May 2020

A Trauma Informed Organisational Development Framework

A Self and Peer Evaluation Toolkit

LANCASHIRE
VIOLENCE REDUCTION
NETWORK

Acknowledgements

Contents

Foreword

Trauma informed practice has always been a "golden thread" of our work within the Lancashire Violence Reduction Network (VRN), supported by our commitment to adopt a public health approach when working with our partners and communities. However, I keep asking myself what does all of this actually mean and will it truly make a difference to the people of Lancashire?

Detective Chief Superintendent - Susannah Clarke

In my role as Director of the VRN, I desire to widen the understanding of the terminology used to describe trauma informed practice and improve how we can influence our work in this area. I want to develop a culture where we reflect on current practices and share what trauma informed work and resources organisations already have in place. Where required, we hope to guide our local organisations and communities to understand the process of embedding a trauma informed approach. We wish to facilitate collaborative learning, identify developmental needs and develop a common language within and across our many local agencies and groups. I hope the Lancashire VRN can assist in raising awareness about how we can promote discussion and respond to trauma more effectively across the communities in Lancashire.

I have spoken to the many colleagues from partner, third sector and community groups and they have expressed a desire to learn, develop and continuously improve their trauma informed approaches. Most leaders have told me that they understand why trauma informed and public health approaches are important to their service delivery, but they need and want more assistance on what to do and how to deliver it.

This Trauma Informed Organisational Development Framework has been written by a team of subject matter experts who understand our Lancashire systems and processes. The team were keen to assist local system leaders in assessing where their organisation stands on addressing the causes of the causes of violence and trauma. By championing prevention, we aim to intelligently use the data and evidence available to us to improve trauma informed practice across Lancashire.

I hope that you and your teams find this resource useful and helpful.

Detective Chief Superintendent Susannah Clarke

Director of Lancashire Violence Reduction Network

1) Rationale

Trauma is recognised as a profound, global, public health burden. The pervasive and harmful impact of traumatic experiences on individuals, families and communities, and the inadvertent but widespread re-traumatisation of children and adults within existing services and systems, has made it essential to rethink 'how we do business'.

Although many people who experience trauma will progress in life without any long-term negative impacts, far too many others will experience more profound difficulties and traumatic stress reactions. That said, research indicates that with appropriate support, people can overcome traumatic events. However, many individuals and families have gone – and continue to go – without appropriate support or interventions. Left unaddressed, trauma can prevent achieving good health and wellbeing.

Over the years, a tendency to focus on the presenting symptoms (e.g. violence or substance 'abuse'), at the expense of addressing underlying issues, has led to huge human and economic costs to society.

Now more than ever, there is an urgent need to tackle the impact of trauma and focus on how public systems can support people to prevent, as well as recover from traumatic events. Only by working together, across systems and with our communities, will we reduce the complex and interconnected social determinants and inequalities, which drive trauma. Consequently, this *Trauma Informed Organisational Development Framework* has been designed to cultivate collective, cross-sector learning, in order to support the ongoing development of trauma informed services.

2) About this framework

This framework has been designed by the Lancashire Violence Reduction Network as a resource to:

- Promote discussion about how we respond to trauma;
- Reflect on current practices;
- Identify what trauma informed practices and resources organisations already have in place;
- Guide organisations to understand the process of embedding a trauma informed approach;
- Carry out self and peer evaluations against specific statements;
- Facilitate collaborative learning;
- Identify developmental needs and next steps;
- Develop a common language within and across multi-agencies;
- Encourage leaders to:

  - Think about their organisation through a trauma informed lens;
  - Develop infrastructure to support cultural change;
  - Incorporate understanding of trauma in all policies and practices;
  - Develop reflective practice and critical thinking;
  - Minimise the impact of vicarious and secondary trauma; and
  - Provide effective supervision to the whole workforce.

Note 1. This framework has been written primarily for organisational development purposes (taking a 'whole systems' approach), however we encourage flexibility in its application; the framework might also be useful for the development of individuals and teams, although individual or team completion is not to be taken as representative of a whole organisation.

Note 2. The Trauma Informed Organisational Developmental Framework refers to the whole of this document, whilst the Self and Peer Evaluation Toolkit refers specifically to Section 6.

Note 3. This document forms one of a number of trauma informed resources produced by the Lancashire Violence Reduction Network. The document is not intended to be used in isolation; it is designed to complement existing trauma informed resources, training and processes that organisations are currently engaging in locally, nationally and transnationally.

