2026

Blackburn with Darwen Systems Resilience Framework Evaluation

Rebecca Hibbin and Deborah Powney

PROVA
EVIDENCE LED SOLUTIONS

Contents

Blackburn with Darwen Systems Resilience Framework Evaluation Report

Executive Summary

Introduction

The Blackburn with Darwen Systems Resilience Framework Evaluation Report assesses the implementation and impact of Trauma-Informed Practice (TIP) across the Borough. The initiative aims to transform service delivery by embedding trauma-informed principles across public, voluntary, and private sector services to create a consistent, system-wide approach to reducing re-traumatization and improving outcomes for individuals and communities.

Key Findings

The evaluation focused on two core implementation strands within the five Managed Networks:

- **Community Champion Strand (CCS)** – Bottom-up implementation through volunteer-led initiatives.
- **Service Lead Strand (SLS)** – Top-down implementation through leadership-driven action planning.

Community Champion Strand: Bottom-Up Implementation

- Community Champions (CCs) co-produced and delivered the Trauma-Informed Community Workshop (TICW) to promote awareness, reduce stigma, and increase trauma literacy at the grassroots level.
- Volunteers adapted the workshop to fit community need with the workshop evolving into an informal, discussion-based model, successfully engaging community groups in reflective conversations.
- TICWs fostered empathy, normalised trauma, and created space for emotional insight and healing, including for the CCs themselves.
- Barriers included volunteer retention, capacity issues, financial sustainability, and limited pathways for CCs to signpost community participants to further support.

Service Lead Strand: Top-Down Implementation

- Four Action Planning Workshops (APWs) guided Service Leads (SLs) through embedding TIP into individual services using structured change management strategies (e.g., Kotter's model).

- SLs developed short-, medium-, and long-term action plans focused on raising awareness, updating policies, and integrating trauma-informed values into service delivery.
- Key barriers included time constraints, inconsistent leadership engagement, service fragmentation, and conflict with some external directives (e.g., accountability frameworks).

Benefits of TIP Implementation

- **Service User Impact**: Enhanced empathy, the normalisation of discussions around trauma, and improved early intervention through trust-building and person-centred delivery.
- **Workforce Wellbeing**: Increased reflective practice, better staff support structures, and stronger emotional resilience.
- **Organisational Effectiveness**: Improved inter-agency communication, integrated policy alignment, and whole-systems thinking focused on prevention.

Barriers to Sustainability and Culture Change

- **Time and Capacity**: TIP is often viewed as an additional task, with staff struggling to embed reflective work within high-pressure environments.
- **Leadership and Policy Buy-In**: Varying degrees of commitment across services slowed TIP implementation and prevented whole-system alignment.
- **Service Fragmentation**: Some services (e.g., Children's Social Care, Education) progressed faster than others (e.g., Adult Services, Primary Care), resulting in inconsistent service experiences.
- **External Constraints**: National policies, Ofsted inspections, and government-led metrics (e.g., attendance, performance) sometimes conflicted with TIP values.
- **Short-Termism and 'Projectitis'**: Reliance on time-limited funding undermines continuity and long-term planning, despite promising results.
- **Inadequate Supervision Structures**: Reflective supervision is not uniformly accessible, especially to non-clinical staff and those in administrative or first-contact roles.

Facilitators of Sustainability and Culture Change

- **Integrated Training Model**: Contextualised, cross-sector training using case studies and lived experience significantly enhanced understanding and commitment.
- **Policy Alignment**: TIP has been embedded into safeguarding, reintegration, and workforce policies, alongside the introduction of a mandatory e-learning module.
- **Reflective Practice**: Where supervision is prioritised, staff reported increased insight, emotional safety, and reduced burnout.

- **Trauma-Informed Champions (TICs)**: Champions promoted cultural consistency and acted as change agents within teams, though role clarity and support need improvement.
- **Shifting Culture**: Widespread use of trauma-sensitive language, humanising service approaches, and cross-sector conversations suggest progress toward cultural transformation.
- **Community Buy-In**: TICWs helped normalise discussions around trauma, foster resilience, and prompted service users to engage more positively with services.
- **Strategic Leadership and Networks**: The TIP Steering Group and Managed Networks laid the infrastructure for sustained interagency collaboration.

Recommendations for Future Implementation

1. **Sustain ongoing Integrated Training and Reflective Practice**
    a. Expand integrated training to include leadership and advanced practitioner modules.
    b. Ensure mandatory induction training includes TIP across all sectors.
2. **Enhance Leadership engagement and policy integration**
    a. Secure senior leadership sponsorship across departments.
    b. Embed TIP into HR, safeguarding, and supervision policies for all staff.
    c. Develop a Local Authority-wide TIP Code of Practice.
3. **Secure sustainable funding**
    a. Move beyond project-based funding with long-term investment in TIP structures.
    b. Explore monetisation of training models and partnerships with the private sector.
4. **Strengthen Community engagement and public awareness**
    a. Continue co-production and conversational delivery of TICWs.
    b. Enhance cultural and linguistic inclusivity in outreach and engagement.
5. **Formalise and support the Champions Model**
    a. Define clear roles, responsibilities, and training pathways for TICs.
    b. Provide protected time and accountability mechanisms to support impact.
6. **Broaden the definition and sector specific application of TIP**
    a. Develop a place-based definition of TIP, adaptable across services and sectors.
    b. Ensure this definition reflects the lived realities of trauma in BwD.
7. **Promote Relational approaches**
    a. Integrate TIP with Restorative Practice (RP) to promote accountability, healing, and repair.
    b. Create organisational environments that are psychologically safe, relational, and empowering.
8. **Establish a Unified Data-Sharing System**
    a. Advance a ‘No Wrong Door’ model to streamline access and reduce duplication.

b. Invest in interoperable systems with sector-specific safeguards.

Conclusion

The evaluation highlights considerable progress toward becoming a Trauma-Informed Borough, with both the bottom-up (CCS) and top-down (SLS) approaches contributing to system-wide transformation. Despite ongoing challenges in leadership, capacity, and integration, the cultural shift is visible in language, relationships, and practice. To ensure long-term sustainability, BwD must embed TIP into governance, secure stable funding, and maintain a shared vision of relational, human-centred public service delivery.

Introduction

The core objective of implementing and rolling out the Systems Resilience Framework in Blackburn with Darwen (hereafter referred to as the 'SRF roll-out') has been to embed trauma-informed practice (TIP) across the Borough to transform service delivery, so that every interaction a vulnerable individual has within education, health, social care, policing, and the third sector is grounded in trauma-informed principles. The vision is to create a system-wide cultural shift where professionals and services work in a way that reduces re-traumatization, fosters emotional safety, and improves long-term outcomes for individuals and communities.

Key aims of the SRF roll-out have been to ensure that members of the public and service users experience consistent trauma-informed responses moving from individual efforts at TIP to a coordinated and systems-wide approach.

Overall, reducing service fragmentation and building a multi-agency approach has been a core goal of the SRF roll-out, to break down silos between the public sector and voluntary/community services, creating a joined-up approach that enables shared learning and integration.

> *"...wherever a member of the public was to go, or wherever a member of our workforce was to go, they would get that same consistent approach in terms of the language that was being used, the way that they were being dealt with...our services all linking together."* (**BwD Roll-out Team**)

The foundations of TIP in BwD date back to 2012 when a population survey on Adverse Childhood Experiences (ACEs) was commissioned by the Director of Public Health (Bellis & Lowey, 2014), replicating the US ACEs survey that was undertaken by Felitti et al in 1998. After this time, some key progress was made including:

- Health visitors introducing routine inquiry on ACEs
- Some voluntary organisations starting to access TIP training

However, early engagement was disjointed, with different teams independently trialling approaches in a piecemeal fashion without coordination, a unified strategy or shared vision. More recently, in 2020 the TIP initiative was brought under the Children's Partnership Board and a multi-agency Trauma-Informed Steering Group was created, bringing together education, policing, health, and social care. In 2020, independent researchers were commissioned to evaluate EmBRACE (Hibbin & Warin, 2021), the package of training and consultant support that was utilised to further embed TIP across the Borough. As a result of the recommendations made within that evaluation for creating a more fully embedded systems-wide approach, five Managed Networks (MNs) were then established (2 Sector-based MNs and 3 Phase-based MNs) to create a shared vision for TIP across BwD, namely:

1. Early Years (preconception – age 5)
2. Children and Young People (5-19, up to 25 for SEND)
3. Vulnerable Adults

4. Communities and Neighbourhoods
5. Health and Social Care

This report documents the evaluation of two strands of action across the 5 MNs, the Community Champion Strand (CCS), and the Service Lead Strand (SLS).

BwD has a unique social and demographic context, with a high level of ethnic diversity and cultural considerations that have needed to be taken into account when trying to embed TIP across the locality. In particular, BwD has a highly diverse population, with 35.7% of residents identifying their ethnic group within 'Asian or Asian British' (ONS, 2021). Along with this high level of Asian heritage comes certain cultural norms, impacting discussions around trauma and mental health, including:

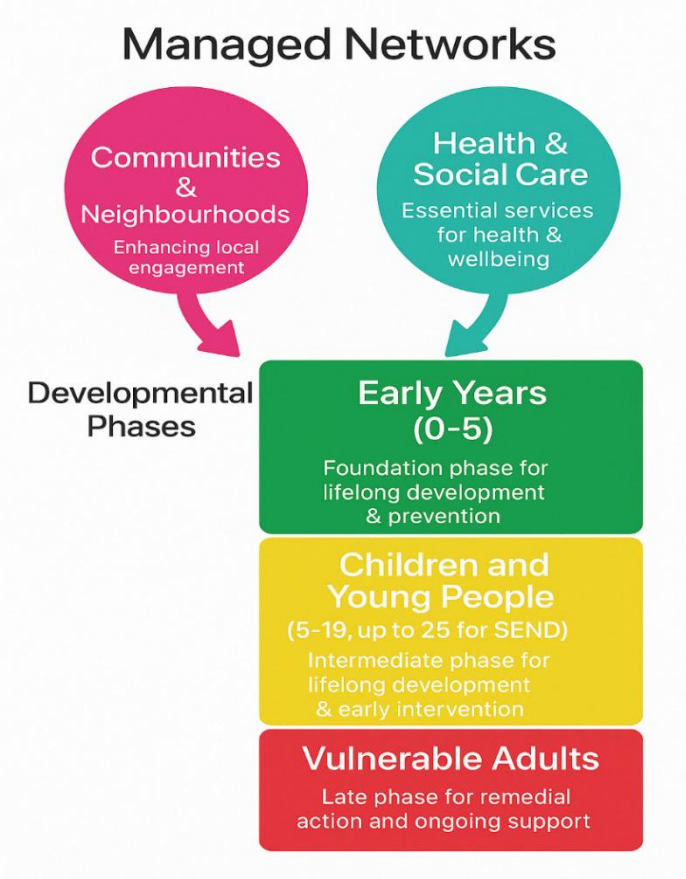

Figure 1: BwD's Managed Networks

Stigma and Silence: Many communities, particularly South Asian and Muslim families, have historically avoided discussing trauma.

Gender Norms: Stigma and silence is even more prevalent for male members of such communities.

Religious and Faith-Based Perspectives: Some community members prefer faith-based support networks over statutory services, making engagement with formal services more difficult.

Figure 2: Cultural norms impacting on discussions of trauma

In addition, there is a high level of socioeconomic deprivation with BwD being one of the most deprived local authorities in the UK ranking 14/317 in the Index of Multiple Deprivation against all local authorities in England (LCC, 2022), with associated high levels of unemployment, low educational attainment, and poor health outcomes. Trauma is deeply interwoven with poverty (Ellis & Dietz, 2017), with childhood trauma being disproportionately high across the Borough, and this impacts on service delivery in a number of ways. In particular, demand for services exceeds capacity where "there are not enough resources to provide TIP training at the scale needed to truly transform services" (**BwD Roll-out Team**). In addition, staff burnout and retention issues are a serious consideration, with many frontline staff working in high-stress environments with high caseloads, leading to secondary/vicarious trauma.

The aim of this evaluation report is to provide a snapshot of the SRF roll-out over one year, to inform the progress to date of the cross-sector systems-wide approach that BwD is currently taking to address the impact of trauma – in relation to ACEs (Felitti et al, 1998, Bellis and Lowey, 2014) as well as trauma more widely conceived (i.e. PTSD/C-PTSD; systemic – Ellis & Dietz, 2017). In addition, the wellbeing of the workforce will be a key consideration of this evaluation, in relation to the idea that they may be dealing with their own trauma as well as that of their service users, within a wider system that is designed to take more of an administrative approach rather than one that is focused on embedding trauma-informed systems and processes.

Overall, this evaluation highlights that significant progress has been made in embedding TIP in BwD, but systemic challenges remain. The next steps require strong leadership, dedicated funding, and ongoing cross-sector collaboration to achieve the long-term vision of a Borough that is fully trauma-informed.

Methodology

This evaluation took a systems-focused approach to understanding the implementation and impact of two strands in BwD's Managed Networks (MNs) – the Community Champions Strand (CCS) within the Communities and Neighbourhoods MN, and the Service Lead Strand (SLS) within the Health and Social Care MN. Both Strands were conceived as part of BwD's intention to implement a systems-focused approach to embedding TIP across the Borough, with the SLS representing a top-down approach to implementing and embedding TIP across services and sectors, and the CCS representing a bottom-up approach through volunteers spreading awareness of trauma-informed principles in the community.

The research employed a mixed-methodology based on observations, focus groups and a workforce survey across services and sectors. Overall, the research took a case study approach to both the SLS and the CCS, and collected the following qualitative data from approximately 90 participants:

Figure 3: Data collection

The evaluation followed the implementation of the CCS from observations of the Trauma Informed Developmental Workshops (TIDW) that took place between September 2023 and November 2023 to design the Trauma Informed Community Workshop (TICW) that was to be taken out into the community to spread awareness and understanding of TIP, as well as observation of delivery of the TICW itself between January-April 2024. In addition, focus groups with the Third Sector Organisation (TSO) facilitators and also the Community Champions (CCs) who delivered the TICW, were undertaken from July-August 2024 to further evaluate the SRF roll-out within the community.

In addition, the evaluation followed the implementation of the SLS through observation of the Action Planning Workshops (APWs) with key Service Leads (SLs) that took place between November 2023 and July 2024, to provide SLs with a dedicated reflective space to implement and embed TIP in their individual services. Data collection included surveys, observations and focus groups to evaluate the SRF roll-out across wider services.

Findings

Community Champion Strand: Bottom-up Implementation

The Community Champion Strand (CCS) was conceived as one element within the Communities and Neighbourhood MN, designed to spread awareness and understanding of TIP across the community in a bottom-up manner.

Observations of the Trauma Informed Developmental Workshop

This section provides key takeaways from the observation of the TIDW within the CCS. This workshop was led by EmBRACE, a package of trauma-informed consultant training and support, and it was facilitated by a TSO to provide a space to collaboratively design the Trauma Informed Community Workshop with volunteers as the vehicle through which TIP was taken out to community groups across BwD. Key themes from the observations of the TIDW included:

- Trauma being a complex and sometimes controversial concept
- The changing structure and delivery of the TICW
- The role of Community Champions (CCs) as connectors in the community
- CCs receiving training and supervision

Figure 4: Key themes from the TIDW

Trauma being a complex and sometimes controversial concept

This aspect was discussed at length by the volunteers during the TIDW, where the goal of the co-produced TICW was seen as being to not define trauma rigidly, but rather to encourage community reflection. More specifically, observed discussions in the TIDWs emphasised that trauma is often misunderstood or ill-defined, with many individuals potentially not recognising their experiences as trauma. As a result, a key aim was to create a TICW that produced "penny dropping moments" in the community, supporting individuals to realise and understand how trauma affects them on an individual basis, as well as within their communities more widely. In addition, there were challenges in defining trauma with different perspectives on what constitutes trauma - from road traffic accidents to war, to the more commonly understood concept of Adverse Childhood Experiences (ACEs; Felitti et al, 1998). This was addressed through a couple of different mechanisms:

- Using real-world anonymised examples to explore different types of trauma
- Balancing more obvious forms of trauma (e.g., war, abuse) with less recognized ones (e.g., neglect, and systemic harms such as discrimination)

The contested nature of trauma links to the concept of 'Adverse Community Environments' (**Error! Reference source not found.** that mirrors the Adverse Childhood Experiences literature (Felitti et al, 1998) in relation to mapping out more systemic forms of disadvantage that can lead to the symptomatic adverse outcomes that are described by the more individualised ACEs model (Felitti et al, 1998; Bellis et al, 2014).

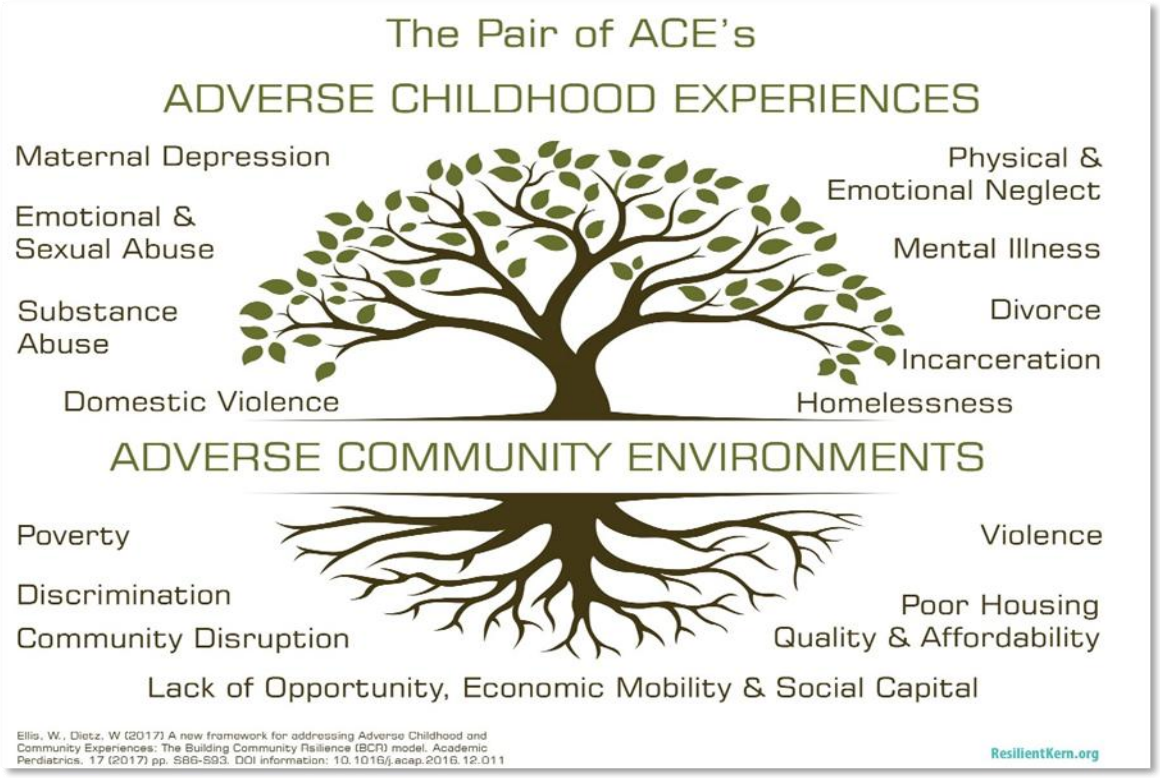

Figure 5: Pair of Aces Tree (Ellis & Dietz, 2017)

While such systemic environmental factors cannot be identified as directly causative of ACEs, the correlation between the two is important to consider when thinking about interventions. Furthermore, it is helpful to visualise the interrelationship between the environmental roots of trauma, and individual ACE outcomes represented by the branches of the Pair of ACE's (Ellis & Dietz, 2017) tree e.g. the impact of poor housing and poverty on maternal depression, mental illness, or substance misuse.

The complex and controversial nature of trauma that was evident from the observation of the TIDW, was also discussed in relation to the idea of 'trauma' being 'a frightening word' with concern being expressed by participants around the possibility of re-traumatising community members by asking them to reflect and unpack their trauma in the context of a co-produced community workshop. This will be unpacked in the '

Final thoughts' section below, and also in the section titled 'Normalising Discussions on Trauma.'

Structure and delivery of the Trauma Informed Community Workshop

It was decided in the TIDW that the delivery of the TICW would be divided into**:**

- Introduction to the term 'trauma', including the Borough's journey, and the role of CCs
- Interactive elements around the theme of trauma, including group discussion and video screenings

Clear boundaries being set around the role of the CCs was seen as being central, so that the TICW was framed as being informative rather than advisory. This was in recognition of the fact that the volunteers delivering the TICW were not 'experts' in trauma, but rather facilitators of discussion. Key considerations for facilitation of the TICW included:

1. Managing dominant and quieter voices in group discussions

2. Avoiding the possibility of re-traumatisation and ensuring a supportive environment

3. The importance of clear boundaries to prevent re-triggering participants, particularly in relation to community members who could present as a suicide risk

4. Highlighting available support resources (e.g., Samaritans) in materials

5. The need to be mindful of unintended disclosures

Figure 6: Key considerations for facilitation of the TICW

6. Avoiding a "therapeutic" space while still allowing reflection
   It was decided that there needed to be initial practice sessions undertaken to get this balance right before rolling out the TICW, taking an iterative approach to evaluation and learning from each session to improve the workshop over time. There was also some discussion of where the groups would be advertised and who would be targeted, with suggestions around putting advertisements for the TICWs on toilet doors in the cinema "as they do for domestic abuse services" (**TSO Facilitator**).

The role of Community Champions

The role of the volunteers delivering the TICW was a key element of consideration including the need for support in managing difficult discussions and preventing re-traumatisation. As a result, there was a focus on the duties and limitations of CCs where they were not seen by community members as trained therapists and should therefore not provide direct trauma support. In practice, this meant serving an informative rather than advisory role, and when sensitive issues arose at any point during delivery the TICW the CCs should signpost to appropriate services.

In addition, it was seen as important that CCs were able to balance inclusivity with sensitivity within the course of TICW delivery, to:

- **Ensure participants felt heard:** through amplifying community voices while simultaneously maintaining safe spaces for open discussions

- **Manage disclosures:** in a way that did not re-traumatise or overburden CCs, in recognition of the importance of volunteer wellbeing

Finally, the name and identity of CCs was of some debate with a few volunteers expressing concerns around the name 'Community Champion', that some felt implied

expertise or superiority. Similarly, volunteers discounted terms such as 'Advocate' and 'Ambassador' due to those names not fitting the role. An alternative suggestion was made by the TSO facilitators who came up with 'Community Awareness Volunteer' as a possible name, and this suggestion met with some approval due to the idea that "people respect the volunteer label" (**Volunteer**).

Community Champions receiving ongoing training and supervision

Ongoing training and reflective supervision with the TSO facilitators was seen as being essential to developing the TICW over time, as well as supporting volunteers to manage their own wellbeing and perceived ability. This was to:

Figure 7: Benefits of ongoing training and supervision for volunteers

Build confidence: Many volunteers felt inexperienced but were reassured that their confidence would develop over time

Provide an opportunity for reflective learning: TSO facilitators encouraged volunteers to reflect after each session and adjust the approach accordingly

Manage Group Dynamics: TSO facilitators supported volunteers to tactfully handle dominant voices and ensure inclusive participation

Final thoughts

Overall, within the development and the delivery of the TICW, there was a clear understanding of the contested nature of trauma, the different ways this could present on both an individual basis and in the community. The purpose of the TICW was seen as being to facilitate discussion rather than provide a therapeutic space, whilst being sensitive to the dangers of re-traumatisation. This was notable in relation to serious concerns expressed by the volunteers relating to people who were potentially suicidal, where they expressed considerable reservations in terms of the potential of the TICW to 'trigger' suicidal ideation. The TSO facilitators supported volunteers in relation to this concern by allaying fears about re-traumatisation in relation to suicide risk. This connects to the literature that suggests there should be less concern about touching on subjects such as suicide that are perceived as sensitive (Polihronis et al, 2022), with some researchers suggesting that mental health practitioners should be directly asking such questions of those individuals that are seen as being a potential risk in this regard (O'Reilly et al, 2016). Whilst the volunteers were aware that they were not experts, it is more likely that their high level of concern and observed sensitivity around the

possibility of re-traumatisation when discussing trauma in the context of the TICW, would result in community members disclosing such thoughts in a trusted environment, rather than being 'triggered' to 'do something silly.'

