

Trauma-informed approaches to violence reduction: A qualitative exploration with multi-agency partners in a Violence Reduction Unit in England

Authors

Hilary Stewart¹, Koser Khan, Joanne Goldthorpe, Fiona Ward, Heather Brown, Paula Wheeler, Lindsay Youansamouth, Susannah Clarke

Institutional Mailing Addresses

HS, KK, JG, FW, HB, PW: Division of Health Research, Health Innovation One, Sir John Fisher Drive, Lancaster University, Lancaster, LA1 4AT, United Kingdom

LY: Centre for Child and Family Justice Research, Department of Sociology, Lancaster University, Lancaster, LA1 4YW, UK

SC: Lancashire Violence Reduction Network, County Hall, Fishergate, Preston, PR1 8XB, UK

Corresponding author

Hilary Stewart: Lancaster Medical School, Faculty of Health and Medicine, Health Innovation One, Sir John Fisher Drive, Lancaster University, Lancaster, LA1 4AT, United Kingdom

h.stewart4@lancaster.ac.uk

¹ Present address: Lancaster Medical School, Faculty of Health and Medicine, Health Innovation One, Sir John Fisher Drive, Lancaster University, Lancaster, LA1 4AT, United Kingdom

Trauma-informed approaches to violence reduction: A qualitative exploration with multi-agency partners in a Violence Reduction Unit in England

Abstract

Trauma and adverse childhood experiences are a public health issue and risk factor for future violence and criminality. This has motivated stakeholders to consider approaches which tackle the root causes of violent crime. One such approach is the dissemination of trauma-informed practice, funded by the Home Office and led by Violence Reduction Units. Violence Reduction Units broadly seek to prevent and reduce violence through early intervention and collaborative working with multi-agency partners. Implementing trauma-informed approaches as a public health means of violence reduction are novel, and there is limited research exploring whether and how these approaches work. This paper presents findings from an evaluation of trauma-informed approaches led by a Violence Reduction Unit in England to explore their acceptability, facilitators and barriers. Drawing upon qualitative interview and focus group data (N=49) gathered during an evaluation in 2022, and guided by Normalisation Process Theory framework, we evaluated the dynamic work involved in adopting trauma-informed approaches in three diverse programmes of work. Findings indicate that trauma-informed approaches are acceptable ways of working for participants, with evidence to suggest that trauma-informed training shapes practice and can be embedded in organisational policies and practice when supported by funding, resources and appropriate leaders. Facilitators and barriers to embedding trauma-informed approaches are considered, for example, leadership, organisational buy in and resources are needed to embed commitment to trauma-informed approaches. Future research should explore whether and how trauma-informed approaches improve outcomes for clients.

Keywords: Trauma; Adverse Childhood Experiences; Trauma-Informed Approaches; Violence Reduction; Violence Reduction Units.

Introduction

Trauma and adverse childhood experiences (ACEs) are understood as a significant public health issue with substantial economic health burden, the costs of which are considered 'unsustainable', and with significant consequences to individuals and communities (1-4).

Trauma-informed approaches have generated international interest and enthusiasm, and are conceptualised as a way of responding to trauma/ACEs, building on a legacy of work which documents the impact of childhood adversity on neurological, biological, physiological and social development (5-7). Research which links trauma and anti-social behaviour, together with growing recognition of the pervasiveness of traumatic experiences amongst criminal justice-involved populations has led to the implementation of trauma-informed practice in criminal justice agencies across the world(3, 7-10) . Trauma-informed approaches to violence reduction have recently found currency in the UK with the government identifying ACEs as a risk factor for future violent offending(11). In response to increasing rates of violence in England and Wales over the period 2014/15-2017/8, the UK government funded the development of Violence Reduction Units (VRUs) which are encouraged to take a multi-agency 'whole systems' or public health approach to tackling serious violent crime at the root(12). Public health approaches to violence are advocated by the World Bank and World Health Organisation as an effective 'alternative to criminal-justice-centred responses' and seek to shift focus to addressing the drivers of violent crime(13, 14). As such, VRUs have been tasked with implementing early intervention and preventive activities for young people at risk of serious violence, including trauma-informed training for frontline staff and support to capitalise on "teachable moments"(12, 15, 16). Such approaches diverge from traditional models of policing as reactive or 'enforcement' and complement the ten-year plan contained within the Policing Vision 2025 to move to proactive and preventative forms of policing (17, 18). Since the completion of our evaluation in 2022, a rapid evidence review for the UK government in 2023 reported that trauma-informed approaches in the criminal justice sector have been found to reduce reoffending, address criminal risk factors, and reduce time to discharge from secure care suggesting that such approaches hold promise in these

areas(19-23). As VRUs are relatively new the evidence base around implementation is limited and there is very little literature or evaluations exploring their impacts (24, 25). As such, there is a gap in understanding how such approaches are being implemented in multi-agency settings in the context of violence reduction and how such approaches shape knowledge and attitudes of staff (15).

The aim of this study was to explore the dynamic work involved in implementing trauma-informed approaches in practice, and the acceptability and barriers to implementation for those involved in delivering trauma-informed approaches across three programmes of multi-agency work supported by a VRU based in England (hereafter referred to as VRU-A). VRU-A aims to embed trauma-informed approaches within their partnership organisations and workforce to ensure that practitioners are informed and skilled in recognising the wider impact of trauma on the causes and effects of violent behaviour and to prevent the re-traumatisation of clients. In the next section the paper provides a brief background to trauma-informed approaches in the context of VRU-A and a summary of the trauma-informed work programmes currently being developed in VRU-A's locale. The paper then proceeds to methods, before presenting findings framed under the Normalisation Process Theory framework (26, 27).

[Background: Trauma-Informed Approaches and VRU-A's work programmes](#)

Definitions of trauma-informed approaches are varied and can incorporate diverse practices across different social spaces(15). This makes it difficult to define a prototypical model against which practice, activities and outcomes can be measured (15). Trauma-informed approaches within criminal justice settings encourage the adoption of a 'trauma lens' to understand disruptive or antisocial behaviours as "trauma symptoms in disguise", (Levenson et al.,(7)) which require careful and compassionate support (4, 7, 19). Although there is not a standardised model, the Substance Abuse and Mental Health Service Administration

(SAMHSA) approach to trauma-informed practice has established itself as a dominant framework for organisations seeking to adopt trauma-informed approaches (28).