Note 4. An existing understanding of trauma informed care, approaches and practices is essential to implementing this framework.

3) Background and context

What do we mean by trauma?

Decades of work have generated multiple definitions of trauma. The Lancashire VRN has adopted SAMHSA's (2014, p.7) definition, which was produced following a review of existing trauma definitions and consultation with an expert panel.

> *Trauma results 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 well-being.*

What do we mean by trauma informed care?

- Trauma informed care (see glossary for further information) originally emerged in healthcare settings, but has since been adopted by criminal justice systems, schools and other services for children, adults and families.

- A primary aim of trauma informed care is to increase an organisation's awareness of how trauma can negatively impact on children and adults, so that they can adapt practices to avoid causing further trauma.

- Trauma informed approaches have been defined as:

> *An organisational change process focused on preventing (re) traumatisation within services.*

Sweeney and Taggert (2018, p.385)

4) How to use the framework

The four phases

The framework is divided into four phases and has been designed to be highly flexible so that each organisation (programme, individual, team or department) can focus on what is most relevant depending on the service they provide.

Phase	Definition
1) Trauma aware	The organisation has a basic understanding of what trauma is, its prevalence and recognises how it can impact on people who use services and staff.
2) Trauma sensitive	The organisation has begun to: explore the trauma informed principles in daily work; build consensus; consider the implications of embedding trauma informed practice; and is preparing for change.
3)Trauma responsive	The organisation is readily responding to trauma, including support for both the people who use the service and staff, and has begun to change the culture to align with the trauma informed principles.
4)Trauma informed	A trauma informed (TI) approach is the norm, accepted and embedded in the organisation so it no longer depends on a few 'champions', 'coaches' or 'leaders'. The organisation continues to work with partners (people with lived experience, communities and multi-agencies) to strengthen and adapt its trauma informed approach. The programme or service has been rigorously evaluated and outcomes demonstrate the positive impact of changes made.

See Appendix 1 for trauma informed principles

Note 1. It is possible to begin at phase 1 and move through all 4 stages. Alternatively, some organisations may find it more appropriate (depending on their journey) to begin at a later phase.

Note 2. Different individuals, teams and departments within organisations may be at different 'phases', at different points in time, along their trauma informed journey.

How to use the framework

Self evaluation

· The statements in each phase are intended to guide evaluation of current practice.
· For each statement, decide if the statement has been **'fully developed' (FD),** is **'in development' (ID),** or is **'under development' (UD).**
· Place a tick within the appropriate column, then write down what evidence you have to support each statement.

Peer evaluation

· Once you have completed the self evaluation, you can then make contact with the VRN who will suggest a peer evaluating organisation.
· The peer evaluation should be a supportive, developmental process, where learning is shared (not a process of critique).
· The peer evaluating organisation should provide feedback under the 'Plan of action / Reflective comments' heading.

Next steps

· If you choose not to take part in a peer evaluation then you can make notes under the 'Plan of action / Reflective comments' heading yourself.
· Continue to work through each phase in order to progress along a continuum of being trauma aware > trauma sensitive > trauma responsive > trauma informed.
· Social life and organisations are continually evolving and therefore it is important to see the development of trauma informed approaches as an ongoing process (i.e. there will be new recruits, new challenges and a need to continually review policies and practices in the context of a changing landscape).

Note 1. The Peer and Self Evaluation Toolkit is not a formal evaluation or certification process.

Note 2. Further details about the peer review process will be provided on the VRN website in due course. In the meantime or alternatively, please contact the VRN (contact details provided on the back of this document).

5) What do we mean by a phased approach?

By taking a phased approach we:

- Anticipate that different organisations will be at different points along their trauma informed journey;
- Also recognise that different people within organisations, are likely to be at different points along the phased continuum;
- Encourage you to refer to the most appropriate phase depending on your (individual, team or) organisation's current practices;
- Take into account that implementing a trauma informed approach takes time; it is a gradual process of continual development (not a training package or a tick-box exercise) and requires 'buy-in' throughout the whole system.

