**Trauma-informed healthcare: where are we at?: Findings From the TAP CARE Study**

**Fay Maxted** [00:00:00] My name is Fay Maxted. I'd like to welcome everyone to today's webinar, Trauma Informed Health Care. Where are we at? And thank you to everyone joining us.

**Fay Maxted** [00:00:14] I'm Fay Maxted. I'm the chief executive of the Survivors Trust, which is a national umbrella agency for voluntary sector specialist rape and sexual abuse support services throughout the UK and Ireland. I'm also a member of the Victims and Survivors Panel for the Independent Enquiry into child sexual abuse. The Survivors Trust Team is delighted to be working with the TAP CARE team to help disseminate their findings and increase the conversation around how to implement trauma informed care. I feel sure you'll gain a lot from today's presentations.

**Fay Maxted** [00:00:51] Before we start, can we go to slide two, please. I'd like to run quickly through some housekeeping. So please note that the webinar is being recorded and we'll be sharing it via email and online within the next seven days. If you have any questions during the presentations, please use the Q&A box and we've left time at the end of all the presentations and we'll be answering as many questions as possible during that time. If possible, please state which speaker and you'd like to address your question too. All participants are muted with cameras off throughout the webinar. The bonus for that is that you can be eating ice cream while you watch. No one will be any of the wiser. But on a more serious note, if it's any point you feel as though you need a break, please do feel free to leave and then rejoin once you feel ready. Next slide, please.

**Fay Maxted** [00:01:57] For any accessibility questions, please contact Kate via her email and Kate, if you could put your email in the chat, that would be helpful. And for the multitaskers amongst us, you can comment on Twitter to get the conversation out to as many people as possible. Please use the hashtag #TAPCARE. Thank you.

**Fay Maxted** [00:02:21] So there is currently much interest in working in a trauma informed way, particularly in health care settings. But what do we actually know about working in a trauma informed way, and what does the evidence tell us? Today, we'll be hearing from members of the TAP CARE research team who'll be sharing valuable insights from the TAP CARE study and sharing how these findings could inform trauma-informed policy and practise moving forwards within. Today's session will first be hearing from Natalia Lewis who'll be presenting the findings from the TAP CARE systematic reviews. And this will be followed by Shoba Dawson, who will discuss the involvement of people with lived experiences in the TAP CARE study. Elizabeth Emsley will then share the findings from the review of UK policies. A final speaker of the day will be Jo Williams, who will discuss how TAP CARE findings can inform system wide trauma informed policy in practise. Following the presentations, there'll be a question and answer session and please post your questions using the Q&A box as we go along. Okay. So now I'm delighted to introduce our first speaker, Dr. Natalia Lewis.

**Natalia Lewis** [00:03:41] Good afternoon. Thank you for joining us today on the hottest day on the record. It is 31 in Bristol at the moment. My name is Natalia Lewis, a researcher at the University of Bristol. Before transitioning into full time research career, I worked as a general practitioner and neurologist. I'm a principal investigator on the TAP CARE study, which stands for Trauma Informed Approaches in Health Care. We are presenting today on behalf of a multidisciplinary team supported by people with lived experience and health care professionals. From research, from clinical practice and from people with lived experience we all have learnt three important lessons. Firstly, many patients and health care professionals have experienced trauma and all healthcare professionals work with people affected by trauma. Secondly, if this experiences and impact are not recognised and realised, services can retraumatize both patients and staff. Thirdly, although it is very important to educate individual healthcare professionals about trauma, then your practises can only sustain if they are supported at the organisation and wider system levels. Over the last 20 years the framework of trauma-informed approach has gained momentum as a new way of service provision which prevent re-traumatisation in healthcare services and improves experiences and outcomes for all. Many UK policies and guidelines recommend, implement and trauma-informed approach in healthcare organisations and wider systems.

**Natalia Lewis** [00:05:51] To understand if trauma informed approaches in health care are effective. We conducted three systematic reviews. First looked at primary care and community mental health care organisations. Second reviewed evidence from other health care organisations. Third review looked at effectiveness of standalone training programmes on trauma-informed care for health care professionals. We also reviewed UK policies and guidelines.