The volunteers were particularly keen on facilitating discussion and supporting penny-dropping moments in community participants. However, they did not want to explore how communities are 'resilient' in a strengths-based manner, as they did not feel they were yet at that point of expert understanding. This highlights the newness of the approach and how BwD is at the forefront of changing systems across the board, starting with the bottom-up strategy that is represented by the TICW delivered by the CCs.

Finally, some concerns were expressed about the third sector's ability to sustain trauma-informed efforts without dedicated funding, and there was acknowledgment from volunteers and the TSO facilitators that financial constraints could impact the long-term success of the initiative. This links to previous research that has been undertaken on the use of TIP through the EmBRACE evaluation (Hibbin & Warin, 2021) that emphasises the importance of taking a long-term view to embedding TIP on a systematic basis.

> "*Building what has been termed a "'whole systems' understanding of resilience" (Popay et al, 2018; p.292) through very embedded practice, was seen as a central long-term element of implementing TIP in schools and other organisations more widely through EmBRACE… the barrier of TIP being viewed as another 'fad' was tackled through a values-led approach that sustained TIP over the long-term*" (p.24-32)

Observations of the Trauma Informed Community Workshop Delivery

This section provides key takeaways from the observation of the TICW that was delivered by CCs and facilitated by the TSO that supported the design and delivery of the workshop.

The researchers attended and observed two groups: a Women's Stitch Group, and an Asian Men's Group. Core themes centred on the evolution of the workshop from the developmental phase described above, and the subsequent delivery of the TICW in the community context. Key Insights for future delivery centred around:

1. Workshop adaptation and flexibility
2. Normalising discussions on trauma
3. Intergenerational and social/cultural pressures
4. Trauma-informed approaches in practice
5. The impact of the ACEs animation

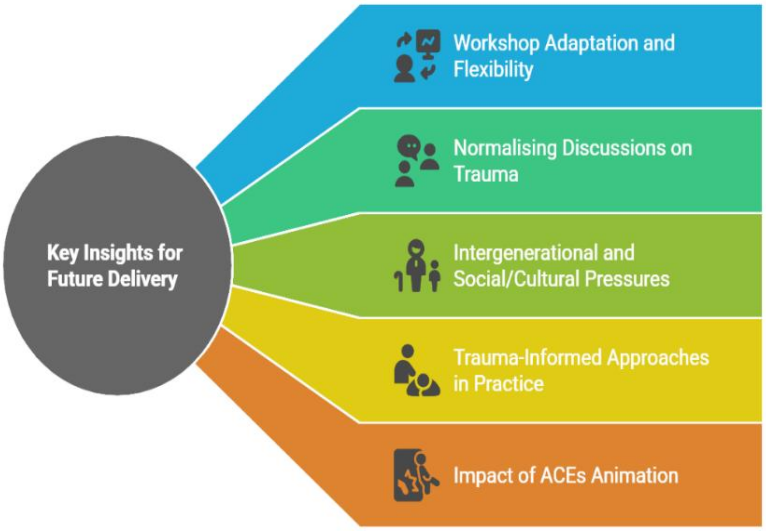

Figure 8: Insights for future delivery of the TICW

Workshop Adaptation and Flexibility

The need for flexibility in the delivery of the TICW was a key theme from the observations of delivery within the two community groups, as it was clear that the structure of the workshop had changed considerably since the developmental phase. **In particular:**

- The workshop had evolved from a rigid presentation into a more informal and conversational approach, allowing for organic discussions.
- CCs were learning to "read the room" and respond to participants' reactions in real-time.

Barriers to engagement included language barriers that had prevented one Women's Group from taking place. In addition, in the Men's Group translation into Punjabi by a TSO facilitator was required to ensure that the TICW was accessible and inclusive to all participants. Furthermore, some participants had never heard of ACEs or TIP before, requiring the CCs and TSO facilitators to start from the basics of explaining a trauma-informed approach.

Normalising Discussions on Trauma

Trauma awareness was a key focus of the two TICWs that were observed, where CCs supported the community groups to understand and identify trauma in everyday contexts and in various forms: cancer diagnosis, mental health struggles, job loss, social isolation, and family conflict. In addition, community members were supported to recognise that trauma responses differ based on individual circumstances and cultural influences.

This emphasises the importance of viewing trauma as a part of life rather than something aberrant that happens to a minority of unfortunate individuals. Rather, normalising the concept of trauma as an everyday occurrence that everyone has experienced on some level that differs only in terms of severity, is key. Such an approach paves the way for considerations about the best ways to instil resilience and foster post-traumatic growth (Parry et al, 2023) once debilitating forms of trauma and maladaptive responses have been identified on an individual basis. Overall, empathy for traumatic experiences was highlighted by the CCs as a key message to:

- Encourage participants to view erratic behaviour as potential expression of trauma rather than acts of defiance
- Emphasise the importance of questioning "Why is this person behaving this way?" rather than reacting with judgement and negativity

Intergenerational and Social-Cultural Pressures

A focus on changing social norms and the role of family dynamics was also evident in the two TICWs that were observed. In the Men's Group there was discussion around intergenerational tension, particularly in relation to late marriages in the Asian community. In addition, the increasing reliance on social media within families was discussed. Within the Women's Stitch Group, family estrangements due to financial disputes were highlighted, as well as the impact of urban planning (e.g., lack of social housing and community spaces) on collective wellbeing. In both groups there was discussion around the tendency of men to supress their emotions, more specifically:

- How men tend to bottle-up emotions, leading to a higher risk of suicide
- Alternative models of emotional expression for men, such as community service activities rather than formal talking groups
- Debate over whether showing emotion is a strength or a weakness in men.

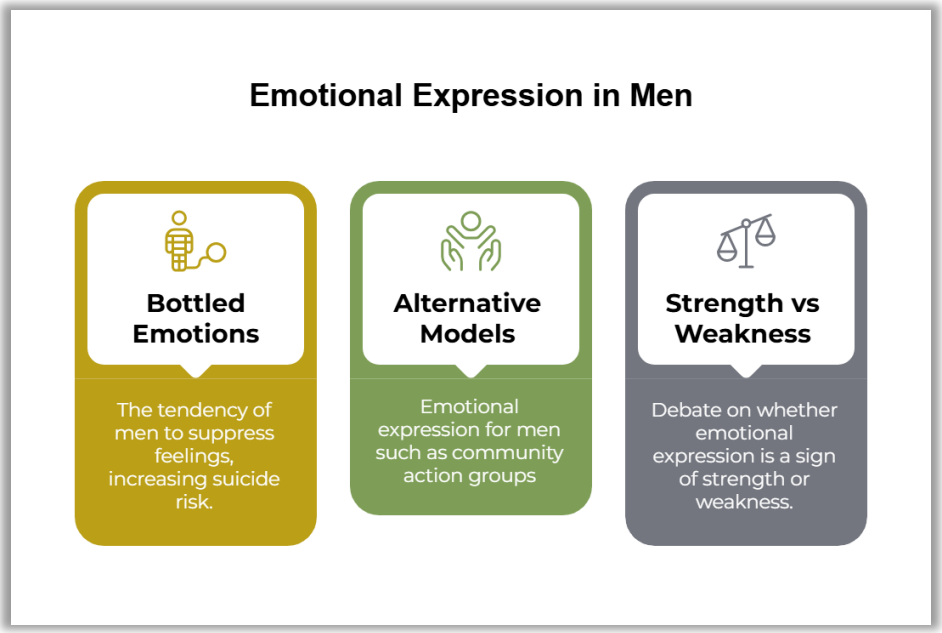

Figure 9: Emotional expression of trauma through a gendered lens

Trauma-Informed Approaches in Practice

Within the observations of the TICWs, discussion with community members centred around 3 core areas:

1. Recognizing trauma in others:

- Participants reflected on their awareness of distress in others and how people's silence or unusual behaviour can indicate trauma
- There was general discussion about how different people and different cultures suppress or express trauma in various ways

2. Real-world examples of TIP:

- The power of a single conversation: one community member told a story about a young man at a funeral whose aggressive behaviour changed when he was asked about his feelings
- An example was given of how a stranger prevented a suicide attempt simply by engaging in a conversation

3. Rethinking cross-sector responses:

- Participants learned about trauma-informed policing and how law enforcement is being retrained to consider trauma before resorting to punitive measures
- An emphasis on trauma-informed education through, for example, showing respect to a misbehaving pupil regardless of the challenging behaviour being expressed, and how this can change educational trajectories and transform lives

Feedback From Participants: ACEs Animation and Informal Workshop Delivery

There were some key learnings from the observation of the TICWs derived from feedback obtained within the course of the workshop. Most notably, participants reflected on the impact of the original 2014 ACEs Animation which they considered to be an emotionally powerful way to introduce the subject of trauma, ACEs and TIP, prompting reflections on their own trauma and past experiences, including one participant recalling her abusive marriage. Overall, the TICW helped community participants to engage in conversations within their communities, and they seemed to leave with a greater willingness to check-in on others experiencing distress. In addition, in the Men's Group one English as a second language participant reported to staff members that he planned to use his new understanding of ACEs to help a friend struggling with mental health issues.

Feedback from participants on the delivery of the TICW was that they appreciated the informal, conversational approach rather than a more didactic model of delivery. There was wide agreement that engagement was more important than simply receiving information on trauma, ACEs and TIP, and it was felt that the structure and delivery of the TICW provided a format that supported information retention and application. This was achieved using the ACEs animation, coupled with conversational discussion of ACEs and trauma, practical application of core messages around recognising trauma in

others, and ways to empathise rather than judge the often-challenging behaviour of people who have been adversely impacted by trauma. However, further insight into sources of support were also highlighted as being essential for community members to follow-up on information provided by CCs in the TICW.

3rd Sector and Volunteer Interviews

The following section identifies core themes from the perspectives of CCs who were supported by TSO facilitators to develop the TICW. The analysis highlights common challenges, learning experiences, and the impact of delivering the TICW in BwD, from the perspectives of both the TSO facilitators, and also the CCs. Representative quotations are provided to illustrate key concepts.

Barriers to TIP Implementation in the Community

The TICW was a recommendation that stemmed from the Citizens' Juries (CJs) that were undertaken through Lancashire Violence Reduction Network (LVRN) in 2021.The TSO facilitator lead who had been involved in that piece of work suggested that embedding TIP into frontline services (that was a key recommendation from the CJs) needed to be replicated across the local community, due to her concerns around "what's going to happen to the public?" going on to suggest that "they need to be built up as well" (**TSO Facilitator**).

During the TICW development, the TSO facilitators emphasised the initial high levels of engagement by the volunteers, followed by significant drop-offs in attendance where "it fluctuated, it went up, went down, and then....it flatlined" (**TSO Facilitator**). While initial interest in volunteering was strong, maintaining consistent engagement proved difficult due to personal life challenges, health issues, and other competing commitments, where "they've got so much on in their personal lives... it doesn't mean that they've got a lot of free time (**Ibid**.)

In the end, just two volunteers out of the approximately 7/8 that originally attended, ended up becoming CCs for the physical delivery of the TICW. Interestingly, both CCs had been part of the CJ process and as a result they were fully bought-into the process and delivery of the TICW, having been involved from the start. In addition, they had a well-developed understanding of the aims, purpose and practice of TIP through involvement in the CJs. It is worth noting the importance that was placed on being present and involved from the conception of the TICW within the CJs, as emphasised strongly by one of the CCs:

> *"...we ourselves had done the previous training...so we already had the insight... because we'd been part of the process, we understood it more and I think, the people that came and left, they'd only just come in on that ... we'd been...part of the whole thing before coming up with the idea of delivering it to the wider community... they didn't really connect in the same way that we connected..."* (**Community Champion**)

Learning and Adaptation in TIP Delivery

As already suggested, there was considerable adaptation of the TICW from its initial iteration in the developmental phase, where a very formal didactic style was taken with CCs 'teaching from the front' during delivery. It became clear that this approach "just completely did not work" (**Community Champion**) in the field, and CCs learnt that their initial over-professionalization of delivery hindered engagement. As a result, through supported reflection with the TSO facilitators, the CCs came to recognise that the initial structured, formal presentation style was ineffective, and they shifted to an informal, conversational approach due to the realisation that "people volunteered more about their own story through dialogue and engagement." (**Community Champion**).

As discussed in the section detailing observations of the development and delivery of the TICW, the role of reflective practice and feedback was key to this process of learning and the TSO facilitators were central to encouraging the development of a growth mindset (Dweck, 2015) in CCs where they "always took feedback and made changes" (**TSO Facilitator**) to their delivery, learning from their mistakes and adapting their practice through reflection on honest feedback. Such feedback was provided within the context of a relational approach that fostered trust between the TSO facilitators and the CCs, helping the volunteers to improve their delivery and facilitation techniques through continuous learning:

> *"We were honest with them. We'd say '[Volunteer's name]... there was an element where you nearly lost the group' And he'd respond, 'Yeah, I felt that too.'"* (**TSO Facilitator**)

The Impact of TI Community Workshop on Volunteers, TSO Practitioners and the Community

Personal growth and self-reflection were key elements of the impact that the TICW had on the CCs who delivered it, as well as the TSO facilitators who supported the development and delivery of the workshop. CCs and TSO facilitators were able to identify their own trauma during the course of TICW implementation, recognising instances of personal difficulty and mental health struggles in their own lives:

> *"Some of the stuff that we've gone through has been quite eye-opening. Even myself, I've identified trauma I wasn't aware of."* (**TSO Facilitator**)
>
> *"I can tell you that I'm suffering from trauma as well myself…I'm trying to open-up about my mental health."* (**Community Champion**)

In addition, the TSO facilitators and CCs reported the significant impact of 'penny-dropping' moments during delivery of the TICW, where several participants experienced

the 'lightbulb' effect of understanding how trauma influences behaviour in themselves and others:

> *"'It all makes sense.' And that's what the community have said… 'gosh, I understand why that person might be doing that. I understand why my grandchild may behave that way, or why my cousin behaves that way', that* ***penny-dropping moment****… 'It's not because they're* ***that****, it's because I know what their childhood was like. And now it makes sense'."* (**TSO Facilitator**)
>
> *"One elderly gentleman realized his friend's anger was rooted in trauma…he listened and he took note of everything we were saying… he mentioned that he has this friend who's always really, really angry and…he tends to isolate himself and… after that session I remember him saying he's going to go away and he's going to speak to his friend and just take the approach that we're telling people."* (**Community Champion**)

Facilitators and Enablers of Success

Supportive relationships and the mentorship provided by TSO facilitators was critical to the CCs' confidence and success in developing and delivering the TICW. As already described, the volunteers felt initially very anxious and lacking in confidence about their ability to deliver the workshop to the community. However, they experienced a high level of support through trust building, open communication and encouraging a growth mindset:

> *"[Name of TSO Facilitator] was very supportive, and so was [name of TSO Facilitator]. We worked on it together, and that made all the difference." (****Community Champion****)*
>
> *"If you don't have that trust, then they won't carry on. That was very important for us to build from day one." (****TSO Facilitator****)*

In addition, taking a flexible approach that encouraged adaptability during the development of the TICW was key. Adaptations such as hybrid meetings were implemented, for those volunteers who were unable to attend in-person. However, the difficulty of maintaining this format was also acknowledged where it was observed that "people tend to just carry on face-to-face meetings and forget about the person who's online so that those hybrid meetings don't always work" (**TSO Facilitator**).

Furthermore, informal feedback and evaluation sessions alongside flexible scheduling where the volunteers and TSO facilitators would "go out for coffee…[and make] our diary more flexible so we could sit down and discuss" (**Ibid**.) were reported as helping to "build relationships… [it] meant they didn't feel pressured" (**Ibid**.) Such an approach

was seen as being crucial in sustaining volunteer engagement, in recognition of the constraints that individuals experienced in the course of their lives beyond the project alongside the importance of building trust through informal opportunities to engage in a more relaxed manner.

Sustainability Challenges and Recommendations

The impact of financial constraints and the need for long-term funding was a core theme emerging from the interview with the TSO facilitators, who both stressed that the continuity of TIP on a system-wide basis was threatened by the lack of sustainable funding to support the TICWs. While the TSO that had been commissioned to facilitate the development and delivery of the TICW perceived the strong value of system-wide TIP across the community Managed Network, in terms of the TICW itself, there was a clear recognition that if it wasn't properly funded it could not be supported long term:

> *"But as a charity there's only so much that we can continue to do so much if there's no money for us... at the end of the day, [TSO Facilitator's name] might be passionate about it, but also I know...there's other projects that need attention."* (**TSO Facilitator**)
>
> *"It would be disheartening if this stopped. The amount of effort that's gone into it... we need long-term funding."* (**TSO Facilitator**)

In addition, expanding volunteer knowledge and their integration with services across BwD was seen by the CCs themselves as something that would enhance their role, where they were "more involved with services in Blackburn with Darwen" so they could "do more than just hand out leaflets" (**Community Champion**). The CCs went on to suggest that they could "visit the services beforehand, spend time with them" so they could then "explain in-depth to participants." (**Ibid**.) to support them in making more effective and informed referrals during workshops.

Merged core themes across observations and interviews:

1. **Flexibility and adaptation**: Both CCs and TSOs emphasised the importance of adapting approaches based on community needs, shifting from formal to informal delivery styles to improve engagement.
2. **Personal growth and emotional impact**: Delivering TIP workshops not only benefited the community but also led to self-discovery and healing for CCs and TSO facilitators alike.
3. **Community Awareness and Empathy**: Workshops helped foster empathy and trauma-awareness in the community, though cultural stigmas around mental health remain a barrier, particularly among older generations and men.
4. **Supportive Relationships and Mentorship**: Mentorship, honest feedback, and trust between volunteers and practitioners were critical to building CC confidence and improving TIP delivery.

5. **Sustainability and Funding Challenges**: TSO facilitators highlighted concerns about the lack of long-term funding, which threatens the continuity of TIP workshops and volunteer engagement.

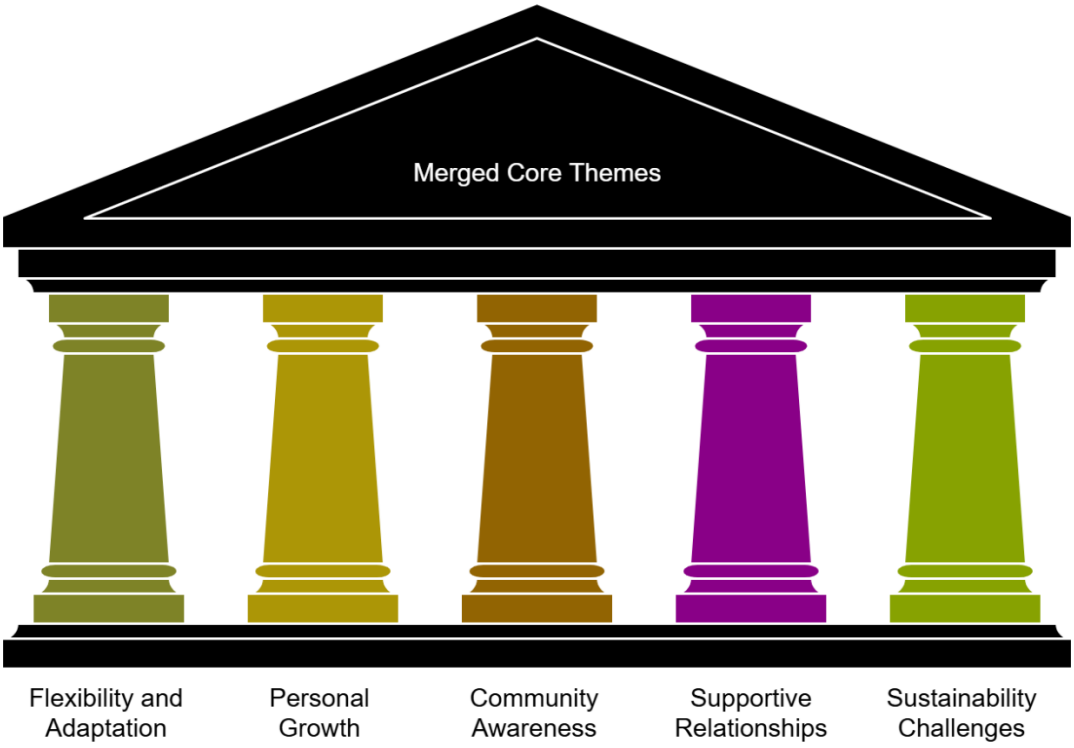

Figure 10: Merged core themes from the development and delivery of the TICW

Conclusion

Overall, the implementation and delivery of the TICW through a bottom-up approach has demonstrated effectiveness in fostering meaningful discussions and enhancing community awareness and engagement. The observations and interviews highlighted the importance of adapting workshops to different audiences, addressing cultural and linguistic barriers, and ensuring that discussions remain safe and non-re-traumatising. The shift from a rigid presentation format to an informal, discussion-based approach harnessing engaging media forms such as the ACEs Animation, proved to be more engaging and effective in promoting understanding and retention of TI principles.

In addition, the workshops provided an avenue for volunteers and TSO facilitators to recognize their own experiences of trauma, reinforcing the reciprocal benefits of TIP in community settings. The role of TSO facilitators as mentors further underscores the value of relational support in volunteer-led initiatives, to provide trusted feedback, motivation and a flexible response to engagement challenges over time within the context of an ongoing professional relationship.

However, certain areas require further development and strategic planning to ensure long-term sustainability, most notably, challenges to volunteer retention, financial sustainability, and service integration must be addressed to ensure long-term success.

A key takeaway is that volunteers with prior exposure to TIP through CJs displayed higher commitment levels, suggesting that embedding TIP principles early in community engagement efforts can foster sustained involvement. As a result, it is essential to prioritise the use of such long-term initiatives such as CJs to recruit from the community and sustain the TICW over time. To ensure the continued success and expansion of TIP across community sectors, the following recommendations within the context of the TICW – that will be expanded on towards the end of this report - are proposed:

1. Source sustainable funding to properly resource the development and delivery of community workshops
2. Continue to take a conversational approach to workshop delivery
3. Continue to use accessible and engaging tools such as the ACEs animation
4. Ensure psychological safety for CC volunteers and community participants
5. Harness co-production in the development of future community workshops
6. Prioritise the normalisation of discussions around trauma
7. Use real life examples to support relatability
8. Increase cultural reflection to understand socio-cultural nuances for minoritised populations
9. Integrate services with volunteer delivery and development
10. Build on existing community engagement structures
11. Provide continuous ongoing support for volunteers

Figure 11: Recommendations to support TIP across the community

Service Lead Strand: Top-down Implementation

Action Planning Workshop Survey: Impact

The Service Lead Strand (SLS) Action Planning Workshop (APW) was delivered by EmBRACE, a package of trauma-informed consultant training and support. It aimed to equip SLs with the ability to understand how to take a change management approach to embedding TIP in their individual services. Participant SLs were sourced from a wide range of services/sectors across BwD and they were provided with a reflective space within the APW over the course of a full day to plan the implementation of TIP within their individual services. This reflective space provided SLs with a rare opportunity to 'sit down' and reflect on ways to embed TIP in their teams, Services and Sectors going forward, which was especially important in Sectors with very large footprints such as Education:

> *"...it was good to be able to reflect...because it seems massive. But if you reflect and work out what your next steps are...it's great to sit down."* (**Education Team: School Effectiveness Officer)**
>
> *"...it's time for us all to sit down and plan the next steps, and that's what this workshop has allowed us to do, it's allowed us to get the time to actually plan the next steps forward."* (**Educational Psychologist)**

The following analysis is based on the results from the APW survey across several key areas, qualitatively exploring the effectiveness of the APWs for SL participants trying to embed TIP in their individual services:

1. Understanding of Trauma-Informed Practice (TIP)
Findings: The workshops successfully extended participants' understanding, although some already had prior knowledge.