Phase 1 →

Trauma aware

Awareness & recognition

Phase 2 →

Trauma sensitive

Sensitivity to trauma, organisational readiness, processes & infrastructure

Phase 3 →

Trauma responsive

Prioritise, create a plan & gather information

Phase 4 →

Trauma informed

Align policies & practices, evaluate, learn & adapt

Adapted from Trauma Informed Oregon (2016)
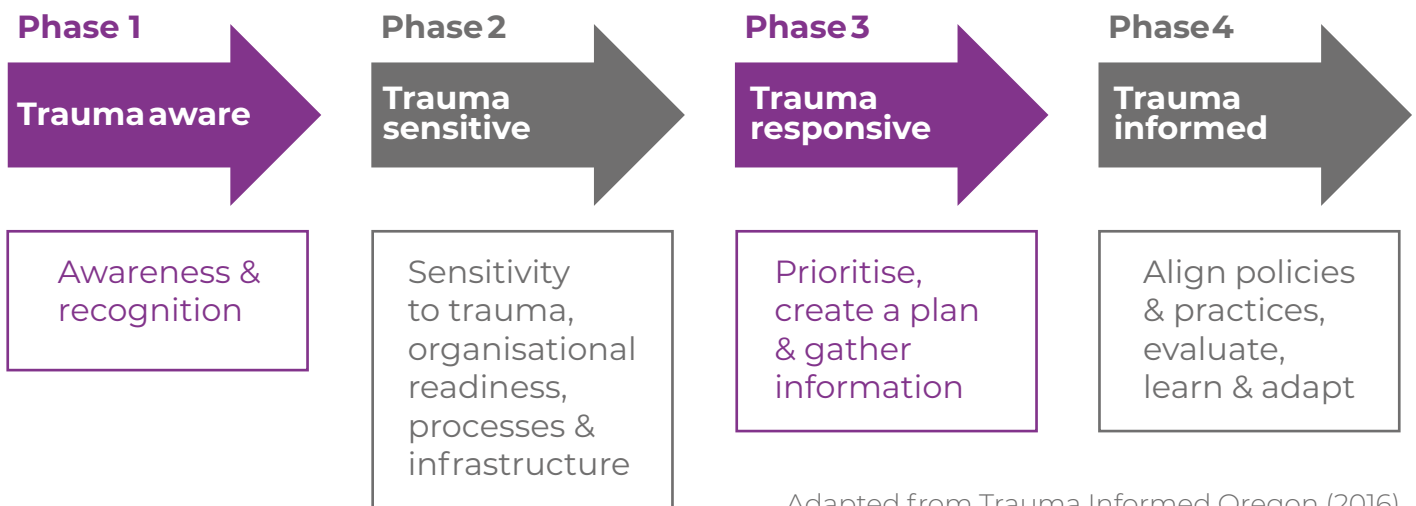
Phase 1: Trauma Aware

Trauma aware	Self evaluation			Peer evaluation	Evidence	Plan of action / reflective comments
	FD	ID	UD			
Most workers are aware of what trauma is and its prevalence						
Most workers understand the trauma science						
We are working towards putting the science into practice						
Most workers recognise the different ways in which trauma can affect people ('service users' and staff)						
We have identified a TI lead and have begun raising awareness of TI practice within the organisation						
Most workers (frontline, management and senior leadership) are committed to TI practice						
Most workers are able to recognise when people are affected by trauma						
The leadership team are beginning to explore the implications of adopting the TI principles and are preparing for change						
The organisation's TI approach works in collaboration with people with lived experience to develop and improve the service provided and share learning (applies throughout)						

Phase 2: Trauma Sensitive

Trauma sensitive	Self evaluation			Peer evaluation	Evidence	Plan of action / reflective comments
	FD	ID	UD			
Workers have attended trauma awareness training						
Workers are sensitive to trauma and its impact on people (i.e. individuals, communities, colleagues and themselves)						
Workers are committed to the principles of TI practice (see Appendix 1)						
Workers have sought out opportunities to implement trauma learning and skills						
The organisation has considered the implications of adopting the TI principles						
Most workers (frontline, management and senior leadership) are committed to TI practice						
Resources (e.g. time and staffing) have been allocated to support TI cultural change						
TI agents of change are starting to influence other staff and are able to call into question non-TI practices and policies						
Workers (frontline, management and senior leadership) value and are committed to TI practice						

