So I was expecting I was expecting those difficulties."*
L	*"I used to give talks regularly with GPs about all this stuff and - and I didn't ever get a good reception, but now people are really interested in it, so you know, I just think it's been a process over time, it seems to have taken an extraordinary length of time, but what I know about my colleagues in medicine is that - once they get it, they'll be off."*

Interview	Subtheme 12: Medical model
J	*"We had quite a quite a bit of dissenting opinion as well. I mean, we - we have quite a medical model psychiatrists, one who's very full model and one's more open in her thinking. Having - having a space to manage all the different perspectives, and yeah, that being okay rather than anyone feeling too threatened."*
K	*"People err on the side of over caution with that rather than actually- that's that person's experience and what grain of truth is there with it? And on what might it relate to? To really kind of makes sense of it is the therapeutic work. But I think there's a real hesitation and I have found that more from the medics- also some of the nursing staff."*
F	*"And medics have a very strong voice- so if you talk about trauma informed care patients will go to see their doctor. They'll think about what medication does that patient need? It was all about medication. Yeah, even if there's been a disclosure of trauma. It'll be about symptom reduction. Then it might be signposting somewhere else to deal with that."*
O	*"But equally we've been switched on to the fact that if we're trying to understand, I guess, what might be classically diagnosed as personality disorder, through a more trauma-informed lense, then how that could potentially undermine our psychiatry colleagues' ways of working or thinking etcetera, so yeah I think we anticipated that getting psychiatry buy in was going to be a barrier but in fact it turned out to not be as big of one as we feared"*

5.26. Theme 4: Advice for Change Advocates

5.26.1. Subtheme 13: Be patient

Interview	Subtheme 13: Be patient
G	*"Uhm, I suppose you know that phrase 'it's a marathon, not a sprint' comes to mind… the outcome will be worth it in the end. You know, even if it takes 20 years to bring this in fully it's totally worth it, because there is no alternative in my my view."*
L	*"I used to give talks regularly with GPs about all this stuff and I didn't ever get a good reception, but now people are really interested in it, so you know, I just think it's been a process over time, it seems to have taken an extraordinary length of time"*
D	*"Okay, so just starting small it sounds like with the seed and then planting them all over the place Indeed, for many people spreading the seeds because if the seed is fertile- and I do believe the seed is totally fertile it will start to grow more anymore and spread and that's how we make changes right- because there's so many changes so many challenges at the moment. But in my view, this is one more reason why we should keep it going."*
F	*You need to hold your own and have patience and tolerance. [laughs] Because if you're working with people who are – well I'm a manager, so I have to be really tolerant of the fact that they don't know what they're talking about* [clinicians that participant supervises]*. They don't really engage in a conversation – they're not really even in the same room, so I think*

Interview	Subtheme 13: Be patient
	that's it, I think you have to know yourself really well. You have to be very, very available and absolutely abide by the principles of confidentiality and create safety for your staff.
H	*I think my way of working anyway is to develop relationships with people over a longer term and trying to kind of pick the right times to introduce new ideas*
I	*So if I could go back and start again I think I'd pick one change to make at a time and spend a long period of time making sure that kind of gets embedded in the service before kind of trying to change anything else. Otherwise, I think it just ends up looking like kind of a flash in the pan. 'We changed all these things. We drifted back to normal working and now no one really talks about it anymore'.*
P	*" I'm losing patience with with them… why is it so slow?! (...) it's just frustratingly slow, so it is just taking them so long and they're just beginning this training with staff where they've got little questionnaires and videos and it's all very good, but it's not enough. I want them to have big signs at the entrance to the hospital and I want them to be more dynamic about it and it's just not... I found it a bit sad actually."*

5.26.2. **Subtheme 14: Be tolerant**

Interview	Subtheme 14: Be tolerant
F	*“I’m a manager, so I have to be really tolerant of the fact that they don't know what they’re talking about [clinicians]. They don't really engage in a conversation – they’re not really even in the same room, so I think that's it, I think you have to know yourself really well. You have to be very available and absolutely abide by the principles of confidentiality and create safety for your staff."*
H	*“If you’re trying to introduce these principles to an environment… or set of professionals who naturally aren’t inclined to thinking the same way that you do as a psychologist... I think you’re on to a loser if you go in and just try to start telling people how to do things differently or pulling people up on not being trauma informed- there something about being able to be quite political and diplomatic- know what battles you need to start and which you need to end."*
H	*"I might have 12 people in a room for supervision. And there was certainly a few who I think a very sensible and interested. Thoughtful. And will probably make very good psychologists if they decided to change careers. There were others who were utterly disinterested, had no intention to change, thought they knew it all. Thought that their perspective on things was the right one and I think it's very, very difficult to change people whose attitudes are that entrenched and they are that defended against changing and I think that goes for all professionals."*

