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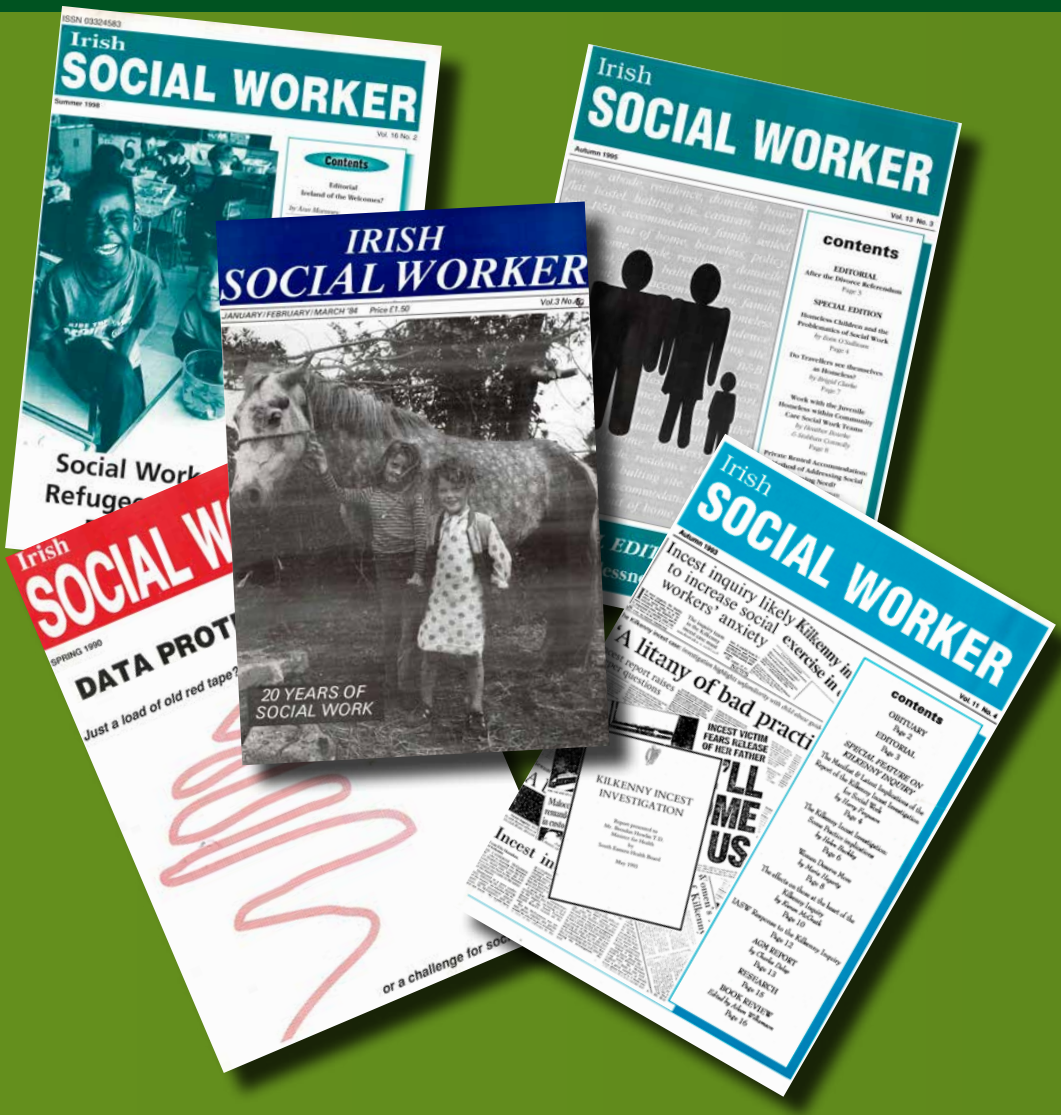

MAKING SENSE OF THE PRACTICE OF TRAUMA-INFORMED CARE: A RESPONSE TO THE NEED TO IMPLEMENT TRAUMA-INFORMED CARE INTO FRONT-LINE PRACTICE.

