Scottish Journal of Residential Child Care
2017 – Vol.16, No.1

Tangible Trauma Informed Care

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Abstract

This article focuses on how trauma informed principles can be translated into tangible practice in residential care in the UK. It suggests that the core components of trauma informed care as identified by Hanson and Lang (2016) can be used as a framework to organise practice and ensure services are adhering to trauma informed practice. This includes using guidance from approaches such as the neuro-sequential model of therapeutics (Perry, 2006). The article focuses on how trauma informed principles and components have been turned into tangible practice in residential care services in the USA, Norway and Sweden and suggests practical steps practitioners can take in becoming trauma informed.

Keywords

Trauma-informed, practice, international

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Introduction

This article shares some of the initial findings from a Winston Churchill Memorial Trust Travel Fellowship that explored trauma informed residential care for children and young people in the USA and Scandinavia.

A key realisation, aside from the research findings themselves, is that a Fellowship is both extremely useful and surprisingly accessible. If there is one request this article makes it is for more practitioners from the UK residential care sector to apply. The trust is open-minded and attempts to have a diverse range of fellows and projects and residential practitioners should not exclude themselves for reasons of experience, status or position.

Trauma Informed Care

Trauma informed care has been defined in many ways: for a review of many of these see Hanson and Lang (2016). At the core of all these definitions is an acknowledgement that many service users have come from high adversity and have experienced traumatic events i.e. those that overwhelm their capacity to cope (Van der Kolk, 2003).

For example, a review in a large residential and secure care provider in Scotland of boys and girls aged between 13 and 16 highlighted high amounts of adversity within the individual child's life and the family system as a whole. The rates of exposure as defined by Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards and Marks (1998) are illustrated in table 1. These figures are based upon file review rather than interview and therefore may be underestimates.

Table 1. Percentage of young people who have experienced specific adverse childhood experiences in a Scottish residential child care service.

Adverse Childhood Experience	Boys (*n*=74)	Girls (*n*=22)
1. emotional abuse	51%	68%
2. physical abuse	39%	36%
3. sexual abuse	8%	18%
4. emotional neglect	51%	68%
5. physical neglect	69%	73%
6. domestic violence	58%	68%
7. household substance abuse	49%	50%
8. household mental illness	39%	45%
9. parental separation/ divorce	80%	68%
10. household imprisonment	19%	36%

Trauma Informed Care (TIC) has been increasingly discussed, promoted and implemented across child care services in the last decade as high rates of trauma and adversity have been recognised. There is a plethora of theories, models, articles and training providers. Many overlap but some also concentrate on different aspects of care e.g. individual treatment compared to organisational policy. The huge amount of material available can provide a challenge for practitioners in care settings looking to choose an applicable model or approach.

Becker-Blease (2017) and Hanson and Lang (2016) highlight a number of criticisms with TIC. One of these is that there is a disproportionate focus in the literature on theory and core principles rather than the tangible practice they suggest. There is sometimes a gap about how practitioners can turn the theory and principles into daily practice and then evaluate their effectiveness.

My fellowship therefore had two core aims:

1. To identify a model of trauma informed care that was best-fit for UK residential care.

2. To find examples of where the model and theory were turned into practical and tangible practice.

This article will describe the findings for both in turn.

A Best-fit model of Trauma Informed Care

The intention was to review the literature on each model that had promise, including the Neurosequential Model of Therapeutics (Perry, 2006), Sanctuary Model (Bloom, 2013), and Neurological Reparative Therapy (Ziegler, 2011). Then to visit sites that had implemented them to review their effectiveness and to take practical ideas to implement in the UK. The hope was that one of the many approaches would have both the anecdotal and research evidence to suggest it would be best for residential care in the UK.

At the end of the fellowship the conclusion was that no single approach fulfils all that a UK residential placement needs from it;– no one model answers all the questions that a residential care setting asks. For example, most of the models work at different levels: some focus upon the organisational and milieu level, while others focus on individual assessments and the implications of these. While many touch on many aspects, they provide most guidance only at one particular level and provide less at others, particularly when compared to an alternative approach. In turn, all contain useful guidance and strategies: there is worth in all.