Phase 3: Trauma Responsive

Trauma responsive	Self evaluation			Peer evaluation	Evidence	Plan of action / reflective comments
	FD	ID	UD			
The organisation has identified current strengths based on the TI principles						
Organisational strengths are being captured and celebrated to create a positive movement and drive further change						
The organisation is able to demonstrate a change in culture towards being TI						
People are supported to safely disclose experiences of trauma where appropriate						
People affected by trauma are signposted / referred to the appropriate services to enable safe disclosure and ensure their needs are met						
People affected by trauma have their immediate needs for safety identified at the earliest possible opportunity so they can be protected from further harm						
The needs of workers exposed to trauma, whether directly or indirectly, are recognised and addressed (e.g. staff supervision and trauma therapy)						
There are processes in place for gathering feedback and meaningful input from 'service users' and staff						
Language used takes into account the TI principles (Appendix 1)						
Workers are able to apply TI knowledge in practice and reflexive practice is supported						
Reviews of outcomes, policies and procedures, and organisational development plans incorporate change through a TI lens						

Phase 4: Trauma Informed

Trauma responsive	Self evaluation			Peer evaluation	Evidence	Plan of action / reflective comments
	FD	ID	UD			
Changes in the organisation's TI journey are clearly evidenced through data collection						
Workers feel supported to deliver TI practice						
Reflexive practice is considered an essential tool and effective supervision is embedded into routine practice						
People affected by trauma are supported to access timely interventions and recover						
The needs of people affected by trauma are prioritised over systems and procedures to reduce the risk of re-traumatisation						
Outcomes, procedures and policies are aligned to a TI approach and embedded in practice						
New recruits, volunteers and promoted staff demonstrate a commitment to the TI principles (Appendix 1)						
All aspects of the organisation have been reviewed and revised through a TI lens						
The organisation's TI practice has been independently evaluated (processes and outcomes) and uses evidence and data to inform decision making						

Appendices

Appendix 1: Trauma informed principles

What are the key principles of trauma informed approaches?

Sweeney and Taggert (2018) consolidated information from a number of different organisations and resources to produce the following 10 principles. We refer to these principles as those cited by the Early Intervention Foundation (2020).

Trauma informed principles
1. Seeing through a trauma informed lens, meaning that there is an **understanding and acknowledgement of the links between trauma and mental health.**
2. **Adopting a broad definition of trauma** extending beyond PTSD, including recognising social trauma and the intersectionality of multiple traumas.
3. **Making trauma enquiries sensitively** and with **knowledge about how to respond.**
4. Referring people to **evidence-based, trauma specific support**, where indicated.
5. **Addressing vicarious trauma and re-traumatisation.**
6. **Prioritising trustworthiness and transparency in communications**, such as limiting the professionals a person is required to repeat their traumatic history to.
7. Moving towards **collaborative relationships** and away from helper-helpee roles, based on trust, collaboration, respect and hope.
8. Adopting **strengths-based approaches** that reframe symptoms as coping adaptations, such as dissociation as an adaptive strategy to escape unbearable experiences.
9. **Prioritising emotional and physical safety** for service users and workers.
10. Working in **partnership with people who have experienced trauma**, for example to design, deliver and evaluate services.

Adapted from Sweeney and Taggert (2018)

Note 1. Other organisations and resources cite different numbers of principles. For example, SAMHSA (2014) refers to the following six principles: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment and choice; and (6) cultural, historical and gender issues. Meanwhile, the NHS Education for Scotland (2017) refer to the following five principles: (1) choice; (2) empowerment; (3) safety; (4) trust; (5) collaboration.

Note 2. Many of the principles overlap with other ways of implementing good practice, such as co-production with experts by experience, collaboration within and across agencies, shared decision making, having a positive and safe environment and strengths-based services. Hanson (2013) argues that there is nothing specific about trauma informed care that is specific to a history of trauma; the need to be sensitive and humane is just good care.

Appendix 2: Trauma informed guidance

What is the guidance for implementing a trauma informed approach?

Sweeney and Taggert (2018) consolidated information from a number of different organisations and resources to produce the following 10 principles. We refer to these principles as those cited by the Early Intervention Foundation (2020).

The three E's of trauma

Events: Events and circumstances may include the actual or extreme threat of physical or psychological harm or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stress or-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

Experience: The individual's experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic.

Effects: The long-lasting adverse effects of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognise the connection between the traumatic events and the effects.

The four R's of a trauma-informed approach

Realisation: In a trauma-informed approach, all people at all levels of the organisation or system have a basic realisation about trauma and understand how trauma can affect families, groups, organisations, and communities as well as individuals. People's experience and behaviour are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past, whether they are currently manifesting, or whether they are related to the emotional distress that results in hearing about the first-hand experiences of another.