SAMHSA takes a public health and preventative approach to trauma, and was originally developed for use in settings where behavioural change constituted part of support the service provides (e.g. in addiction support services(28)) recognising that services which were not trauma-sensitive may fail to meet the needs of those living with the impact of trauma. . Broadly speaking, trauma-informed approaches are premised on growing recognition of the prevalence and impact of trauma, and an awareness that those with trauma histories may face greater barriers when using services that are not trauma-informed(6). Moreover, 'trauma-informed' describes a continuum of practice, ranging from trauma-aware (for organisations early in the development of awareness) to 'trauma-informed' (for organisations that have achieved a cultural shift throughout the organisation)(31). Following consensus building with stakeholders, including those with lived experience as service users, SAMHSA developed six trauma-informed principles which organisations are encouraged to use to audit their environments, policies and practice:

- **Safety** – prioritising physical and psychological safety for clients;
- **Trust and Transparency** – conducting operations with transparency to facilitate trusting relationships between all members of an organisation;
- **Peer Support** – facilitating support from peers with shared lived experiences to encourage hope, recovery and healing;
- **Collaboration and Mutuality** – promoting the meaningful sharing of power and shared decisions;
- **Empowerment, Voice and Choice** – nurturing belief in personal strengths and developing self-advocacy skills;
- **Cultural, Historical and Gender Issues** - acknowledging community-specific trauma and its impacts, and responding with appropriate support (28)ⁱ.

The expression of these principles will vary across roles and levels within an organisation. For example, enacting “safety” may look different in frontline interactions with clients than it does in managerial or leadership roles. However, achieving this principle depends on policies, systems, and structures that embed safety at an organisational level(28) . Trauma-informed organisations, for instance, prioritise both physical and psychological safety by adapting environments, policies, and practices to minimise the risk of re-traumatisation. This may include avoiding practices such as seclusion or restraint in custodial settings, recruiting staff who embody the values of the service and reflect the diversity of the service-users, and fostering trusting, respectful relationships between staff and clients. (6, 15, 19, 29). Trauma-informed approaches should therefore be understood as operating across multiple, interconnected levels(32). It is suggested that organisations which work in trauma-informed ways can also better support staff wellbeing (for example, with issues of vicarious trauma and compassion fatigue) by implementing supportive procedures(28). However, this relies upon embedding trauma-informed principles within organisational structures, which can be challenging and resource intensive(29-31). Indeed, although integral to developing trauma-informed services, addressing power imbalance (via collaboration and peer support) and engaging with cultural, historical and gender issues are less reported on within literatures, although trauma disproportionately effects sexual and ethnic minority groups(32) (19).

In VRU-A, three programmes of activities were identified as trauma-informed work and had been in operation since 2020:

1. *Diversion Programme*: A police custody intervention programme delivered in partnership with local football and community trusts. Recognising the impact of trauma on individuals’ trajectories and as a risk factor for criminal behaviour (10), this programme takes a trauma-informed approach to working with clients and aims to reduce re-offending in young adults aged 18-35 years who have been detained for violence. Coaches work with clients holistically to identify unmet needs, establish individual action plans, support access to

activities (such as job-seeking skills workshops or fitness classes) and making onward referrals to appropriate supportive services (e.g. housing, benefits and employment support, addiction services, mental health support).

2. *Trauma-informed Education*: Recognising that trauma experiences can impact children's abilities to emotionally regulate, learn and develop(33), schools were provided trauma-informed training, resources, mentorship and coaching. This included development of school-specific action plans on making school environments, policy and practice trauma-informed (e.g. removing punitive approaches to behaviour) and placing emphasis on the importance of positive relationships between staff and pupils(33). This programme aims to increase resilience in children and young people, reduce exclusion rates, increase attendance and raise attainment in schools.

3. *Trauma-informed Training*: A programme which focused on trauma-informed workforce development through the delivery of trauma-informed workshops and training across a range of statutory and voluntary organisations. The participants interviewed worked in local government, health, education and the third sector and had attended training developed for leaders and managers, as well as 'train the trainer' programmes and were responsible for cascading the approach across their organisation.

Each programme theorises the importance of working in trauma-informed ways to deliver support to potentially vulnerable persons, although the application of the approach and the goals of the programme are distinct across settings. Our analysis does not assess to what extent these programmes achieved their broader outcomes, but rather discusses the acceptability of trauma-informed approaches and dynamic work involved in implementing trauma-informed approaches in practice. The paper will now discuss methodological approach before proceeding to the empirical section and discussion.

Methods

The study was granted ethical approval by [Anonymized] Research and Ethics committee. A qualitative, exploratory approach was taken, using Normalisation Process Theory (NPT) to guide data collection and synthesise findings across this evaluation. NPT is a theory of implementation that has been used to support evaluations of complex interventions by exploring how new ways of working are embedded and normalised in organisational contexts(26, 27). NPT conceptualises social phenomena through four constructs which characterise the mechanisms and investments made by individuals/organisation when implementing an intervention(26):

- Coherence (sense-making work when operationalising new practices)
- Cognitive Participation (relational work when building a community around new practice)
- Collective Action (operational work when putting an approach into practice)
- Reflexive Monitoring (appraisal work that reflects on how it is going)

Using a theoretical framework to guide research can be practical, helping to structure thinking and encourage exploration of issues that might otherwise not have been considered. Flexible application of NPT is encouraged by its developers(26, 27). NPT constructs can be framed as a series of simple statements and questions which enable researchers to consider the social processes of implementing an intervention, or in this case, an approach. As such, the NPT framework is not a way of measuring an implementation, but a critical framework to think through the factors which may inhibit or promote a practice, intervention or approach. The NPT framework emphasises that an implementation should be understood as a dynamic process and as such is engaged in ongoing and interactive practices of accomplishment(27, 34). The NPT framework enables a theorisation of the complexity of social systems through recognition of the way that implementations, such as the trauma-informed approach can be thought of as an “ensemble” of material and cognitive practices(34). Our topic guides for interviews and focus groups were organised around the

four NPT constructs and based on a literature review and VRU aims and objectives for implementing trauma-informed approaches. Examples of NPT constructs and questions that guided the analysis are provided in table 1 below.

Table 1. Examples of NPT constructs and questions

NPT Construct	Examples of questions that guided analysis
<i>Coherence</i> – exploring how participants understand and attributed meaning to trauma-informed approaches	<ul style="list-style-type: none"> • Do participants see the trauma-informed approach as a new and valuable way of working? • Do individuals understand what the approach requires of them?
<i>Cognitive Participation</i> – exploring participants' commitment to embedding and promoting the approach	<ul style="list-style-type: none"> • Are participants committed to the approach? • How able do they feel to promote the trauma-informed approach?
<i>Collective Action</i> – exploring the work of enacting trauma-informed approaches and translating it into collective practices	<ul style="list-style-type: none"> • What factors (relational, contextual, skillset) support or inhibit implementing the approach in practice? • Does the approach complement existing ways of working?
<i>Reflexive Monitoring</i> – exploring how participants appraise trauma-informed approaches in their work and its future applications	<ul style="list-style-type: none"> • What do participants think is important for taking the approach forward in their work?

A total of 49 participants contributed to the evaluation (see Table 2 for a summary of work programme, participant background, data collection methods and number of participants). Purposive sampling was used to recruit participants from each of the three programmes. Interview or focus group were chosen according to the convenience and preference of participants, and consent was obtained prior to participation.

Table 2. Summary of Work Programme; Participant Background; Data Collection Method; and Number of Participants.