Key learning points:

- Differences between phases of TIP (Trauma Aware, Trauma Sensitive, Trauma Responsive, Trauma Informed)
- The use of EmBRACE's audit tool to assess service progression
- The importance of collaboration and learning from the experience of others
- Some mentioned that they were already aware of some TIP principles but found value in applying structured frameworks like the audit tool

2. Change management process
Findings: The workshops provided valuable insights into structured change management but may need more emphasis on practical applications for those already familiar with the concepts.

Key learning points:

- The majority of respondents acknowledged that the workshops helped them to understand change management strategies

- Kotter's 8-step model was particularly helpful in structuring their approach, with some participants having not heard of the model before
- Other participants noted that they were more focused on listening to experiences of TIP over change management strategies

3. Development of Action Plans
Findings: Clear progression in action planning from awareness to policy changes. Some participants stated they were only at the beginning of planning, indicating a need for further support in developing their action plans.

A structured approach to action planning was evident:

- **Short-term:** Raising awareness, induction training updates, and embedding TIP in policies
- **Medium-term:** Identifying TIP champions, mandatory training inclusion, and refining safeguarding policies
- **Long-term:** Full integration into Local Authority structures and wider services

A summary of the Action Plans developed through the course of the APWs centred on four core areas of 1. Training and Development; 2. Self-Assessment and Action Planning; 3. Evidencing and Embedding Good Practice; 4. System and Culture Change:

Training and Development

- Awareness training roll-out.
- Embedding trauma-informed principles into policy and supervision.
- Encouragement to attend trauma-informed training.
- Developing the training offer for Schools in BwD.

Self-Assessment and Action Planning

- Use of audits, self-assessments, and team-level reviews.
- Ongoing evaluation of staff understanding and readiness.
- Reflective practices in meetings and supervision.

Evidencing and Embedding Good Practice

- Reviewing policies, procedures, and key performance indicators through a trauma-informed lens.
- Applying trauma-informed principles across the whole education system, not just schools.
- Supporting staff who may have lived experience of trauma.

System and Culture Change

- Building awareness and urgency across all levels.
- Establishing TIP as a standing agenda item.
- Fostering organisational buy-in and culture shift.

4. Identification of Quick Wins
Findings: Some quick wins were found, but barriers limited broader immediate implementation. Quick wins included:

- Including TIP in service contracts

- Team collaboration on TIP
- Training access for all schools

5. Barriers to Implementation
Findings: The workshops helped SL participants to identify barriers but overcoming them remained a challenge and there were a few services that struggled to identify quick wins. However, some services had strong support from management, reducing barriers overall.

Key barriers included:
- Time constraints due to workload and resource limitations
- Team capacity issues to attend and deliver training
- Different service areas being at different stages of embedding TIP, requiring tailored approaches

6. Strengths Supporting TIP Implementation
Findings: Strong foundational support for TIP was observed, but ongoing engagement is needed. Many services have:
- Dedicated time for reflective practice
- Trauma-informed Champions and CPD programs
- Monitoring and impact assessment tools
- Relational strengths such as collaboration, public engagement, and social media use were highlighted

Final Conclusion & Recommendations
Overall Effectiveness: The APWs were largely effective in extending knowledge, structuring action plans, and raising awareness of TIP. However, structural barriers such as time constraints and team capacity need to be addressed for sustained impact.

Recommendations:
1. **Follow-Up Workshops** – To support participants in refining action plans and overcoming implementation barriers
2. **Dedicated Support Teams** – Assign TIP facilitators to assist services in embedding TIP
3. **Practical Tools & Templates** – Provide standardized action plan templates for easy adaptation
4. **Time Allocation Strategies** – Encourage leadership to allocate dedicated time for TIP integration

Workforce Survey: Roll-out Progression Across Services

A mixed-methods survey was conducted to understand how the SRF roll-out was being implemented, and while a comparatively small number of responses were received (n=29), it was still possible to discern some insights from the survey. In particular, respondent's understanding of TIP was high, with 93% of respondents reporting that they had a 'very well-developed' (30%) or 'quite well-developed' (63%) understanding of TIP.

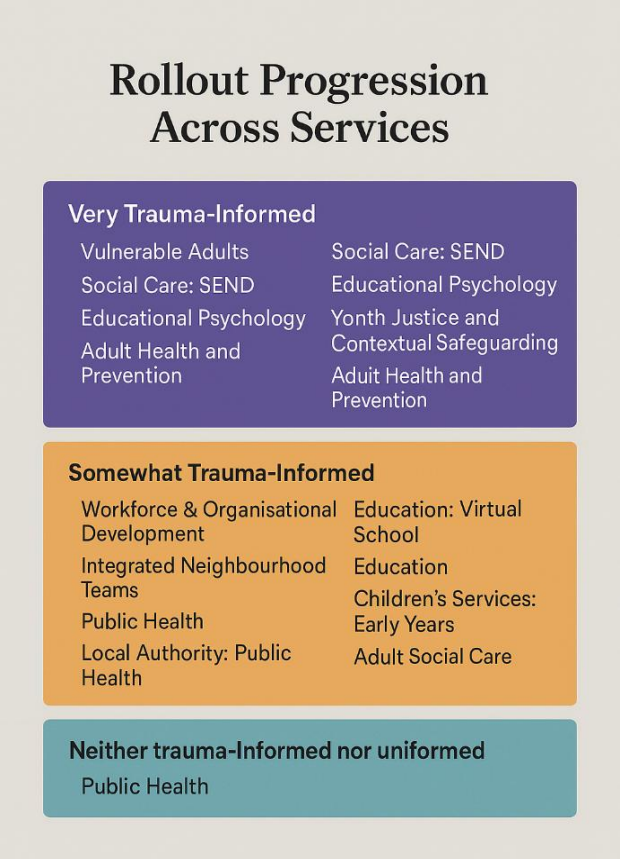

Figure 12: Levels of TIP across services and sectors

In a slight reduction to individual understandings, 27% of respondents felt that their wider service was 'very trauma-informed', with 58% feeling their service was 'quite trauma-informed', and a further 16% feeling that their service was 'neither trauma-informed nor trauma-uninformed' (8%) or 'not very trauma-informed'(8%).

There was variation in the spread of services reporting these estimations, with some respondents in specific sectors suggesting that their service was 'very trauma-informed' whilst others in similar services/sectors (e.g. Social Care and Neighbourhoods) reported a less positive estimation of 'somewhat trauma-informed or 'neither trauma-informed nor uninformed':

Only two participants to the survey reported that their services were 'not very trauma-informed', and both of these were in public health.

Relatedly, in terms of the phases of the journey to trauma aware, trauma sensitive, trauma responsive and trauma informed (LVRN, 2020), participants reported the following estimation of where their individual service sat:

- trauma aware: 8% (n=2)
- trauma sensitive: 8% (n=2)
- trauma responsive: 58% (n=15)
- trauma informed: 27% (7)

In terms of the phase they felt their sector as a whole was currently in, there was a significant down-tick in respondents view of progress in sector-wide TIP:

- trauma aware: 52% (n=12)
- trauma sensitive: 30% (n=7)
- trauma responsive: 13% (n=3)
- trauma informed: 4% (n=1)

The participants reporting their sectors were either trauma responsive or trauma informed were:

- Adult Health and Prevention
- Adults: Neighbourhoods and Prevention
- Family Support: Early Years
- Education: Virtual School

In contrast, the vast majority of respondents (52%) reported that their sectors were only at the start of their trauma aware journey, despite a number of them (27%) having estimated that their individual service was 'very trauma-informed' in a previous question. This reflects the lack of consistency in TIP where some services might be operating in a highly trauma-informed way whilst being couched in a sector that was much less trauma-informed as a whole.

Encouragingly, 74% of respondents reported that SLs had provided recent training for understanding and embedding TIP in their service; and 90% of respondents reported that their service had taken steps to develop practitioner understanding and knowledge of TIP in recent weeks/months, indicating success of the APWs in supporting SLs to embed TIP in their individual services. The steps taken to develop practitioner understanding of TIP in Services included:

- Trauma-informed inductions
- One-day basic awareness training
- Whole school trauma-informed training
- Continuous Professional Development in TIP
- Updating policies and wellbeing practice to support trauma-informed team discussions
- Encouragement of team members to lead sessions and training on TIP
- Identifying key leads in all areas of education service including three trauma-informed leads in one immediate team
- Use of reflective practice
- Discussions of TIP in teams and with external partners
- TIP Action Planning Workshop offered and attended
- Links to trauma being discussed in case management meetings
- Trauma being added to the team meeting agenda for future meetings to cover different topics relating to trauma with staff

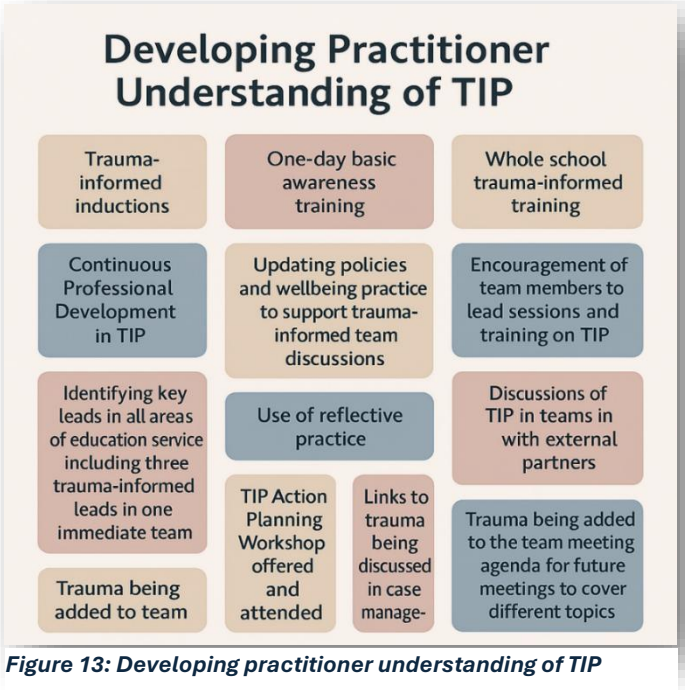

Figure 13: Developing practitioner understanding of TIP

Capacity-based Infrastructure:

Participants were asked about the capacity-based infrastructure i.e. **the organisational strengths that are strongly supportive** of achieving specific aims and outcomes (Hibbin et al, 2021), they estimated to be present in their individual service. Capacity-based strengths included:

- My service consistently measures/monitors the impact of trauma-informed interventions on service users.
- My service provides dedicated time for reflective practice and/or supervision.
- My service has trauma-informed champions and trauma-informed continuing professional development through all levels of the organisation.
- My service consistently measures/monitors the impact of trauma-informed systems and processes on staff wellbeing.
- My service consistently measures/monitors the impact of trauma-informed systems and processes on internal policy.
- My service has bespoke KPIs focused on trauma-informed practice.
- My service makes consistent use of trauma-informed publications and resources.

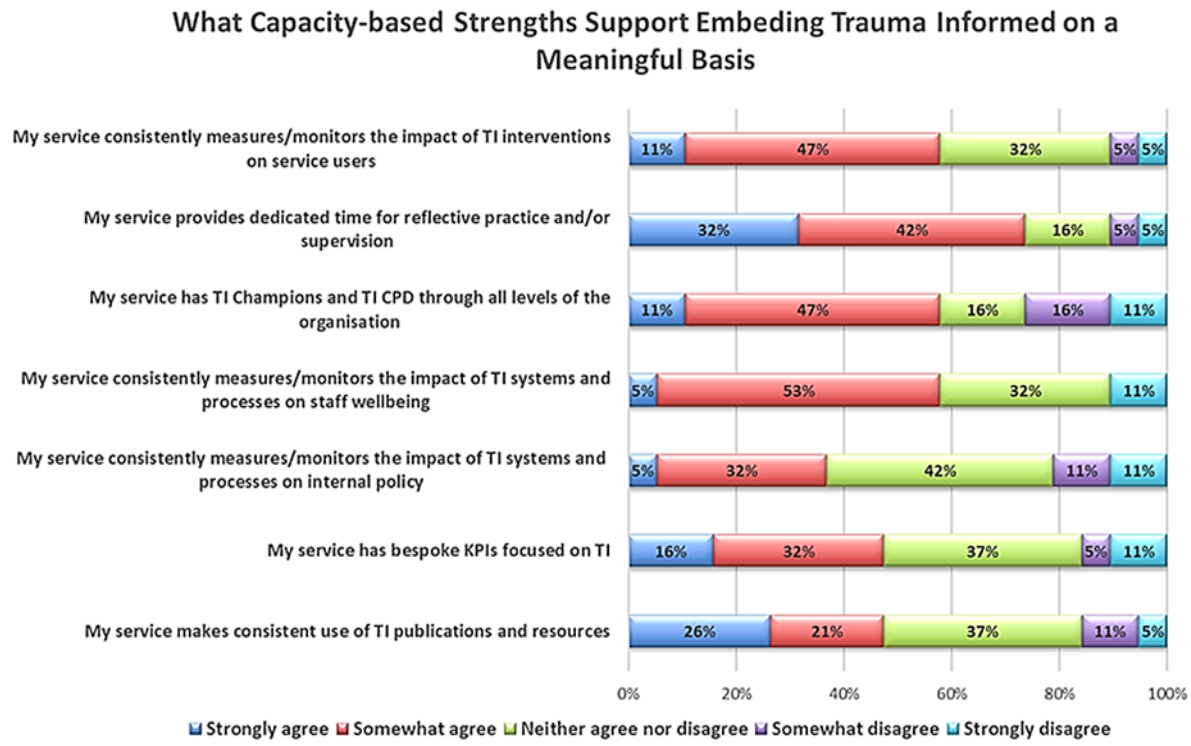

Figure 14: Capacity-based strengths to support TIP

Qualitative examples of the kinds of capacity-based infrastructure that were in-evidence included **the following responses from participants**:

Figure 15: Qualitative examples of capacity-based strengths

Relational Infrastructure:

In addition to capacity-based infrastructure, participants were asked what relational infrastructure i.e. **the networks and relationships that are strongly supportive** of achieving specific aims and outcomes (Hibbin et al, 2021), they estimated to be present in their Service. Relational strengths included:

- My service provides incentives to support public engagement in relation to the use of trauma-informed practice.
- My service provides non-digital means of engaging with the public over trauma-informed practice, e.g. printed newsletters and/or physical events.
- My service makes consistent use of social media to communicate successes and awareness-raising in relation to the use of trauma-informed practice.

- My service makes consistent use of feedback from public engagement activities on the use of trauma-informed practice.
- My service has high levels of public engagement through co-production of trauma-informed projects with local populations.
- My service makes consistent use of knowledge-exchange activities around trauma-informed practice with other services/sectors.
- My service makes consistent use of feedback from other services/sectors on the use of trauma-informed practice.
- My service has high levels of collaboration and co-production with other services/sectors in relation to trauma-informed practice.

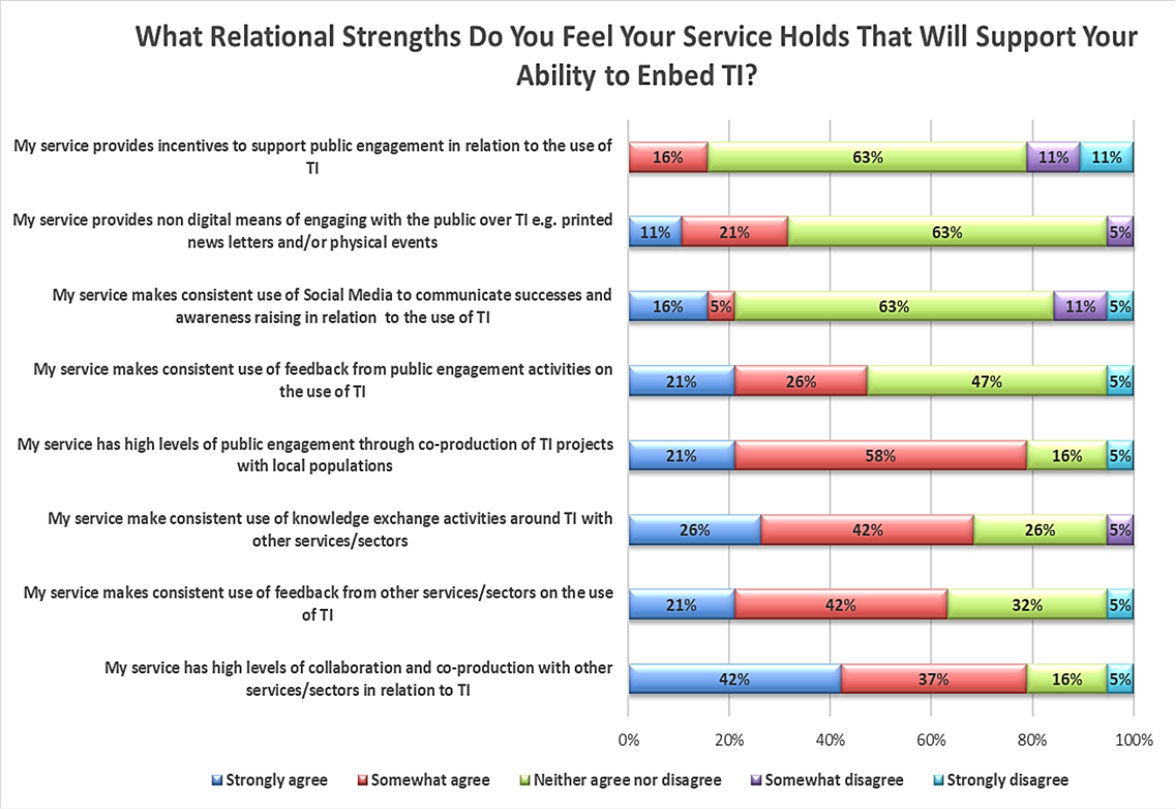

Figure 16: Relational strengths

Qualitative examples of the kinds of relational infrastructure that were in-evidence included **the following responses from participants**:

Figure 17: Qualitative examples of relational strengths

Action planning Workshop: Observations and Focus Groups

This section identifies key themes from the APWs, synthesizing qualitative data from observed discussions in the AWP itself, with focus group interviews with SLs and the local authority team delivering the SRF roll-out, alongside some of the workforce survey findings. The focus groups with SLs took place in the final APW in June 2024. In addition, interviews with the team responsible for the SRF roll-out were undertaken towards the end of the project, to reflect upon how implementation in the SLS had taken place over the previous year. Core themes from the analysis centre on:

- **Shape of TIP in services and across sectors**
- **Benefits of TIP**
- **Barriers to TIP**
- **Enablers of TIP**
- **Workforce Wellbeing**
- **Sustainability of TIP**

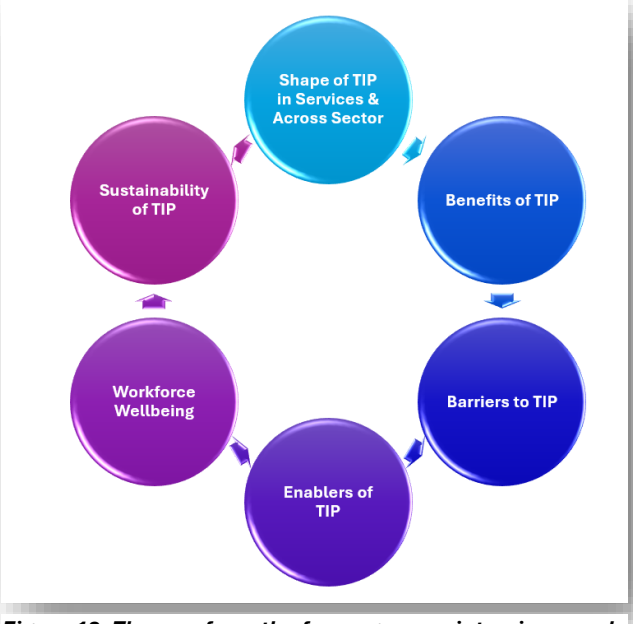

Figure 18: Themes from the focus groups, interviews and the workforce survey

The Shape of TIP in Services Across Sectors

Definitions of trauma and TIP have been previously provided by Lancashire's Violence Reduction Network (2022), including SAMHSA (2014) that defines trauma as resulting "from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing" (p.7). Relatedly, the LVRN (2022) go on to define TIP as "an organisational change process focused on preventing (re) traumatisation within services" which by their own admission is a "broad definition of trauma" that extends "beyond PTSD, including recognising social trauma and the intersectionality of multiple traumas" (LVRN; p.12).

Participants within this evaluation defined TIP in a variety of ways, relating to different approaches of working with service users to ensure that within service (re) traumatisation did not occur. These included:

1. Being cognisant of, and responsive to, power imbalances in both practice (service users ~ practitioners) and the workforce (practitioners ~ managers ~ senior leadership team)
2. Workforce wellbeing and Human Resource policies that support practitioners, enabling them to 'put their oxygen masks on first' to improve retention and reduce burnout

3. Prioritising interventions, interactions and systems that are undertaken ***with***, not ***for*** or ***to,*** working within the Social Discipline Window (Watchel, 2013), valuing Lived Experience and creating the collaborative conditions for:
    - Empowerment and agency
    - Trust and transparency
4. Flexibility of provision to support choice and individual needs through a person-centred approach.
5. Humanising approaches that avoid judgement, shame and personally reactive responses through a focus on:
    - An understanding of behaviour as communication
    - De-escalation techniques when behaviour is challenging
6. Reflective, holistic and strengths-based conservations taking a PACEful approach employing playfulness, acceptance, curiosity, and empathy.

There were multiple responses that captured these elements in diverse ways, and a selection of these representative quotations are provided in **Box 1**, to illustrate the shape of TIP as described by practitioners across the dataset as a whole.

Conclusion: The Shape of TIP

The findings above highlight the multifaceted nature of TIP across services and sectors, emphasizing the importance of relational, strengths-based, and person-centred approaches. The definitions provided by the LVRN and SAMHSA underscore the broad scope of trauma, extending beyond PTSD to include the more systemic effects of social, environmental and intersectional traumas. Practitioners across various services have interpreted TIP through a range of lenses, reflecting its adaptability and the necessity for sector-specific applications.

A key element of TIP is the recognition and mitigation of power imbalances. This applies both in relation to direct service provision (between practitioners and service users) and within the workforce hierarchy. Ensuring that interventions are conducted within the Social Discipline Window where actions/decisions are undertaken ***with*** individuals rather than **for** or **to** them (Watchel, 2013), fostering empowerment, trust, and agency is key. Many practitioners emphasised the significance of a humanising approach, which prioritises emotional safety, understanding behaviour as a form of communication, and de-escalation techniques.

Flexibility and personalization emerged as crucial components of effective TIP. Practitioners described the importance of meeting individuals in spaces where they feel safe and comfortable, whether that be in schools, homes, or community settings. The ability to adapt service delivery to individual need, strengthens engagement and reduces the likelihood of re-traumatisation. Furthermore, the role of curiosity, self-reflection, and continuous learning within organisations was repeatedly noted as essential in sustaining TIP and adapting services to emerging needs.

One of the most emphasised themes is the PACE model (Hughes, 2017; Hughes, Golding and Hudson, 2019), which as an acronym stands for Playfulness, Acceptance, Curiosity, and Empathy). This model served as a guiding principle rather than a rigid framework, and was seen to be particularly useful when working with children and young people. This approach is not about applying a set of predetermined strategies but about fostering a 'way of being' that encourages meaningful and supportive interactions. Practitioners reported that integrating PACE into their practice helped establish deeper connections and provided service users with a sense of safety and trust.