**Natalia Lewis** [00:06:25] When we started our first systematic review, we quickly realised that people use different terminology and interpretations of the framework of trauma-informed care. Despite different terminology when we analysed eight most cited frameworks for trauma-informed approach, we realised that they will provide a high-level guidance on how to transform an organisation in a trauma-informed way rather than prescribe what people actually have to do.

**Natalia Lewis** [00:07:08] Like the British pop band Bananarama sang "it ain't what you do it's the way that you do it" and that's what gets results. Analysis of the most cited frameworks demonstrated they all in general aligned with the U.S. Substance Abuse and Mental Health Services Administration Framework for Trauma-Informed Approach, which starts from the assumption that every patient and member of staff have the potential of being exposed to trauma and been impacted by this experiences, and therefore by realising then recognising this experiences and their impact, we can respond in that trauma-informed manner which will prevent retraumatisation improves experiences and outcomes for both patients and staff. A trauma-informed transformation of the whole organisation is guided by the principles of safety, trust, peer support, collaboration, empowerment and cultural sensitivity. And these principles and assumptions should be implemented across the ten implementation domains.

**Natalia Lewis** [00:08:37] When we found studies that evaluated a trauma-informed approach we realised that although they all followed the same assumptions and principles, they develop bespoke, unique models of trauma-informed approach which will carefully tailor to their organisational needs, abilities and preferences. And despite this variability, all the models had in common the following domains: an allocated budget, a working group, or a committee which was guiding the transformation process with representatives from all staff groups, including leadership and people with lived experience, ongoing training and support for all staff, and the redesign and changes in physical environments and clinical practises.

**Natalia Lewis** [00:09:44] Despite extensive searches, we only identified six studies that evaluated trauma-informed approaches in primary care and community mental health care. Numbers and brackets indicate how many studies that just reported each outcome. The arrow shows the direction of the effect. Opposite-to-opposite arrows indicate that different studies reported conflicting results for the same outcome. At the individual patient level we found some evidence in support of increased self-confidence, safety, health management, quality of life and pain. However, the evidence for mental health and substance abuse outcomes was conflicting. At the care team level there was a consistent evidence for improvement in staff acceptance, attitudes, patient perceived support, confidence in care and feeling in control of their treatment. At the organisation level there was some evidence that staff psychological readiness to provide trauma-informed services increased and the organisational culture changed. This was captured through staff feeling safe, supported and valued by the organisation. Patient satisfaction improved, however, the evidence for change in staff uptake of screening for trauma and self-care activities was conflicting.

**Natalia Lewis** [00:11:32] Our second systematic review found 11 studies from other health care work organisations and identified some evidence for improved retention amongst patients and staff. A mixed effect on perceived quality of service and staff accepting attitudes towards trauma-informed approach. There was some evidence that patients perception of trust, safety and empowerment increased, but there was reduction and restraint and seclusion practises in line with the first systematic review with the effect on mental health and substance misuse, symptoms was mixed.

**Natalia Lewis** [00:12:20] Our third systematic review identified 23 studies which evaluated effectiveness of stand alone training programmes for health care professionals. Most of this study measured staff psychological readiness to provide trauma-informed care before and immediately after training and reported mixed-effect on knowledge, attitudes and confidence and improvement in self-reported skills. In contrast, very few studies measured professional behaviour and practises. There was a limited evidence for a reduction in restrictive practises, for increase in enquiries about trauma and patient disclosure for incorporation of information about trauma into consultation. However, the effect on patient doctor communication and referrals to specialist services was mixed.

**Natalia Lewis** [00:13:27] To conclude, TAP CARE systematic reviews have identified limited and conflicting evidence for the effectiveness of trauma-informed approaches in health care. However, this limited and conflicting evidence shows that if a trauma-informed approach is implemented at a whole organisation level and tailored to the organisational needs, abilities and preferences, it can produce some changes in some psychological, behavioural and health outcomes. Standalone training programmes produced mixed effect on professional psychological readiness, behaviour and practises with regard to provision of trauma-informed care. Thank you very much for your attention.

**Shoba Dawson** [00:14:22] Good afternoon, everyone. My name Shoba Dawson. I'm a researcher based at the Centre for Academic Primary Care at the University of Bristol. I am a methodologist with interest and expertise in evidence, synthesis and increasing ethnic diversity in research. Next slide, please.