Recognition: People in the organisation or system are also able to recognise the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

Respond: The programme, organisation, or system responds by applying the principles of a trauma-informed approach to all areas of functioning. The programme, organisation, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organisation, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviours and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realises the role of trauma in the lives of their staff and the people they serve.

Resist re-traumatisation: A trauma-informed approach seeks to resist re-traumatisation of clients as well as staff. Organisations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfilment of the organisational mission. Staff who work within a trauma-informed environment are taught to recognise how organisational practices may trigger painful memories and re-traumatise clients with trauma histories.

Source: SAMHSA (2014)

Appendix 3: Trauma informed activities and components

What are examples of trauma informed activities and components?

In a search of published literature, websites, national (U.S.) resources and feedback from professionals, Hanson and Lange (2016) identified a variety of strategies for becoming trauma informed. Hanson and Lange's (2016) mapping found 15 components, across three domains: workforce development (WD); trauma focused services (TFS); and organisational environment and practices (ORG). In the table below, we highlight the activities and components that were most commonly identified as important elements of trauma informed care.

WD	TFS	ORG
Training all staff in awareness and knowledge on the impact of abuse and trauma	Use of standardised, evidence-based screening/assessment measures to identify trauma history and trauma-related symptoms or problems	Collaboration, service coordination, and information sharing among professionals within the agency and with other agencies related to trauma informed services
Measuring staff proficiency in defined criteria to demonstrate trauma knowledge/practice	Inclusion of child's trauma history in child's case record/file/service plan	Procedures to reduce risk of client re-traumatisation
Strategies/procedures to address/reduce secondary trauma stress among staff.	Availability of trained, skilled clinical providers in evidence-based, trauma-focused practices	Procedures for consumer engagement and input in service planning and development of a trauma informed system
Knowledge/skill in how to access and make referrals for evidence-based trauma focused practices		Provision of services that are strengths based and promote positive development
		Provision of a positive, safe physical environment
		Written policies that explicitly include and support trauma informed principles
		Presence of a defined leadership position or job function specifically related to trauma informed care

Source: Hanson and Lange (2016)

Appendix 4: What have we learnt from evaluations?

A report published by the Early Intervention Foundation in February (2020) provides information on current evaluations of trauma informed care (summarised below).

**What have we learnt from evaluations so far?**

- 'While it is reasonable to assume that increased client choice and trust represent improvements in services, the extent to which these improvements will also reduce symptoms of trauma, anxiety and other forms of stress, or lead to sustained improvements in outcomes, has not yet been rigorously tested' (p.78).
- Most evaluations of trauma informed approaches currently lack rigour and the findings are mixed:
    On the whole, most findings from less rigorous studies are positive and include improvements in:
    i. Practitioners' knowledge;
    ii. Increased placement stability for children;
    iii. Reductions in reports of depression, family difficulties and child behavioural problems.
- Trauma informed practices that have been evaluated often lack a comparison group, which means that their findings are still preliminary.
- 'Findings from the first randomised trial of trauma informed care are less positive'; the study found little difference in outcomes (p.78).

What needs to happen next?

- Many trauma informed activities overlap with existing practices, so it is important to clearly outline how each activity is expected to add value over current practices, to improve short- and long-term outcomes.
- More rigorous evaluations of the impact of trauma informed care on child and adult outcomes are needed 'before trauma informed care can be considered a proportionate and evidence-based response to childhood trauma and adversity' (p.79).

Note. The Early Intervention Foundation is a 'What Works Centre', and part of the 'What Works Network' (launched in 2013) to embed robust evidence at the heart of policy-making and service delivery in England, Scotland and Wales.