The shape of TIP across services reflects a shift towards relational, person-centred, and strengths-based approaches that prioritise empowerment, agency, and emotional safety. These findings reinforce that trauma-informed work is not about a rigid set of strategies but a dynamic way of engaging with individuals and communities. However, it is not entirely clear that the working definitions of trauma and TIP reflect the nuanced shape of trauma-informed across BwD as it was described by practitioners within this evaluation. As a result, it is recommended that BwD consider developing and adopting its own definition/s of TIP in a manner that captures sector specific nuances, alongside a broad definition of trauma-informed that can be applied to all sectors.

Box 1: The Shape of TIP in participants responses

"...this little girl wouldn't engage with me. So, I found out she wants to be a nail technician...I said, 'do you want to do my nails?' So, I ended up with these great big diamonds on my nails...and it's always my first name...especially at Secondary School, you still get called Miss, but... they've gotten the opportunity to see you as a human being...and there's always going to be a power imbalance isn't there? Because you're an adult..." (**Educational Psychologist**)

"To quote a young man I work with...[he] said 'you're dead normal you are' - those power differentials - breaking them down is really important." (**Educational Psychologist**)

"... families are feeling that there's places that they can go where they're not judged, they're understood, they can be open and honest." (**BwD Roll-out Team**)

"For us, it's in school, or at home...its wherever they want to be. We're really flexible with that...we would go to the house, we would go to school, we would see them at Community Centre...or go on a walk." (**Clinical Psychologist**)

"...And you do things like 'what's your least favourite subject?' I'll come [out] with things like that so that they can engage" (**Educational Psychologist**)

"Willing and passionate people across the service...to champion the outcomes for clients, want to do things with people not for them, and promote independence and resilience...and end revolving door and re-traumatising clients." (**Adult Services: Neighbourhoods**)

"If you'd have done what you've just done - 'Oh, this guy needs this and this and this' and just given me a list... I would have walked away because it would have been too much...I just wanted someone to walk alongside me for a little bit." **(BwD Roll-out Team**)

"I think it's just experiencing somebody who shows that they care and understands you as an individual—your needs, your history, your background, your likes, and preferences—and works with you in a way that considers all of that and looks at you holistically and shows you that unconditional positive regard and empathy." (**Child Exploitation and Missing From Home)**

"I've had quite a lot of staff, they get upset if a young person's not engaging with them, and they'll take it personally. And I've been doing interesting things in supervision. Like, 'do you wonder why you're feeling upset about that? Could that be linked to something?' And you as a staff member...Those behaviours are not always related... It's about being curious... (**Young People's Services: Intervention Manager**)

"PACE, we like pace a lot. Like it's a way of being with developmentally traumatized people. And it's, it stands for playfulness, acceptance, curiosity, and empathy...but it's not a set of strategies. It's a way of being" (**Clinical Psychologist**)

"...so we spend all our time in people's front rooms.... you might be sat there, you might see paintings on the walls, and it's just getting that common ground before they start talking to you... you get more information by sitting and listening... because obviously, there's a form to be filled in...Whereas if you put that to one side, put it behind your back... and just have a talk... And as I think Social Care as a whole the majority of Social Workers, that is what they do...approachable." (**Social Care: Direct Payments**)

Benefits of TIP

Understanding service user needs

As already suggested, there was strong agreement amongst participants that implementing and embedding TIP through a focus on power differentials, collaboration within the Social Discipline Window (Watchel, 2013), and person-centred flexibility of service provision, with an approach that was strongly humanising, PACEful (Hughes, 2017; Hughes, Golding and Hudson, 2019) and strength-based resulted in better engagement and understanding of service users' needs. This enhanced level of engagement was seen as a key element of a preventing problems downstream where practitioners suggested "if we can look at trauma and start to address that, then we might be able to make a difference in terms of that prevention agenda, trying to support people…to have better outcomes overall" (**BwD Roll-out Team**). Systemic barriers in School were noted as a particular barrier to understanding the experiences and individual need of children and young people, where a "focus on education and attendance" would hinder the ability of Schools to "understand what the world is like for this child when he goes home" (**Principal Social Worker: Children's Social Care**).

Creating safe, supportive environments for active prevention and early intervention through a Public Health approach

The use of TIP was viewed as being central to creating supportive, empathetic environments, with a focus on breaking down stigma and judgmental attitudes, amplifying the voices of service users, and also encouraging communities to take responsibility for spotting the signs of trauma, again as part of the prevention agenda to improve outcomes and catch problems upstream. This was demonstrated in practitioner responses through one service undertaking an intervention focused on "neglect in the community" (**Principal Social Worker: Children's Social Care**) where the aim was "to try to get anybody who's having contact with children and families to be looking at the signs so we can try to get support in early, rather than traumatising children because often we don't find out until it's really, really bad" (**Ibid**.)

While it was also recognised that they would sometimes "have to immediately move the child" (**Ibid**.) which was in itself traumatising, there was a concurrent focus on removing judgement and taking a public health approach. Here practitioners talked about "supporting families at that early stage and understand that they're probably not wilfully neglecting their children actually, it's probably because the drug and alcohol use, relationship difficulties that they have, the past trauma, that means that they're struggling to provide a standard of care" (**Ibid**.)

Workforce wellbeing and effective practitioners

Benefits of TIP for practitioners focused on the creation of more reflective, empathetic, and supportive workplaces where staff could process vicarious trauma exposure and reduce the stress of their caseloads. This extended to the idea that TIP created a more effective workplace due to the ambition of creating a system that was joined-up and coordinated between and within services, including HR systems and processes. While this ambition had not yet been realised due to its complex and aspirational nature, the recognition of its importance was clear:

> *"So…it's the system and the database and the information sharing that absolutely needs to be in place and it will take a lot of time to get there because everybody necessarily uses different systems. I think that developing the Managed Networks was to try and get that better conversation in place."* (**BwD Roll-out Team**)

The focus on both wellbeing support and workplace efficiency were seen as two pillars of TIP that would ultimately impact positively on staff burnout and retention once a truly trauma-informed response had been realised across the workforce. Here practitioners observed that staff "going off sick and then not coming back" (**BwD Roll-out Team**) in the absence of "a proper conversation about how to support them in what's happened" was a key element of TIP that could be understood as being "about looking after your staff workforce…" (**Ibid**.)

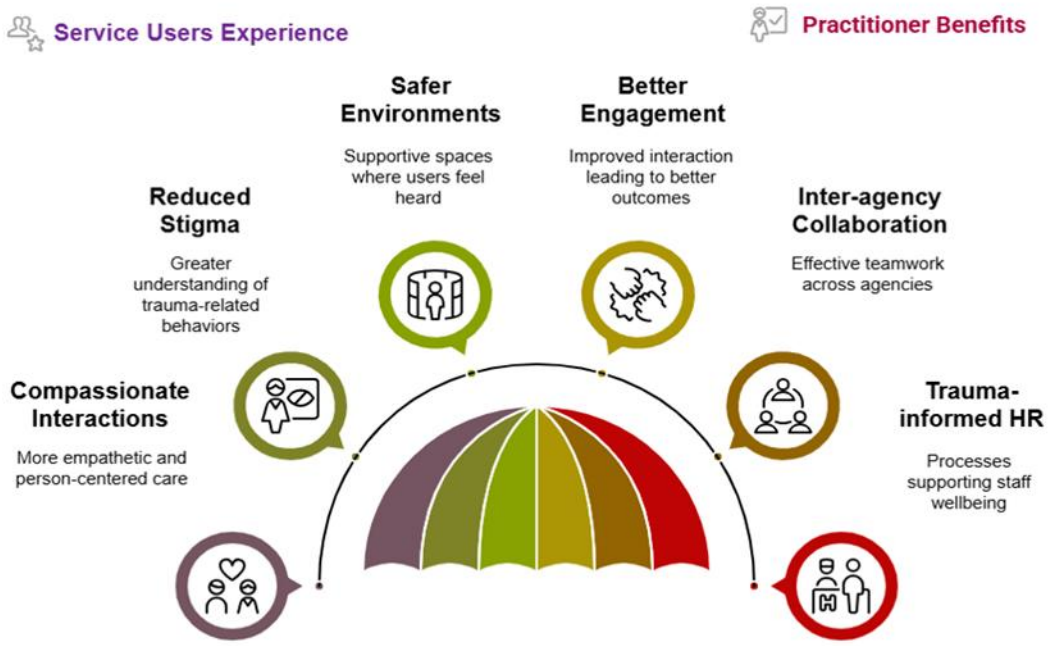

Figure 19: Benefits of TIP

Barriers to TIP

TIP has become increasingly prevalent in Social Care and health-facing services, to the extent that for those individuals working in these services it is hard to imagine that anyone could be unfamiliar with trauma-informed ways of working. However, respondents to the workforce survey reported a "general lack of understanding/awareness/interest amongst other professionals" (**Adults Neighbourhoods and Prevention**) around TIP. Here it was reported that "people still don't understand trauma and how it affects the human mind, body and soul and the effects that it can play in our mental, physical, emotional, spiritual and social interactions, both within our personal selves and the outer world" (**Ibid**.)

This is a key challenge, and addressing it will require continued awareness-raising and sustained trauma-informed practice. Other key challenges included having the physical time and capacity for TIP, leadership buy-in, workforce capacity, and system fragmentation, and these will be explored below.

Time and Capacity for TIP

TIP was viewed as an added "extra" by several SLs, rather than an integrated approach across all systems, services and sectors. Many participants felt TIP was not yet embedded into their service but rather seen as an additional responsibility on top of already high workloads, due to the lack of ring-fenced time and resources for TIP. Practitioners reported that "one of the key barriers is a lack of time and resources from people who really want to engage but feel like, 'it's on top of my day job'" (**BwD Roll-out Team**). In addition, respondents to the workforce survey reported that "there is so much other 'stuff' that staff are being asked to do on top of their existing roles & responsibilities that there is a) lack of willingness to take on more and b) lack of time and capacity" (**Survey**: **Service/Sector not stated**).

The impact of this lack of time was emphasised by practitioners where it was suggested that "developing trust and understanding with clients brings a commitment of time from professionals [and] large caseloads and pressures can hinder this (**Survey: Adult Services/ Neighbourhoods**). In addition, it was observed that in an environment of low trust, service-users can be actively harmed, due to non-engagement resulting from historical poor experience of a system that could be actively retraumatising. Here one practitioner reported that "people get passed around or closed if they don't engage in the first instance, often due to fear, previous experience or lack of understanding as to what the service provides" (**Ibid**.) As a result, the overall impact was a lack of practice-based working within the Social Discipline Window (Watchel, 2013), where "people still feel things will be done to them not done with them" (**Ibid**.)

This lack of time and capacity for TIP was most obviously demonstrated through the lack of regular reflective supervision for staff with roles that were responding to high levels of vulnerability, as well as some level of access for staff in roles that were less obviously connected to supporting service users in this regard, but who may still be exposed to secondary trauma in the course of their work. Therefore, while some sectors had built-in reflective supervision (most generally in clinical roles), other sectors had supervision that was more obviously focused on case management, while other members of the workforce again e.g., front desk staff and admin teams, entirely lacked mechanisms and spaces to formally process the impact of secondary trauma, with obvious implications on retention through sickness and burnout:

> *"When I was a teacher, I'd go home thinking, 'Why do I feel like this?'—and it hit me: I was absorbing the students' exam stress. That's what happens to staff—they hear others' trauma but have nowhere formal to reflect, and it builds up. Who's listening to the listeners?"* (**Educational Psychologist**)
>
> *"As psychologists, supervision is drilled into us—it's reflective, with a focus on trauma and its impact on us. But for other staff, it's often just case management, not space to process."* (**Clinical Psychologist**)

Leadership, Hierarchy and Organisational Complexity

This lack of time for implementing TIP was further worsened by the size of BwD Council that was described by one participant as "just a giant being" (**Social Care: Direct Payments**), as well as difficulties understanding how to prioritise and implement changes in an organisation that had high levels of complexity generally and a hierarchy where "anything that wants to be changed, it's got to go through different levels and be approved by different people… and you just need somebody that's on holiday or whatever and it stops there for a while" (**Ibid**.) This problem was also reported as being the case in Educational Psychology where they "have very distinct processes that you do something that then has to go to your line manager…then has to go to Finance, then has to get checked by legal or HR and then by the time it's come back you've forgotten or you're thinking actually do you know what, I'd rather do something different" (**Educational Psychologist**). In addition, practitioners described the challenge of undertaking changes within a long-standing staff team where "you can't just decide you want to change something" (**Young People's Services: Intervention Manager**) and the need to make sure that it's "implemented by all staff and understood… takes time" (**Ibid**.) This necessitated an evidence-based and differentiated approach that was "about prioritizing what changes we need [and] how do I how do I sell those changes to get staff on board - because that's different with different people" (**Ibid**.)

The difficulties getting approvals for trauma-informed initiatives are likely exacerbated by variation in leadership buy-in across services and sectors, making it harder to prioritise TIP in workloads. This is connected to support for trauma-informed policies such as structured reflective supervision where practitioners reported that "supervision, reflection… can be incorporated within the day rather than being quite informal…for all our teams, embedded into a culture" (**Clinical Psychologist**), but that wasn't something that they could really "address it without Senior Leadership…to say alright, okay" (**Ibid**.) Relatedly, it was difficult for staff to know how they could influence lack of good practice in trauma-informed when they came across it, asking how they could "we influence that at an organisational level" (**Child Exploitation and Missing From Home)**. Here practitioners gave the example of a recent "aggression and violence

policy [that didn't] seem very trauma-informed" asking "how do we challenge that?" (**Ibid**.)

In addition, observations from the APW indicated that not all Senior Leaders and Managers had bought-into TIP due to the lack of connection to the front line where it was reported that it was "not deemed a priority" (**Survey: Health Inequalities/ICB Population Health)** so they could understand it and to see the importance of it. This lack of prioritization ran the risk of trauma-informed becoming little more than a tick-box exercise.

> *"We have no sponsor - it's at risk of becoming a tick-box exercise rather than an embedded culture shift across the system. People see it as someone else's responsibility, a nice to have rather than a necessity for many of our communities."* (**Survey: Health Inequalities/ICB Population Health)**

Fragmentation Across Services

Another key barrier that seemed to stem from an early lack of cohesion at the start of BwD's trauma-informed journey (as is often the case when innovations are first introduced) was the lack of consistency that was reported where different services would trial their own way of engaging with TIP. As the SRF roll-out became more co-ordinated over time and through the development of the MNs, this transformed into inconsistencies in terms of varying levels of TIP adoption across sectors and services. Here, some teams were further ahead in embedding TIP, while others reported that their "policies…[and the] services we deliver are not yet consistent with the TI approach" (**Survey: Public Health**).

In particular, Children's Services and Social Work were seen to be further ahead with embedding TIP due to it "fitt[ing] in nicely" with their "systemic practice model, because that is very trauma-informed…because we're Social Workers… we're kind of trained to think in that way" (**Principal Social Worker: Children's Social Care**). Similarly, Education was viewed as having an increasingly well-developed understanding of TIP. However, practitioners described the challenge of embedding the approach in a consistent fashion across the "wider Education sector….not just schools…but also the link with the Admissions Team, the Statutory Assessment Team, all the others - Transport, Inclusion Officers, which are focused on attendance" (**Education Team: School Effectiveness Officer**). As a result, the sheer size of Education over such a large footprint of different schools, was a significant barrier to embedding TIP.

> *"This process made us think beyond schools—to Admissions, Statutory Assessment, Transport, Inclusion… the whole Education sector. It's huge, and that's a barrier in itself. Even getting one school trauma-informed is a challenge—then add 73 schools, constant staff turnover, and trying to keep the message consistent across such a large system."* (**Education Team: School Effectiveness Officer**)

Policing and the Private Sector were viewed as being further behind other sectors overall, with practitioners reporting that "working with Policing [had] been harder" (**TI Roll-out Team**) going on to describe how they didn't "seem to have great connections into the Police locally" and they were "trying to build those connections" (**Ibid**.) In addition, "the biggest gap" was reported as being the Private Sector with practitioners suggesting that they would "ideally…like to work with workplaces" (**Ibid**.)

Connected to this were differences in terms of training where newly qualified social workers had experienced the curricula inclusion of TIP in their degree qualifications, resulting in them coming to the service well-informed, while existing staff didn't have the same level of knowledge or training (**APW Observation**). Fragmentation was also reported in relation to the "turnover of staff [and the] size of the service" (**Workforce Survey: Education**) which resulted in a large capacity issue when staff were both "new to the organisation as well as the roles they're doing" (**Survey: Health and Wellbeing Coaching**), resulting in a large upskilling requirement where it was reported that "training them up is a big one" (**Ibid**.) In addition, fragmentation occurred when "staff at different levels and staff in front-facing roles not directly working with families" (**Children's Services: Early Years**) did not have the same level of training or understanding of TIP as those who were more hands-on with service users.

Finally, fragmentation of TIP in public health was reported due to them working in a more siloed way because of the barriers experienced in relation to the stretched nature of primary care. As a result, while this sector was not reported as being trauma un-informed, their ability to engage in an integrated way with other services and sectors, was more limited. This barrier relating to the siloed nature of primary care will be discussed further in the Integrated Training section below.

> *"…it's changed a lot from when I was last involved with primary care and it's very much more, I don't know, disjointed every GP practise almost runs independent, even if they're in a group, they've all got slightly different ways of doing things."* (**TI Roll-out Team**)

Conclusion: Benefits and Barriers

The benefits of TIP across services have been widely acknowledged, particularly in enhancing engagement with service users, fostering supportive environments, and improving workforce wellbeing. The findings indicate that a trauma-informed approach, when fully embedded, leads to more compassionate and person-centred service delivery, ultimately preventing further harm and supporting early intervention.

A key advantage (as well as a defining feature) of TIP is its role in addressing power imbalances, promoting collaboration, and ensuring that interventions are delivered *with* rather than *to* service users. This creates conditions for trust, empowerment, and transparency, which are essential in fostering long-term engagement. However, while frontline practitioners recognize these benefits, systemic barriers such as time constraints, leadership buy-in, and service fragmentation hinder the full integration of TIP across sectors.

One of the most significant challenges is the perception of TIP as an "additional" responsibility rather than an embedded approach. Many professionals expressed that high workloads and competing priorities limit their ability to implement TIP effectively. This is exacerbated by the lack of reflective supervision, particularly in roles that are exposed to high levels of trauma. While clinical staff often have formal mechanisms for debriefing, other roles, such as social workers, front-line staff, and administrative workers, lack structured support, increasing the risk of burnout.

Leadership commitment remains a crucial factor in trauma-informed implementation. The hierarchical nature of decision-making within Councils and large organisations slows down progress, making it difficult for TIP initiatives to be swiftly integrated into policy and practice. Additionally, disparities in TIP adoption across sectors further contribute to fragmentation, with some areas, such as Children’s Services and Youth Justice, being more advanced in implementation than Adult Services, Policing, and the Private Sector.

Despite these challenges, the findings suggest that TIP has the potential to improve both service user outcomes and workforce wellbeing when implemented cohesively and supported at all levels. The need for a coordinated, whole-system approach to TIP is evident, with an emphasis on consistent training, policy alignment, and inter-agency collaboration is clear.

Enablers of TIP

Successful strategies for embedding TIP into services included the Integrated Training model, E-training, service level policy changes and the Champions model. These strategies will be unpacked below.

Integrated Training

BwD has undertaken several layers of training to embed TIP across sectors with the ambition of training 3,000 – 5,000 staff. BwD's Integrated Training takes a blended learning model to spread awareness, improve accessibility and develop practical understanding and application of TIP across the Borough in a non-siloed manner. Through a core team of 16 voluntary trainers who deliver a whole day in-person workshop to services, BwD adapted from the longstanding LVRN's training, to create a contextualised and place-based approach that was bespoke to the services that were attending on the day:

> *"We basically Blackburn with Darwen-ified it and we have changed it quite significantly… we were able to really pin it onto our services."* (**BwD Roll-out Team**)

An important element of the training was the case study approach where practitioners described the use of "real life examples…that we've built in case studies… which were very meaningful for us" (**BwD Roll-out Team**). The use of case studies in the Integrated Training were "built… across the whole of the training day" (**Ibid**.) rather than being just a small element as it had been under previous training packages. This diverse bank of case studies that BwD were building over time allowed "people constantly [to] go back to those case studies to build the knowledge" (**Ibid**.)

In addition, the cross-sector, mixed workforce nature of the training where staff from multiple sectors (health, social care, education, policing, third sector) trained together, was a key and non-negotiable mechanism for avoiding the siloed learning and working that can often be the norm in large and complex organisations such as a local authority. This allowed for a relational approach to be taken to enhance cross pollination between services and mirror wider recommendations in relation to multiagency practice through a public health approach (Harris & Fallot, 2001), within which TI can be understood to reside.

> *"It's very dynamic - people from different backgrounds in the same room, building relationships that carry on outside. In one session, Adult Social Care, Shared Lives, and Children's Residential staff realised they could collaborate on supporting young people with mental health needs. That kind of cross-pollination is what makes the training so powerful."* (**BwD Roll-out Team**)

Having the lived experience element that had come through Changing Futures on the training team was also a key part of the Integrated Training where it was considered "really powerful…having that lived experience voice in the room" (**BwD Roll-out Team**).

The purpose of this inclusion was to provide a sense check of the impact and benefit of different ways off approaching TIP, to ensure that inadvertent damage was not being done through well-intentioned but ultimately unhelpful approaches:

> *"One of our training team, who had lived experience, said, "If you'd have done what you've just done - 'Oh, this guy needs this and this and this' and just given me a list… I would have walked away because it would have been too much…I just wanted someone to walk alongside me for a little bit."* **(BwD Roll-out Team**)

Finally, Senior Leadership trauma-informed training for Corporate and Council leadership teams had been developed to help leaders understand how trauma-informed approaches improve workforce wellbeing so as to improve retention issues, as well as focusing on recruitment and "generally how their services are being run" (**BwD Roll-out Team**). Here practitioners suggested that they "didn't expect to get them all there, but there must have been twenty staff in the room from Senior Leads across the Council" going on to express surprise at how on "quite a long half day…they all stayed" (**Ibid**.) In terms of engagement, practitioners went on to report that "they were very much on board and understood kind of the impact that TIP would have on their particular area" (**Ibid**.)

> *"Senior Leaders did a half-day training—and they stayed for all of it. Around twenty senior staff from across the Council were there, fully engaged, saying, 'Yes—we're behind this.'"* (**BwD Roll-out Team**)

Overall, the approach to training in BwD was differentiated, bespoke and contextualised, providing opportunities for cross-pollination, and an understanding of how TIP could apply across diverse sectors, services and teams. Importantly, it mirrored the values that are prioritised through TIP itself, particularly in relation to the value placed upon lived experience and the collaborative, relational approach that was created through the insistence on mixed workforce teams. However, one of the SLs also suggested that "just doing a day's training doesn't make someone trauma-informed" (**Intervention Manager, Young People's Services**), providing the reminder that training packages need to be ongoing and differentiated for maximum impact:

> *"It's not a tick-box—it requires understanding attachment, abuse, participation, collaboration… it's like safeguarding—you wouldn't become a DSL from one training session. It's much bigger than that."* (**Intervention Manager, Young People's Services**)

This had been recognised by BwD Roll-out Team, who by no means were under the illusion that they were anywhere other than at the start of the Integrated Training roll-out, suggesting that there was “more we need to do” (**BwD Roll-out Team**), with next steps involving management and leadership and Advanced Practitioner Training programmes.

E-training

In addition to the Integrated Training, the Council was working towards embedding 45-minute e-training package that was to be “delivered through [BwD’s] Me Learning system” (**BwD Roll-out Team**), the Council’s online learning platform. As reported by the Roll-out Team, this platform was not just open to the Council, rather “certain courses are… available for people beyond the Council” (**Ibid**.) Other practitioners talked about the benefit of the “new learning module…as part of that mandatory training for all staff who start in the department” (**Education Manager Virtual School**) in staff inductions so that it didn’t “matter when they start in that cycle, because it's part of that [induction] process” (**Ibid**.) This ensured that TIP was “on people's radars, right from the start” (**Ibid**.), to tackle variable levels of experience from the ground up.