**Shoba Dawson** [00:14:42] Thank you. So today I'm going to mainly talk about how we involved patients and other stakeholders in the systematic review process itself. So in line with some principles of TIA, that's a trauma-informed approach. We thought it was a good idea to involve not just people with lived experience of trauma and health services, but also people who are responsible for planning, funding and delivering health services. So as a result of this, what we did was we set up two advisory groups, really. One with people with lived experiences. We had eight people involved throughout the review as we progress to the latter part of the review we did have some drop out and we had like four people who stayed involved throughout all the way through to dissemination. And then the second advisory group consisted of health care professionals and service providers, funders, etc. And again, we tried to involve them throughout, but by the time we got to the end of the review, we had like three or four people who were actively involved in it. So we met with these two groups once every six months or so. We thought it was best to keep these two advisory groups separately, simply because we were concerned and there were also concerns from their patients that, you know, at some point or the other, some of the health care professionals they may have come across to discuss their health conditions and problems. So that's why we thought it was best to keep the group separate. We also ensure that we paid people for their time to get involved in the study. So this was in line with the National Institute for Health and Care Research Centre for Engagement and Dissemination Payment Guidance, really. So as a result of that, everyone was offered a payment of up to £25 an hour.

**Shoba Dawson** [00:16:38] Next slide, please. Thank you. So in terms of levels of involvement, we were very keen to involve people throughout the different stages of their systematic review itself, but we did offer them flexibility, so they had the opportunity to pick and choose the extent to which they wanted to be involved. And obviously everyone was quite new to the whole systematic review process itself. So to begin with, in the first session we provided them with an informal in-house training on what a systematic review is, the different stages involved and how we would like to involve them in the review process itself. So this included brainstorming, research questions for them, so for example, they helped and supported us to also reframe the research questions for the first systematic review that Natalia presented the findings for. And this was all at the protocol development stage. So leading up to the registration on Prospero, we did all of this. We also asked them to list outcomes that were meaningful and important to them. While patients listed the various outcomes, health care professionals identified the inconsistent use of terminology in the UK. So this included, for example, adverse childhood events, often confused with trauma-informed approaches which are sometimes again confused with trauma-informed care practise or even psychologically informed environments. Sometimes they were used as synonyms, other times they all meant different things altogether. So in terms of involving them itself, so we involved them in the data extraction phase, interpretation of the study findings and also in dissemination of the study findings. More information in terms of how we involve them in detail can be found in the preprint linked to which will be available later on in the slide. Next slide, please.

**Shoba Dawson** [00:18:30] And lastly, one of the things we did was we gathered reflections from patients in terms of their experience of being involved in our study itself. For those who are interested when the slides are shared, if you were to click on this link, you'll be able to read more on that. Thank you so very much for listening to me.

**Elizabeth Emsley** [00:18:51] Hi there everyone, I'm Lizzie Emsley. I'm a GP academic trainee in Bristol, so I spend half my time doing research here at the Centre for Academic Primary Care in Bristol and the other half my time working in inner city practice in Bristol. And I'm here today to share our findings from the Trauma-Informed Care Policy Review part of the study. So as we've found in the systematic review side of the of the study, we, we noticed that while we need a bit more evidence for trauma informed care, we should make that stronger. We did see that in UK policies there is significant support and endorsement for trauma-informed care and it's also something that's being talked about in UK policies. So we're really keen to understand more about the UK policy landscape when it comes to trauma-informed care and to understand that in greater detail. Next slide, please.