The best-fit model appears to be a strategy whereby a residential service utilises the guidance and tools from a range of approaches, one that takes the most useful and salient of these for their own specific service.

This has potential costs though: how does a service ensure that there is integrity to trauma informed principles and that this inclusive approach does not become disorganised and inconsistent?

A solution is to use an over-arching framework that can provide a core definition of trauma informed care that can then organise the guidance from different models *within* it. A framework that can provide a structure to ensure that practice remains trauma informed.

Hanson and Lang (2016) provide such a framework. In their critique of trauma informed care they reviewed numerous approaches and identified those themes that were core and important to all. They concluded that there were fifteen core components of trauma informed care for children and young people. These components were organised into three levels: workforce development (WD),

trauma focused services (TFS) and organisational delivery (ORG). Abbreviated versions of each component are provided below;

Table 1. Components of trauma informed care services from Hanson and Lang (2016)

Level	**Component**
WD	1. Required staff training in the impact of trauma
WD	2. Measure staff proficiency in knowledge of impact of trauma
WD	3. Processes to prevent and help with staff secondary trauma
WD	4. Staff knowledge about when and how to access trauma focused therapy
TFS	5. Use of standardised and evidence-based assessments of trauma history and symptoms
TFS	6. Include child's trauma history in file and care plan
TFS	7. Availability of trained, skilled clinical providers in evidence-based trauma focused therapies
ORG	8. Collaboration and information sharing *within* the agency related to trauma informed services e.g. between care and education
ORG	9. Collaboration and information sharing *with other* agencies related to trauma informed service e.g. CAMHS and social work
ORG	10. Procedures to reduce risk for re-traumatisation of children
ORG	11. Input from children and purchasers in service planning and development of a trauma informed system
ORG	12. Provide services that are strength-based and promote positive development
ORG	13. Provide a positive, safe physical environment
ORG	14. Written policies that explicitly include and support trauma informed principles
ORG	15. Presence of a defined leadership position or job function specifically related to TIC

Hanson and Lang (2016) acknowledge the difficulty for those attempting to navigate the competing models and theories. Their fifteen components can provide practitioners within residential care the flexibility to include a range of models while maintaining integrity and anchoring to trauma informed principles. The strengths of each model can be taken and the limitations avoided.

The following section gives a brief rationale for the inclusion of each component followed by examples of how they can be translated into tangible practice. This includes where specific models and approaches can give guidance and be used to meet a specific component.

The Practical and Tangible

The descriptions below are sourced from the anecdotal evidence of services who have implemented trauma informed care for a number of years. They do not represent the findings of any research trials or similar evaluation. Nor do they include a review of the literature and evidence base that informs such practice. Instead, they are themes derived from the learning of a range of practitioners, services and countries including the USA, Norway and Sweden. The hope is that the reader can take this learning to inform how they may implement the components of trauma informed care within their own services.

Many of the examples may already be known to staff, and may be viewed as simply good child care. One criticism of trauma informed care is that it recommends what should occur for all children, whether they have experienced traumatic experiences or not (Hanson & Lang, 2016). This article is inclusive and describes numerous practices that may be used without a trauma rationale in order to highlight how many existing practices can be consistent with trauma informed care, and to inform those who are not already using them. If they are already known to the reader it is also hoped that they will confirm practice and provide a rationale for their use.

With the introduction of any new intervention or strategy there are consequences that are both positive and negative. In places some of the potential drawbacks of implementing the strategies are noted. For some, implementation involves additional costs and staff resources and it is acknowledged that this is particularly difficult given the pressure on resources and funding.

1. Required staff training in the impact of trauma.

The rationale for knowledge in this area is self-explanatory but how best to achieve it is less clear. Services had found that a range of approaches had been useful.