In addition, the e-training package was designed to get around the problem of certain services and sectors struggling to release staff for the whole-day Integrated Training, such as primary care staff where “trying to get any GP / primary care staff released for a whole day is nigh on impossible” (**BwD Roll-out Team**). However, there were policy constraints in relation to this as well, that went against the contextualised approach that the Integrated Training had tried to create, where training had to be delivered exclusively on primary care platforms due to them having “their own packages that they subscribe to” where they didn’t “tend to do any others, unless it's on their platform” (**BwD Roll-out Team**).

Service Level Policy Changes

A key indicator of TIP becoming embedded in an organisation, service or sector, is it’s travel from localised good practice in front-line interactions and interventions, into key policies to ensure that individual actions align with organisational objectives, legal frameworks and ethical standards. There was evidence of TIP being integrated in this way, across a variety of different policies. Several key policies delivered on the level of the service user had changed, or were in the process of changing, to integrate a trauma-informed approach: namely Schools Safeguarding, Reintegration, Adoption Bridging, Case Management, Service Delivery, and Supervision policies.

School Safeguarding Policies where from September 2024, the Safeguarding Policy explicitly referenced ‘trauma-informed’ as a non-optional element for the first time “that goes right across every school in every setting" (**Education Team: School Effectiveness Officer**).

- **Reintegration Protocols** where attachment-aware reintegration was being increasingly used over immediate exclusions.

> *"...a much more structured process for reintegration—everyone working together to make it work. It's about the mainstream school still being responsible, not just out of sight, out of mind. That whole attachment, that feeling of abandonment... schools understanding why pupils are going into alternative provision and what support they'll need. Even if it's not named, it's the approach"* (**Education Team: School Effectiveness Officer**)

- **Adoption Bridging Policies** to consider, monitor and support TIP and attachment needs of children and young people who are on the adoption pathway.

> "*I've just done the adoption bridging policy... that takes into account all the trauma and attachment...when they're gone to the adoption pathway, how we monitor and support change of school...and the timescale and what support and what kind of school they need to be going into and what the school receiving school can offer... What are they going into what they've come from and making sure that the two talk*" (**Education Manager Virtual School**)

- **Case Management and Service Delivery Policies** where the impact and possible links to trauma are now discussed in case management meetings, and trauma-informed discussion is embedded in team meetings and supervision sessions as well as amplifying the voices of parents and children and young people in group meetings:

> *"...we changed the way that we do core group meetings... rather than... professionals saying, 'Oh, what do you think's going on there?' - people come out with all the negatives... giving parents and young people... the opportunity to talk first, I think is really key to getting people to think that this is somebody's life. It's not just us as professionals giving our opinions... it is still their lives and their need to be given their opinions"* (**Principal Social Worker: Children's Social Care**)
>
> **"***I think a really good example for social care is changing child protection conferences, and how they're run. And how they're so trauma-informed and so trauma-aware now... That's a massive change for social workers"* (**Education Manager Virtual School**)

The Champions Model

Reflecting on the approach taken in the CCS where CCs took the message of TIP out into the community, services across BwD were also encouraged to embed a model whereby they assigned specific members of the workforce to become Trauma Informed Champions (TICs) within individual services and key networks where they could spread good practice in TIP. One such network that every school was allocated to were the School Improvement Groups, where SLs talked about "looking at those schools who've got really good practice…[and] identifying schools within each of those [SIGs] …who may well go… towards an award or become that Champion, and share that good practice in there" (**Education Team: School Effectiveness Officer**).

Originally, these individuals were just those people who had attended the training, but the BwD Roll-out team, reported that they were "now expecting them to take a more active role in embedding these approaches" (**BwD Roll-out Team**). The rationale for this was to move practice away from one-off training, into something that was more sustainable over the long-term, in terms of spreading responsibility, encouraging ownership and supporting good practice across the whole system. However, there were also some concerns expressed around difficulty knowing the depth of trauma-informed knowledge that TICs held, so that they could have real influence rather than just symbolic.

> "*…we've identified Champions, but we don't know how much the Champions know. We don't know the Champions in each school, what do they know? Have they done a quick one-hour ACE training online? What do they actually know?"* (**Young People's Services: Intervention Manager**)

Workforce Wellbeing

Developing trauma-informed HR policies and support for workforce wellbeing was seen as being central to creating a trauma-informed organisation that prioritised supporting staff to 'secure their own oxygen supply', so they could then attend to vulnerability in service users. This was in recognition of the impact and psychological toll that working in public-facing roles in services that are often dealing with high levels of trauma and vulnerability, can take on frontline staff. In addition, while service users in the community are frequently the intended recipients of different trauma-informed initiatives, it was suggested that without organisational HR policies that protect and

> "*…we're making staff aware of trauma informed so that they know the impact on the community. And we're taking that on board without thinking,' what impact is this having on our staff?' Even reception staff and business support teams who take social care phone calls often hear traumatic disclosures but have no wellbeing support. Trauma-informed wellbeing policies are not just for frontline workers; they should be for everyone."* (**Educational Psychologist**)

support the workforce, it is not possible for an organisation or service to claim the status of being trauma-informed.
This 'absorption of trauma' was seen as necessitating a focus on wellbeing support, and sickness policies that explicitly recognised the impact of secondary/vicarious trauma and offer support mechanisms within that. Managing secondary trauma through creating nuanced and responsive HR policies was seen as being central to improving retention across the board, and importantly, this was regardless of whether a team or service was mental health-facing or not.
Other areas where TIP was seen as being relevant to staff wellbeing was in absence management where SLs reporting that their approach to "return to work" had "completely changed [to] a gentle approach on managing phased returns and back to work interviews" (**Survey: TSO/Public Health**). However, the difficulty here in changing language and ideas around 'just getting on with it' was also acknowledged, with the Roll-out Team suggesting that "it's hard for people to shift ideas about procedure around absence and not going down a performance management route for not attending" (**BwD Roll-out Team**).

> *"…a lot of the Heads of services were a bit like, 'I don't really know why this is relevant to me'… by the end… 'I totally get it.' If you have a staff team, then everybody in your staff team has mental health… your staff are going off sick and not coming back… there's no proper conversation about how to support them… that's about Trauma Informed Practise… and they're like, 'yes, because I'm losing money through recruitment!'"* (**TI Roll-out Team**)

Reflective Supervision

It was difficult to disentangle reflective supervision from trauma-informed workforce wellbeing policies, as supervision was seen by participants as a central element to supporting the workforce in relation to the impact of secondary/vicarious trauma. Reflective supervision was more common amongst teams such as Educational and Clinical Psychology where it was observed that "supervision is something that's kind of drilled into us from an early age… and it's something that's given a lot of priority," **Clinical Psychologist**). In addition, there was a qualitative difference to supervision that was seen as being "generally just much more reflective…with a clinical focus, especially with regards to trauma, in terms of the impact on ourselves" (I**bid**.), to support staff dealing with the impact secondary trauma. In contrast, clinical practitioners reflected on differences in "other professional groups [where] it's maybe not given the same level of priority" and staff would not "have the same experience of supervision [with it being] more often case management" (**Ibid**.), than supervision that was fully reflective in nature.

Reflective supervision was seen as being important to help staff manage and reflect on their personal responses to professional interactions with services users and to understand the impact of their own trauma on the trajectory of their work:

> *"It's about changing the staff's perception. I've had staff get upset when a young person's not engaging… and in supervision I'll ask, 'Do you wonder why you're feeling upset about that? Could that be linked to something?'… It's about learning through those conversations, helping people understand trauma—applying it to themselves, and then to the young person."* (**Young People's Services: Intervention Manager**)

However, while the use of supervision was becoming more prevalent with 14/19 respondents somewhat agreeing (n=8) or strongly agreeing (n=6) that their service provided dedicated time for reflective practice/supervision, it's use in case management was still the norm, particularly in social care teams, resulting from the constraints of working with high caseloads with a lack of time and capacity to engage in reflective work. The inability to provide sufficient dedicated time to cover the complexities of individual cases whilst simultaneously focusing on the interrelationship between professional and personal practice, was seen as a significant barrier to TIP:

> "*If we're thinking Social Care, I don't know about in other areas, it tends to be more case management-focused. And they have a certain number of cases that they have to discuss and get through…sometimes when the staff go to tell me something I'm like 'don't tell me, because I don't have time'… if you've got a certain number of cases you've got to get through in that supervision, it's really tricky. So, they probably need another thing outside of that."* (**Clinical Psychologist**)

Overall, it was felt that there was a "need for more consistent approaches to workforce support [including] peer support, reflective practice and supervision where necessary" (**Survey: Public Health Trauma Informed Practice and Physical Health**), particularly in teams holding "traumatic topic areas [that] are exposed to potentially triggering material regarding suicide and child deaths, for example" (**Ibid**.) As a result, a more well-defined approach to supervision that prioritised the needs of the practitioner on a responsive basis was seen as the most impactful way of supporting a trauma-informed approach in a variety of services, where case management could be combined with more reflective forms of supervision in a manner that was supportive of both wellbeing and professional practice:

> *"…it just needs to probably be clear about the function of the supervision type… our management supervision is very different… it holds different functions doesn't it? If it's case management, it's to go through cases. If it's more clinical… you would discuss maybe one or two cases in depth, but more talk about the worker, and how they are… all supervisions should incorporate all of those different elements… one might focus on the personal, restorative element… another might be more on the formative stuff, the processes… it could be flexible depending on the needs of the staff… just having a different model."* (**Clinical Psychologist**)

In addition, power dynamics were an important consideration in terms of identifying the best individuals to be leading supervision, where SLs suggested that they "wouldn't have supervision with managers" (**Educational Psychologist**) in situations where "peer supervision…for the team to talk to each other" (**Ibid**.) about certain topics was more appropriate. Here, it was suggested that there was "a power imbalance" where staff would not want to "sit and tell your manager that you're not coping, and actually…you're going to bed at three o'clock every day…and you're hiding under the duvet" (**Ibid**.) As a result, the idea of a manager taking a lead on more reflective/clinical forms of supervision was seen as being antithetical to the aims of TIP, where creating safety through avoiding power imbalances was a priority in the context of workforce wellbeing, as much as it was in service-user focused work.

Finally, the use of less formal forms of supervision was regarded as something that was seen in teams where "the relationships are strong" resulting in "a lot of peer supervision that's going on [where] people seek support from each other" (**Child Exploitation and Missing From Home**). However, this came with a caveat of ensuring that open-door policies for informal support from key staff members, either by virtue of their position within the team/service or because of their natural ability to provide support, needed to be avoided in favour of more structured forms of peer support.

> "*That worries me - an open-door policy. I used to say this to Head Teachers, sometimes you need to shut the door, because your door's always open. But there are some days when you can't cope with it, so actually, that's where for me, this idea of it being formalised, is better, because you as a manager have got to think about yourself. So having an open-door policy if someone says 'oh I really need to speak to you' and you think 'I'm just saturated today.'*" (**Educational Psychologist**)

Models of supervision:

- **Reflective (Clinical) Supervision** → Used in psychology and some social care teams, but not universally embedded.
- **Case Management Supervision** → The dominant model in social care, focused on processing cases rather than staff wellbeing.
- **Peer Supervision** → Used informally in some teams, particularly where staff prefer to talk openly outside of management-led supervision.
- **Informal Supervision** → An open-door approach used in many teams but seen as unsustainable in high-pressure environments.
- **Mixed Model Supervision** → Some teams have both formal and informal structures but lack clear policies.
- **Supervision Gaps** → Many frontline staff (e.g., admin, reception, and education support staff) do not receive trauma-informed supervision.

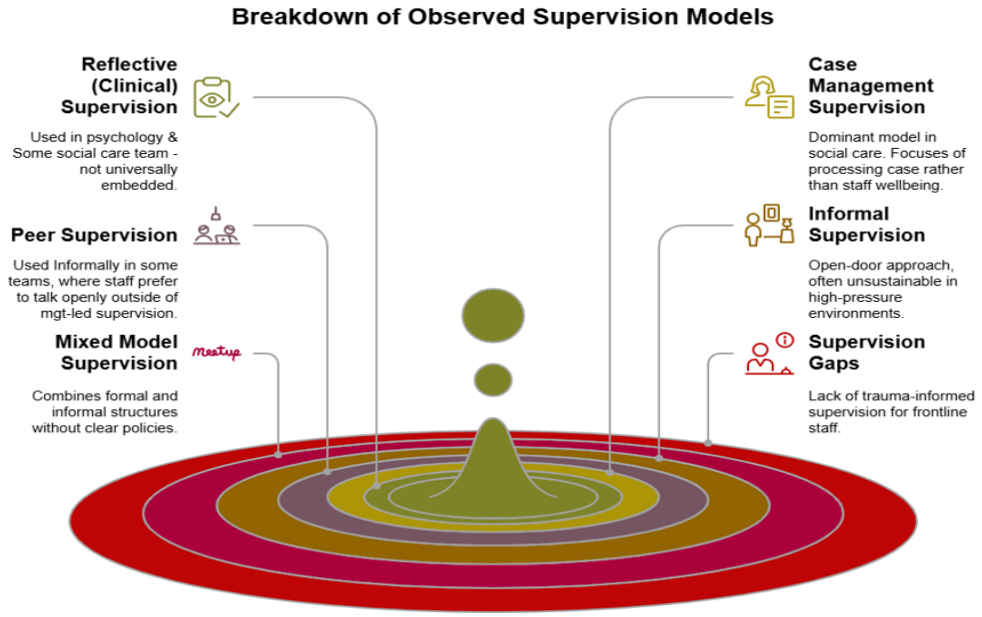

Figure 20: Models of supervision

Conclusion

The process of embedding TIP into services in BwD has demonstrated a multi-faceted and dynamic approach, incorporating contextualized training, governance integration, and workforce support. The training model adopted by BwD has been particularly successful in ensuring cross-sector learning, promoting collaboration, and avoiding siloed working, which has traditionally hindered effective multi-agency responses. The inclusion of real-life case studies lived experience input, and a relational approach to integrated training delivery, has ensured that TIP is not just theoretical but directly applicable to practitioners' daily work.

However, challenges remain in ensuring that TIP is fully embedded beyond training sessions. While workforce engagement has been positive, concerns have been raised about the sustainability of training as a standalone intervention. Many service leads emphasised that a single training session, regardless of how well-structured, does not automatically translate into a trauma-informed workforce. This highlights the need for ongoing reinforcement through reflective practice, supervision, and policy alignment.

The governance integration of TIP has been another significant step in embedding trauma-awareness into organisational structures. The inclusion of TIP within mandatory training, recruitment materials, and service-level policies (such as safeguarding, reintegration, and case management policies) demonstrates a systemic shift towards trauma-informed principles. However, while progress has been made, inconsistencies in policy adoption across sectors remain a concern. Some services, particularly Children's Social Care, have advanced further in embedding TIP, while others, such as Adult Services, Policing and the Private Sector, still require greater alignment.

Workforce wellbeing has emerged as a central theme in TIP implementation. The recognition that frontline staff, administrative workers, and even leadership teams are exposed to secondary/vicarious trauma has prompted efforts to integrate TIP into HR

policies, recruitment strategies, and performance management. The shift towards embedding reflective supervision, peer support, and structured wellbeing initiatives marks an important cultural shift in ensuring that staff resilience is prioritised. However, gaps remain in ensuring that all staff have access to trauma-informed supervision, particularly in services where case management is prioritised over reflective practice.

The Trauma-Informed Champions (TICs) model has played a critical role in sustaining TIP within teams. By assigning specific staff members to champion TIP within their services, organisations have been able to extend trauma-informed approaches beyond training days and into everyday practice. However, concerns have been raised regarding the clarity of the TICs' roles, with some feeling isolated or lacking formal recognition and structured support. Ensuring that TICs have a clearly defined remit, time allocation, and training will be essential in strengthening this model further.

The embedding of TIP within BwD services has shown promising progress, with contextualized training, cross-sector collaboration, and governance integration serving as key enablers. However, for TIP to be fully realized as an embedded practice rather than a stand-alone initiative, specific recommendations are suggested within the Recommendations section of this evaluation report.

Sustainability of TIP

Overall, long-term success and culture change for TIP within services and sectors across BwD, was observed as depending on embedding TIP into policy, training, and workforce development. There was evidence of such changes taking place, but there were also barriers to culture change, and these will be discussed below.

Evidence of Systemic Change

Changing cultures are notoriously difficult to measure across such a complex and differentiated system as a local authority. As suggested by Hibbin & Warin (2021), in their evaluation of BwD's EmBRACE model, it is only when there is a universal conversation around trauma where all sectors and services have a well-developed understanding of TIP - written into policy and implemented in practice - that culture change can be stated to have taken place:

> *"…if we're going to change the culture, everybody does it, and it becomes truly embedded and everybody's buying into it. What supports of course is my oft-mentioned 'universal conversation', because if it becomes the norm, we won't be talking about sustainability, it will just be what it is – seatbelts, smoking, same as all the other things…"* (Hibbin & Warin, 2021; p.24-25)

While it cannot be stated definitively that this universal conversation had become established as the norm, the Systems Resilience Framework (SRF) that was being

implemented through the five Managed Networks (MNs) across BwD had enjoyed some success in changing the culture in pockets of policy and practice across the Borough. A key indicator of this was the changing language that was becoming increasingly observed, with references to TIP becoming more prevalent and established over time in different contexts and practices. This changing language was evident in some of the reported interactions with service users, where children and young people would sometimes be written ***to*** in cases notes, rather than about, reflecting a clear shift to

> *"So, I've noticed that difference…especially doing audits of files…cases across different Social Work teams… just the way that young people are written about now… the language, the praxis, I can say for me, there's been a big shift… So they even write now - not everyone - but they'll write to the child, on the case notes…not talking about them - 'I came to see you today. You told me how…' so if the child then requests their file…which I think is a really nice. But again, that's not consistent. Not everyone does that"* (**Child Exploitation and Missing From Home**)

more trauma-informed ways of engaging:

Similarly, participants reported how they had observed that "in meetings the language is changing…as more people from different teams are doing the [Integrated] Training" (**BwD Roll-out Team**), with one external audit providing validation about this observed shift:

> *"Our team is multi agencies…we work alongside the Police, Health. I support parents whose children are being exploited…we had a team coming to audit our work back in September. And they commented that they thought the language that we use, language that they heard…was really positive. And they thought we were practicing in a way that was trauma-informed, which was nice to hear back, [to] have reflected back to us"* **(Child Exploitation and Missing From Home**)

This changing use of language was therefore a key indicator of systemic change to more trauma-informed ways of working and interacting, and it was positioned by practitioners as being a direct result of the journey that BwD had been on, and the Integrated Training that was being rolled-out across services and sectors. However, it was also noted that training was just the start of the process, and it needed to be followed up by more substantive changes in systems and processes to include a focus on TIP as an indicator when reviewing cases, as a basis for intervention, and also as a way of interacting on an interpersonal basis, to embed consistent engagement with trauma-informed across the board:

> *"…training is key. But then you've got to follow that up by changing your processes, your forms, your language… otherwise, you'll just do the training, and they just carry on doing what they do… we've got some people who are really systemically and really trauma-informed, and then there's other people who… are trauma aware, but… don't really put that into practice… when they're doing an analysis, they're not bringing that through, even though when you talk to them, they'll say, 'oh, yeah, well, I know that they experienced this as a child'….[and how] that is affecting how they're behaving now - but they don't, write that down. even when you've been at it for a few years, you still end up with people in on different levels"* (**Principal Social Worker: Children's Social Care**)

Other green shoots for TIP were observed from the survey data, where one participant reported that contracts and Service Level Agreements had started to include trauma-informed requirements in all their Social Determinants of Health contracts as well as "recognising the need to extend this across all other contracts and Service Level Agreements" (**Workforce Survey: Public Health**). In addition, some teams were taking the initiative to embed TIP into guidelines and principles through writing "some practice standards" (**Clinical Psychologist**), so that they would "be able to audit against those standards once they're written…and make sure that we are working in a trauma informed way as much as possible" (**Ibid**.) Such standards can be understood as an important step in ensuring consistency and quality in day-to-day practice.

The specific policy changes that were reported as being implemented in some sectors/services (i.e. Safeguarding, Reintegration, Adoption Bridging, Case Management and Service Delivery) can also be understood as indicators of, and milestones along the way, to cultural change, and these have been discussed above in the section detailing Error! Reference source not found.. Broader trends in relation to an expansion of TIP are summarised in the Table below.

Table 1: Summary of service level policy changes

Sector	Emerging Trends in Trauma-Informed Practice
Education	• Expanded focus on TIP beyond schools to include statutory assessment teams, admissions, inclusion and transport teams • Trauma-informed Champions introduced across education services
Children's Social Care	• Embracing of systemic practice with training for social workers and education staff • Shift towards trauma-informed child protection conferences and family meetings
Adult Services	• Efforts to balance case management with trauma-sensitive approach focusing on impact and possible links to trauma in Case Management meetings
Public Health	• Enhanced supervision structures to support staff well-being in high stress roles related to Mental Health • Reflective supervision encouraged to prevent burnout
Voluntary Sector	• Small voluntary organizations implementing TIP training despite resource challenges
Workforce Development / Cross Sector	• Trauma-informed principles embedded in professional development initiatives • Integrated training with a dedicated member of staff to provide support • Introduction, financial support for and emerging uptake of One Small Thing Quality Mark for compliance and best practices

Challenges to Systemic Change

Within-organisational barriers to implementation on a practical basis obviously impact on the ability of BwD to move towards systemic change. These have already been discussed in

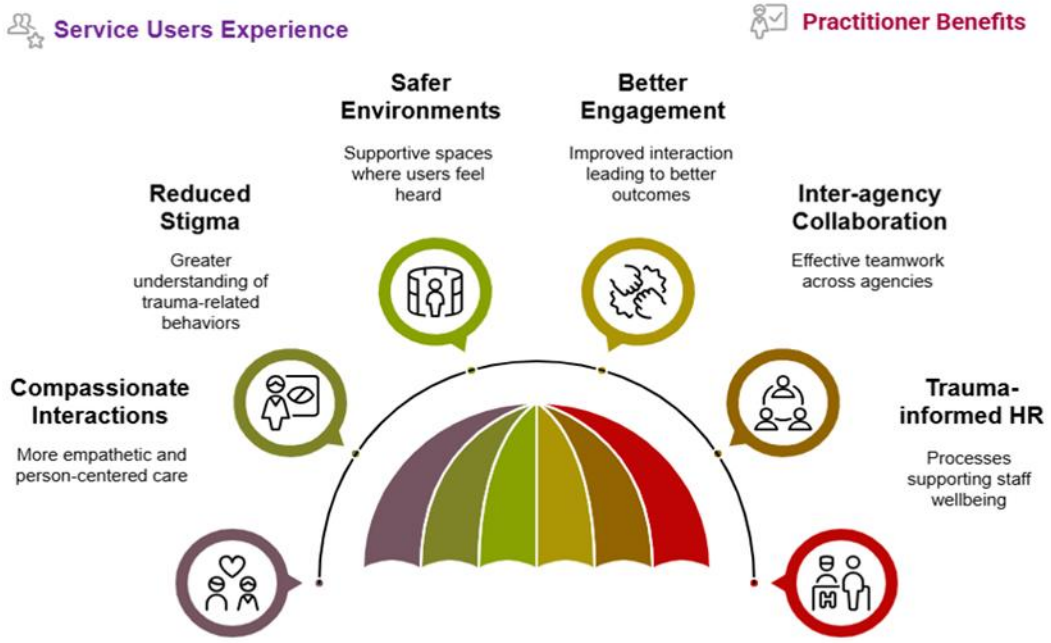

Figure 19: **Benefits of TIP**

Barriers to TIP , and they included:

- A lack of time and capacity for TIP where trauma-informed was seen as an added responsibility
- Variation in leadership buy-in as well as the bureaucratic nature of the Local Authority where with a lack of flexibility to support a trauma-informed approach or processes to challenge poor practice on an organisational level
- Fragmentation across different services with a lack of consistency

However, there were also challenges to implementation that were external and therefore more systemic in nature, and these will be discussed below.