**Elizabeth Emsley** [00:19:43] So in order to do this, we first wanted to have a look at how a trauma-informed approach is represented, discussed, talked about in UK health policies and in order to understand that we did a document review. So what that means is we found around 50 documents from the UK talking about policy with regards to trauma-informed care or any sort of related terms, and we analysed these documents. Those documents came from around 2012 to 2021, and we see a particular clustering of documents from around 2018. And I think that's perhaps really testament to the hard work from the trauma-informed community where we're seeing it gaining popularity. The documents come from a range of places, so from across the UK, from Scotland, Wales, Northern Ireland and from England. Also, some of the documents, a very sort of high level UK government documents and others are more regional, local, focussed, and some of them also have a very strong voice from service users and also from those with lived experience of trauma. Moving on to the second part of our study and what we wanted to find out was to really explore the understanding of trauma-informed care amongst policymakers and health professionals. So to understand a bit more about how they perceive it and also how it's being implemented in UK healthcare. And in order to explore this understanding amongst those who write policy and who implement policy around trauma-informed care, we did some interviews. So we interviewed professionals involved in trauma-informed care, including in the writing and implementation of trauma-informed care policy. And we interviewed 11 participants on Zoom, and these participants came from a range of backgrounds, including the NHS, local authorities and third sector organisations. So we had these two areas that we were looking at how it's being described, how it's being represented in policies, but then also how it's being understood and how it's being implemented in that on the ground. And we brought those two areas together in an analysis to look at areas of patterns and trends and areas of agreement, areas of disagreement on trauma-informed policy in the UK. Next slide, please.

**Elizabeth Emsley** [00:21:52] So what do we find? Firstly, this first question of how a trauma informed approaches represented, how they described, how they talked about in UK health policies. All we can see really strongly was that, particularly in high level UK governmental parliamentary documents, we can see that, yes, trauma informed care is being promoted, it is being endorsed. But when you look into things a little bit further, we need a lot more detail, a lot more guidance. There was a shortage of those areas and also there was a shortage in terms of information about resource allocation, how is being funded. And so, yes, promotion and support of these initiatives, but we need a lot more detail in terms of those specifics about guidance, funding, resource allocation. Next slide, please.

**Elizabeth Emsley** [00:22:36] And then on to our question about how a trauma-informed approach is understood amongst those who work in trauma-infromed care and those who are involved in policy around trauma-informed care. So firstly, there was some debate around trauma-informed care terminology. So I think Shoba, which just recently mentioned about trauma and other related terms like adverse childhood experiences and psychologically informed environments. And there was debate about this in terms of where does trauma -informed care sit with that related terminology like adverse event, adverse childhood experiences or ACES psychologically informed environments or simply good clinical practise? Where does it sit in relation to all of these terms? And in interviews we could see that some people felt that it's a bit of an umbrella, that all these terms, sit underneath the umbrella, and it acknowledges what people have been through in the past all those terms that just sort of an acknowledgement of what someone's been through in the past. Others felt actually perhaps there are some differences here, perhaps adverse childhood experiences or ACES are more of a research academic term, whereas trauma-informed care is more of a sort of practical service level term. So some debate around the terminology.

**Elizabeth Emsley** [00:23:42] Where we saw quite a bit of agreement amongst the policy documents and in interviews with that trauma-informed care is an organisational approach which needs to be tailored to the specific organisation and most importantly to those service user needs. And that involves looking at your organisation and seeing where there might be gaps, what the service user needs are, and then tailoring the model or the framework to those needs. It's not a one size fits all model. It's something that is very much dependent on the organisation and on those services users needs. As part of this understanding of trauma-informed care, there was also discussion around it being presented as as a remedy or as a solution to a range of health service challenges. And that includes acknowledging the widespread prevalence of trauma and the impacts of that in the population. Also, trauma-informed care as a remedy to or solution to achieving integrated care and also is a remedy or solution to perhaps the widespread collective trauma of the COVID-19 pandemic that we might will be experiencing. So it's perhaps being presented as a means of addressing a range of health service challenges. Next slide piece.

**Elizabeth Emsley** [00:24:54] Coming on to how it's being implemented. And when we spoke to when we spoke to informants and looked at policy documents, we can see quite piecemeal implementation across the UK. So while in Scotland and to a degree in Wales, there is a clear published strategy on national trauma-informed care, in other parts of the country or parts of the UK. That wasn't always the case. And for example, in Scotland we can see this really coordinated strategy and it's really leading the way. In England, while we do see initiatives across England, it's much more patchy and we have some hotspots where it's really happening, perhaps related to a really active local trauma-informed community. And so overall, this piecemeal implementation and there's perhaps a range of reasons for this. And in interviews we heard about the fact that in the Scottish Government there is significant buy in and support for trauma-informed care. A range of reasons for why this might be happening.