Work Programme	Participant Background	Data Collection Method	Number of Participants
Diversion Programme	Diversion Programme coaches	Interviews	7
	Football Trust Managers	Focus Group (x1)	7
	Custody Suite Staff	Focus Group (x2)	8
Trauma-Informed Education	School leaders, teachers, pastoral and classroom staff	Focus Group (x3)	20
Trauma-informed Training	Multi-agency professionals who had attended leaders and managers training. Participants worked in local government, health, education and the third sector	Paired Interview	2
		Focus Group (x1)	4
		Interview	1
Total Number of Participants			49

Table 3 shows the demographic characteristics of our sample (reported disability, gender, ethnicity, and age).

Table 3. Participant Demographics.

Age	N	Disability	N	Gender	N	Ethnicity	N
18-24	1	Yes	2	Female	9	White – British	24
25-34	5	No	24	Male	17	White and Asian	1
35-44	9	Prefer not to say	1	Prefer not to say	1	Indian	1
45-54	8	Not stated	24	Not stated	24	Prefer not to say	1
Prefer not to say	1						
Not stated	24						

We were able to collect this data for 26 participants. Participants were adults aged between 18-64, two reported having a disability, 9 were female and 17 male, 24 participants reported having a white-British ethnic background, one mixed white and Asian and one from Indian background. Two participants chose to provide age group only and 23 participants did not provide any demographic data. Therefore data was not analysed in relation to demographic characteristics.

Interviews and focus groups were audio recorded and transcribed. Transcripts were analysed with the support of NVIVO software. First they were analysed inductively by members of the research team (Anonymized), using reflexive thematic analysis as described by Braun and Clarke (35, 36) to explore if there were any themes particular to each programme, then deductively, against the NPT constructs to synthesise findings around how trauma-informed approaches are being implemented holistically across the programmes. To

ensure trustworthiness of the analysis (that codes and themes represented the data accurately based on subjective scrutiny) and to ensure consistency of the application of the NPT framework, the process was shared and discussed with other members of the research team (Anonymized). While a formal inter-coder reliability codebook was not used, the team worked closely and iteratively throughout data collection and analysis, which facilitated shared understanding and alignment in coding. No substantive discrepancies emerged during the analytic process. Authors Anonymized and Anonymized (7&8) work for VRU-A that commissioned the original evaluation were not involved in the conduct or analysis of the evaluation, but have supported the development of this paper.

Findings are presented under the NPT constructs of *Coherence*, *Cognitive Participation*, *Collective Action* and *Reflexive Monitoring*. Where quotations are included to support the findings, the reference number refers to the interviewee. For focus groups, it refers to the whole group rather than individuals.

Findings

Coherence: Understanding the value and benefits of trauma-informed approaches

Across the three participant cohorts, the level of previous experience with trauma-informed approaches was mixed, however, understanding was broadly coherent. Some said the approach was “*completely new*” (104) to them, whilst others considered themselves very trauma-informed. Although new to some participants, the approach was often seen to build upon existing knowledge of Adverse Childhood Experiences (ACEs) and was considered complementary to pre-existing professional practice, for example Contextual Safeguarding roles, behaviour management strategies (e.g. Team Teach) or clinical training in specialist services (e.g. perinatal mental health). Participants described that the trauma-informed approach had positively challenged them to think about clients’ behaviours and needs in new and different ways.

401: it's just enabling people to actually see behaviours from a different perspective and with some empathy

104: I think it really helps us to understand the types of people that we're coming into contact with on a regular basis and to understand that we're not just dealing with someone that's committed an offence, we're dealing with someone who's potentially had a really turbulent life or...some trauma

Understandings were described by participants as a “*change in mindset*” (101) and “*looking at the bigger picture*” (304). The trauma-informed approach was welcomed as a way of understanding client/pupil behaviour as potentially stemming from the impact of traumatic experiences.

3022: it's having an understanding of what's happening in the brain and what triggers children. It's just a bigger understanding, isn't it really

3029: pointing out that, you know, they have misbehaved but also really taking into account, I know this child, I know this child has this trauma

This new way of thinking was considered to transform taken-for-granted beliefs about criminality/challenging behaviour as innate and encouraged more “*openminded*” (104) approaches to understanding the trajectories of people who may have previously been considered inherently ‘bad’.

101: being trauma-informed and being open to that person not specifically being a bad person, just 'cause they've ended up where they are.

Broadly there was agreement across participant cohorts that the trauma-informed approach sought to embed understandings of the prevalence and impact of trauma “*recognizing we've all got triggers*” (301), and how trauma may shape clients' trajectories and behaviour. Implementing the approach was seen as offering an alternative to punitive methods of

dealing with 'bad' or offending behaviour through equipping participants with more empathetic and compassionate responses.

401: So actually what we want to do is provide a service for patients recognising that actually people do present in different ways based on their life experiences. And also actually in those services, people are experiencing trauma at the time. So we just want people to be more compassionate, I guess.

There was acknowledgement from some school staff participants that unless someone had received trauma-informed training, these new ways of working with pupils could "*appear as though they're being let off the hook for certain behaviours*" (302). However, these compassionate responses were understood as part of a broader holistic approach to working with clients/pupils and responding to unmet needs or "*what's missing in their life*" (106). The trauma-informed approach was broadly recognised as equipping participants with "*the knowledge of how to deal with those individuals and how to support them*" (102) and identifying organisational procedures or practices that were not conducive to taking a trauma-informed approach.

Although levels of understanding and appreciation of the approach among participants was good, participants noted that this was not always the case with others in their organisation or in the wider networks they worked with. It was anticipated that as the approach was rolled out across services and organisational levels it would disseminate the importance of the approach to wider networks.

Cognitive Participation: How do people and groups come to participate in trauma-informed approaches?

Responses under the construct of cognitive participation were more varied across participant cohorts. There was initially some organisational hesitancy towards enrolling the trauma-informed workstream amongst the Football Club Trustees responsible for delivering the

Diversion Programme and seconded staff. Participants suggested that prior to fully understanding the approach, managers were not interested, or perceived the programme as high-risk, with concerns about safeguarding staff and the sustainability of the work/funding. However, some participants described promoting the beneficial value of the programme for local communities and that the service fitted well with activities that Football Trusts delivered as part of their community engagement programme. On reflection, it was suggested that the trauma-informed approach had encouraged Football Trusts to be more “*openminded, little bit more inclusive*” (104). Once the approach had been enrolled in the Diversion Programme some participants (101; 104) described the stigmatising attitudes of other coaches within the Trust as Diversion Programme were perceived to be “*bringing a criminal into the Trust*” (104). However, participants were committed to the approach and said that being trauma-informed was “*about changing that mindset*” (101) and helped to challenge the “*automatic perceptions and responses*” (104) towards offending behaviour within the wider Trust.

Diversion Programme coaches, by virtue of being associated with local Football Trusts, considered themselves well positioned to work with clients in trauma-informed ways because of the familiarity and approachability of respective clubs. This enabled staff to build consistent and positive relationships with clients in relaxed environments.