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About the Author

Dr Maria Lotty is a Senior Programme Coordinator and Lecturer in the Centre for Adult Continuing Education, University College Cork. She has over 20 years of professional social work experience that reflects a comprehensive experience of working with children and families in assessment, therapeutic and project management roles. She is the author of the *Fostering Connections: The Trauma-informed Foster Care Programme* which she systematically developed through her doctorate study. She is also the creator of the *Continuing Professional Development Certificate in Trauma-informed Care: Theory and Practice* in University College Cork. Her interests are in biopsychosocial interventions for children and their families within child welfare, protection and foster care settings and continuous professional development for practitioners.

Abstract

Trauma-informed Care is an approach that is gaining momentum in front line social work practice and allied professions that work directly with children, young people, adults, and their families who have experienced trauma. However, to date, clear ways to integrate Trauma-informed Care into practice specific to the Irish context are lacking. In this article, firstly, the author describes the development of Trauma-informed Care as an approach to ameliorate trauma exposure. Then, the barriers that impede the progression of integrating this approach into front-line practice are discussed. As a response, a university-based Continuing Professional Development programme has been developed. The theoretical framework that underpins the programme is presented that draws from the author's doctoral research and extensive practice experience. The paper concludes that front-line practitioners play an integral role in wider service and systems-level Trauma-informed Care implementation.

Keywords: Front-line Practice; Trauma-informed Care; Continuing Professional Development; Implementation.

Introduction

Trauma-informed Care (TIC) is an approach that seeks to ameliorate the impact of trauma (Elliott, Bjelajac, Fallot, Markoff & Reed, 2005). It is an approach that has been influenced by a growing awareness of the implications of childhood trauma for the whole lifespan and the need to respond in effective ways (Berliner & Kolko, 2016). This awareness has been strengthened by a number of developments, notably the increased understanding of traumatic stress through research on the neurobiology of stress (Porges, 2011) and the impact of trauma on brain development (Riem et al., 2015). The Adverse Childhood Experiences Study (ACE) (Felitti et al., 1998) found strong associations between the impact of childhood trauma and long-lasting consequences for health from an epidemiological related perspective (Kelly-Irving & Delpierre, 2019). TIC development was driven by the concerns of practice leaders in the light of increased awareness and knowledge of trauma impact. The approach is underpinned by a biopsychosocial model, integrating research from fields of neurobiology, attachment, trauma, and resilience (Bath & Seita, 2018).

Initially, TIC focused on the identification and development of trauma-specific evidence-based treatment (EBT) (Black, Woodworth, Tremblay & Carpenter, 2012). However, attention shifted to the implementation of TIC in front line practice setting such as child welfare. A distinction must be made between TIC front-line practice and more intensive trauma-specific treatment that require rigorous clinical training, and supervision to be implemented with fidelity (Mersky, Topitzes & Britz et al., 2019). Practitioners and researchers were concerned that most children, young people and their families who come into contact with child welfare services often have chronic and complex trauma histories but do not receive mental health treatment (Strand & Sprang, 2018). Despite developments in the field, it became apparent that there was also a need to embed TIC at a wider systems and service level to support clinicians and front-line practitioners. There was growing recognition that agency culture could undermine TIC practices and as a result, the effectiveness of interventions may be compromised, leading to negative outcomes and retraumatisation. (Quiros & Berger, 2015) fuelling the field of organisational TIC led by Sandra Bloom (2010). Here the emphasis was on embedding the guiding principles of trauma-informed at an organisational level involving policies and culture.