Interview	Subtheme 14: Be tolerant
H	*I think one of the difficulties with prison work I think, is you would -it sometimes entails having to bite your tongue with things that don't fit with the trauma informed perspective. But you know that if you go in too heavy on trying to promote your agenda or way of seeing things you're going to alienate people even more? So I might not agree with some of the things that get said in meetings about some of the boys, but if I'm sat around the table as a lone voice amongst twenty officers and I start critiquing what they're saying or offering a different view in a really quite explicit way. [Yeah] there is a risk attached to that so I think my way of working anyway is to develop relationships with people over a longer term and and trying to kind of pick the right times to introduce new ideas*
D	*"one of my colleagues- was a psychiatrist in the now became a psychotherapist, and is very analytical orientated which I totally respect but is definitely not my approach. I keep saying to him-trauma informed and ACES do not belong to one model to model of therapy, one model of practice, one model of anything. This is a knowledge that for me that is extremely, extremely important."*
J	*"developing conversations with people without being too preachy or teaching. Or that you're trying to tell people what to do. I think it's just about opening up a dialogue."*
L	*"I was the GP in the service that would be, you know, cast in the ** *, almost as the witch, I can remember being told by one GP at a meeting* 'why don't you go and run a creche? Why you doing general practice?' *stuff like that... I mean - it was - it's taken a long time and it's only just coming- the GPs are coming on board in now with trauma informed practice"*

Interview	Subtheme 14: Be tolerant
P	*"I was always speaking up [about trauma informed care] at the meetings and I was turn credibly passionate about it. There was a carer, a care representative who clashed with a lot- She was terribly defensive about trauma being recognized as something that could happen in the family or the traumas could be things that could happen to people by their parents or... it was just awful. And I know I almost gave up at that stage because that's the kind of resistance you meet that you just have to sit there and tolerate it."*

5.26.3. **Subtheme 15: Make use of research**

Interview	Subtheme 15: Make use of research
I	*"Something that has been really helpful for me has actually been to make sure that I'm really quite informed about the research round kind of the role of trauma in kind of severe mental health problems, you know what trauma informed care actually looks like. I think if you really know your stuff about the research, it's easier to have those debates as they come up"*
B	*"Perhaps you know, dig out some research. That supports that position as well."*
L	*"first of all the clinicians who's interested needs to get in themselves informed of the science, and then be shown - do things like run training sessions with the staff in the practise - And I mean - you know - show the resilience movie, which is very powerful and moving."*
L	*"...what helped you to make a service trauma informed?"* *"...absolute certainty that I - the science that I'm really talking about is from Harvard University in America, (...) absolute certainty that they are, you know, an excellent University with excellent researchers and that their standard, their evidence base is top notch. So I suppose I feel certain that that what they are describing it has been very very well evidence based and researched and that that I'm not just making it up."*

Interview	Subtheme 15: Make use of research
I	*"Particularly people say things like, well, I worked with someone with quote, unquote, borderline personality, and they didn't have any trauma? So I can say- '*actually, you know there's really interesting research to say that actually people when people do get that diagnosis often have you know if they don't have discrete trauma, they might have a long history of neglect*.'"*
D	*"So when came across the film resilience and I watched it and then invited several colleagues, invited the service users as well, actually to come to the to the launch (...) because for me from the beginning that was very important- getting the focus on research."*
D	*"I think you need to make the professionals delivering the work aware of what that is- so adverse childhood experiences and trauma and how that impacts the child, young people and the parents behaviour psychologically- healthwise because we know this is huge there as well. So I think that is definitely one point."*
E	*"... if it's not in the service you're working in, whether it's in conferences or seminars or reading, finding that space, to think of the person rather than just the difficulty they present is fundamental, and that will help build more kind of trauma informed individualized care."*