101: It's familiarity, isn't it? I think it's that you open the cell and it's like Oh it's [FOOTBALL CLUB1], it's [FOOTBALL CLUB8], it's that immediate connection..., it's about breaking down those barriers.

107: ... I don't think you'd want to sit with a Police officer for 12 weeks on a course, but if you sat with someone in a football uniform and you know, and I could show them around the grounds if they're massive football fans and I could show them some memorabilia and things like that, ...that really establishes a connection straight away because they are obviously proud of their community.

The Diversion Programme service and trauma-informed way of working with clients in custody was occasionally met with “*raised eyebrows*” (104) from police custody suite staff. However, Diversion Programme coaches promoted the approach to others they came into contact with as part of their role. Interviews with wider members of the custody team indicated that awareness and understanding of the Diversion Programme was limited, although upon learning more details of the approach, custody staff were usually receptive to the Diversion Programme service and willing to learn more:

101: when we first started ...going into custody, we had a lot of ‘who are you? What are you doing here? We... didn't invite you here. Why you're here?’ Now, I think they might be starting to understand like who we are and what we can offer to them 'cause at the end of the day, if we're stopping one person from reoffending, wherever, we're reducing their workload.

The positive reception of Diversion Programme led to opportunities for coaches to enrol others through delivering training to other such as custody suite staff and wider networks such as probation services. Participants said delivering such training had been slowed by the pandemic and they anticipated more opportunities to disseminate the approach in the future.

Diversion Programme staff described that they “*bought into*” (104) the approach, noting that the approach had the potential to effect change beyond the individual client they were working with:

104: ... I'm a massive fan of the trauma-informed approach. I've really bought into it on a personal level and a professional level...whilst we're looking at trying to reduce reoffending by doing that, you're also reducing the amount of victims. I do kind of carry that approach when I'm working

where I maybe helping someone that's committed an offence, but I'm also helping, you know, reduce the number of victims in the future as well.

Participants from Trauma-informed Education workstream were committed and willing to engage with the approach, suggesting that it offered valuable ways of working with both pupils/parents and fellow staff. School staff said that the approach fitted well with teaching practice, behaviour management strategies (Team Teach) and safeguarding processes, with some suggesting that much of their practice was already considered trauma-informed and that the training enhanced understanding of children's homelife situations:

301: I think it fits in quite well with my job role 'cause I spend most of my time on the phone to parents or dealing with the pupils that need to come and talk ...I'll get more knowledge about home life. So you just know what they're going through and why maybe they behave the way they do at certain times

School staff reported that trauma-informed training had given them strategies to deal with difficult situations which teaching training had not prepared them for. Moreover, taking a trauma-informed approach was thought to make teaching more effective as children working in calm conditions associated with trauma-informed classroom environments were "*ready for learning as opposed to fighting*" (301). As such, school staff agreed the approach should form a part of their role, and that it was a valued strategy for *de-escalating* challenging situations and readying pupils to learn.

302: ... unless they're open to receiving the information and for whatever reason they're not, if we're not able to do deal with that then we're not going to be able to do our jobs anyway.

302: We spend a lot of time with these children, so it's right that we are aware of this and that we know how to deal with things, and strategies,

because your teaching training doesn't give you enough ammo, really, to be able to deal with every situation.

Some participants identified that there were a few teaching staff within schools who were not on board with the approach. Such members were described as "*ritualised in their practice*" (301) and wedded to the idea of consequences for misbehaviour: "*a huge thing trying to change the mindset of some members of staff that have been here a long time to get them out of that constant word of consequence*" (301). However, participants were committed to embedding the approach and spoke of reluctant staff as being "*heavily outnumbered*" (301). In this respect, the approach being based upon scientific understandings of the impact of trauma on bodies and behaviour was important, where participants described the approach as being backed by evidence:

302: "I think it's giving us an evidence base to say, look, this is what we do... it's not just 'cause we think it's a great idea like it gives everyone a bit more weight to say, look, it's actually based on science"

In the Trauma-Informed Training cohort, participants identified the approach as something their respective organisations would benefit from and should buy into. However, for some individuals newer to the approach there was some concern that leaders within their organisations did not consider the approach relevant or important to their service. This was broadly attributed to a lack of awareness. Part of the task was about enrolling wider members of staff to understand the importance of the approach, so that they might be able to persuade other third sector organisations:

401: "...it's about how do we actually open them up to understand this approach and then for them to become influencers because [Third Sector Organisation is] all about influencing other organizations that we work with.

The approach was considered a valid and legitimate way of working that was relevant to the broad range of clients that the Trauma-Informed Training group worked with:

402: I think a trauma-informed way of thinking, trauma-informed practice, it feels as though it helps us best understand the needs of their clients and offer the right support, right place at the right time....

Additionally, the approach was considered an appropriate and legitimate way of supporting staff wellbeing, with the issue of resilience and vicarious trauma considered a pertinent issue facing organisations. Some participants were not sure that vicarious trauma was supported appropriately in services that routinely worked with traumatised clients (403) and emphasised the importance of access to clinical supervision. Participants suggested that spaces be created where experience could be reflected on and best practice could be shared. Participants stated they were committed to rolling the training out more widely across their organisation. Universal roll out of the trauma-informed approach was something that was considered important across all participant groups:

403: I think there's a lot more work to do in terms of trauma-informed services... I think that needs to be much wider than just the police, healthcare have awful long way to go, as have prisons.

Collective Action: How are trauma-informed approaches enacted in collective practices?

Operationalising the approaches in practice were distinct to each cohort by virtue of their distinct professional responsibilities. However, all groups described work undertaken to embed the approach in collective practice. For the Diversion Programme, when it came to operationalising the approach in practice, the cohort said that during early phases of implementation there was a lot of “background work” (110) to enact, for example, developing risk assessment, safeguarding and lone working policies. Additionally, there had been some teething issues when integrating within custody suites (e.g. delays to security vetting).

Overall, Diversion Programme coaches considered themselves to have integrated well within custody suites and developed positive working relationships with staff, however, police staff in custody settings did not feel they had been informed about the Diversion Programme offer. Occasionally where police and custody staff were ambivalent towards the approach and the work of Diversion Programme coaches, it made interactional working more challenging as Diversion Programme staff said they felt they were “*getting in the way*” (102) and had to explain their role and approach to police and custody suite staff, many of whom were on six-monthly rotations. Diversion coaches thought that some custody suite staff were more open to the programme than others:

102: it's just a couple of dependent on their mindset, really as to whether they're in the job to help rehabilitate, whether they're just there to collect the paycheck at the end of the month.