In Ireland, the need for services across sectors that work with those who have experienced trauma including services for homeless people (Lambert, Gill-Emerson, Horan & Naughton, 2017), criminal justice settings (Mulcahy, 2019), child protection and welfare services (Lotty, 2019) and the early years sector (Lotty, 2020) have highlighted the need for the implementation of TIC. The recent national mental health policy published in 2020, *Sharing the Vision: A mental health Policy for Everyone* has set out TIC as a core principle of mental health service delivery firmly anchoring TIC on the national vision for mental health provision in Ireland. The Prevention and Early Intervention Network (2019) policy paper recommended a strategy to develop a trauma-informed workforce for all working with children and families, through the provision of preservice professional training and continuing professional development.

Further to calls for the implementation of TIC, it is gaining momentum in front line practice in social work and allied professions across spheres of health, child welfare, juvenile and criminal justice, mental health, and education (early years, primary and secondary), youth and community work, outside formal clinical settings, that work directly with children, young people, adults, and their families who have experienced trauma (Lotty, 2019). However, to date, clear ways to integrate Trauma-informed Care into practice specific to the Irish context are lacking. In this paper, the barriers to progressing the integration of TIC into front-line practice are discussed. Then, a theoretical framework is presented that is being implemented through a Continuing Professional Development (CPD) Certificate Programme in University College Cork which was developed as a response to support the practice of TIC in front-line roles.

Barriers to practising Trauma-informed Care

Defining Trauma and Trauma-informed Care

SAMHSA (2014) offer a wide definition in defining trauma as involving an event, series of events, or a set of circumstances that is experienced by an individual as physically harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and

spiritual wellbeing. Trauma usually involves a deeply distressed or disrupting experience that results in intense physical and emotional responses. It can involve traumatic experiences such as maltreatment, unplanned removal from home, a serious car accident or a natural disaster (Rayburn, McWey, & Cui, 2016). However, trauma has been described as an elusive concept difficult to define (Mersky, Topitzes & Britz, 2019). There has been discourse about whether trauma is an event or the consequence of an event (Mersky et al., 2019). Further to this, one may ask is trauma also the ongoing experiences associated with an event(s) and its ongoing implications across health, emotional and behavioural domains, and social relationships? There is also discourse about the distinction to make between adversity and trauma. Bath (2017) points out the risk of the conflation of different types of adversity and the misapplication of theory and research findings in practice. The lack of clarity suggests the need for a deeper understanding of the individual experiences of trauma and adversity, differential susceptibility (Woolgar, 2013) and resilience to the impact of these experiences (Bell, Romano & Fylnn, 2015). It may the case that some adverse childhood experiences (ACEs) may not have been experienced as traumatic. An ACE (score) in itself gives us no context. Furthermore, the impact of ACEs can be buffered by positive childhood experiences (PCEs) such as safe, stable, nurturing relationships (Bethell, Jones, Gombojav, Linkenbach & Sege, 2019). Lacey and Minnis (2019) highlighted the need for a more critical view of ACE conceptualization calling for an urgent review of the application to practice settings. Anda et al., 2020, also contributing to this discourse, a significant contribution given Dr Anda, was one of the leading investigators in the original ACE study (Felitti et al., 1998) describing the ACE score as a 'crude measure of cumulative childhood stress exposure that can vary widely from person to person' (Anda et al., 2020, p293). Mersky et al., (2019) point out that despite the nearly universal recognition of the significance of trauma experience, it remains there are discrepancies in how it is conceptualised and applied citing TIC as a prime example of this.

To date, there is no unified definition of Trauma-informed Care. The National Childhood Traumatic Stress Network (NCTSN), in the USA, in applying the concepts of TIC to Trauma-informed child welfare systems (TICWS) that led to a definition of a TICWS. TICWS is identified as a system

> In which all parties involved recognise and respond to the varying impact of traumatic stress on children, caregivers and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery (Chadwick Trauma-Informed Systems Project, 2012, p. 11).

The definition is wide, incorporating trauma experience on providers and survivors recognising that all of these groups are affected by trauma. It includes exposure to primary traumatic experiences and also the exposure to secondary trauma by those caring for or working with children and families that have experienced trauma. The definition goes beyond the development of knowledge and awareness of trauma impact but emphasises the need for the system to apply that knowledge in daily practices, in the culture of the organisation and

in interagency partnerships.