'Projectitis' and Waiting Lists

Short-term funding and the time-limited nature of interventions in a commissioning system that prioritises the turnover of projects, was highlighted by participants. This structural/systemic barrier that has been previously termed 'projectitis' (Warin & Hibbin, 2020) in the literature, relates to difficulties embedding initiatives due to new external funding priorities or internal changes in Senior Leadership. Here, short-termism was directly linked to working in a trauma-informed manner:

> *"Systemic barriers exist. We can all work in a trauma-informed way but by only ever giving out [the] short commissions we offer services and then have to remove them again when funding comes to an end. Due to the nature of the system, funding can rarely be repeated even if the intervention is working, without going back out to tender, which can lead to unexpected changes in provider etc."* (**Local Authority: Public Health**)

Compounding this issue of the short-term nature of funding, where practitioners reported that "processes within the sector can at times go against trauma-informed principles [with] "capacity issues in other services such as mental health support can often generating extensive waiting lists which can prevent young people from receiving timely support" (**Survey: Young People's Services**). From this response the interrelationship between systemic barriers is clear, where funding is removed from a service/intervention (even when it is working) that could provide respite for service users when waiting lists in other parts of the system precluded their timely support.

External Directives

Participants also talked about external pressures that resulted in higher levels of perceived risk in taking a strongly trauma-informed approach that might have been preferred within a specific service or sector, regardless of what Senior Leadership might want to pursue. One participant described the bravery that was required to confront accountability measures imposed by an Ofsted inspector in one school, suggesting that taking a trauma-informed path required an evidence-based defence of the use of TIP,

that would have presumably not have been required if more punitive and attainment-focused initiatives had been taken as the preferred approach:

> *"...you can't [completely change] a behaviour policy or aggression policy, you've got to then incorporate... National elements that Central Government have said... and you've got your legal side... it's quite difficult to be trauma-informed when you've got other factors... they've still got to include quite behaviourist aspects... from the Department for Education, that comes from Central Government, that comes from the diocese if they're a Church School... I think that is the same for us as a Local Authority... it's not as easy until the whole thing is trauma-informed or you go, 'I'm gonna take the risk'... you've got to be really brave... an Ofsted inspector had questioned why do we work it in that way... I said, 'this is an Ofsted inspection—tell the inspector to read their own research'... you've got to be really brave to go 'forget that, let's be trauma-informed'... it's scary. Because there's lots of negativity towards Local Authorities nationally, isn't there in terms of media? There's lots of pressures..."* (**Educational Psychologist**)

Similarly, another participant emphasised the ideological clash between "Government driving attendance - where they're coming from 'they must be in school or otherwise, you will get punished'" (**Education Manager**), in contrast to schools that took the position of it "not [being] about that number and that statistic, it's actually, where are they, what's happening to them when they're not there?" (**Ibid**.) Overall, Government objectives in relation to attendance tied to the accountability agenda where "schools have the predominant function, of delivering the National Curriculum" (**Ibid**.) over more holistic forms of accountability tied to student wellbeing, was seen as a particular challenge to those schools who are interested in taking a trauma-informed approach. However, it wasn't just the Education sector that experienced such externally oriented barriers; as reported by the BwD Roll-out team, primary care staff were reported to struggle to engage with the integrated training due to the capacity issues related to Government directives:

> *"Because they were talking about could Pharmacy, do the training because Pharmacy were at the meeting and I was at and [they were] saying 'well we just don't have the capacity to be able to release anybody' because they're under... because of the changes to what they're offering under new government stuff."* (**BwD Roll-out Team**)

Hard to Reach Sectors

On top of these generalised barriers that were seen across services, the BwD Roll-out Team reported that some services and sectors were harder to reach in terms of embedding TIP than others; in particular, participants here talked about how getting "GP primary care staff released for a whole day" for the integrated training was "nigh on

impossible" (**BwD Roll-out Team**). As a result, much less comprehensive siloed training had to be delivered instead, which lost the cross-sector and contextualised character of the full day Integrated Training where staff members from different sectors would mix and consider the application of TIP from a variety of perspectives.

Further challenges that came out of survey responses included the difficulty of "maintaining focused interventions and appropriate throughput of cases within a trauma-informed approach, as well as difficulty "accessing appropriate mental health specialisms to support such work" (**Workforce Survey: Adult Social Care**). This reinforces the difficulty reported by the BwD Roll-out Team in relation to primary care staff being particularly difficult to on-board with the Integrated Training within the system-wide approach, due to capacity issues alongside Government directives discussed above. As a result, buy-in relied on finding someone who could drive the agenda forward in hard-to-reach teams and sectors:

> *"I think it's changed a lot from when I was last involved with Primary Care and it's very much more, I don't know, disjointed - every GP practise almost runs independent, even if they're in a group, they've all got slightly different ways of doing things. Unless you get somebody who's got that interest."* (**BwD Roll-out Team)**

Individual Accountability and TIP

Another challenge described in the survey that was an outlier perspective obtained from a single participant, is the idea that when an individual is presenting "with both trauma and ASB, striking the right balance between trauma-informed principles and accountability" (**Workforce Survey: Adult Social Care**) is a complex line to walk. This is particularly the case for services that are adult-facing, where taking a trauma-informed approach can be understandably more complex when the challenging behaviour is coming from an adult rather than a child. While this was not a strong focus in participant responses overall, it is felt that it warrants consideration, as a concern that has been articulated by practitioners in previous evaluation research with regards the idea that TIP can sometimes feel like a 'soft option' (Hibbin & Warin, 2021), especially when someone is behaving very badly.

Data Integration and No Wrong Door

A key element of a systemically trauma-informed approach that is widely recognised as being central to the way service users experience stress and feelings of marginalisation, that can exacerbate past trauma and also create attrition in terms of engagement, is the interface between the service users and their requests for support:

> *"I think it is about people, somebody coming to Service and feel that they'll listen to them, heard they're supported that they're that they're not dismissed. Or told that it's not this door, it's that door or it's not this Service, it's that Service"* (**BwD Roll-out Team**)

Feelings of being passed from pillar to post in an incoherent system where service users don't know where or how to access the most appropriate support had been identified by the BwD Roll-out Team as a central challenge when trying to embed a trauma-informed approach. The solution was seen as pursing a No Wrong Door model (Centre for Mental Health and NHS Confederation, 2022; Children's Commissioner for Wales, 2022), a key element of which is the need for integration within a shared data environment where all services are 'joined-up' and data is ported into a system that identifies service users and their relevant data at different parts of the system, before signposting them to the most appropriate service. The local authority team responsible for the roll-out of TIP suggested that "developing the Managed Networks was to try and get that better conversation in place" (**BwD Roll-out Team**) around information sharing

> *"It's all fine. They're all completely interlinked and speaking to one another!...No, they're completely not. And that's the problem. So, there are pieces of work going on, but again they're separate...So we've got one data system that's used by our 0 to 17 system... And we have another that's used by our GP service....another piece of work that I'm involved in is trying to work across our wellbeing teams within the Council so that they can use the same data system as the GP [and] transfer information across the record between them, which will be really, really useful because obviously a lot of people access health, through a service that isn't necessarily called Health - they'll go to the Wellbeing Service and they'll talk to them about their blood pressure...but then they need to inform the GP that that's happened.*
>
> *And currently we've got data sharing agreements in some Practises, but not all...There's also another piece of work that's happening around that No Wrong Door approach. Understanding what the experiences of somebody trying to contact a particular department in the Council and actually looks like, what it feels like for that person who picks up the phone and calls that dashboard number. And then they have to go to that person and that person...how do we streamline it so that they're not having to reach out and they're directed to the right service quicker.*
>
> *So, it's kind of all of those, it's the system and the database and the information sharing that absolutely needs to be in place and it will take a lot of time to get there because everybody necessarily uses different systems... I can't say that it's going to be a quick a quick fix."* (**BwD Roll-out Team)**

and data integration, going on to suggest that “when people work in a particular area, all they see is that area and don't consider that once that person has left their area, where are they going?” (**Ibid**.) As a result, there was a perceived need to understand where different services were “passing [people] on to and what does that feel like for them" (**Ibid**.), to get past the barrier of siloed working hindering a No Wrong Door approach. However, as suggested by the BwD Roll-out Team, data integration was a complex, challenging and aspirational project due to the need for multiple data sharing agreements and data platforms that could be linked together.

Understanding the barriers to data integration is a key step to working toward integration in a shared data environment. These barriers can be divided into 6 key areas:

1 Legal and Ethical Barriers

- **Data Protection Laws:** Regulations such as GDPR restrict data sharing between organisations to protect personal privacy.
- **Confidentiality Issues:** Sensitive information (e.g., health records, criminal records, child protection data) may have different disclosure rules, limiting cross-sector data sharing.
- **Informed Consent Challenges:** Obtaining permission from individuals to share their data across multiple agencies can be complex, especially for vulnerable groups like children or individuals with mental health conditions.

2. Technical and Systemic Barriers

- **Incompatible IT Systems:** Different agencies often use separate databases with varying formats and structures, making interoperability difficult.
- **Lack of Standardized Data Formats:** Differences in how data is collected, categorized, and stored prevent seamless integration.
- **Limited Access to Real-Time Data:** Many agencies operate on outdated systems that do not support real-time data sharing, leading to delays in service coordination.

3. Organisational and Cultural Barriers

- **Siloed Working Practices:** Different sectors have their own priorities, cultures, and workflows, which can create resistance to collaborative data sharing.
- **Lack of Trust Between Agencies:** Concerns about how shared data might be used (e.g., social care data being used punitively in criminal justice) can prevent agencies from sharing information.
- **Professional Boundaries and Roles:** Professionals may have concerns about overstepping their roles if they gain access to another sector’s data.

4. Resource and Funding Barriers

- **Limited Financial Investment:** Developing integrated data systems requires significant funding, which may not be prioritised in budgets.

- **Staff Training Gaps:** Frontline staff and administrators may lack the necessary skills to use integrated data systems effectively.
- **Sustainability Issues:** Even if integration is initially funded, long-term maintenance and upgrades may be neglected due to financial constraints.

5. Data Quality and Accuracy Issues

- **Inconsistent or Incomplete Data:** Different agencies may collect different types of data, leading to gaps or inconsistencies.
- **Data Duplication or Mismatches:** Without a common identifier (e.g., a unique case number), the same individual may be recorded differently across systems.
- **Lack of Data Validation Processes:** Errors in one system can propagate across integrated databases if not properly checked.

6. Public Perception and Political Barriers

- **Concerns Over Surveillance and Data Misuse:** Individuals may be wary of their personal information being shared across multiple agencies.
- **Political and Policy Changes:** Government priorities shift over time, meaning integrated approaches may not be sustained.
- **Community Resistance:** Some communities may be hesitant to engage with services if they fear that shared data could be used against them (e.g., undocumented migrants fearing data sharing between health services and immigration authorities).

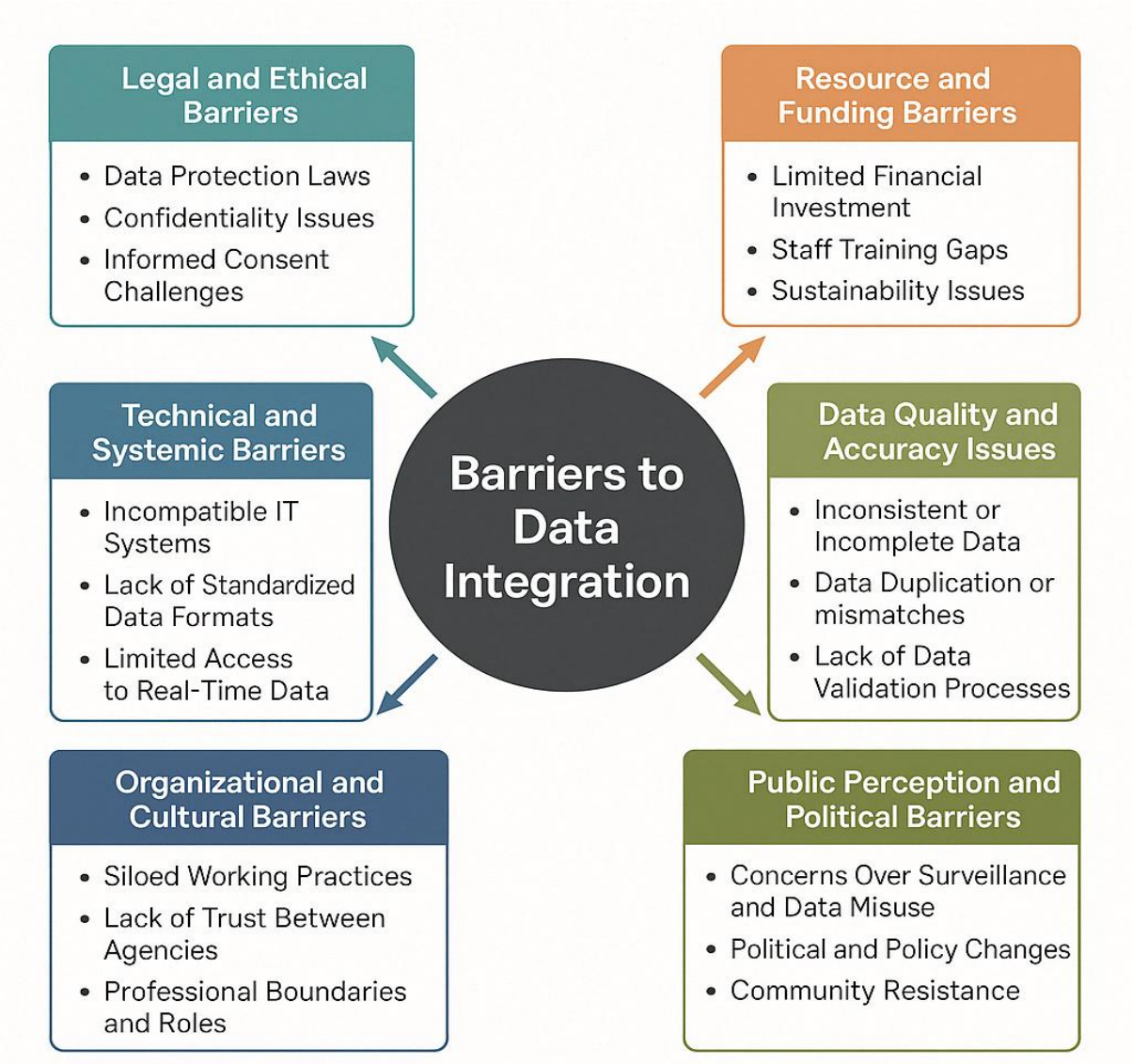

Figure 21: Barriers to data integration

Overcoming These Barriers:
To implement an effective No Wrong Door approach in social care, health, education, and criminal justice, organisations can:

- **Develop clear legal frameworks** for cross-sector data sharing while ensuring privacy protection.
- **Invest in interoperable IT systems** with standardized data formats.
- **Foster cross-sector collaboration** through training and joint working protocols.
- **Secure long-term funding** for integrated data systems.
- **Engage communities and individuals** to build trust in data sharing practices.

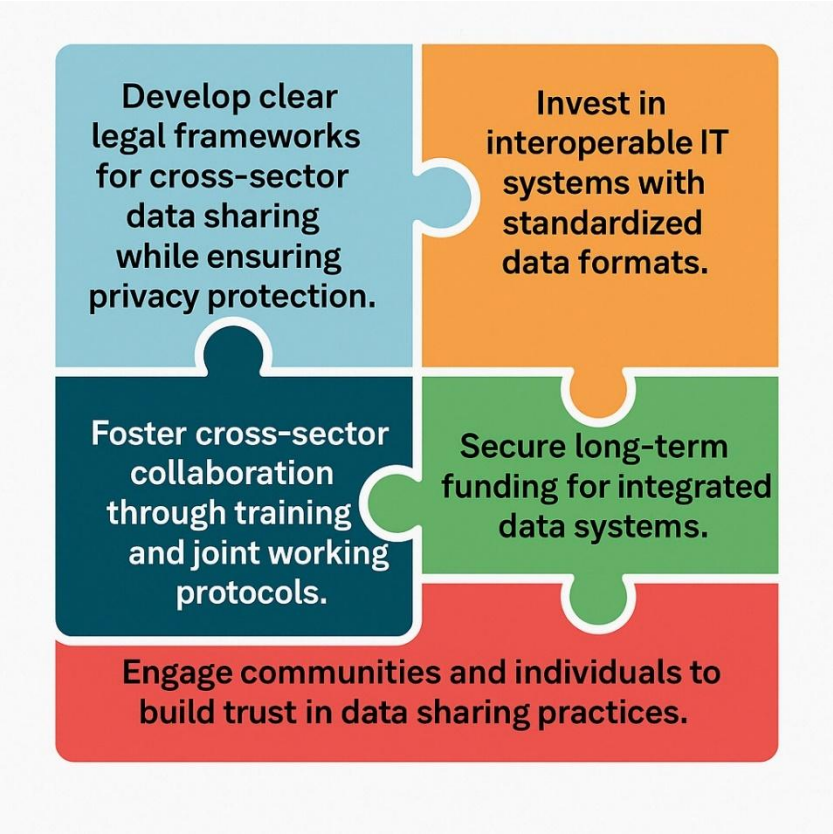

Figure 22: Overcoming barriers to data integration

Conclusion

The sustainability of trauma-informed in BwD relies on embedding TIP into policies, workforce development, and service governance. While there is clear evidence of systemic change, including shifting language, policy modifications, and cross-sector Integrated Training, full cultural transformation remains an ongoing challenge and a long term project. Achieving lasting change requires consistent application across all levels of service delivery, ensuring that TIP is not just a theoretical concept but a fundamental principle guiding interactions, interventions, and policy frameworks.

One of the strongest indicators of systemic change is the observed shift in language and practice across services. Practitioners and auditors have reported an increase in TIP-conscious language, reflecting a deeper understanding of trauma and its implications. The transition from writing ***about*** children in case notes to addressing them **directly** is an example of how practice is becoming more person-centred and reflective of TIP principles. However, these changes are not yet universal, and inconsistencies remain across teams and services, reinforcing the need for further training and systemic embedding.

Despite these advancements, barriers to TIP implementation persist. A key issue is the perception of TIP as an ‘added responsibility’ rather than an integrated approach to service delivery. Many professionals recognize the value of TIP but struggle with the capacity to incorporate it into their daily workloads. This is further compounded by variations in leadership buy-in, where some senior managers fully support the initiative

while others remain hesitant, limiting the pace of organisational change. The bureaucratic structure of the Local Authority also presents challenges, as approval processes for systemic changes can be slow and rigid, preventing flexibility in response to emerging needs.

Service fragmentation remains another significant barrier to sustainability. While some sectors, such as Children's Social Care and Education, have made considerable progress in embedding TIP, others - particularly Adult Services, Housing, and Policing - lag behind. These disparities create inconsistencies in service provision, making it difficult to achieve a universal trauma-informed approach across BwD. The lack of a standardized training mandate across all sectors has contributed to this uneven adoption, further reinforcing silos between services.

Finally, systemic barriers that were entirely beyond the control of individual services, sectors or the local authority itself added an additional layer of complexity to the implementation of TIP. While this is something that could be mitigated by a degree of evidence-based 'bravery' in the face of interlocutory Ofsted inspectors, in some regards the clash between the competing demands of government functions and directives with those of local services, meant that compromises had to be made.

Discussion

The concept and science of Adverse Childhood Experiences (Felitti et al, 1998) underpins the trauma-informed approach taken in BwD, emphasising that fact that early negative experiences can lead to adverse health outcomes in later life. Since Bellis et al (2014) undertook the first ACEs UK survey in BwD, replicating the U.S. ACEs survey results from Felitti et al (1998), TIP has become synonymous with a 'public health approach' to managing vulnerability across a variety of sectors, including Policing (Harris and Fallot, 2001; Christmas and Srivastava, 2019). In recent years, a variety of Toolkits and Organisational Frameworks have been developed, including Lancashire VRN's Organisational Development Framework (Youansamouth et al, 2020); TI Wales (ACE Hub Wales, 2022); and TI Practice: A Toolkit for Scotland (Homes & Grandison, 2022). In addition, London has recently developing a Trauma Responsive Roadmap across Local Authorities, Policing and the Third Sector (London VRU, 2025).

However, despite this plethora of activity around TIP, the Early Intervention Foundation (EIF) (2020) has emphasised that while ACEs are strongly linked to negative life outcomes, including mental health issues, substance misuse, and social inequalities there is also a need to be cautious against an overly deterministic view of ACEs. The EIF (2020) goes on to stress the need for evidence-based interventions rather than relying solely on ACE screening as a predictive tool for the presence of adverse-childhood-experiences. The Systems Resilience Framework (SRF) roll-out of TIP across Blackburn with Darwen aligns with the EIF's (2020) findings by focusing on **system-wide responses** rather than individual-level screening. The emphasis has been on creating trauma-aware services, enhancing workforce training, and fostering cross-sector collaboration to support individuals who have experienced trauma.

In addition, while ACE awareness has clearly increased over the last ten years, as highlighted by the EIF (2020) there is limited robust evidence to suggest that simply identifying ACE exposure leads to improved outcomes without complementary, structured interventions around adverse-childhood-experiences. Structural inequalities such as poverty, housing instability, and unemployment, that are conceptually summarised through Adverse Community Environments (Ellis & Dietz, 2017) contribute significantly to trauma exposure. The EIF (2020) argues that systemic social changes (e.g., tackling poverty and discrimination) are essential alongside trauma-informed practice to create lasting impact. While challenging the systemic barriers to social equity and equality is a long-term endeavour evidenced through the transformation to a fully Trauma Informed Borough, the evidence from this evaluation suggests that the Integrated Training, the Service level policy changes, and the Champions Model were cumulatively putting the Trauma Aware and Trauma Sensitive milestones in place, to enable the move to more fully trauma-informed response to take place over the long-term.

Overall, the effectiveness of the bottom-up approach to embedding TIP through the Community Champion Strand (CCS) and the top-down approach through the Service Lead Stand (SLS) was an effective way of managing this initial stage in the journey to becoming fully trauma-informed.

Community Champion Strand

Normalising Discussions Around Trauma

Through the Community Champion Strand (CCS), the Community Champion's (CC's) were able to learn, practice and develop the Trauma Informed Community Workshop (TICW) in the reflective space of the Trauma Informed Developmental Workshop. They then took the TICW out to community settings where further feedback from the Third Sector Organisation (TSO) that supported the development of the co-produced workshop, enabled them to further refine the workshop over time. The impact of the TICW on both the CCs delivering the workshop, and the community participants that receiving it, is an important step towards moving the idea of trauma away from a frightening concept, to an approach that normalises discussions of trauma and paves the way for emotional growth and resilience.

Understandings of trauma continue to evolve, and there is growing recognition that it is not a simple or universally defined concept. While recent shifts in discourse have helped bring attention to hidden or marginalised forms of harm, some researchers have raised concerns about the tendency to label a wide range of difficult experiences as 'trauma' (Seligman, 2000; Joseph & Linley, 2004). While the intention is often to validate people's pain, this broad framing risks over-pathologising distress and blurring the lines between trauma, adversity, and everyday challenge. From a psychological perspective, particularly within positive psychology, there have been calls to round-out this focus on harm by also recognising people's capacity to adapt and grow. The theory of post-traumatic growth developed by Tedeschi and Calhoun (1996; 2018), highlights the possibility that after traumatic events, some people experience meaningful personal changes. These might include shifts in priorities, stronger relationships, or a renewed sense of purpose. This is not to say that trauma is ever desirable, or that growth is guaranteed. Rather, it reminds us that distress and strength can co-exist, and that recovery does not always mean returning to how things were. This more balanced view fits well with trauma-informed approaches, which are not only about preventing harm, but also about creating the conditions where people can reflect, rebuild, and reconnect. When trauma is seen only as damage, there is a risk that individuals feel stuck with a version of themselves that is reduced to their worst moments. Positive psychology reminds us that people also have the capacity for meaning-making, agency, and movement - even in the context of suffering.