Navigating positive working relationships with clients was also discussed, and coaches reported positively on their affiliation with Football Trusts as fostering an identity separate to the police, one which enabled them to gain trust with clients:

106: I think when you walk into custody, see you in a badge, a tracksuit, so we're a bit different from the police officers you're dealing with, it makes them think straight away like 'Ah you're not a police officer', not here to like send them down, you're there to actually help

Coaches described their work as supporting clients with “*positive interventions*” (102) to prevent them from reoffending. This included facilitating access to treatment services, housing, financial/benefits advice, volunteering opportunities and community-based activities. Establishing connections with services such as addiction support was considered broadly successful as Diversion Programme coaches described making good contacts with relevant agencies. There were two notable exceptions to this. Diversion Programme

coaches described facilitating access to housing for clients as almost impossible because of a lack of availability of housing in the area, and that this occasionally had an impact on clients' trust in the Diversion Programme. Coaches also described the challenge of accessing mental health services for their clients and that long waiting times for appointments potentially jeopardised client engagement with the Diversion Programme:

103: It's knowing that, we could speak to the client and say look the support is there but it is the waiting list ... but trying to build that bigger package as well. So yeah, we can't get mental health support at the moment, but let's get some fresh air. Let's go and do some activities that will just make you feel better.

102: if you're seeing some of the barriers [housing/homelessness] from early on then sometimes that can reflect poorly for the client because they lose that like the trust in you when you can't sort that out straight away

As such, broader contextual environments were considered to negatively impact the extent to which coaches felt able to ensure physical and psychological wellbeing for their clients. Despite these challenges, Diversion Programme coaches described trying to engage clients in other activities whilst waiting for support, and were positive about being able to meet a range of other needs for clients (including access to employment, education, training, developing positive peer networks and interest in activities/hobbies).

The Trauma-Informed Education cohort described making adaptations to their behavioural policies in recognition that punitive approaches were incongruent with being trauma-informed.

301: Our behaviour policy wasn't particularly trauma-informed and some of the ways we went around dealing with some behaviours were not the best practice ever

Examples included: implementing 'no shouting' policies; the creation of 'safe spaces' that children could use as part of an agreed process with staff; adapting language regarding misbehaviour: and less punitive approaches to absences and uniform transgressions. A number of classroom and digital behaviour management resources were also described as supporting new trauma-informed ways of working such as "Class Dojo" and "Trackit Lights" behaviour tracking system. Adaptations were also made in recognition of staff wellbeing, for example through adapting a programme of support as described in the quote below:

301: Employee Assist that is something that any staff can go and get themselves, it's support and counselling and things like that so that it's not just the children and the parents we're supporting as well. It's the staff

As with the Diversion Programme cohort, integration of trauma-informed approaches was mediated by broader contextual factors as school staff reported long waiting times for access to external support services such as children's mental health services (e.g. CAMHS).

Trauma-Informed Training cohorts described themselves as able to perform the tasks required when implementing the approach and considered themselves to have the necessary skill set for trauma-informed practice. However, participants identified that they were at various stages of becoming trauma-informed. For one participant in Trauma-Informed Training, it was thought that their service "*naturally attract[s] people I would suggest who do have a have a trauma-informed attitude*" (401). Another participant described the approach as fitting well with "*psychologically minded*" services (403). Some participants described that implementing the trauma-informed approach had had benefits for their organisation as they now facilitated counselling sessions, resilience building courses, as well as embedding flexible access to mental health support to support staff wellbeing:

401: one huge change that HR have done, we use the platform Bright HR, which has an extension that's like a counselling platform. And then there's a 24/7 hours service and they've recognized that we need to have that in place as an organization for people to be able to make those calls whenever they need.

One participant described that as a result of the training provided by VRU-A, they cascaded the trauma-informed approach across their organisation through mandated training. Although the approach had increased participants confidence in advocating for clients' needs, participants said they would appreciate opportunities to reinforce the approach.

402: So for me it's about having those reminders ... having those bite size, refreshers if you will through supervisions. Meetings, even just discussion within the office between colleagues keeping it at the forefront

Similarly, the Diversion Programme and Trauma-Informed Education groups reported that operationalisation of the approach would be enhanced if opportunities to reinforce the training were available. Moreover, some participants noted unless you were delivering the training on a regular basis it was easy to lose confidence and forget aspects of the training. Embedding the approach in practice was considered challenging when dealing with large organisations, staff sickness and turnover.

304: there's a big staff team here is over 90 members of staff. It'll take a while to embed it across the school. But yeah, I think the message is slowly getting through. I think the majority are looking at the bigger picture now

103: ... we will be doing trauma-informed and ACE informed training next week. And even though I've done it, it's about doing it again and just reaffirming that knowledge and taking this information in really. Even if you

don't use it every time, there will be that one time where it is important and you've really got to throw yourself into it and support that person.

All three participant cohorts reported positively on the leadership and mentoring provided by VRU-A which was considered important for maintaining trust and confidence in the approach. In the Diversion Programme, the VRU-A lead is a former police sergeant who is “*keen on making sure [Diversion Programme] are being looked after in custody*” (105). As a “*well-respected former police sergeant*” (101) and approachable leader, he was considered to bestow gravitas to the approach:

101: for him to come in and say why we are here and what we do and believe in it, I think that might change a lot of mindsets, so all right, well, if [POLICE SERGEANT1] says it's a good thing it must be a good thing.

School staff spoke very positively of the VRU-A lead responsible for overseeing their workstream and valued their opinion as an expert with strong experience of putting trauma-informed theory into practice in schools, and she understood the local educational context: “*she gets what our school is about*” (304). The Education Lead regularly met with schools to deliver additional training in engaging ways and provide guidance on “*next steps*”, such as how to disseminate the approach to families (302).

301: That's been really important to keep us going. Yeah, [Education Lead]'s brilliant... [Education Lead] has helped us through a lot of it.

302: I think because we are part of the school, we can't see things that she sees. She's given me some really key things to work on, like some of the environments, like the key language. I think it's also really important to have somebody who's experienced, that has the scientific research

backing behind what she's telling us. She also delivered it in a really fun way.

The importance of having the right leaders driving the trauma-informed work forward was also identified in Trauma-Informed Training:

401: I think the vision to have the county trauma-informed is brilliant and its high aspiration for anyone to declare. But the people who are driving it forward, I definitely [think it's] the right people and you sense that when you're actually participating in the training as well. So you know I think it's excellent.

Reflexive Monitoring: How do participants appraise the trauma-informed approach?

Across all participant cohorts, the trauma-informed approach was considered a useful way of working with clients and pupils/families. Broadly, participants agreed that a universal trauma-informed approach across services would improve multi-agency working and make implementing the approach easier. Approaches for reflexive monitoring differed across each cohort.

Reflecting on how they might demonstrate the impact of trauma-informed approaches, Diversion Programme coaches said that clients' progress was monitored in Views (a software designed for charities, non-profits and social purpose companies to organise and analyse data in a single platform) and Excel spreadsheets. Diversion Programme coaches used 'Views' to record client outcomes including facilitated support into treatment services, housing, financial/benefits advice, volunteering opportunities, education and employment training and community-based activities. Coaches were positive about the data collection systems, however suggested that whilst Views was good at recording 'solid' outcomes such as getting people into work, there were also significant 'softer' outcomes for clients such as increased confidence or improved wellbeing that could potentially be missed. One coach also said there may be an information gap in recording things that had not worked so well:

'from my experience we do tend to record a lot of the positive stuff so maybe if there's a way of easily collecting challenges and setbacks and recording them' (104).