Interview	Subtheme 15: Make use of research
I	*"I mean, there's always more and more research kind of coming out(...) when it comes to that kind of research done and I think it does help kind of keep my motivation. When I kind of find out about other work that's being done elsewhere. You know, this work really is, it's really important and this is like this is the way services should be going."*
O	*"I've been really influenced by some of the stuff written by Karen Triesman, I don't know if you've come across her (S: yeah I have), so all of her bits about 'each interaction can be an intervention' it doesn't have to be massively ground-breaking it doesn't need to be this huge thing but actually if you're willing to engage with complexity and acknowledge it for what it is rather than trying to run away from it or denying it, that's one of the biggest things you can do, yeah, so I guess back to your point it's about going back to your original motivation"*
K	*"The helpful forces are… knowing that those people out there who really strongly advocated, that they have achieved some progress, and knowing that other places like Scotland have had- made a real difference with progressing it and the videos and research and things like that, so I think there's it. Well, I guess it's worldwide really, isn't it? But I think some countries I think Australia is done quite a lot of work on it as well."*
A	*" I suppose one way is trying to build those personal relationships with the more senior and getting them on board and showing them the research. "*

5.26.4. **Subtheme 16: Be strategic**

Interview	Subtheme 16: Be strategic
K	*“just be very opportunistic so it’s kind of not necessarily fighting a battle, but it’s a bit, even though sometimes it is about it is little battles, but it’s about you being clever, I suppose with with push- push where it moves- to take your opportunities where you can to be savvy with what’s what’s changeable.*
O	*"I don't know if that’a barrier or not but at the moment we’re trying to create a trauma working group comprising of our staff and our CLIENTS, to kind of, the idea will be that once the staff are all trained up, whether it’s fortnightly or monthly to kind of talk about, these are the ideas that we have come away from the training day with, these are some of the things we could do, these are some of the changes we said we would make. When are we actually making them and can we put some plans in place to make sure we follow through with some of the actions. But you know it’s, it’s that bit, I don’t know if I’ve said this already, but typically, it , because some of the ideas are coming from a more psychologically informed place, we don’t want it to be reliant on the psychology team to hold this or carry this "*
A	*"some of the work there that I tried to do is introduce daily group, a psychology group, thinking about sort of formulation you know with the team sort of trauma informed formulation and to some degree it hit - so you know they did want to sort of listen to what I had to say, but then ultimately there was such a pressure to push patients through that just like medication, then just became the quick fix. (...) we accepted anyone who wanted to come and we we tried to kind of recruit nurses to join us, one to be part of the process and two, to learn a bit more about what therapy is or the group does."*

Interview	Subtheme 16: Be strategic
I	*"So if I could go back and start again I think I'd pick one change to make at a time and spend a long period of time making sure that kind of gets embedded in the service before kind of trying to change anything else. Otherwise, I think it just ends up looking like kind of a flash in the pan. 'We changed all these things. We drifted back to normal working and now no one really talks about it anymore'."*
D	*"I think there are simple steps so we can reach this ideal and there are big steps. The simple steps would be again raise awareness- So training, training is key but again for the charities and the companies to invest in training- the training just needs to be accounted for in the targets they need to meet because we a target to work toward- there is no way for me to ignore that fact. So we would need it advocate for the government commissioners to start introducing trauma informed as a goal, as a target for the services especially family services and young people services and children's services, early help services right because trauma informed is very much linked to adverse childhood experiences the way we do trauma informed- we cannot disconnect both. So it is about prevention right? So I do think that we need it in - to raise the advocacy for the government to become more aware – I'm talking about local government and national as well. So this can be put into the targets for the service as well for the contract and then the money will be able to be allocated to training for me that's the first thing. I think you need to make the professionals delivering the work aware of what that is- so adverse childhood experiences and trauma and how that impacts the child, young people and the parents behaviour psychologically- healthwise because we know this is huge there as well. So I think that is definitely one point."*