There is some agreement that TIC is underpinned by a set of practice principles: safety, choice, trustworthiness, collaboration, and empowerment (Elliott et al., 2005; SAMHSA, 2014). These humanistic principles reflect the core elements of professional therapeutic practice (Becker-Blease, 2017) and are strongly aligned to the values of social work practice (Knight, 2015). These principles are consistently interwoven and applied throughout the phases of social work services (Levenson, 2017) where the provider and survivor experiences physical and emotional safety (Safety), are provided clear and appropriate messages about their rights and responsibilities (Choice), experience respectful and professional boundaries (Trustworthiness), are afforded a significant role in planning and evaluating services (Collaboration), and are provided with an atmosphere that allows them to feel validated and affirmed with every contact with the agency (Empowerment) (Institute on Trauma and Trauma-Informed Care, 2015). TIC is seen as a paradigm shift away from a traditionally deficit orientated understanding of trauma, that individualises the person's difficulties and minimises the wider contextual influences on a more compassionate and contextualised standpoint (Knight, 2015). TIC is concerned with issues of social justice, power relationships and human rights (Tseris, 2018) placing the response to trauma within a strengths-based framework that considers the person's broader ecological context (DeCandia & Guarino, 2015). This is often captured in the literature as a shift away from the question 'what is wrong with you?' towards the more empathetic question 'what has happened to you? (American Academy of Paediatrics, 2014).

Continuing Professional Development Training in Trauma-informed Care

Current gaps in social work knowledge and expertise in trauma-informed care practices have been highlighted in the national child welfare agency and mental health service provider (Lotty, 2019; Shannon & Gibbon, 2012). This is not unique to the Irish experience with the need for social worker training identified in other jurisdictions (Austin & Isokuortti, 2016; Ottaway & Selwyn, 2016) . There has been a surge of interest in 'trauma-informed practice' in recent years as a practice approach in Ireland. This is apparent in the language of trauma emerging in child protection offices across the country and is becoming part of 'practice speak' (Lotty, 2021). However, it remains concerning that there is no national systematic strategy to train social workers within the child welfare or mental health sectors.

Internationally, practitioner targeted TIC information is currently being disseminated, often through resource-heavy training programmes, have been criticised (Becker-Blease, 2017). There is a lack of regulation in such trauma-informed training and education initiatives reflected in the dearth of research on their content and quality (Birnbaum, 2019). Further to this, there is a lack of research on the impact of such training (DePrince, 2011). Despite the numerous TIC training, challenges remain in the operationalising TIC skills and strategies of practitioners (Donisch, Bray & Gewirtz, 2016).

Collaborative Practice

Collaboration is identified as a core principle to the implementation of TIC. In Ireland shortfalls in collaborative practices within agencies and

between agencies have been highlighted that have responsibility for working with children, young people, adults, and their families that have experienced trauma (Lotty, Bantry-White & Dunn-Galvin, 2021). Drawing from Bedwell et al.'s (2012) definition of collaboration for present purposes, collaborative working relationships may be characterised by being an evolving, reciprocal process with active participation in striving for a shared goal. Thus, in the context of building collaborative practice, this involves an evolving process where the collaborative relationships are underpinned by the values of mutual respect, trustworthiness, active participation, and validation. The communication process is effective in enabling information to be shared, each party's contributions are valued and incorporated into the decision-making processes around the individual. These collaborative relationships are underpinned by a shared common goal of building embodied, relational safety and safely coping towards recovery and growth.