In Trauma-Informed Education, the difficulty of capturing these softer outcomes was also echoed. Several different tools and systems were identified that were used to describe and record staff's work with children and families (CPOMS, Arbor, Boxall, ScholarPack and Pivots), however it did not appear that any of the tools mentioned were specifically for recording trauma-informed practice or outcomes. Teachers said that such tools did not fully capture the positive outcomes that were observed by teaching staff who had built relationships with the children they worked with. The development of case studies were seen as a useful tool to capture processes and outcomes and were in progress in all schools but not available at the point of evaluation.

The Trauma-Informed Training cohort considered it was too early to say whether implementing the approach had had positive impacts on the clients they worked with, and a number of participants described the trickling down of trauma-informed practice as delayed as a result of the pandemic, noting that it was desirable to complete trauma-informed training face-to-face rather than as an online course. Outcomes for clients were not yet being recorded, however, some suggested the use of case studies to demonstrate impact. There was broad recognition that both quantitative and qualitative data was required and served different purposes: for all participant cohorts both stories and 'hard facts' were required to demonstrate impacts for clients. Participants also acknowledged the need for developing processes that can capture both short- and long-term outcomes.

Participant cohorts described both formal and informal appraisal of the work. Diversion Programme coaches participated in weekly team meetings which involved information-sharing and the opportunity to reflect on practice. The opportunity to share best practice was identified as important and something that the Diversion Programme cohort sought to further embed, with one participant saying "*themed meetings (...) where we could discuss certain things would be good*" (105). This was supported by the Football Trust managers who said

that taking part in the focus group had been an opportunity to connect with other Trusts and hear how the trauma-informed programmes were working in different locations and suggested that in future they could work together to:

111: ...share best practice, what are some of the issues that are coming out of certain areas, how we can all learn from each other because we've already said [VRU-B region] is completely different to [VRU-A region] but equally [TOWN1] is completely different to [TOWN6]. So, we're all going to have different needs and issues but actually we can probably still take something from each area and learn from some of the young people we work with

Similarly, participants in schools described opportunities to reflect on the approach and referred to regular staff meetings which usually had space for discussions about individual children if there were particular concerns or a child needed pastoral support. These were usually cases where there were safeguarding issues rather than children impacted by trauma. One school said they had a half-termly 'reflective staff meeting' where case studies are discussed:

301: so we'll look at what is working well, what could we have done and get everybody buying into it so that everybody is responding to those children in the same way. And that is really important. So that reflective practice and timetabling that into your school every six weeks is really important

Reflection also took place through more informal routes via conversations between staff about their work with specific children and families. As one school said:

304: I think we are quite a reflective team to be fair and we do reflect daily, half daily and when we work together will say could we have done that any better, what went well for us, what went wrong and, you know, if it has

gone wrong, we will say, Oh my gosh, we didn't really handle that very well
did we? What can we do to make that better?

Some Trauma-Informed Training participants described creating 'working groups' where members of staff could attend to discuss practice with other professionals from across services. The creation of dedicated Microsoft Teams spaces where staff could share and collate trauma-informed resources from across VRU-A multi-agency partners was also mentioned. A central repository for resources was one option suggested that could be created and more widely publicised as it was reported that communicating the availability of resources across multi-agency partners was not always reaching the right professionals. Although a few participants indicated that reflective practice was inbuilt within their roles, for example, professionals working in mental health services, others identified that this was not part of their ongoing practice, however they also said that creating protected time for reflective appraisal was being considered.

Discussion

The evaluation found that trauma-informed approaches were broadly acceptable to participants across all cohorts with evidence that participants valued the training provided by VRU-A and had been able to adopt and apply these approaches in practice. There was a strong appreciation of the value of working in trauma-informed ways to support clients/pupils. Participants described that trauma-informed approaches enabled greater understanding of individuals' trajectories and behaviour and promoted responses that were compassionate, empathetic, and person-centred. Identifying that trauma-informed working was worthwhile and participants suggested that the wider dissemination of the approach would encourage consistent ways of working to support vulnerable individuals, for example, facilitating collaborative working across services (12). Moreover, appreciation of the approach equipped participants with an understanding of practices and environments that were potentially harmful or retraumatising for those with histories of trauma.

The evaluation identified that processes of initiating the approach were diverse across cohorts. For Diversion Programme, initial hesitancy towards the programme was perhaps more pronounced as a result of the perceived risk of working with clients who had previously been detained in custody as well as negative attitudes towards this client group.

Organisations which have not previously engaged with this client group may need support and guidance when initiating such programmes of work, for example, initiating trauma-informed work in settings with clients who are perceived as dangerous may require safeguarding protocols or changing mindsets about working with potentially stigmatised groups. It is also important to recognise that there are likely to be client groups for whom building trusting client relationships may be more difficult as a result of historic distrust in, for example, social services, police, and mental health teams. As a recent study on repeat violence commissioned by the Scottish Government reported, in areas of historic marginalisation and socio-economic deprivation, there is a lack of trust in state institutions, and “cultures of non-cooperation with the police” (37). Therefore, trauma-informed grassroots community development approaches (as separate to the police) may play a critical role in violence prevention and reduction activities (37).

In Trauma-Informed Education participants reported there was some resistance when enrolling all members of staff in the approach which participants attributed to deeply embedded punitive attitudes: participant suggested that for a minority of staff, trauma-informed approaches were considered to be unduly lenient towards pupil misbehaviour. In the Trauma-Informed Training cohort, barriers to enrolling the approach more widely were the perceived irrelevance for some services. A report by Public Health England notes that partners working in multi-agency approaches to violence prevention sometimes consider violence reduction outside the scope of their professional remit. However, it is suggested that this may be worked upon by strong collaborative working that impresses “the broader implications of violence to generate a collective understanding across all partners within the local system” (38). Although those involved in the evaluation perceived the approach to be a

legitimate way of working with clients/pupils, greater awareness of the approach and its relevance to the wider population may support the enrolling of wider networks and reluctant actors, especially when bolstered with evidence which dismantles traditional punitive approaches to, and beliefs about, antisocial or disruptive behaviour. Relatedly then, the role of strong leadership, 'trauma-informed champions' and opportunities to reinforce the approach were identified as facilitating organisational engagement.