This is why it matters to separate experience from identity. As McAdams (2001) points out, identity is shaped through the personal stories we create and rework over time - not by the events themselves. Frankl (2004) similarly argued that we are not defined by what happens to us, but by how we respond to it. Trauma may shape a person's view of themselves or the world, but it does not have to define who they are. This is a vital message within trauma-informed work: that people are more than what they have been through, and that their futures are still open.

Cultural Considerations of Stigma and Silence

Another key finding from the evaluation of the TICW in the CC Strand, was the finding that cultural stigmas around mental health remain a barrier, particularly among older generations and men. Such findings highlight the importance of understanding trauma disclosure within its cultural, relational and community context. UK research identifies stigma, shame, fear of judgement, family reputation and cultural dissonance with mainstream services as barriers to mental health help-seeking among South Asian communities (Prajapati and Liebling, 2022; Howe and Sanger, 2022; Ethnic Health Forum, 2021). This is particularly relevant to trauma-informed practice because silence should not be interpreted as absence of need; it may instead reflect the perceived social risks of disclosure. For South Asian men, these barriers may be intensified by gendered expectations around strength, responsibility and emotional restraint, making it especially difficult to speak directly about traumatic experiences (Prajapati and Liebling, 2022; Ethnic Health Forum, 2021).

In local authority contexts such as Blackburn with Darwen, this suggests that trauma-informed systems change must extend beyond statutory services and into trusted community and faith-based networks. Blackburn with Darwen's SRF provides a "top down-bottom up" approach, while local trauma-informed community work funded by Public Health within BwD seeks to engage third-sector and faith partners across the borough (Blackburn with Darwen Borough Council, 2022; Healthy Living Blackburn with Darwen, n.d.). This is important because faith leaders, community organisations and trusted local networks may provide more acceptable first points of contact for some residents than direct approaches to statutory services (Ethnic Health Forum, 2021; Prajapati and Liebling, 2022).

At the same time, culturally responsive practice should not assume that people always want support from someone within their own cultural or faith community. In close-knit communities, shared background may increase trust for some, but for others it may heighten concerns about confidentiality, gossip or their trauma becoming known locally (Prajapati and Liebling, 2022; Howe and Sanger, 2022). Trauma-informed practice therefore requires choice, transparency and confidentiality, including options to access culturally knowledgeable support both within and outside immediate community networks. The implication for BwD is that normalising conversations about trauma should involve reducing shame, building trust, working with faith and voluntary-sector partners, and creating multiple safe routes into support rather than relying on a single model of culturally matched provision (Blackburn with Darwen Borough Council, 2022; Spring North, 2024).

Service Lead Strand

Time to Think and Reflect

Through the dedicated reflective space of the Action Planning Workshop (APW), Service Leads (SLs) were supported to develop structured TIP action plans. The benefit of providing staff with such time to plan, reflect and develop, cannot be underestimated. As suggested by two of the SLS participants, the APW provided them with much needed

space to consider next steps for embedding TIP across their services. The provision of space to reflect ties into one of the core findings from the evaluation, that there was a strong value for reflective practice overall; from those staff members that responded to the workforce survey 31.6% strongly agreed, and 42.1 % somewhat agreed their service provided dedicated time for reflective practice and/or supervision. This represented almost 74% of the surveyed workforce suggesting their services provided some level of reflective practice, which is a highly encouraging statistic. In contrast to performance-focused supervision that is concerned with on monitoring, evaluation and oversight, reflective supervision provides dedicated time (Virmani & Ontai, 2010) for a supervisory process that supports:

- Deep collaboration between supervisor and supervisee (Weatherston & Barron, 2009)
- A non-judgemental and supportive relationship between the supervisor and the supervisee that emphasises perspective-taking and professional curiosity (Susman-Stillman et al., 2020; Marshall et al, 2022)
- Reflective capacity to attune the practitioner to the emotional states of themselves and others; how personal thoughts, feelings, experiences, and biases may influence behaviours, to improve professional responses and efficacy (Tomlin et al, 2014; Susman-Stillman et al., 2020; Barron et al, 2022)

The benefits of reflective supervision have been found to include improvements in professional wellness, including motivation and efficacy, as well as in emotion regulation and reflective capacity (Barron et al., 2022). However, even though practitioners reported services valuing reflective practice/supervision, challenges such as time constraints due to heavy caseloads, variable levels of leadership buy-in, and service fragmentation were identified as being barriers in relation to having the time for regular dedicated reflective supervision. Dedicated time for reflective forms of supervision is particularly pressing for staff working in vulnerability-facing roles such as Educational and Clinical Psychology, who as a general rule tend to get more access to reflective supervision as a matter of course. However, for non-clinical roles which may on occasion need some level of supervision when encountering a particularly challenging client, there tends to be less recourse to access reflective practice/supervision.

This idea of non-clinical supervision has been reinforced by an evaluation of Power The Fight's Therapeutic Intervention for Peace Project that worked with 175 young people at two mainstream secondary schools and one alternative provision in group work and 1:1 therapeutic sessions, co-developing therapeutic group workshops with young people, adapting and implementing culturally sensitive psychoeducation, Cognitive Behavioural Therapy (CBT) techniques, reflective discussion and art therapy (Williams et al, 2024). The Therapeutic Intervention for Peace Project also provided clinical supervision for all practitioners, including those in non-clinical roles, developing "a distinct model for work with front facing practitioners in non-clinical roles…for 1 hour every 2 weeks on a one-to-one basis [where the] agenda is set by the supervisee, with the supervisor supporting to hold the thread of the conversation across sessions" (Williams et al, 2024; p.29). A value for non-clinical reflective supervision for staff

working directly with vulnerable clients should be prioritised as a key and non-negotiable element of effective TIP that supports both service user and practitioner wellbeing, and professional efficacy in-role.

Humanising Approaches to Difficult Behaviour

Another core element of the evaluation was the impact of TIP on managing behaviour in a humanising way. The benefit of approaching vulnerable populations in a manner that was - to coin the language of our participants - 'PACE-ful' (Hughes, 2017; Hughes, Golding and Hudson, 2019; Sinarski, 2023), where playfulness, acceptance, curiosity and empathy is applied to all interactions, links to attempts to pursue a trauma-informed approach across different contexts to improve outcomes in a preventative manner. However, as noted by the YEF, in terms of large and scientifically rigorous studies "there is very little research on the impact of training staff and redesigning systems with the primary aim of recognising and responding to trauma" (2025, Online). However, small scale evaluations such as the Relational Inclusion Primary Pilot found evidence of such improved outcomes in Primary School and Pupil Referral Unit students including improved emotional regulation; increased emotional literacy and self-awareness; positive behavioural shifts; improved social relationships; boosted confidence, resilience, and engagement; improvements in attendance; and the creation of safe, inclusive school environments (ACT, 2025).

The use of strongly humanising approaches can counter a cultural tendency toward punitive action in the face of misbehaviour, where the 'will to punish' (Parsons, 2005) in the UK is 'deeply embedded' and linked to high rates of school exclusion and imprisonment for young people across UK and Wales through the mechanism of the 'school to prison pipeline' (Irby, 2014). Parsons (2005) goes on to note that therapeutic and restorative approaches are strongly undermined by both right-wing politics and the populist press, arguing that "'goodies for baddies' is hard to sell" (p.192). However, if TIP is chosen as the basis for more humanising forms of intervention, consideration of other practices that are more explicitly focused on repairing harm also become relevant, so that poor behaviour can be challenged without compromising trauma-informed principles.

Restorative Practice (RP) is one such example of a relational approach that provides a framework for supporting the reparation of harms after they have occurred (Green et al, 2013; RJC, 2023; Hibbin, 2024) that can be defined as "as a preventative and solution-focused approach emphasising the restoration of relationships through effective, open and positive communication" (Hibbin, 2024; p 496). It is suggested that conflict resolution through RP should be encouraged within BwD across sectors, as part of a dual approach to acknowledging trauma and supporting associated vulnerabilities, alongside providing the nurturing boundaries that individuals who have experienced trauma may require, in recognition of the idea that in many cases 'harm creates harm'. For example, novel approaches to conflict resolution have been explored by Hibbin (2024) in the context of Education, where the use of RP through Coaching has been found to be strongly supportive of both relational repair and the development of

emotional literacy. Notably, Coaching Groups were found to operate "as a direct plumbline back to pro-social skills, as the site where RP could be tacitly modelled and rehearsed by both staff and students" (p.508). Not only would such an approach support the wellbeing of the workforce who may be in the firing line of trauma responses through the work they do with vulnerable populations, but it would instil agency in those individuals who have caused harm through their behaviour, by creating a culture where taking some degree of responsibility was the norm. Ultimately, this would create a joined-up approach that moves TIP in BwD into a diversified framework that incorporates a variety of humanising and person-centred methods to support both services users and the workforce under the banner of Relational Practices, as an overarching model that is currently gaining traction in the academic literature (Lamph et al, 2023).

Systems Resilience and Sustainability

Policing and the Private Sector

The findings suggest that the next stage of Blackburn with Darwen's Systems Resilience Framework should focus on bringing Policing and the Private Sector more fully into implementation. This is important because trauma-informed systems change cannot be sustained if it remains concentrated in services already closest to children, families, health, social care and community support. The SRF is explicitly intended to support whole-system change across sectors, so its long-term success depends on extending shared trauma-informed language, practice and accountability into less embedded parts of the local system (Blackburn with Darwen Borough Council, 2022). Policing is central to this because police officers and staff often encounter people at moments of crisis, vulnerability, conflict or harm. For people affected by trauma, police contact can either reinforce fear and mistrust or provide an opportunity for recognition, safeguarding and referral into support. Trauma-informed policing is therefore relevant not only to specialist safeguarding roles, but also to neighbourhood policing, response, custody, domestic abuse, exploitation, serious violence and victim support. It also has an important workforce dimension, as police officers and staff are themselves exposed to repeated traumatic incidents and require organisational support, supervision and wellbeing structures to sustain trauma-informed responses (College of Policing, 2023; Violanti et al., 2021).

The Private Sector is also important because residents encounter trauma, distress and vulnerability in everyday civic and economic spaces, not only in statutory services. Employers, landlords, transport providers, shops, leisure services, commissioned providers and security staff may all come into contact with people experiencing domestic abuse, exploitation, homelessness, mental distress, poverty or crisis. With appropriate awareness, signposting and safeguarding pathways, private-sector partners can contribute to earlier identification, safer responses and better routes into support. This is consistent with trauma-informed principles of safety, trust, choice, collaboration and empowerment across organisations and systems, rather than only within clinical or statutory settings (Office for Health Improvement and Disparities, 2022; Emsley et al., 2022).

However, bringing these sectors into the SRF should not rely on generic one-off training alone. Evidence on trauma-informed implementation highlights the need for leadership, policy alignment, reflective practice, workforce support, clear referral pathways and evaluation (Emsley et al., 2022; Home Office, 2024). For Policing, this means embedding trauma-informed principles into operational practice, safeguarding, custody, neighbourhood work, partnership decision-making and workforce wellbeing. For the Private Sector, a proportionate tiered approach may be more appropriate, beginning with awareness, safe-response principles and signposting for public-facing organisations, with deeper organisational work for larger employers, commissioned providers and strategic partners.

Overall, including Policing and the Private Sector is essential if BwD is to move from trauma-informed awareness to whole-borough trauma-informed infrastructure. Trauma is encountered in streets, workplaces, homes, shops, custody suites, neighbourhoods and public spaces, not only in specialist services. A sustainable trauma-informed borough therefore requires shared language, shared pathways and shared responsibility across all sectors that shape residents' everyday experiences of safety, trust and support.

Integrated Training

The findings suggest that BwD's use of integrated, cross-sector trauma-informed training is an important mechanism for moving from individual awareness to whole-system change. Training services and sectors together helps create a shared language around trauma, adversity, resilience and relational practice, reducing the risk that different parts of the system interpret distress, risk or "non-engagement" in inconsistent ways. This is important because TIP is not simply a set of individual practitioner skills; it requires organisational and system conditions that support safety, trust, collaboration, choice and empowerment across services (Office for Health Improvement and Disparities, 2022; Emsley et al., 2022).

Integrated training also has practical benefits for partnership working. When practitioners from education, health, social care, policing, the voluntary sector and community-facing services train together, they are more likely to understand each other's roles, thresholds, pressures and referral routes. This can strengthen relational infrastructure between services, support earlier conversations about need and risk, and reduce fragmented responses for service users. Learning from Violence Reduction Unit delivery found that trauma-informed training was valued by partners and contributed to sustaining a public health approach and effective multi-agency working (Home Office, 2024). In this sense, BwD's approach is valuable because the training itself becomes a form of system-building: it creates connections between people who may later need to coordinate support around the same children, families or adults.

The inclusion of lived experience further strengthens this model. Trauma-informed training is more likely to be meaningful when it is grounded in real-world case studies and the voices of people who have experienced different forms of trauma. Lived experience can help practitioners understand how services are felt by those who use them, including how assessment, language, thresholds, professional curiosity, waiting

times or repeated retelling may be experienced as unsafe or re-traumatising. Co-production literature also emphasises that involving people with lived experience can help address power imbalances and improve the relevance, accessibility and legitimacy of service design and training (McGeown et al., 2023).

However, lived experience should not be used tokenistically. It needs to be supported through safe preparation, choice, consent, appropriate payment/professional development, emotional support and clear boundaries, so that people are not expected to repeatedly disclose trauma for organisational learning. When done well, co-produced and co-delivered training can model trauma-informed values in practice: collaboration, empowerment, voice, trust and relational safety. For BwD, this means that integrated training is not only a method for spreading knowledge, but a way of embedding a shared, relational and community-informed trauma-informed culture across the whole system.

No Wrong Door

Finally, the need for sustainability through processes that join sectors and services together in a meaningful way can be understood through the principle of No Wrong Door (Centre for Mental Health and NHS Confederation, 2022; Children's Commissioner for Wales, 2022). In the UK, this approach has been implemented in North Yorkshire as an integrated service and practice model for adolescents in, or on the edge of, care. The model is based on the idea that young people should be able to access the right support regardless of where they first present, rather than being passed between services or required to navigate fragmented systems themselves (Social Care Institute for Excellence, n.d.; Local Government Association, 2018).This is particularly relevant to trauma-informed systems change because TIP depends on predictability, trust, relational continuity and emotional safety. These qualities are difficult to sustain where people are repeatedly required to retell their stories, meet new professionals, or move between disconnected thresholds and referral pathways. A No Wrong Door approach therefore aligns closely with trauma-informed practice because it seeks to reduce system-generated harm, including delay, duplication, repetition and the experience of being turned away (Centre for Mental Health and NHS Confederation, 2022).

For Blackburn with Darwen, the relevance of No Wrong Door (Centre for Mental Health and NHS Confederation, 2022; Children's Commissioner for Wales, 2022) is not necessarily that the North Yorkshire model should be replicated in full, but that its principles can inform the next stage of trauma-informed systems development. The findings from this evaluation suggest that the Borough has made progress in building shared language and cross-sector commitment. The sustainability challenge is now to embed this into the everyday infrastructure of the system through shared pathways, lawful and proportionate information sharing, relational continuity, and clearer mechanisms for joint decision-making across services. Data and information sharing are central to this. Without effective integration, different services may each hold only partial knowledge of a person's needs, risks, strengths and relationships. This can result in duplication, missed patterns and inconsistent responses. By contrast,

integrated approaches allow professionals to build a fuller contextual picture and coordinate support around the person rather than around organisational boundaries. The North Yorkshire RAISE approach illustrates this by using intelligence and information from embedded No Wrong Door roles and the wider partnership to develop shared understandings of risk and coordinated plans to manage harm (North Yorkshire Safeguarding Children Partnership, n.d.).

A No Wrong Door lens also strengthens the equity dimension of TIP. People and communities facing poverty, racism, disability, language barriers, stigma, insecure housing or distrust of statutory agencies are often least able to navigate complex systems (Marmot, 2020). For this reason, integration is not simply an administrative or efficiency issue; it is central to accessibility, fairness and prevention. The implication for Blackburn with Darwen is that trauma-informed sustainability will depend on moving from awareness-raising to trauma-informed infrastructure: shared data, shared pathways, shared language and shared responsibility across sectors (Centre for Mental Health and NHS Confederation, 2022).

Overall, No Wrong Door offers a useful organising principle for the next phase of trauma-informed systems change. Its value lies in challenging services to take collective responsibility for people whose needs do not fit neatly into single-service categories. For Blackburn with Darwen, this means creating a system that is easier to navigate, harder to fall through, and more capable of responding to trauma in joined-up, relational and preventative ways. Recent research that is currently being undertaken by Hargreaves & Hibbin (In Press) exploring the use of Domestic Abuse Risk Assessments in multiagency data sharing between police, health and third sector services through Lancashire's Shared Care Record to support victim-survivors of domestic violence and abuse, is one potential way that data integration can be harnessed to create a systemically resilient approach. It is suggested that further efforts to utilise existing data integration frameworks and services to create an efficient and cost effective approach to data sharing, should be explored wherever possible.

Overall Conclusion

The implementation of TIP within Blackburn with Darwen's (BwD) Systems Resilience Framework (SRF) represents a bold and progressive effort to embed trauma-informed principles across complex, multi-agency systems. This evaluation of BwD's SRF roll-out of TIP has demonstrated that significant progress has been made in embedding TIP in both policy and practice across the whole Borough. The findings indicate that both top-down (Service Lead Strand) and bottom-up (Community Champion Strand) approaches have contributed to systemic change, with the potential for long-term cultural transformation. The evaluation has also highlighted not only the practical outcomes of the SRF roll-out, but also how these efforts are underpinned by key theoretical frameworks, continuing the strongly evidence-based approach that was originally taken through the BwD ACEs survey (Bellis et al, 2014) over ten years previous. At the heart of the BwDs Framework is the conceptualisation of the impact of Adverse Childhood

Experiences (Felitti et al., 1998) and wider structural Adverse Community Environments (Ellis & Dietz, 2017) on individual health outcomes over time. This ecological model positions trauma not just as a personal pathology but as a structural and environmental condition, often rooted in poverty, discrimination, and systemic disadvantage. The SRF roll-out reflects this perspective by focusing on relational and systemic responses rather than individual-level screening, aligning with recommendations from the Early Intervention Foundation (2020) to avoid deterministic or deficit-based interpretations of ACEs.

Central to the SRF roll-out has been a commitment to normalising trauma rather than pathologising it. This has enabled the development of psychologically safer, more empathetic services, and opened the door for the integration of strength-based approaches such as Post-Traumatic Growth (Tedeschi & Calhoun, 1996; 2018). By shifting the focus from trauma as damage, to trauma as a potential catalyst for personal and collective resilience, the SRF begins to redress the imbalance in trauma discourse, which has traditionally centred on harm. This rebalancing also aligns with theoretical insights from positive psychology (Joseph & Linley, 2004) and constructivist models of identity (McAdams, 2001), which frame trauma recovery not only as a process of coping, but of meaning-making and re-authoring one's narrative. The TICWs, in particular, illustrated how community conversations rooted in lived experience can become a vehicle for collective understanding, emotional insight, and empowerment - moving trauma from silence to shared language. However, cultural considerations also need to be taken into account when these community conversations take place, to ensure that the stigma and silence that can be prevalent for many community members from minoritised backgrounds is managed in a culturally sensitive manner that does not compound the difficulties in disclosing traumatic experiences that some may face (Prajapati and Liebling, 2022; Howe and Sanger, 2022; Ethnic Health Forum, 2021).

The implementation of innovative approaches to supporting the workforce includes the use of reflective supervision across various services, reflecting key findings from the literature on relational safety (Virmani & Ontai, 2010; Barron et al., 2022) and emotional containment in trauma-exposed workforces (Tomlin et al., 2014). While gaps in provision remain, the recognition that supervision must support the wellbeing of practitioners, not just their performance, is a notable cultural shift. However, it is suggested that building relational safety for practitioners and service users should also include elements of other approaches that fall under the broad banner or Relational Practice (Lamph et al, 2023) to include the use of Restorative Practice (Green et al., 2013; Hibbin, 2024) as a complementary framework to TIP, to allow for relational repair and greater levels of accountability when harms have occurred. This aligns with the Social Discipline Window (Watchel, 2013), which emphasises working *with* individuals - neither to nor for them - as the most balanced and empowering mode of practice.

The emphasis on whole-system cultural change, rather than isolated interventions, has enabled progress toward a sustainable, relational model of public service. However, challenges remain, particularly in sustaining TIP through policy integration, leadership buy-in and overcoming sectoral barriers where TIP is less well-established arising from

a variety of constraints often connected with capacity, such as those experienced within Primary Care. Findings reiterate the persistence of structural and institutional barriers, including siloed services, time and capacity limitations, and the pressure of external directives that often prioritise performance metrics over relational approaches. While the Integrated Training that has been implemented across the Borough is making significant strides in reducing much of this sioled working across services and sectors, barriers still remain. These challenges echo wider critiques of the public sector's tendency toward 'projectitis' (Warin & Hibbin, 2020), where short-term funding cycles and shifting priorities inhibit long-term cultural change. To mitigate these challenges, it is recommended that TIP is not only embedded into policy and practice but into the very governance structures of public service - ensuring trauma-informed values are protected from being sidelined in the face of competing agendas. The development of a Trauma-Informed Code of Practice, the establishment of a No Wrong Door model (Centre for Mental Health and NHS Confederation, 2022; Children's Commissioner for Wales, 2022), and the formalisation of the Champions framework are critical next steps in this process.

Ultimately, the Blackburn with Darwen's Systems Resilience Framework is more than a programme of training or policy change - it is a cultural endeavour. Drawing from theory, evidence and lived experience alike, it seeks to rehumanise public service through empathy, relationality, and structural awareness. While the journey to full trauma-informed transformation remains ongoing, the foundations that have been laid are both theoretically robust and practically promising in realising the ambitious aim of becoming a fully trauma-informed Borough.

Recommendations

To ensure the long-term sustainability of TIP in BwD, several key actions are recommended. These will be split across the two strands – CCS and SLS – to provide a roadmap to embedding TIP from the bottom-up and the top-down, over the long term.

Community Champion Strand

1. **Co-produce content with the Community**
   Recommendation: Continue to develop the TICW collaboratively with local volunteers and TSOs, and make co-production a core element of service design with the community more generally
   Rationale: Co-production fosters ownership, relevance, and buy-in, especially when volunteers have prior exposure to trauma-informed principles (e.g., through CJs).

2. **Maintain an informal, conversational approach to the TICW**
   Recommendation: Deliver TICWs using informal, discussion-based formats rather than rigid, didactic styles.
   Rationale: Informal settings encouraged deeper engagement, real-time adaptability ("reading the room"), and "penny-drop" moments of personal insight into trauma.

3. **Prioritise psychological safety and clear boundaries**
   Recommendation: Train CCs to maintain safe, non-triggering spaces by:
   - Managing group dynamics
   - Avoiding therapeutic advice
   - Clearly signposting support services

   Rationale: Avoiding re-traumatisation and ensuring volunteer and participant wellbeing is essential, particularly when discussing sensitive topics like suicide or abuse.

4. Normalise and contextualise trauma
   Recommendation: Frame trauma as a shared human experience with diverse expressions, from systemic injustice to interpersonal harm. More work is needed to reduce stigma, especially around men's mental health, intergenerational conflicts and cultural considerations of trauma.
   Rationale: Promotes empathy and reduces stigma, especially in communities where trauma and mental health remain taboo. A focus on the trauma as a normal part of life within the context of strength-based conversations and the concept of post traumatic growth should be included in community discussions of trauma and ACEs.

5. **Leverage real-life examples to enhance engagement**
   Recommendation: Encourage the use of personal narratives and case studies in workshops to normalize discussions on trauma. Develop more multimedia resources, such as videos/animations.
   Rationale: Relatable examples with emotional resonance is more engaging and memorable, making TIP concepts more accessible allowing community members to connect on an emotional basis with the core messages of TIP.