**Elizabeth Emsley** [00:25:46] Now in terms of implementation, there are also some factors which help implementation of trauma-informed care and some factors which make it more difficult. And those are within the organisation and beyond the organisation. So within the organisation there was discussion into about if there's sort of senior leadership involved, that can be helpful and if that's if they're supportive of for informed care, that is helpful. Others spoke about really active grassroot bottom-up implementation, which can also help and be useful. And there was also discussion of sort of trauma-informed care champions in organisations which can help to gain support for trauma-informed care. And there was discussion around allocation of time and resources, which can be difficult in times which can help if if it's allocated, it can help implementation, but if it's not available then it can make it really hard to implement. Beyond the organisation again, allocation of resources affects the implementation of trauma-informed care, but there are also perhaps political factors in the region which can which can make a difference, and also nationally. We noticed as well this evidence of policy gaps. So if I describe that it's the endorsement for trauma-informed care in policy, but the fact that we perhaps need more evaluation, we need more evidence around the effectiveness of trauma-informed care. And we could see that coming through in our in our in our review. And in terms of implementation, that's something really important to consider. If we have a strong evaluation, strong evidence that's really going to help in terms of implementation. And again, in interviews we heard about how that's difficult. Evaluation can be really hard to do if you you need you need the time, you need the resources, and that can be very challenging at times. Next slide, please.

**Elizabeth Emsley** [00:27:25] So what about the future of trauma informed care in UK policy? Where do we go from here? And there's already already really fantastic networks being established and sharing of good, good practise when it comes to trauma-informed care. And that's something that we, we hope can be really strengthened nationally and regionally to help coordinate and harmonise trauma-informed initiatives across the UK. In interviews, we heard about calls for sort of more central leadership within the UK government and again that can help in terms of coordination and support for and funding of trauma informed initiatives. And as part of that, establishing a robust evidence based specific to the UK for trauma-informed care and its policy is really important. So we think that it's important to support and fund evaluation of trauma-informed initiatives, so that we can build a very strong UK evidence base for trauma-informed care, we can learn what works, we can learn what's good practise, what can be extended elsewhere and what can be shared across the UK. Thank you very much. Next slide, please.

**Elizabeth Emsley** [00:28:25] So thank you very much for listening and thank you for your support for the studies that we've mentioned today. We've had a range of funders, including The NIHR and some other organisations mentioned here. Thank you very much for listening.

**Jo Williams** [00:28:49] Good afternoon. My name's Jo Williams. I'm a consultant in public health from Bristol City Council and a senior lecturer at the University of Bristol. I'm here in my capacity as one of the co-directors of the Adversity and Trauma HIT. I'm speaking on behalf of colleagues of the HIT, we really welcome the opportunity to be part of this webinar today and to support the dissemination, the findings of the TAP CARE study work. In the local area across Bristol, North Somerset and South Gloucestershire, we've been using the ten implementation domains already described to develop a system-wide approach to trauma-informed policy and practise. And over the next few minutes, I'm just going to outline some of these developments and just give a few illustrations of how the TAP CARE study is so valuable in informing this work. So next slide, please.

**Jo Williams** [00:29:48] It's already been highlighted the importance of leadership in developing the system, particularly from the TAP CARE policy review. And we're really fortunate in the local area that the Healthier Together Executive of our new integrated care system has committed to both supporting and championing the development of trauma-informed work in the new system. In practise, that has included appointing a trauma champion at board level and the senior responsible officer and ensuring that we have a group within the governance structure of the integrated care system to bring people together to work on this. So we have the Trauma-Informed Oversight Group with membership, both from what was the clinical commissioning group, now the ICP and partner organisations. So we can work together. Also, partners have come together to jointly and the post help coordinate the work.

**Jo Williams** [00:30:51] It's been highlighted in the policy review that's just been presented how we don't have a single policy framework for England. And the need to adapt the system to the local context. So in the local area, we've agreed a set of principles for trauma-informed practise. They're very closely aligned to the ones you've already seen with some local changes. And over time you are gradually seeing trauma-informed work appear more and more in our corporate and our partnership policy and strategy documents, and we in particular developing approaches to commissioning of services. Engagement and involvement is so essential to bring in a range of voices and perspectives to develop the system at all levels. And we've seen how patients and professional stakeholders have been involved throughout the stages of the TAP CARE study. Shaping the study every stage and this level of engagement and involvement is just exemplary. We can learn from these approaches in TAP CARE as we continue to ensure that we have engagement and involvement in our locally developing system. And we've hugely benefited from the input of public members in our trauma-informed system oversight group, the insights of patients and service users and also more recently, staff, particularly from our equalities groups. Next slide, please.