- All services found that it was important to give staff time to be taught by a knowledgeable trainer out of the usual demands of their job. It would not be appropriate to review different training providers but services noted that there was a significant amount of free online training available if training is difficult to source. For more information, see: https://www.crisisprevention.com/Blog/April-2012/Top-10-Recommended-Trauma-Informed-Care-Online-Res.
- Many services felt that a focus on training in the milieu had the greatest value. This was described as many things, but may perhaps be best

captured as 'mentoring' (Foster-Turner, 2005). For example, in one service each shift had a member of the training team present throughout and acting as a member of staff. They had a supervisory role where they would model good practice, provide feedback and help staff adhere to the model and ethos of the service. These trainers would regularly meet with a senior manager and discuss challenges to the implementation of trauma informed care and examples of good practice. The role was more than a manager as it had the explicit aim of helping the service adhere to the trauma informed framework both at the individual staff level and at organisational level.

- In many UK services the direction of training is usually one way – the 'experts' or professionals from a different discipline train care staff. In one service all new professionals e.g. therapists, trainers, teachers and managers were required to do a high number of shadow shifts within a unit in order to understand both the realities of the role of front-line staff and how the principles behind the services were translated into practice.

2. Measure staff proficiency in knowledge of impact of trauma

The ways in which services measured staff proficiency were varied and included online training with tests and competency based assessments. This is one component where there are clear things to learn from the UK. Currently in Scotland NES, the NHS Education aims to create a Knowledge and Skills Framework which hopes to achieve highly effective and evidence based training and skills development for all those who have contact with survivors of trauma. See here for more detail: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx.

It may help increase continuity and transparency regarding trauma knowledge and skills if those in the care sector align themselves with this process and also inform it from a care perspective.

Related to this are some self-evaluation tools that allow services to assess how trauma informed they are and to structure their planning including the *Creating cultures of trauma-informed care (CCTIC): A self assessment and planning protocol* (Fallot & Harris, 2009). More examples can be found here: https://www.ncbi.nlm.nih.gov/books/NBK207183/.

3. Processes to prevent and help with staff secondary trauma

The demands of working with young people who have experienced trauma is well documented (Salloum, Kondrat, Johnco, & Olson, 2015). Hanson and Lang (2016) focus on the concept of secondary trauma (i.e. experiencing trauma symptoms as a result of exposure to another's traumatic experiences and symptoms). Importantly though there is an additional and real risk of primary traumatisation through exposure to the violence, self-harm and other concerning behaviour children in residential care can present with.

A number of services had prioritised staff well-being with the understanding that staff were the services most important resource and that they would be most effective in supporting children and young people when they themselves were supported. Some tangible examples of staff support included:

- Time and space for reflection. This was a core element of different services and highly valued by all staff. This included a daily meeting where staff were able reflect and raise concerns or good practice prior to a shift start. It also prompted discussion about how to respond in a trauma informed way to children who were presenting with a new behaviour. There was a focus on making this discussion safe, reflective and non-punitive.
- Availability of free and anonymous external counselling.
- A psychologist or similar professional who was linked to a specific unit and who could identify where additional support may be required.
- Implementation of trauma informed debriefing including psychological first aid processes after incidents (La Greca & Silverman, 2009).

4. Staff knowledge about when and how to access trauma focused therapy

There are many trauma focused therapies including trauma focused CBT (Cohen, Mannarino, Kliethermese, & Murray, 2012), Eye Movement Desensitisation and Reprocessing (Diehle, Opmeer, Boer, Mannarino, & Lindauer et al., 2015) and Narrative Exposure Therapy (Crombach & Elbert, 2015). There are other interventions that if not specifically trauma focused have the potential to overlap with this by exploring children's previous experiences e.g. Life story work (Gray, De Clerck, Wild, Crouch, Price, Tokunaga, & Marques, 2017).