One of the strengths of the VRU is that it is not solely focused on training and workforce development (and includes ongoing mentorship and access to resources/funding) given that evidence suggests that training alone rarely leads to sustained improvements in practice, improved outcomes for clients and evidence-based support (6, 39, 40). As other evaluations of trauma-informed ways of working have suggested, providing opportunities for supervision and supporting reflexive practice is an important part of embedding trauma-informed practice in organisations(41, 42). VRU-A approaches included working closely in partnership with organisations, for example, schools had a dedicated trauma-informed lead to help develop action plans alongside the training being delivered to staff. Organisations need to have trauma-informed practice embedded at a strategic level so that it may inform organisational policies and trauma-informed interventions (43) and our findings support that VRU-A have influenced some of this within the organisations they have worked with, for example, changes to school behavioural policies. Tebes et al.,(44) have also indicated that interventions that involve services such as criminal justice, health, education and child welfare can potentially reach whole populations as individuals are often involved in some of these systems across their lives. It is therefore important when developing trauma-informed approaches that organisations do not limit their approach to simply offering training.

Facilitators to organisational engagement included strong leadership and the importance of someone championing the work. This is supported by Fallot and Harris (45) who identify that engaging leaders play an important role in sustaining trauma-informed initiatives This

highlights the importance of allocating appropriate resources such as time for someone to take a leadership role or appointing a designated lead. Senior leadership and buy-in can also address organisational barriers in engaging with and implementing trauma-informed approaches. Research suggests that time constraints are a barrier to implementing trauma-informed practice for practitioners(46). This may be compounded by the volume and complexity of information needed to support trauma-informed learning(47). Participants indicated undertaking considerable background activity to support delivery of the programmes, therefore it is important to recognise the time required to develop practice and implement approaches.

The need for appropriate resource allocation more generally was also raised in order for those involved to effectively undertake their roles and support the individuals they work with. If there are insufficient follow-on services to respond to specific needs that arise during trauma-informed interactions there is a danger of unmet need being amplified.

Implementation of trauma-informed approaches may potentially increase demand for other services as a result of enhanced understandings of trauma and responding to client needs in more holistic and trauma-sensitive ways. Although there was enthusiasm for universal dissemination of the approach across all participants, it is important to recognise the extent to which a systems wide trauma-informed approach can meet client/pupil needs is likely to be constrained by broader socio-political and fiscal contexts(48-50). Moreover, organisational commitment to supporting staff is needed, requiring robust mechanisms and resources for support and debriefing (29, 30)

We found that those involved in trauma-informed programmes were also reflecting on implementation through formal and informal processes which included reflective meetings as well as dedicated staff/team meetings and working groups. These spaces were considered important facilitators to capturing good practice, learning and sharing knowledge.

Participants from across the programme were also able to describe notable impacts such as attitudinal changes amongst professionals in how they worked with others, viewed

situations/behaviours, calmer working environments and better relationships. However, they also described the challenges of evidencing outcomes. In particular participants felt that there was a need to capture softer outcomes that current data collection systems did not readily facilitate.

Future Research

Whilst it was not in the scope of this evaluation to measure the impact of trauma-informed approaches, we recognise that more detailed evaluations of trauma-informed approaches are required to better understand outcomes for clients and whether trauma may be reduced by trauma-informed practice as highlighted in the literature(6, 51-53). The need for system-based measures for trauma-informed approaches have been emphasised in order to evidence impacts on population health, the findings of which might also facilitate wider buy-in from public services (44).

Limitations

One notable limitation of the research relates to self-selection or 'volunteer bias', that is, the participants who took part in this evaluation may represent a group more inclined to view trauma-informed approaches in broadly positive ways. Indeed, as suggested by the participants themselves, there were individuals within their organisations who were critical of the approach. Participants considered these individuals to be 'heavily outnumbered', therefore speaking critically about trauma-informed approaches in such spaces may not be well-received and thus underreported.

Conclusion

Our findings demonstrated that trauma-informed approaches can be embedded within organisations resulting in changes in practice, particularly when led by an organised network and with additional resources such as funding, trauma-informed leaders and project managers. We found trauma-informed approaches had been embedded into practice in a number of ways such as being included in mandatory training, policies and procedures, indicating that those involved were committed to establishing trauma-informed practice within organisations. Key considerations in implementing trauma-informed approaches

include considering the wider factors that may influence trauma, and adequate resource provision that considers the additional needs that may arise when delivering such approaches. It is also important to recognise that becoming trauma-informed is not necessarily something that happens instantaneously but requires time and those involved in VRU-A programmes were in the early stages of this 'journey'. Therefore, when assessing impacts, it is important to consider short, medium and long-term aspirations. Future evaluations also need to think beyond defined quantitative indicators and find ways to capture softer outcomes.

Data availability: The data that has been used is confidential.

Declaration of Interest

LY/SC work for the LVRN, however, were not involved in the design, conduct or analysis of the evaluation. They facilitated access to participant organisations and have supported the development of this paper.

Funding Statement

The evaluation was funded by the Lancashire Violence Reduction Network, via the Home Office, but the views expressed are those of the authors and not necessarily the wider Lancashire Violence Reduction Network or Home Office. The Lancaster research team (HS, KK, JG, FW, HB, PW) were supported by the National Institute for Health Research Applied Research Collaboration North West Coast (ARC NWC) whilst undertaking commissioned work for the LVRN.

Acknowledgements

This research is supported by the National Institute for Health Research Applied Research Collaboration North West Coast (ARC NWC). The views expressed in this publication are those of the author(s) and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care.

References

1. Felitti VJ. Adverse childhood experiences and adult health. *Academic pediatrics*. 2009;9(3):131.
2. Lanius R, Vermetten E, Anda RF. *The Hidden Epidemic: The Impact of Early Life Trauma* 2010.
3. Bellis MA, Lowey H, Leckenby N, Hughes K, Harrison D. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of public health*. 2014;36(1):81–91.
4. Bloom SL. Advancing a national cradle-to-grave-to-cradle public health agenda. *Journal of Trauma & Dissociation*. 2016;17(4):383–96.
5. Dawson S, Bierce A, Feder G, Macleod J, Turner KM, Zammit S, et al. Trauma-informed approaches to primary and community mental health care: protocol for a mixed-methods systematic review. *BMJ open*. 2021;11(2):e042112.
6. Asmussen K, Masterman T, McBride T, Molloy D. Trauma-informed care Understanding the use of trauma-informed approaches within children's social care. 2022.
7. Levenson JS, Prescott DS, Willis GM. Trauma-informed treatment practices in criminal justice settings. *Handbook of issues in criminal justice reform in the United States*: Springer; 2021. p. 483–502.
8. McAnallen A, McGinnis E. Trauma-Informed Practice and the Criminal Justice System: A Systematic Narrative Review. *Irish Probation Journal*. 2021;18:109–29.
9. Adams EJ. *Healing invisible wounds: Why investing in trauma-informed care for children makes sense*: Justice Policy Institute Washington, DC; 2010.
10. Leitch L. Action steps using ACEs and trauma-informed care: a resilience model. *Health & justice*. 2017;5(1):1–10.
11. Office H. *Serious Violence Strategy*. 2018.
12. Craston M, Balfour R, Henley M, Baxendale J, Fullick S. *Process Evaluation of the Violence Reduction Units*. Research Report 116.: Home Office; 2020.
13. Mitton K. Public health and violence. *Critical Public Health*. 2019;29(2):135–7.
14. Levell J. *Boys, childhood domestic abuse and gang involvement: Violence at home, violence on-road*: Policy Press; 2022.