**Jo Williams** [00:32:29] Now whilst the focus of TAP CARE is on healthcare, the study findings have highlighted the need for cross-sector collaboration and how that's part of the implementation frameworks. And this wide collaboration is essential to developing this working on new integrated care system. Building cross-sector collaboration means we have a common language, a common approach, and that people using our services will have a common experience in different types of services. And we're really fortunate locally to have really good cross-sector collaboration, for example, between health and social care, with the police, with our schools, voluntary sector organisations and our universities, and of course today's webinar is demonstrating many of those collaborative links.

**Jo Williams** [00:33:17] One of the systematic reviews talked about training and workforce development and how there's still mixed evidence of effectiveness. And locally, we want to enable our staff to build their skills and confidence. But we realise we don't have all the answers yet about the best way to do that. Locally, we've developed a knowledge and skills framework building on engagement with young people and adults. But in the light of the TAP CARE findings, we'll continue to evaluate our approaches to training and look at ways to do this collaboratively cross-sector.

**Jo Williams** [00:33:51] And just a final comment on evaluation. There's so much learning from the top case study, but it's also highlighted where there are still gaps in the evidence and seeing that in systematic reviews and the sort of highlighting the evidence policy gap. As we develop the local system, we're really striving to learn from such evidence and to build an evaluation at every stage. And we're really fortunate to have the Bristol Health Partners in place and their support through the HIT to enable us in this work. So through the adversity and trauma HIT, we're working together to build bridges, to bring in research evidence and to develop our approach to evaluation. And this work of the HIT is very closely aligned to the work in the integrated care system. So just to finish, let me express my thanks to colleagues in the TAP CARE study who've carried out such careful and thoughtful work. It can help us build on the evidence base as we develop our local trauma informed policy in practise and as we work together to continue to evaluate that work. Thank you.

**Fay Maxted** [00:35:03] Thank you, Jo.

**Fay Maxted** [00:35:04] I'm going to now hand over to Claudia Williams, who's going to answer some of the questions that you've been posting throughout the session, she is going to facilitate this session. So any questions, please do put them in the Q&A box and hopefully we'll we'll get round to them in the time we have left.

**Claudia Williams** [00:35:30] Thanks so much, Fay. So we do have one question aimed at Natalia and Natalia. Will you be able to provide the pre-print or published articles for the systematic reviews?

**Natalia Lewis** [00:35:43] Well, so the final slide for today, you will see how you can stay connected with the TAP CARE study and there will be a link to the study webpage. The Systematic Review One paper is under review in Health and Social Care in the Community since December, so the preprint is available. You can access it from the web page of the study. Our policy review paper is under review at BMC Health Services Research, and I understand that Lizzie will upload preprint very soon. So if you follow the TAP CARE study, we will be uploading publications and all academic outputs in due course.

**Claudia Williams** [00:36:29] Brilliant. Thank you, Natalia. And so another question from Ann. Is there a sense that it is better and easier to live to deliver trauma-informed care across primary care before tackling acute care settings?

**Elizabeth Emsley** [00:36:49] I could I could contribute a little bit here and if anyone else wants to chip in as well. I think having a look certainly at the policy review, we could see that the area actually most commonly referenced was mental health services. And so perhaps it is difficult to say for sure in terms of where it's being implemented, perhaps that's a particular area of focus amongst services. At the moment, I think it's not clear that it's specifically easier to implement in one sector than others. I don't know if anyone else would contribute have.

**Natalia Lewis** [00:37:22] Um, yeah, I agree with Lizzie. I mean, it is a universal approach. It can be implemented in any health care organisation. Our second systematic review found that if it was implemented with newly employed staff or lacking a newly set service, it was easier to do than trying to change and existing service and established organisation. This is one of the findings in systematic review two.