While for many the recovery from a traumatic event occurs within the family, system or care environment this may not be the case for some and therapeutic support may be helpful. In all services there was trauma focused therapy available and the staff were knowledgeable about how and when to access this. This knowledge had built through close and integrated working with trauma therapists who had provided awareness to staff on this area in addition to their regular case work. This is discussed in more detail under component seven.

5. Use of standardised and evidence-based assessments of trauma history and symptoms

Using standardised and evidence-based assessments can help ensure staff understand the experiences of children, uncover unknown experiences and measure the degree of symptoms: all important factors in an effective care plan. Milne and Collin-Vézina (2015) review some of the key measures and assessments used and useful sources can be found here: https://www.childwelfare.gov/topics/systemwide/assessment/family-assess/childneeds/trauma/.

There was no single favoured assessment used by services. In general there was a preference for those that were brief and accessible, given the learning needs and concentration difficulties of many young people. The Child Revised Impact of Events Scale (Perrin, Meiser-Stedman, & Smith, 2005) and has evidence of being a valid screening measure with children in residential care in the UK (Morris, Salkovskis, Adams, Lister, & Meiser-Stedman, 2015). Measures that did not directly ask the children and young people and that relied upon observations were also widely used to avoid intrusion and over-assessment. Kisiel, Conradi, Fehrenbach, Torgersen and Briggs (2014) provide a useful review of many measures with a focus on their use in practice.

There were also some other heuristic methods used i.e. those that did not provide a formal measurement of history or symptoms but that provided a framework for understanding the child. The primary example was the Neurosequential Model of Therapeutics Metric (Perry, 2013). This requires the practitioner to review the child's adverse and relational developmental history and also rate the child's current functioning. Services felt that this tool had been useful in encouraging understanding of a child's history and the key domains to target. Although they felt the tool had some limitations regarding standardisation and sensitivity they felt it had been a useful aspect of trauma informed practices.

6. Include child's trauma history in file and care plan

The inclusion of a child's history in core documents aims to ensure that all staff care informed about the child's background and can understand their concerning behaviour in light of the child's experiences. The hope is that this prompts the most helpful response from staff avoiding those which trigger symptoms and distress.

Some practical examples of this included:

- Placing key anniversaries of traumatic or difficult events in file and diary available to all staff;
- Initial assessments that obtain the child's own views of what were their difficult experiences (often by a mental health professional) and this being communicated with key staff;
- Collaborating with the child to list things that scare or make them anxious. This could include places, types of people, events, dates, times of the day etc;
- Agreeing what language to use when an event needs to be discussed or mentioned. For example, a child may prefer a different word to 'abuse' or 'rape' and this can be represented in the file.

7. Availability of trained, skilled clinical providers in evidence-based trauma focused therapies

As noted in component four, sometimes trauma-focused therapies may be beneficial. In the UK the assumption and perhaps the ideal is that the health service provides this service to all young people, be they in care or not. Unfortunately, the reality is that health services often lack the resources to do so or have referral criteria that exclude those without a specific diagnosis of a mental disorder. Those young people who have experienced adversity and traumatic experiences that in part drive mental health difficulties and concerning behaviour are sometimes excluded. Where they do meet criteria, it is often very difficult for a NHS service to work with the staff and milieu to a significant degree, to the frustration of many health clinicians. The responsibility for supporting, if not 'treating', a young person's mental health needs can therefore lie with the staff that care for them.

In all services visited, even in those in countries that provide universal health care, there were in-house clinicians who were integrated within the service. In some, they were linked to a particular unit and were there daily, both providing support to individual children and also working at the level of the milieu or life-space. This was described as more effective than other models where children and young people were taken to external clinics, although at a higher cost of resources.

A full review of all trauma focused treatments is not feasible here but it should be noted that there was use of various methods with practitioners believing that an integrated, phased and multi-modal model was most appropriate.

8. Collaboration and information sharing within the agency related to trauma informed services

Having a consistent approach towards a child has been seen as an important part of child care for many years (Gardner, 1989). Services reported difficulties achieving this including communication challenges and differences in opinion between services such as care and education departments that may sound familiar to those working in the UK.