Interview	Subtheme 16: Be strategic
D	*Okay, so just starting small it sounds like with the seed and then planting them all over the place Indeed, for many people spreading the seeds because if the seed is fertile- and I do believe the seed is totally fertile it will start to grow more anymore and spread and that's how we make changes right- because there's so many changes so many challenges at the moment. But in my view, this is one more reason why we should keep it going.*
O	*"...it needs to be kindof about empowering people in the team itself that it's about their responsibility just as much as it's about me being the qualified psychologist on the ward.(...) I think if anything for this to work it needs to be reliant on not just psychology to make it happen"*
J	*"Find out who are your allies in and around you. Who's gonna help. Who's on the same wavelength? And start with that."*
N	*"I would tell them to - definitely get staff to look at the service users history so that they can see and really understand the trauma rather than just the presentation."*
L	*"Then of course, the other thing that's very very powerful in practise, and - I think where I - and has partly been why It's worked for me is - is - is doing it, you know. I mean on this occasion where the GP asked me to see this woman who I was mentioning whose lid had properly flipped, he was at in the position where he knew he wasn't able to manage it and so then - then he's interested immediately in the fact that I was able to manage it and then - and then of course you know that*

Interview	Subtheme 16: Be strategic
	opens the conversation, doesn't it? What is it - What is it your doing? You know what - And then you can have a conversation about it."
H	*"one of the things I sometimes do is try to go for the hardest issue that's bothering the service, so the most disruptive client that everyone's given up on. Where the rhetoric around them is really unhelpful. Showing that doing things differently can have good effects when we're thinking about people slightly more holistically with a trauma hat on can actually get benefits because they feel heard and looked after and safe and then they- generally speaking. Uh, tend to engage a little bit better with relationships in services."*

5.27. Appendix T - Advice shared from trauma-informed change advocates

The verbatim advice that participants shared in interviews has been summarised:

Advice to trauma-informed change advocates
1. Don't give up!   - If you believe in it just keep going, don't let the barriers get in your way   - Just persevere, know that you will have knock-backs but it will be worth it in the end. There is no alternative in my view.   - Be persistent.   - Don't apologise for being idealistic.   - You won't have success every time but you need to keep trying.   ***2. Look after yourself***   - Take time for reflection and learning from changes and mistakes   - It's too easy to spread yourself thin   - It can be emotionally wounding, can get quite painful   - Be wise about not getting worn out   ***3. Get management on board***   - Buy-in is important, have as many stakeholders, investors, academic supporters, different types of clinicians, service users   - Support needs to come from the top down as well as bottom up   - Get buy-in from the top, it is helpful to have people in powerful positions supporting your funding bids   - Get management on board early   - Have a manager on board who makes it mandatory for everyone to attend meetings   ***4. Stay connected to allies***   - Find others who believe in what you're doing and support each other

- Ensure that you can bring people along with you, stay supported
- Find like-minded colleagues
- Ensure that you have support
- Trying alone to advocate for a different perspective can be very isolating
- Find your allies- who is going to help, who is on the same wavelength- have regular meet-ups to develop ideas
- Make connections, or make sure you don't feel alone by reading the research
- Join us! We can support each other, join our learning community

5. Be patient

- Start small and don't expect too much too soon
- It's a marathon, not a sprint
- Develop relationships with people over a long term and try to pick the right time to introduce new ideas
- Start small, plant seeds of knowledge with others that support you
- Don't try to do too much too quickly- make sure that changes are firmly embedded in practice before moving on from them so that services do not drift back to normal when interest dies down
- Changing principles and ways of working isn't something you can do quickly and when you work in isolation it is even harder

6. Be tolerant

- Sometimes you need to bite your tongue as if you go in too heavy trying to promote your agenda or change people you will likely alienate them from your views
- Be tolerant of colleagues who do not yet know about this way of thinking
- Don't just go in and tell people how to do things differently or tell them off for not being trauma-informed

- Develop conversations without being too 'preachy' or telling people what to do- just open up a dialogue

7. Make use of the research

- Use the trauma-informed research evidence to back-up your arguments
- Stay informed about the research around trauma-informed care and the role of trauma in severe mental health services, understand what trauma-informed care actually looks like so that when you are challenged you can speak with confidence about the evidence base (e.g. rates of depression and trauma, rates of voice hearing and trauma, relationship between neglect and trauma rather than discrete trauma and borderline personality disorders)