For example, children in foster care receive support across a number of agencies. Whilst psychological intervention is provided by primary care community psychological services and children with mental health difficulties are generally referred to specialist services run by the Child and Adolescent Mental Health Services (CAMHS) (Tusla, 2014). The responsibility for meeting the complex needs of these children falls between the services of Tusla and CAMHS. However, the National Review Panel (2019) highlights that the burden of responsibility falls disproportionately on Tusla and that Tusla has no control over decisions made by health, mental health, or disability services. The Independent Child Death Review Group (Shannon & Gibbons, 2012) identified specific failures in the Irish mental health services. These include weaknesses in sharing information between agencies, children's mental health needs not being identified, delay or failure in assessment and lack of service coordination. It highlighted the need for interagency collaboration. The Office of the Ombudsman (2020) recently highlighted a lack of collaborative practice between Tusla and the HSE Disability Services. Lotty (2021) has also highlighted the need for more collaborative practices within the child welfare and protection and foster care contexts that reflect a Trauma-informed Care approach to support a unified therapeutic endeavour to maximise benefits for children in foster care and their families. She recommended that the development of practice guidance that reflects a Trauma-informed Care approach explicitly stating the importance of collaborative practices between practitioners and foster carers. In recognition of the policy and practice gaps, Tusla has stated it aims to develop a practice handbook on permanency planning as part of Tulsa's Business Plan (Tusla, 2018), however, this has not been operationalised to date.

Responding to the need

Given the barriers to practising Trauma-informed Care discussed above, there is a need for a TIC practitioner programme to support the implementation of TIC in front-line practice.

In response to this need, the Continuous Professional Development Certificate Programme in Trauma-informed Care: Theory and practice was developed. The programme was developed by the Center for Adult Continuing Education in University College Cork drawing from the author's recent PhD study and extensive professional social work practice experience (Lotty, 2019). The programme aims to support the implementation of TIC in practice with the benefit of the rigour of university standards of internal departmental review and external examiner review.

In order to provide clarity of the definition of Trauma-informed Care the programme uses the working definition of the practice of Trauma-informed Care as follows:

> The practice of Trauma-informed Care is a holistic therapeutic practice approach that reflects a mindset and skillset that promotes empowerment and growth for both the service user and practitioner.

The programme is underpinned theoretical framework that reflects a biopsychosocial (Gask, 2018), consilience (Seigel, 2015), socio ecological (DeCandia & Guarino, 2015) perspective and the principles of best practice in therapeutic intervention (Figure 1). The understanding of trauma reflects the person's own subjective experience of their lived experience. This may involve the experience of traumatic event(s), and its ongoing implications for the individual experience across multisystemic, relational and cultural contexts. Further to this, the practice of Trauma-informed Care is identified as involving four key elements that reflect a parallel process for the service user and the practitioner:

1. **Knowing:** having specialised knowledge and understanding of the lived experience of trauma exposure on service users and self (the practitioner),
2. **Doing**: having a skillset that effectively recognises and responds to the impact of trauma exposure on service users and self (the practitioner),
3. **Not doing:** Actively avoiding practices that retraumatise and
4. **Using what works:** Using evidence-based practices for trauma.

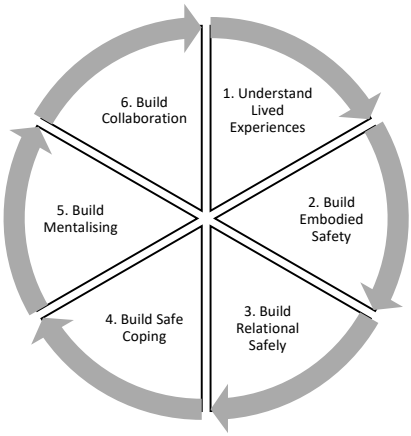

Figure 1: ***A Framework for practising TIC in frontline practice***

The framework has one overarching principle and six theoretical principles:

Overarching Principle

The practice of Trauma-informed Care is an approach that equips the practitioner to engage therapeutically with those who have lived experience of trauma. The practice involves supporting recovery and growth through the shared experience of partnership and empowerment.

Principle 1: Understand Lived Experiences

Practising Trauma-informed Care requires practitioners to develop a Trauma-informed Care mindset, a specialised knowledge that reflects an understanding and awareness of the lived experience of trauma exposure, and its ongoing implications both concerning those they work with and with themselves.