There were some tangible examples of ways to increase collaboration and information sharing in the services, including:

- An individual in the organisation who was responsible for the implementation of trauma informed practices. See component fifteen for further discussion of this;
- Daily liaison between care and education to given information on that night or day's events and the approach staff were taking with recommendations for continuity;
- Representation from each service at each others' reflective meetings;

- A single daily log that all services use and complete (often kept electronically). This was often extended to a single child's file, again accessible to all staff.

9. Collaboration and information sharing with other agencies related to trauma informed service e.g. social work services

As above, ensuring a trauma informed, consistent response from all those supporting a child is important. Some examples to achieve this with external agencies included:

- An initial assessment that provided a description of the child's experiences and the related symptoms which was shared with key services. This also made initial care and treatment recommendations;
- A liaison role for the trauma informed lead professional who communicated the approach the service was taken and the rationale why. This included awareness and training to services;
- Initial planning meetings that explicitly reviewed the known adversity and traumatic experiences the child had experienced from which a narrative / chronology was prepared for the child's file.

10. Procedures to reduce risk for re-traumatisation of children

The tem re-traumatisation has been used to mean both further exposure to traumatic events and also where children are vulnerable to new experiences triggering the overwhelming feelings and reactions associated with a previous traumatic event (Kammerer & Mazelis, 2006).

There are numerous events, interactions, and contexts in residential care that could serve as trigger, including staff responses to the child and being exposed to other children's concerning behaviours such as violence and self-harm.

The area that perhaps received most attention from services was the method with which children were held by staff when they were an immediate risk of harm to themselves or others. Encouragingly, many services felt that the implementation of trauma informed principles had lead to a significant decrease in holding children to the benefit of both children and staff. They suggested that this was because of:

- A better understanding of the child's behaviours and the factors driving it. This was in part due to the sharing of the child's experiences and symptoms as noted in component six and the training received;
- A better recognition of potential triggers (including internal trauma symptoms such as intrusive memories or images) and greater emphasis on frequent and numerous strategies to help the child regulate and prevent arousal building to difficult levels for the child. A tangible sign of this were documents that were often collaboratively designed with the child that identified key triggers, preferred responses from staff and

coping skills they were attempting. These were similar to behavioural support plans that staff may be familiar with but also included triggers such as dates, places, context, facial expressions, how close they preferred others to be and anything else that could trigger symptoms and dysregulation.

11. Input from children and purchasers in service planning and development of a trauma informed system

There is a growing literature on the benefits of involving children and service users in the design and development of services (Worrall-Davies & Marino-Francis, 2008). The perspective presented by children can often be difficult for staff and adults to anticipate and can provide valuable guidance.

There are a number of examples of involving children throughout this paper, including children designing the actual building of a service. There were also services who involved children in many different aspects of service delivery, including how to deliver trauma focused therapies and how to complete initial assessments. Some practical ways to achieve this included:

- Weekly meetings between staff and young people;
- A young people's council where the group would have chance to meet managers and staff;
- Representation of children on working groups where appropriate;
- Qualitative analysis of children's views completed within formal research projects.

12. Provide services that are strength-based and promote positive development

This is the component that perhaps had the most number of tangible examples. There was an understanding in all services that children's development had been affected by the adversity and trauma they had experienced and that this meant the child had not developed important capabilities, skills and attributes. They viewed their task as promoting development across all domains where development had been affected. The services felt that an area of key importance was to support and develop emotional regulation abilities given the difficulty children had with this and the often severe concerning behaviour emotions could trigger.

Supporting and Developing Emotional Regulation

It is not just children who have experienced trauma who need to manage their emotions and release emotional stress and tension. The difference is that these children often do not have the skills, knowledge and capacity to regulate and the emotions are severe and powerful (see Blaustein & Kinniburgh (2010) for more discussion of this).