8. Be strategic

- You do have to be quite political and diplomatic
- Consider who in your service is most likely to be affected by these issues, connect with them and ensure that their voices are heard
- Show, rather than tell colleagues how this approach can be helpful- with case examples or helping out in cases that colleagues might be struggling with
- Push where it moves!
- Think strategically about how the changes can be best approached
- Consider embedding 'trauma-informed thinking' in a subtle way, for example bringing it into team formulations
- Think carefully about how to manage hierarchical issues to ensure that your proposals land well

Several participants spoke about specific tools or methods that had been helpful to them in their journeys. These are summarised below:

<u>Learnings from trauma-informed 'change advocates:</u>

- *Start a working group that meets regularly to discuss making trauma-informed changes to your service*

    - *Ensuring that this working group takes responsibility for making concrete changes*
    - *Do this as soon as possible*
- *Focus on education and inspiration as a way of getting the people you work with excited about a trauma-informed approach*
    - *Methods suggested: screening films about the topic (Resilience film by James Redford) sharing research papers, sharing examples of good practice*
- *Prioritise staff wellbeing and support so that open discussions and reflective spaces can be shared where colleagues are able to consider their own vulnerabilities*
    - *The way this is provided may vary dependent on professional training background. Methods suggested: reflective supervision, coaching, staff wellbeing activities to improve peer support and connections, positive and safe relationships with line managers*
- *Record the trauma-informed work that is done so that this can be shared with commissioners as examples of good practice*
- *Make trauma-informed training a part of inductions for all staff to take part in e.g. alongside fire-safety or safeguarding training*
- *Advocate for a monthly reflective case discussion in which clinicians can share examples of work and the team can try and formulate difficulties from a trauma-informed perspective*
- *Show your team how trauma-informed work can help- offer to help out with a tricky case and bring a trauma-informed formulation to the work*
- *When you are feeling disheartened find ways to connect with people who share an interest in trauma-informed approaches*
- *Sometimes it is helpful to re-connect with why you are interested in trauma-informed changes. Staying up to date on research and key figures in the field is helpful. This can be done through following twitter feeds of trauma-informed researchers or seeing whether important trauma-informed papers have been referenced in new pieces of work.*

- *If you do not have a supervisor who can support you in trying to make trauma-informed changes, attempt to connect with someone who can fill this role outside of your service*

Specific advice about resources for motivation and inspiration:

For inspiration about trauma-informed changes on a large scale:

- Follow the work done in Scotland:
    - *https://www.gov.scot/publications/adverse-childhood-experiences-aces/pages/trauma-informed-workforce/*
    - *https://vimeo.com/334642616*
    - *https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/*

For inspiration from social media:

- Follow John Read at @ReadReadj on twitter who often speaks about anti-psychiatry and ideas related to trauma-informed work
    - Also radio interviews with John Read:
- Follow Lucy Johnstone @ClinpsychLucy on twitter who shares information and ideas from the perspective of the Power Threat Meaning Framework

For inspiration from a CAMHS perspective:

- Follow the work of Dr Karen Treisman
    - Watch her TED talk: *https://www.ted.com/talks/karen_treisman_good_relationships_are_the_key_to_healing_trauma*
    - Her twitter: @dr_treisman
    - Her website: *http://www.safehandsthinkingminds.co.uk*
- TED talk explaining ACES by Nadine Burke

- *https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime/up-next?language=en*

To connect with allies:

- Join the mailing list for the conference at UEL (managed by John Read and how participants were recruited)
- Connect with EHCAP who offer training and 'emotion coaching' for professionals wishing to retain a focus on the ACEs in their work
  - *https://www.ehcap.co.uk/training*
- Attend events run by the London ACES hub
  - *https://www.londonaceshub.org/*
- Attend events run by the UK Trauma Council
  - *https://uktraumacouncil.org*

Literature that has helped participants:

- Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development?. *Mental Health Review Journal*.
  - https://www.emerald.com/insight/content/doi/10.1108/MHRJ-01-2015-0006/full/html
- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
  - https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
- Battling barriers and misconceptions- Angela Sweeney & Danny Taggart (2018) (Mis)understanding trauma- informed approaches in mental health, Journal of Mental Health, 27:5, 383-387, DOI: 10.1080/09638237.2018.1520973
  - https://www.tandfonline.com/doi/pdf/10.1080/09638237.2018.1520973?needAccess=true