15. Wilson H, de Lima ES, Davis G, Preece C, McBride T. Understanding the potential of trauma-informed training in Violence Reduction Units. 2022.
16. MacLeod S, Cutmore M, Deoudes P, Brennan I. Violence Reduction Units - Impact evaluation feasibility study. Research Report 117.: Home Office; 2020.
17. Christmas H, Srivastava J. Public health approaches in policing. Public Health England and College of Policing. 2019.
18. Van Dijk AJ, Herrington V, Crofts N, Breunig R, Burris S, Sullivan H, et al. Law enforcement and public health: recognition and enhancement of joined-up solutions. *The lancet*. 2019;393(10168):287–94.
19. Revolving Doors. Trauma-informed approaches to supporting people experiencing multiple disadvantage: A rapid evidence assessment. The Department of Levelling Up HaC; 2023.
20. Cordis Bright. Evaluation of the Enhanced Case Management Approach: Final Report. Cardiff: Welsh Government; 2017.
21. Collins SE, Lonczak HS, Clifasefi SL. Seattle's Law Enforcement Assisted Diversion (LEAD): program effects on recidivism outcomes. *Evaluation and program planning*. 2017;64:49–56.
22. Miller NA, Najavits LM. Creating trauma-informed correctional care: A balance of goals and environment. *European journal of psychotraumatology*. 2012;3(1):17246.
23. Greenwald R, Siradas L, Schmitt TA, Reslan S, Fierle J, Sande B. Implementing trauma-informed treatment for youth in a residential facility: First-year outcomes. *Residential Treatment for Children & Youth*. 2012;29(2):141–53.
24. Emsley E, Smith J, Martin D, Lewis NV. Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives. *BMC Health Services Research*. 2022;22(1):1–12.
25. Caulfield L, Quigg Z, Adams-Quackenbush N, Timpson H, Wilson S. Reflections on good practice in evaluating Violence Reduction Units: Experiences from across England and Wales. *Evaluation*. 2023;29(3):276–95.
26. McEvoy R, Ballini L, Maltoni S, O'Donnell CA, Mair FS, MacFarlane A. A qualitative systematic review of studies using the normalization process theory to research implementation processes. *Implementation Science*. 2014;9:1–13.
27. May CR, Johnson M, Finch T. Implementation, context and complexity. *Implementation Science*. 2016;11(1):1–12.
28. Substance Abuse and Mental Health Services Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. 2014.
29. Wilton J, Williams A. Engaging with complexity. *Providing Effective Trauma Informed Care for Women*, London: Centre for Mental Health. 2019.
30. Newell JM, MacNeil GA. Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best practices in mental health*. 2010;6(2):57–68.
31. Wall L, Higgins DJ, Hunter C. Trauma-informed care in child/family welfare services: Australian Institute of Family Studies Melbourne; 2016.
32. Champine RB, Hoffman EE, Matlin SL, Strambler MJ, Tebes JK. "What Does it Mean to be Trauma-Informed?": A Mixed-Methods Study of a Trauma-Informed Community Initiative. *Journal of Child and Family Studies*. 2022:1–14.
33. Wall CRG. Relationship over reproach: Fostering resilience by embracing a trauma-informed approach to elementary education. *Journal of Aggression, Maltreatment & Trauma*. 2021;30(1):118–37.
34. May C. Towards a general theory of implementation. *Implementation Science*. 2013;8(1):1–14.
35. Braun V, Clarke V, Rance N. How to use thematic analysis with interview data. *The counselling & psychotherapy research handbook*. 2014;3:183–97.
36. Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative research in psychology*. 2021;18(3):328–52.

37. Batchelor SA, Gormley, Caitlin. Repeat Violence in Scotland: A Qualitative Approach. Edinburgh; 2023.
38. England PH. A Whole-System Multi-Agency Approach to Serious Violence Prevention. Public Health England London; 2019.
39. Williams TM, Smith GP. Does training change practice? A survey of clinicians and managers one year after training in trauma-informed care. *The Journal of Mental Health Training, Education and Practice*. 2017;12(3):188–98.
40. Purtle J. Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. *Trauma, Violence, & Abuse*. 2020;21(4):725–40.
41. Roberts G, Halstead S, Pepper R, McDonnell L. Social care professionals' perceived barriers to implementing attachment and trauma-informed care training in their practice. *Developmental Child Welfare*. 2023;5(1):3–20.
42. Hibbin R, Warin J. EVALUATION REPORT FOR 'EMBRACE' (EMOTIONALLY AND BRAIN RESILIENT TO ADVERSE CHILDHOOD EXPERIENCES) An evaluation of EmBRACE, a whole school/organisation package of training and consultant support 2021.
43. McCartan KF. Trauma-informed practice. HM Inspectorate of Probation Academic Insights: London, UK. 2020.
44. Tebes JK, Champine RB, Matlin SL, Strambler MJ. Population health and trauma-informed practice: implications for programs, systems, and policies. *American journal of community psychology*. 2019;64(3-4):494–508.
45. Falloot RD, Harris M. Creating cultures of trauma-informed care. Washington DC: Community Connections. 2009.
46. Huo Y, Couzner L, Windsor T, Laver K, Dissanayaka NN, Cations M. Barriers and enablers for the implementation of trauma-informed care in healthcare settings: a systematic review. *Implementation Science Communications*. 2023;4(1):49.
47. Bruce MM, Kassam-Adams N, Rogers M, Anderson KM, Sluys KP, Richmond TS. Trauma providers' knowledge, views and practice of trauma-informed care. *Journal of trauma nursing: the official journal of the Society of Trauma Nurses*. 2018;25(2):131.
48. Quiros L, Berger R. Responding to the sociopolitical complexity of trauma: An integration of theory and practice. *Journal of Loss and Trauma*. 2015;20(2):149–59.
49. Isobel S. The 'trauma' of trauma-informed care. *Australasian Psychiatry*. 2021;29(6):604–6.
50. Isobel S. Trauma-informed qualitative research: Some methodological and practical considerations. *International Journal of Mental Health Nursing*. 2021;30(S1):1456–69.
51. Overstreet S, Chafouleas SM. Trauma-informed schools: Introduction to the special issue. Springer; 2016. p. 1–6.
52. Becker-Blease KA. As the world becomes trauma-informed, work to do. *Journal of Trauma & Dissociation*. 2017;18(2):131–8.
53. Champine RB, Lang JM, Nelson AM, Hanson RF, Tebes JK. Systems measures of a trauma-informed approach: A systematic review. *American journal of community psychology*. 2019;64(3-4):418–37.

ⁱ For a more in-depth discussion of these principles see original work by SAMHSA and also Levenson et al's (2021) work on trauma-informed practice in criminal justice settings.