**Jo Williams** [00:37:54] Could I just added comment. I think this is one of the great opportunities now with integration across the system, between primary care market trusts and social care, that we can have common approaches and support one another in building these organisational approaches. So I hope that that sort of not one versus the other that we can work together.

**Claudia Williams** [00:38:19] Thank you all so much for your insights there. So the next question for the panel is what sort of data capture would you recommend to be able to measure outcomes for patients?

**Natalia Lewis** [00:38:32] And if I may, I will respond to this question. So if you look at a preprints and you will look at the studies which we included, you will see that every study used different measurement tools. So my feeling that because a trauma-informed approach must be tailored to the organisational needs, abilities and preferences, the evaluation framework should be tailored to the organisational needs, abilities and preferences. You should develop your evaluation framework with health care providers in the organisation you are working with. But there are bespoke questionnaires. There are validated standardised questionnaires. There are qualitative methods of assessment. I didn't have time to say that we didn't find any evidence for cost-effectiveness of trauma-informed approach in health care. There's a huge gap on that. So it is a developing field. But look at published examples. Maybe you can borrow and adapt to your particular context.

**Claudia Williams** [00:39:48] Brilliant. Thank you, Natalia. So another question for the panel, perhaps for Shoba. How did you incorporate a trauma-informed approach to working with your advisory group of people who have lived experience? To what do you attribute the dropout rates?

**Shoba Dawson** [00:40:05] Thank you so very much. I must confess, we didn't really specifically adopt that trauma-informed approach when working with the advisory group as such, simply because we looked at everything from a more of a patient and public involvement perspective and we carried on it along those lines. However, one of the things we did do was as we were recruiting people to take part in the study and help and support us from an advisory capacity, people had the opportunity to share their experiences to the extent that they were comfortable with. They could do the same at a very early on meeting as well, and force meetings if anyone had any issues, qualms, etc. We were always available for a chat as well. In terms of dropout, it was mainly because of other personal commitments, really. So this was something we did follow-up with people where we could, and that was the main reason why they did drop out. And fortunately nothing else to do with their situation or circumstance in that sense. Thank you.

**Claudia Williams** [00:41:11] Thank you, Shoba. And so another question. Does the guidance consider trauma-informed approaches or training for non-clinical staff? For example, receptionists.

**Natalia Lewis** [00:41:25] When I listed the most common components which were found across included studies, I mentioned one component which we called ongoing training and support for all staff. And the idea of the whole organisation or system approach is that all members of staff from all groups must be trained because it is their organisation system level approach and all non-clinical staff should be trained alongside with clinical staff and management, etc.. Yeah. Yeah, of course, only all for all staff.

**Jo Williams** [00:42:08] Can I just bring a reflection from the local area? That knowledge and skills framework across Bristol, North Somerset and South Gloucestershire would apply to all staff, but with different components, perhaps depending on the role. So really that as a whole team and an organisation, everyone needs to be taking the same approach, but with their different roles, needing different types of training.

**Claudia Williams** [00:42:35] Brilliant. Thank you so much both. And so a question for the panel. And if Jody was to develop an audit tool for their team within an NHS organisation to review how trauma-informed they were, what would your advice be?

**Natalia Lewis** [00:42:55] I would advise to go to the existing frameworks and evaluation frameworks and instead of inventing the wheel, just take the existing one and adapt it to your trust needs, preferences and abilities. There are several, several frameworks available and we will share a link to at least two papers which summarise one example, which are tools and frameworks you can use. There are more research, evidence frameworks and more kind of best clinical practise frameworks. I don't know if Angela Kennedy or her team is in the audience. They can share a link to their narrative approach, which is based on sharing best clinical examples. Yeah. So it's all in literature. You can take, adapt and apply to your particular setting. We will share links to the studies.

**Claudia Williams** [00:44:05] Thanks so much, Natalia. And so a question from Emdhi. They would be interested in understanding what was incorporated, incorporated in the competence framework identified in the BNSSG and whether you have any key suggestions in building staff skills and confidence, especially across systems.