Principle 2: Build Embodied Safety

Practising Trauma-informed Care requires an

understanding of the implications of traumatising experiences on embodied experience. It requires, at its foundation skills that support building the experience of embodied safety.

Principle 3: Build Relational Safety

Practising Trauma-informed Care requires an understanding of the implications of traumatising experiences on relationships. It requires, secondly skills that support building the experience of relational safety.

Principle 4: Build Safe Coping

Practising Trauma-informed Care requires an understanding of the implications of traumatising experiences on emotions and behaviours. It requires, thirdly skills that build ways of coping safely through healthy emotional and behavioural strategies.

Principle 5: Build mentalising

Practising Trauma-informed Care requires an understanding of the implications of traumatising experiences on mentalising. It requires, fourthly skills that build healthy mentalising supporting understanding of own and others mental states.

Principle 6: Build Collaboration

Practising Trauma-informed Care requires an understanding for the need for collaborative practice to maximise opportunities that support recovery and growth. It requires, lastly skills in collaborative practice that drive a unified therapeutic endeavour that reflects a shared and consistent approach.

The programme is a level 9, National Framework of Qualifications (NFQ), Special Purpose Award that runs over 16 weeks on a part-time basis assessed through two assignments (UCC, 2021). It introduces practitioners to the practice of Trauma-informed Care as a response to the implications of traumatising experiences across the life span through a coherent accessible framework discussed above. The programme focuses on both developing practitioners' knowledge of the approach's principles and theoretical underpinnings as well as the application of the approach in their role. It examines the theoretical base of Trauma-informed Care in an accessible and applicable way with attention to the stress response system, attachment trauma and resiliency theories. The programme also introduces practitioners to the applications of the approach and explores practitioners' critical thinking on the current debates about the implementation of Trauma-informed Care.

Ongoing calls are evident for Trauma-informed Care integration in service provision across sectors that have key practice roles to support children, young people, adults, and their families who have experienced trauma. The need for a shared definition, theoretical framework and implementation are evident. This framework supports the implementation of TIC by providing a shared language and consistent approach that aims to support practitioners to provide a unified therapeutic intervention to promote recovery, resilience, and healing. It also must be borne in mind that Trauma-informed Care requires specialised knowledge and skills, it is an intentional therapeutic approach, described here as involving a TIC mindset and skillset. The risk being that intervention may inadvertently retraumatise or the opportunity for connection is missed or the understanding of how to create moments of connection safely remains absent.

Whilst the overall goal is the wider implementation of TIC across service systems and agencies, developing the practice of TIC by font-line practitioners is an essential component,

of this. Thus, the practice of TIC by the front-line practitioner is central to the implementation at all levels. The practice of TIC is likely to support the wave of change within and between agencies, as practitioners become champions of TIC, a core and foundational strategy to the implementation process (Quadara, 2015). TIC practitioners also support a person's engagement in TIC evidence-based treatments. The high attrition in trauma treatment has been well recognised (Wamser-Nanney & Steinzor, 2017) and the need for stability prior to engaging in deeper clinical therapeutic work (Vanderzee et al, 2018). Thus, a person is more likely to access and engage in such services when he/she is experiencing stability in his/her life. TIC practitioners have a unique position to become the anchor for such treatment, providing foundational supports to build experiences of embodied safety, relational safety, and healthier coping strategies to support stability and such engagement.

Conclusion

In this paper, the development of Trauma-informed Care as an approach to ameliorate trauma exposure has been discussed. Barriers to integrating the approach into the realm of front-line practice have also been discussed. To support front-line practitioners to practice Trauma-informed Care in the Irish context, the CPD Certificate in Trauma-informed Care: Theory and Practice has been developed by the Centre of Adult Continuing Education, in UCC. The programme is underpinned by a theoretical framework and working definition of the practice of Trauma-informed Care which has been presented. Front-line practitioners play an integral role in wider service and systems-level Trauma-informed Care implementation and thus require support in this endeavour.

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