There were a number of tangible examples of how staff supported emotional regulation:

1. Educate children about emotions, arousal and trauma models

Providing education to children about what traumatic experiences were, how they affect us and how to cope with them was an important aspect of many services. There were some practices that seemed most effective:

- Not labelling the experiences as "trauma" to avoid it becoming another diagnostic label but instead talking about "bad things", "worse things" or similar;
- Using the many videos available on line e.g. about trauma, the fight and flight response, how emotions work and arousal and tension;
- Range of apps that look at emotional regulation;
- One service had visual explanations of trauma concepts and emotions that were visible around the unit and in communal areas.

2. Have a range of regulation activities and make them accessible.

The activities listed below are a fraction of those available and are noted because they were common of highly valued by services.

Fidgets

All services reported the positive effects of 'fidgets'. These are simply objects that the child can handle and manipulate to help them regulate themselves. They are not given when the child is in difficulty, but are encouraged when the child is seeking something to manipulate or fidget with. They should therefore always be available as they are most likely to be useful when the child is at a low level of difficulty.

In classrooms there were often fidget boxes that had a range of textures, malleability, colour, weight, and size. Children were able to chose one or two and have them on their desk. There was more than one of each object to avoid possessiveness. Services reassured that they were not thrown often as the children had chosen the object and wanted to keep it.

Resistance

Materials that resist pressure and force can be useful to release tension and frustration. There were many creative and innovative ways staff had implemented this idea ranging from encouraging children to push against walls to bands around the legs of chairs so they could push their feet onto them. Some children also 'wore' a hoop of lycra around their body both for the resistance and sensory experience.

Balance

Services reported that engaging children in tasks that required them to balance could help them focus, distract them from anxious thoughts and help their under-developed sense of balance. As one teacher noted, it allowed pupils to tip

back their chairs and balance in class. Staff also noted yoga balls and rocking chairs could fulfil this function and were also reported to have a soothing effect.

Exercise

There is evidence that physical exercise can help children's executive functioning and self-regulation (Best, 2010). There are significant practical difficulties to encouraging children to exercise when they do not want to that are not often discussed in the literature. While many services will admirably have physical education classes and sports teams, these do not cater for some children. There were many examples in services where exercise and activity were encouraged in different ways:

- Accessible within the life space: ranging from gym equipment, climbing walls, ladders to climb and soft-play blocks;
- Outside play parks at close access. Many services had these immediately outside the residential unit;
- Games that include staff such as tag, assault courses inside and outside and piggy in the middle;
- Adolescents often respond more to joint activity with key care givers, such as trips to the gym with staff, rather than being left to attend on their own;
- Asking individual children to complete their pre-agreed strategies. For example, one child in class would repeatedly go into the hallway and do star-jumps when he wanted to or the teacher suggested it to him.

Staff also noted that many exercises and games had the potential to excite children and increase arousal and could then be difficult to manage. To avoid this, these activities were completed within a structure and boundaries, as with any other activity for these children. For example, one group of eight children had a gym class in an empty hall. The rules were given at the beginning when the children were calm (i.e. the game is tag, only touch the shoulder, and a five minute warning before the game ends). There was then a gradual increase in activity e.g. stretching before the game began and was played for the period. Before the children returned to classroom work the staff member gradually reduced the children's arousal by doing a warm down followed by the children lying down and taking deep breaths.

Games

The role of play in development and learning has been discussed in many areas of child care (Kolb, 2014). There are many games that can help children develop skills in a way that would be difficult to do without the element of play. For example one service had a daily hide and seek game in the school for primary aged pupils. This included having the lights turned out in one room, adults playing with the children and pupils taking turns to be the hider or the seeker. Staff noted how children had to learn to regulate their excitement in order to avoid discovery and that staff had used this to teach them deep breathing

amongst other strategies. It also gave children the option to explore the dark in a safe way, but only if they chose this place to hide. While not all children will take part in these activities, services reported that engagement was higher where both staff and young people took part and were more effective than direct attempts to teach emotional regulation skills.