6. **Reflect socio-cultural and linguistic realities**
   Recommendation: Adapt delivery to cultural, intergenerational, gender-based and language needs. Use bilingual facilitators where needed. Discuss culturally relevant topics (e.g., emotional suppression in men, marriage pressures) and consider the development of community-based initiatives that address findings from this evaluation and other place-based research, with regards such things as alternative ways of engaging beyond talking groups for men, and more generally the lack of community spaces to support wellbeing.
   Rationale: Cultural relevance increases accessibility, trust, and retention of TIP messages. The application of feedback from service users into clearly defined 'You Said - We Did' approaches to transform the socio-cultural environment, increases wellbeing and builds trust between the local community and the Local Authority.

7. Integrate CCs with local Services and enhance Community signposting
   Recommendation: Create structured pathways between CCs and Local Services (e.g., mental health, housing, domestic abuse support) to improve signposting and referrals. Organize joint training sessions or site visits to familiarize volunteers with available community resources.

Strengthen pathways to professional support services for individuals seeking further assistance within the delivery of the TIWC.
Rationale: CCs felt limited by only being able to hand out leaflets—greater service integration would enhance their effectiveness and ensure safer referrals.

8. Invest in long-term, sustainable funding
Recommendation: Secure dedicated, long-term resources to support TIP initiatives and volunteer engagement.
Rationale: Volunteer drop-off and project discontinuity were directly linked to personal pressures and funding gaps.

9. Use accessible, impactful tools
Recommendation: Include accessible media like the ACEs animation to prompt reflection and understanding.
Rationale: These tools created emotional resonance and facilitated deeper discussions around trauma.

10. Build on existing Community engagement structures
Recommendation: Use platforms like CJs to recruit and orient future CCs in delivering TICWs and other trauma-informed initiatives over time. Establish structured training pathways that integrate TIP principles early in community engagement programs.
Rationale: Volunteers with previous involvement were more committed and better understood TIP concepts.

11. Sustain and expand training and supervision
Recommendation: Ensure CCs have opportunities for peer feedback in a supportive relational format. Try to embed reflective supervision where possible for CCs who may be exposed to vicarious trauma during delivery of the TICW.
Rationale: To support CC's confidence in delivering the TICW through honest relationship-based mentorship, as well as handling complex discussions with community members that are supportive and strength-based. In addition, an acknowledgement of CCs becoming live to their own trauma through the course of workshop development/delivery is an important requirement of supervisory support.

Service Lead Strand

1. **Further refine BwD's definition of trauma and TIP**
Recommendation: BwD should consider formulating its own place definition of both trauma and TIP that includes the elements described above, as well as consulting widely across services and sectors to ensure that the definition is fit for purpose for the specific context of BwD, ensuring adaptability to different services/sectors.
Rationale: Having a place-based definition will ensure that TIP is fit for purpose within BwD's unique socio-cultural context.

2. **Incorporate BwD's definition of trauma and TIP into training, policy and practice**
   Recommendation: Ongoing learning should incorporate a new bespoke and place-based definition into training and embed it further within policy and practice across services and sectors.
   Rationale: Linking the definition to training, policy and practice will ensure that all members of the workforce become familiar with the culture of TIP in BwD over time.

3. **Support the adaptation of the definition to different settings**
   Recommendation: Supporting the workforce to adapt BwD's definition of TIP to individual contexts, to produce a refined understanding of what TIP looks like from the perspective of Education, Social Care, Public Health, the CJS and the 3rd Sector, as well as the individual services within each of those sectors.
   Rationale: Having an adaptable definition across a wide range of services and sectors will support a whole system approach to TIP.

4. **Integrate TIP as a core practice rather than an add-on**
   Recommendation TIP should be embedded within all service areas as part of standard practice rather than being seen as an optional or additional responsibility. Develop sector-specific strategies to integrate TIP into daily workloads rather than as an "extra" task.
   Rationale: Providing dedicated time for TIP and integrating it into all policies will ensure that it is not relegated to an optional add-on rather than a core and non-negotiable practice.

5. **Increase policy alignment and leadership engagement**
   Recommendation: Ensure that all policies including those related to safeguarding, HR, workforce wellbeing, and service delivery have trauma-informed policies that are aligned with the wider ethos of BwD's approach to TIP. In addition, Senior Leadership should actively champion TIP, ensuring policies reflect trauma-informed principles and are integrated across all levels of service delivery.
   Rationale: Without full policy integration and also buy-in/support from Senior leadership, TIP will not travel the distance from beacons of good practice to systemic cultural change across services over time. TIP needs to be written into all policies to support a fully trauma-informed approach across the whole system.

6. **Standardize and sustain TIP training across Services**
   Recommendation: Ensure all staff, regardless of experience level, receive consistent opportunities for training, addressing gaps between newly qualified and existing practitioners. Ensure that e-learning packages are not used in isolation and are located primarily within induction materials rather than used as a core part of training, to ensure that a contextualised and deep approach to learning and CPD is through the Integrated Training is prioritised.
   Rationale: Pursuing a 'cradle to grave' approach to training will ensure that all staff members are exposed to the ethos of TIP from the moment they join a service within any of the sectors across BwD.

7. **Establish new iterations of TIP training across Services**
   Recommendation: Consider creating training that supports staff to challenge internal and external pressures that hinder the adoption of TIP, as well as training

that supports the design and implementation of trauma-informed policies within individual services. Develop continuous learning opportunities beyond initial training sessions, including advanced practitioner training and leadership programs.
Rationale: Training targeted at developing trauma-informed system, policies and leaders as well as training staff to challenge non-trauma-informed practice when they see it, in other services and sectors, will challenge localised poor practice and provide opportunities for staff members to become expert practitioners through ongoing CPD.

8. **Ensure sustainable funding and resource allocation**
   Recommendation: Secure dedicated fundings for TIP and consider monetising the exiting good practice that exists in TIP within BwD.
   Rationale: TIP initiatives require dedicated time and resources to be successfully integrated and maintained in service structures.

9. **Equip Schools and other Services for children and young people as key sites of accountability measures**
   Recommendation: Schools and children's services should be equipped with the evidence-base to shore up their ability to defend their decisions in TIP in the face of potential resistance from accountability measures.
   Rationale: Accountability measures through Ofsted are a key point of pressure for schools and Children's Social Care services wanting to adopt a trauma-informed approach. To support schools to challenge some accountability measures, ensure they have a suite of evidence to enable them to counter claims from Inspectors where appropriate, with regards practice that may not be as attendance and attainment focused as desirable.

10. **Prioritise reflective practice/supervision as a key means of supporting the workforce**
    Recommendation: Ensure differentiated reflective supervision and peer support mechanisms are available to all staff who are exposed to secondary trauma, not just those in clinical roles. Ensure that those staff members who are consistently working with vulnerability and complex forms of trauma, have regular opportunities to engage in differentiated forms of supervision focused on practitioner wellbeing as well as case management. Provide dedicated time for reflective supervision and trauma-informed team discussions.
    Rationale: Opportunities to engage in reflective forms of supervision actively supports the workforce, preventing burnout and improving staff wellbeing.

11. **Enhance workforce wellbeing and support structures**
    Recommendation: Develop and implement HR policies that explicitly recognize the impact of secondary trauma and provide structured wellbeing support. Introduce protected time for wellbeing initiatives within job roles and performance appraisals.
    Rationale: Trauma-informed HR and wellbeing policies support staff through difficult personal circumstances as well as undertaking their roles in the context of challenging behaviour from service users, in both clinical and non-clinical roles, reducing burnout, fatigue and sickness.

12. **Strengthen governance and policy integration with commissioned Services**
    Recommendation: Standardize TIP requirements across all commissioned services to create consistency in the approach.
    Rationale: Ensuring that all commissioned services require TIP as a key and standard requirement will spread the practice of trauma-informed across all services, including newer one that are less familiar with BwD's approach as well as maintaining trauma-informed standards across the Borough as a whole.

13. **Formalize the Trauma-Informed Champions model**
    Recommendation: Provide TICs with clear role descriptions, expectations, training, and protected time within their roles to lead TIP efforts effectively, ensuring they have the authority to influence team practices. Establish TICs at both frontline and senior leadership levels to ensure systemic influence and policy change.
    Rationale: Ensuring that the TIC role is fully and meaningfully embedded across services and roles, providing TICs with a clear brief and remit to influence and champion trauma-informed policy, practice and change beyond a simple advocacy role, will further strengthen the culture of trauma-informed across the Borough.

14. **Strengthen trauma-informed accountability and develop an organisational Code of Practice**
    Recommendation: Establish accountability measures and a constitutional approach to embedding TIP within key values within an organisational code of practice for BwD to ensure that TIP is not deprioritised due to competing demands.
    Rationale: Embedding TIP within BwD's accountability measures will ensure that Senior Leaders prioritise TIP during strategic decision-making. In addition, developing a TIP Cod of Practice for the Local Authority will ensure that it is more difficult to deprioritise TIP, as well as ensuring the recruitment of new personnel are recruited on the basis of their buy-in to BwD's trauma-informed ethos and culture.

15. **Enhance data integration and cross-sector collaboration**
    Recommendation: Implement a No Wrong Door approach to ensure seamless service access. Develop a unified data-sharing system that allows real-time, secure access to service user information across sectors to strengthen inter-agency collaboration.
    Rationale: A unified data-sharing system that allows real-time, secure access to service user information across sectors to strengthen inter-agency collaboration will improve communication, reduce service duplication and actively prevent re-traumatisation for service users who have to repeatedly retell their trauma-story.

16. **Address hard to reach sectors**
    Recommendation: Develop tailored engagement strategies for resistant sectors, particularly Primary Care, Academy Trusts and Criminal Justice. Create alternative training formats, such as E-learning modules, to accommodate staffing constraints in high-demand services.
    Rationale: All services need to be on board with the Integrated approach to TIP through contextualised and cross sector training that actively prevents siloed working, to support the ambition of a fully Trauma-Informed Borough.

17. **Promote Restorative Practices alongside TIP through a broadly relational approach**
    Recommendation: Introduce Restorative Practice (RP) frameworks to balance trauma-informed care with personal accountability through a broadly Relational approach that values the reparation of harm alongside an understanding of behaviour as communication. Encourage RP as a complementary approach to TIP in settings where harm resolution is necessary.
    Rationale: Pursuing a broadly Relational approach that utilises TIP alongside other Relational practices such as Restorative Practice, will allow BwD to align itself with current academic thinking and best in relation to the use of TIP. In addition, RP alongside the use of trauma-informed will support practitioners and victims who have been harmed in the course of their work or community interactions, to avoid TIP being seen as a soft option, and to encourage the use of 'nurturing boundaries' when managing/supporting challenging and harmful behaviour.

18. **Establish a Quality Assurance Framework for TIP implementation**
    Recommendation: Develop clear, measurable benchmarks to assess the effectiveness of trauma-informed initiatives across services through routine audits, feedback mechanisms from service users, staff and community members to improve practice, and performance evaluations to ensure TIP principles are consistently applied. Align TIP quality assurance measures with existing regulatory and safeguarding standards to maintain accountability and credibility. Establish a dedicated oversight body or task force to monitor TIP implementation and provide ongoing support for service improvements.
    Rationale: A Quality Assurance Framework is vital to ensure trauma-informed practice (TIP) is consistently and effectively applied across services. Clear, measurable benchmarks and routine audits enable organisations to track progress, identify gaps, and improve practice, supporting organisations to move beyond intent to demonstrate impact through consistent evaluation of how TIP principles are being applied in real-world settings. Feedback from staff, service users, and communities ensures TIP remains responsive and inclusive. Aligning QA measures with existing regulatory and safeguarding standards promotes integration, accountability, and enhances credibility and compliance across sectors. A dedicated oversight body provides strategic direction and sustained support, helping to embed TIP across systems.

19. **Establish partnerships with Universities and other research institutions**
    Recommendation: Conduct rigorous studies on the impact of TIP across different sectors. Support research initiatives that evaluate TIP effectiveness in Public Health, Education, Social Care, the Criminal Justice System and the Voluntary Sector. Develop a shared knowledge hub to disseminate research findings, best practices, and case studies that inform policy and practice. Facilitate opportunities for academic institutions to co-develop training programs and research secondments to ensure TIP approaches are evidence-based and continuously refined. Encourage cross-sector collaboration in research to identify sector-specific challenges and innovative solutions for TIP implementation.
    Rationale: Partnering with Universities and research institutions strengthens the evidence base for trauma-informed practice (TIP) across sectors. Rigorous research helps evaluate TIP effectiveness and identify sector-specific challenges. A shared

knowledge hub enables the dissemination of best practices, case studies, and findings to inform policy and practice. Academic partnerships can also support co-designed training and research secondments, ensuring TIP approaches remain evidence-based, relevant, and innovative. Cross-sector collaboration fosters continuous learning and drives system-wide improvement.

References

ACE Hub Wales (2022) Trauma-informed Wales: A societal approach to understanding, preventing and supporting the impacts of trauma and adversity. Cardiff: ACE Hub Wales.

Ambition Community Trust (2025) Relational Inclusion: A Primary Pilot Relational, Inclusion and Guiding Principles. Available at: https://ambitioncommunitytrust.org/

Barron, C.C., Dayton, C.J. and Goletz, J.L., 2022. From the voices of supervisees: What is reflective supervision and how does it support their work? (Part I). *Infant Mental Health Journal*, *43*(2), pp.207-225.

Bellis, M.A. and Lowey, H. (2014) Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Blackburn with Darwen: Public Health/Local Authority report.

Blackburn with Darwen Borough Council (2022) Trauma Informed Systems Resilience Framework. Blackburn: Blackburn with Darwen Borough Council. Available at: https://democracy.blackburn.gov.uk/documents/s19018/Appendix%201%20for%20EB%20Trauma%20Informed%20Systems%20Resilience%20Framework_v1.pdf

Centre for Mental Health and NHS Confederation (2022) No wrong door: A vision for mental health, autism and learning disability services in 2032. London: Centre for Mental Health and NHS Confederation. Available at: https://www.centreformentalhealth.org.uk/publications/no-wrong-door/

Children's Commissioner for Wales (2022) Making Wales a No Wrong Door Nation: How are we doing? Swansea: Children's Commissioner for Wales. Available at: https://www.childcomwales.org.uk/publication/making-wales-a-no-wrong-door-nation-how-are-we-doing/

Christmas, H. and Srivastava, J. (2019) Public health approaches in policing. London: Public Health England/College of Policing.

Dweck, C.S. (2015) 'Carol Dweck revisits the "growth mindset"', Education Week, 35(5), pp. 20–24.

Early Intervention Foundation (2020) Adverse childhood experiences: What we know, what we don't know, and what should happen next. London: Early Intervention Foundation.

Ellis, W.R. and Dietz, W.H. (2017) 'A new framework for addressing adverse childhood and community experiences: The Building Community Resilience model', Academic Pediatrics, 17(7S), pp. S86–S93.

Emsley, E., Smith, J., Martin, D. and Lewis, N.V. (2022) 'Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives', BMC Health Services Research, 22, 1164.

Ethnic Health Forum (2021) Improving the mental health of South Asian populations in the UK. Available at: https://www.ethnicinclusion.org.uk/wp-

content/uploads/2021/12/Improving-Mental-Health-Of-South-Asian-Populations-in-the-UK-Report-Dec-2021-1.pdf

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S. (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences Study', American Journal of Preventive Medicine, 14(4), pp. 245–258.

Green, S., Johnstone, G. and Lambert, C., 2013. What harm, whose justice?: Excavating the restorative movement. *Contemporary Justice Review*, *16*(4), pp.445-460.

Hargreaves, H., and Hibbin, R. (In Press). The benefits and barriers to creating a shared care record for a public health approach to safeguarding victim-survivors of domestic abuse.

Harris, M. and Fallot, R.D. (2001) 'Envisioning a trauma-informed service system: A vital paradigm shift', *New Directions for Mental Health Services, 2001(89), pp. 3–22.

Healthy Living Blackburn with Darwen (n.d.) Trauma-informed communities. Available at: https://www.healthylivingbwd.org.uk/trauma-informed-communities/

Hibbin, R., 2024. Relational responsibility, social discipline and behaviour in school: re-orienting discipline and authority through a distributed network of relational accountability. *Pastoral Care in Education*, *42*(4), pp.492-512.

Hibbin, R. and Warin, J. (2021) EmBRACE evaluation report. Available: (PDF) 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

Holmes, D. and Grandison, G. (2022) Trauma-informed practice: A toolkit for Scotland. Edinburgh: Scottish Government.

Home Office (2024) Trauma-informed practice: learning from experience of Violence Reduction Unit delivery 2021 to 2023. London: Home Office.

Howe, J. and Sanger, S. (2022) 'How discourses of sharam (shame) and mental health influence the help-seeking behaviours of British born girls of South Asian heritage', Educational Psychology in Practice, 38(3), pp. 343–361.

Hughes, D.A. (2017) 'Dyadic Developmental Psychotherapy (DDP): An attachment-focused family treatment for developmental trauma', Australian and New Zealand Journal of Family Therapy, 38(4), pp. 595–605.

Hughes, D.A., Golding, K.S. and Hudson, J. (2019) Healing Relational Trauma with Attachment-Focused Interventions: Dyadic Developmental Psychotherapy with Children and Families. New York: W.W. Norton.

Irby, D.J., 2014. Trouble at school: Understanding school discipline systems as nets of social control. *Equity & Excellence in Education*, *47*(4), pp.513-530.

Joseph, S. and Linley, P.A. (2004) 'Positive change following trauma and adversity: A review', *Journal of Traumatic Stress, 17(1), pp. 11–21.

Lamph, G., Nowland, R., Boland, P., Pearson, J., Connell, C., Jones, V., Wildbore, E., Christian, D.L., Harris, C., Ramsden, J. and Gardner, K. (2023) 'Relational practice in health, education, criminal justice, and social care: A scoping review', Systematic Reviews, 12, 194.

Lancashire County Council (2022) Indices of Deprivation 2019: Lancashire and Blackburn with Darwen. Preston: Lancashire County Council.

Lancashire Violence Reduction Network (2020) Trauma-informed organisational development framework. Preston: Lancashire Violence Reduction Network.

Local Government Association (2018) No Wrong Door: Services for young adolescents in care in North Yorkshire. London: Local Government Association.

London Violence Reduction Unit (2025) The case for a trauma-informed London

Marmot, M., 2020. Health equity in England: the Marmot review 10 years on. *Bmj*, *368*. Available: Health equity in England

McAdams, D.P. (2001) 'The psychology of life stories', Review of General Psychology, 5(2), pp. 100–122.

McGeown, H., Potter, L., Stone, T., Cresswell, K., Mountain, G. and Mason, O. (2023) 'Trauma-informed co-production: Collaborating and combining expertise to improve access to primary care with women with complex trauma', Health Expectations, 26(5), pp. 1895–1907.

North Yorkshire Safeguarding Children Partnership (n.d.) No Wrong Door – RAISE approach. Available at: https://safeguardingchildren.co.uk/professionals/procedures-practice-guidance-and-one-minute-guides/no-wrong-door-raise-approach/

Office for Health Improvement and Disparities (2022) Working definition of trauma-informed practice. London: Department of Health and Social Care.

Office for National Statistics (2021) Census 2021: Ethnic group, England and Wales. Newport: Office for National Statistics.

O'Reilly, M., Kiyimba, N., Karim, K. and Stafford, V. (2016) 'Managing distress in child and adolescent mental health services: A qualitative study of clinicians' perspectives', Child and Adolescent Mental Health, 21(4), pp. 207–213.

Parry, S., Cox, N., Andriopoulou, P., Oldfield, J., Roscoe, S., Palumbo-Haswell, J. and Collins, S., 2023. Mechanisms to enhance resilience and post-traumatic growth in residential care: A narrative review. *Adversity and Resilience Science*, *4*(1), pp.1-21.

Parsons, C., 2005. School Exclusion: The Will to Punish 1. *British Journal of Educational Studies*, *53*(2), pp.187-211.

Polihronis, C., Cloutier, P., Kaur, J., Skinner, R., & Cappelli, M. (2022). What's the harm in asking? A systematic review and meta-analysis on the risks of asking about suicide related behaviors and self-harm with quality appraisal. Archives of Suicide Research, 26(2), 325–347. doi: 10.1080/1381118.2020.1793857

Popay, J., Simpson, G., Ring, A., Porroche-Escudero, A., Barr, B., Mosedale, S., Sadler, G. and Wheeler, P., 2018. Improving health and reducing health inequalities through a systems resilience approach. *Morecambe Bay Medical Journal*, *7*(12), pp.292-294.

Prajapati, R. and Liebling, H. (2022) 'Accessing mental health services: A systematic review and meta-ethnography of barriers and facilitators for South Asian service users in the UK', Journal of Racial and Ethnic Health Disparities, 9, pp. 598–619.

Restorative Justice Council (2023) Restorative practice guidance. London: Restorative Justice Council.

SAMHSA (2014) SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Seligman, M.E.P. (2000) 'Positive psychology, positive prevention, and positive therapy', in Snyder, C.R. and Lopez, S.J. (eds.) Handbook of Positive Psychology. Oxford: Oxford University Press, pp. 3–12.

Sinarski, J. (2023) Riley the Brave's Big Feelings Activity Book: A Trauma-Informed Guide for Counsellors, Educators, and Parents. London: Jessica Kingsley Publishers.

Social Care Institute for Excellence (n.d.) North Yorkshire No Wrong Door. London: Social Care Institute for Excellence.

Spring North (2024) CYP Trauma Informed Blackburn with Darwen Strategic Network. Available at: https://springnorth.org.uk/cyp-trauma-informed-blackburn-with-darwen-strategic-network/

Susman-Stillman, A., Lim, S., Meuwissen, A. and Watson, C., 2020. Reflective supervision/consultation and early childhood professionals' wellbeing: A qualitative analysis of supervisors' perspectives. *Early Education and Development*, *31*(7), pp.1151-1168.

Tedeschi, R.G. and Calhoun, L.G. (1996) 'The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma', Journal of Traumatic Stress, 9(3), pp. 455–471.

Tedeschi, R.G., Shakespeare-Finch, J., Taku, K. and Moore, B.A., 2025. *Posttraumatic growth: Theory, research, and applications*. Routledge.

Tomlin, A.M., Weatherston, D.J. and Pavkov, T., 2014. Critical components of reflective supervision: Responses from expert supervisors in the field. *Infant mental health journal*, *35*(1), pp.70-80.

Violanti, J.M., Fekedulegn, D., Andrew, M.E., Hartley, T.A., Charles, L.E., Miller, D.B. and Burchfiel, C.M. (2021) 'Adverse childhood experiences and police mental health', Policing: An International Journal, 44(2), pp. 360–373.

Virmani, A.E., and Ontai, L.L., 2010. Supervision and training in child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, *31*(1), pp.16-32.

Watchel, T. (2013) Defining restorative. Bethlehem, PA: International Institute for Restorative Practices.

Warin, J., and Hibbin, R., 2020. Embedding restorative practice in schools. *Technical Report*. Available: Embedding_Restorative_Practice_in_Schools._Jo_Warin___Rebecca_Hibbin__2020-libre.pdf

WEATHERSTON, D., WEIGAND, R.F. and WEIGAND, B., 2009. Reflective Supervision. *Australian Association for Infant Mental Health*.

Williams, B.M. and Daly-Lynn, J., 2025. A qualitative exploration of the therapeutic characteristics of the art of therapy: Perspectives on Ayres Sensory Integration. *PLoS One*, *20*(5), p.e0322433.

Youansamouth, L., Irwin, S., Srivastava, J., and Clarke, S. (2020) Trauma-informed organisational development framework. Preston: Lancashire Violence Reduction Network.

Youth Endowment Fund (2025) Trauma-informed training and service redesign. Available at: https://youthendowmentfund.org.uk/toolkit/trauma-informed-training-and-service-redesign/