**Jo Williams** [00:44:28] Yes, I can comment on that. It's probably best if we share the link to that document so that you can have a look at detail yourself. It is currently actually hosted on the Keeping Bristol Safe Partnership website, but it applies across the whole geography. So I can make sure that's shared. And I think it's important to sort of also describe that just again that the particular I guess focus will be slightly different for different staff groups. For example, at the moment, Avon and Somerset police are doing a very significant multi-agency training programme which is benefit to many agencies, but has had different levels of training. So sort of much briefer training on offer through to sort of nine day training for some senior agents. So I think the best thing would be to have a look at that document and to come back if you've got any further questions.

**Claudia Williams** [00:45:29] Brilliant. Thank you, Jo. And so we have a comment and a question from Sally, and Natalia, while we are all hopefully becoming more trauma-informed, there seems to be little about implementation, so regarding "it's the way that you do it", are you able to comment on any papers or examples of successful practical implementation of trauma informed strategies?

**Natalia Lewis** [00:45:56] Yeah. I mean, all our paper studies, which we included in our systematic reviews, they were all successful implementations, they just produced different outcomes, but they all demonstrated that if you implement it at the whole organisation level, you really can change at least in some patients, in some members of staff, you can change their psychological readiness, you can change their behaviour and practises, you can improve patient health outcomes. By the way, we didn't find a single study which would evaluate health of members of staff as a result of implementing a trauma-informed approach. So a look at our preprint for systematic review one and all the studies which we included are a perfect example of a successful implementation of a trauma-informed approach in the real world health care organisations.

**Claudia Williams** [00:46:58] Thank you, Natalia. A question from Luke. One of the worries from GP's in their area is about undertaking a trauma enquiry approach in that they'll need to make lots of onward referrals to services that are already overstretched. And so did any of your research find evidence to support or refute this?

**Natalia Lewis** [00:47:22] So the evidence shows. And you saw I think it was a systematic review two that referrals to specialist support services, the evidence was conflicting. Some findings, some studies showed that it increased, some so such that it showed that it was increased. I mean, implementing a trauma informed approach means extra burden on staff. This is true. And you cannot load this extra burden without providing structural support and providing referral pathways and psychological support to staff. So that is why it looks like if you tried to implement bits of pieces from a trauma-informed approach framework, like for example, a training one or training which trains your staff to ask, identify and refer. It does result in changes in awareness, but it doesn't result in changes in practises. So to achieve changes in practise and to sustain you have to change the system, the organisation and why this is done. My feeling that it is not a quick fix, a trauma informed approach. It is a long and painful process. This is my feeling from the research evidence. I don't know, maybe people in the audience have a different experience from best clinical practise, but this is what research shows. I came across one paper from America where they said that they started picking up improvement in outcomes and experience after two years since they started implementing a system wide approach.

**Claudia Williams** [00:49:13] Thank you, Natalia. Just very aware of time. We've got about 2 minutes left, so if any of your questions haven't been answered, we will do our best to get that information over to you via email. So, Natalia, I would like to finish with a final question. What are the next intended steps for the TAP CARE project?

**Natalia Lewis** [00:49:31] We just started planning a next step. We want to bring this evidence into practise. We want to work with general practises in the Bristol, North, Somerset and South Gloucestershire area. Practises, which are research active, would like to implement a trauma-informed approach at the organisation level and we would like to collaborate with them to try and help them to adopt a generic framework. Let's say for example the one developed in business is due to their organisational needs, abilities and preferences. So if you are a GP or anyone working in general practise in this area. Please get in touch. Use the contact details on next slide and we will be happy to work with you on implementing this approach. We will disseminate our findings further. We are working on the piece of animation. We will be producing policy briefings, infographics. So we will try to disseminate our findings to non-academic audiences and would really looking forward to work with policy makers to really help them to use our research findings in policy and practise.

**Fay Maxted** [00:50:57] So finally, thank you for taking the time to attend today, on the hottest day that we've ever experienced in this country. Please do keep in touch. Follow @CAPCBristol on Twitter or sign up to the Centre for Academic Care newsletter using the link this displayed on the screen. And you can also find more information about the study on their website, which is www.bristol.ac.uk/tapcare-study. And next slide, please.

**Fay Maxted** [00:51:38] So for anyone who's been affected by trauma or any of the discussions today and would like information or support, we've included details of key organisations on this final slide for people to find to help. Thank you very much for attending, look after yourself in this heat. And thank you all. Goodbye.