Sensory Soothing

Many services felt that considering young people's sensory needs had been helpful in supporting their regulation. Services suggested that the high arousal levels, symptoms and stress that children can experience can contribute to sensory sensitivity. An example given was how after prolonged stress lighting can seem bright, noises sharp and loud etc. Staff felt that this sensitivity could in turn trigger further stress or anger. To respond to this, services had implemented the following:

- Had both bright and dark places in the unit that children could choose to be in;
- Had minimised sharp overhead lighting;
- Had both loud and quiet areas of the unit e.g. music and TV were allowed in the lounge but the kitchen was quieter;
- Many of the items noted above including fidgets, lyra, resistance bands, blankets and cushions were available;
- Bathing with scents was encouraged in the evening to wind down;
- Over-ear headphones were available in class as well as the unit to dampen noise;
- Children were asked about their preferences including food and smells they found aversive / attractive;
- Some units formally assessed sensory needs using standardised assessments e.g. sensory profile (reference);
- Staff helped children put together a soothing box tailored to their own preferences. This could include anything that the child felt helped them soothe including paint-brushes, feathers, stress-balls, scents, photos, music etc.

Massage

Massage can be a powerful way to reduce arousal and there are numerous care services in the UK that source this for children. It is a potentially controversial area and there are powerful attitudes to touch in general with children in care (Steckley, 2011). In the services visited there was a consensus that it could be an extremely useful and effective way to help children regulate. There were many ways this was delivered, too, ranging from professional masseuses visiting units to staff being trained in basic approaches and delivering this on a daily basis. For example, in one unit children reported that their favourite thing about living there was getting a foot massage before bedtime. Again, the appropriateness of this is to be deemed by each individual service.

13. Provide a positive, safe physical environment

Safety is a universal theme across all trauma informed care models and frameworks. Every service visited had this at the core of their practice. It has a clear rationale: how can carers hope to help children regulate emotions and develop alternative coping strategies if that child continues to feel fear? They are unlikely to move away from the coping strategies they developed in dangerous environment until they believe the threat has ended.

The principles of all child care are applicable here: no aggression of violence from carers and instead calm, empathic and warm caregiving but there were also other ways that may not have been developed without a trauma-informed rationale. For example:

- One service had involved children in the design of their unit building and built a large castle like building based on the children's design. While this may be beyond the resources of most services it highlights how important some services prioritise safety for children;
- Having many well lit areas including outside e.g. in car parks etc;
- Having the ability to lock their door away from other young people (while staff remain to have access);
- Ensuring the staff team can protect children from each other i.e. intervening quickly in any conflict between children;
- One service felt that high surveillance of children ensured safety This was made tangible by movement sensors in their room that would alert staff if a child left his bed. The intrusion on privacy and individual rights is a significant one and it is not presented here as a recommendation, only as an example of high supervision in some services;
- The Sanctuary Model has been promoting safety as a core aim of services for many years and has a number of practical examples of this in practice including safety plans, an example can be found here: http://sanctuaryweb.com/Portals/0/2010%20PDFs%20NEW/2010%20Bloom%20Safety%20Plans.pdf;

Predictability

Creating consistency, structure and continuity was a core aim of all those services visited. This is probably best described collectively as creating a *predictable* environment. Service providers argued that creating a routine and structure that is predictable and safe can enable the child to expect that this will continue and that harm is unlikely. Without predictability like this the child may have difficulty predicting how the future will be and therefore base any expectation of their future on their past i.e.previous traumatic experiences. If they expect more traumatic experiences to occur then they are likely to remain in a distressed state that leads to concerning behaviour.

One of the most valuable findings of the fellowship was that predictability, structure and routine was possible to achieve at a level that appeared to

significantly help children. There were factors that seemed to make this more likely: young children i.e. pre-adolescent, a controlled environment e.g. not in an urban setting where external factors such as other young people could disrupt plans and a high staff to child ratio. There are services in the UK that also appear to have achieved this and they too seemed to have achieved this due to the high levels of staff and minimal external factors, such as with secure care.

To provide the reader with some tangible examples of how predictability was provided there is a description below of the morning routine of one unit that looked after approximately twenty children in a single unit.

> *At the same time each morning the staff group would meet in the communal area and discuss whether there was any specific information that needed to be shared regarding young people before they were woken. Each staff knew their role and would do this at the same time i.e. the same member of staff would wake the same group of children. The lights were dimmed and staff spoke quietly while they woke the children up. Each child was woken and then given feedback on what they did well the previous day and what was expected of them for that day i.e. a target for improvement. The children then went through the same order of routine; bathroom including washing and teeth, then dressed, then breakfast. The children were staggered into groups and had a specific amount of time to complete the tasks. The same person served breakfast and the children then walked to the education department in the same staggered groups as they were woken. All throughout the staff kept the volume and lights low and praised and reinforced any child's positive behaviour.*

This is an extreme example and is only described to illustrate how structured and routine care can be. There are obviously both negatives and positives to such a rigid level of structure and routine and many practitioners may question whether this risks institutionalisation and sacrifices spontaneity. The balance is difficult and only individual services can decide upon what is appropriate for them.

14. Written policies that explicitly include and support trauma informed principles

Services that had fully embraced trauma-informed principles had this as a running theme throughout a number of policies. This was perhaps most visible in policies on assessment, treatment and holding safely. The policies explained the rationale for procedures and protocols through a trauma model. As an example, in one transition policy it noted how many children had negative expectations of the future given their difficult past and therefore should be informed in detail about their future placement through a number of ways including meeting staff, visiting on numerous occasions, being given information (e.g. pictures, videos,

literature etc.) and be asked to express anxieties they have about the placement. This often meant that, where appropriate for the individual child, children had a period of numerous weeks transitioning to a placement rather than a quick and uninformed transition.

15. Presence of a defined leadership position or job function specifically related to TIC

In each service visited there was a lead of trauma-informed care. This person was usually a therapist or psychologist. There were numerous titles given to the role but they all provided the same role: translating the theory of trauma into practice and ensuring integrity and adherence to the principles.

They often provided an important link between services and essentially provided a common language with which to discuss young people, their experiences and their behaviours. Anecdotally this significantly increased collaboration within the services and resulted in a greater consistency and continuity of care.

In addition to this the role meant that the individual had the responsibility to develop and drive a project plan to implement trauma informed care across a service. Many of the services reported using guidance from *Implementation Science*, for more information, see Mitchell (2011).

Conclusion

This article suggests that residential care organisations who wish to implement trauma informed care can do so by following the core components listed by Hanson and Lang (2016). There are numerous approaches that can be implemented within this framework including the neuro-sequential model of therapeutics and the sanctuary model in addition to specific tools and standardised assessments.

Many of the practical examples can be implemented with relatively limited cost or may already exist in some services. However, translating all components into practical and tangible actions and processes presents a challenge to practitioners working in difficult environments, with challenging children and limited resources.

Trauma informed care does not present a panacea to the difficulties facing children who have experienced trauma. A key criticism of the approach is that it has been subject to very limited evaluation and little is known about whether it can increase the effectiveness of care in meeting the needs of young people who have faced traumatic experiences.

There is at least strong anecdotal evidence from carers and services that trauma informed care improves the care children receive. Services report that it provides useful explanations of children's concerning behaviour that can help carers respond in confident and helpful ways.

As residential care implements trauma informed principles in more settings there are going to be significant tests to how the theory is translated into practice. Becker-Blease (2017, p.137) argues that 'even the most experienced clinician or researcher cannot rely on intuition alone to create trauma-informed settings' and highlights how attempts to be trauma informed may end up having unforeseen negative consequences. This will be an important area of study as the field develops and more practice becomes trauma informed.

About the author

Dan is a forensic psychologist who has worked in residential and secure care for over ten years. He has completed research including that which seeks young people's views on their experiences of care. He is currently working to increase trauma informed care in residential and education services.

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