Appendix 5: A trauma informed journey
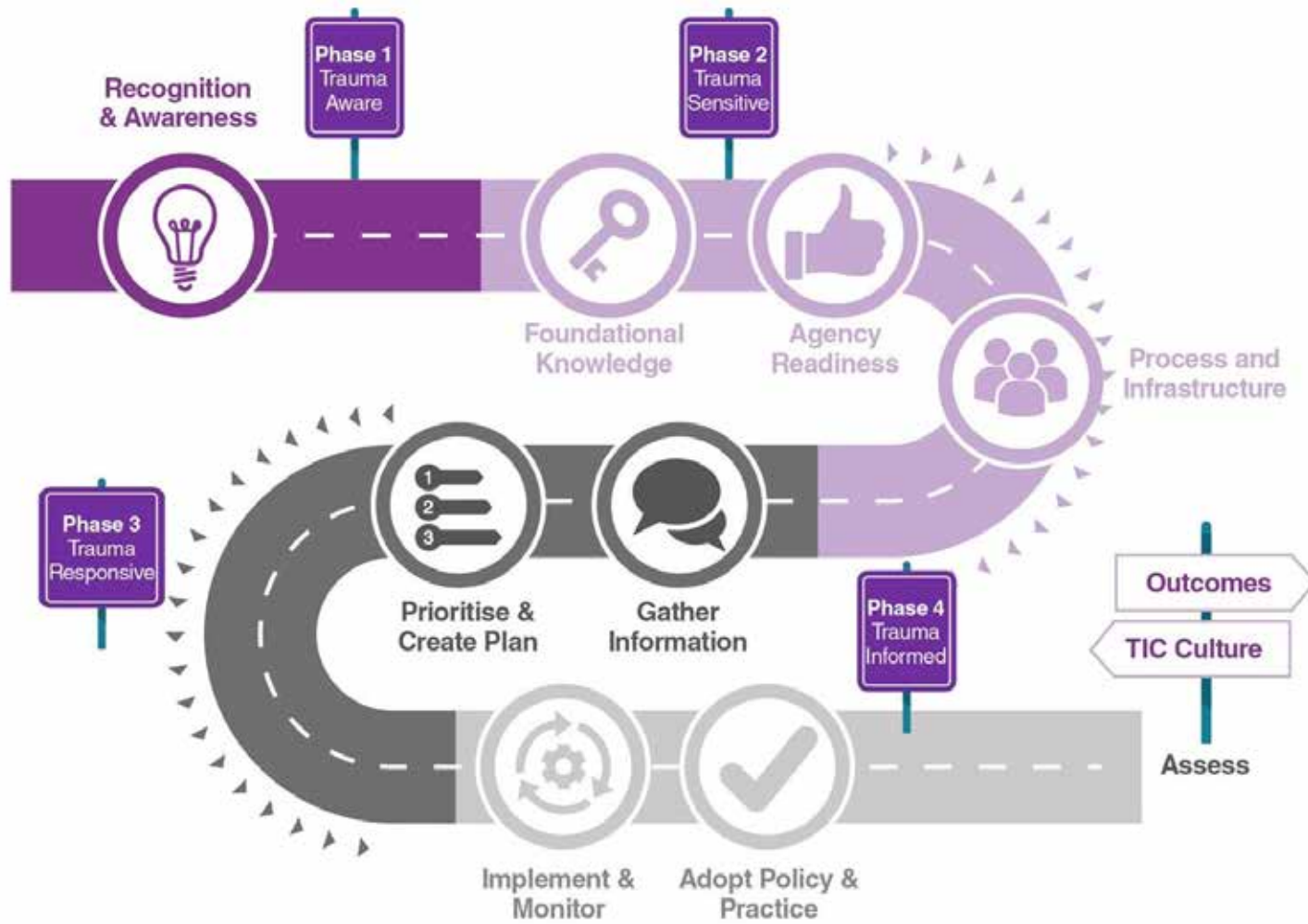
Adapted from Trauma Informed Oregon (2016)

Appendix 6: Case studies

The Well Communities, Lancashire and Cumbria:

The Well is a not-for-profit community that supports people who are recovering from drug and alcohol addiction through therapy, counselling, peer mentoring, employment training and social activities. In May 2020, the Well in Lancaster, piloted the Self and Peer Evaluation Toolkit. Beginning at phase one, the Chief Executive Officer worked through each statement to assess whether the various aspects of trauma related practice were 'fully developed', 'in development' or 'under development'. The self evaluation was beneficial in identifying and evidencing areas of good practice, such as: induction training educating about ACEs and trauma; counselling for the 'Well Community' members; clinical supervision for staff; and co-production with people with lived experience (throughout the design, development and delivery of services). The peer evaluation led to the production of an action plan consisting of 'next steps'. Plans are now in place to work collaboratively with a peer organisation to review the Well's policies, in order to ensure that they align with the trauma informed principles and guidance.

Moorside Primary School, Lancashire:

In May 2020, a key member of the senior leadership team conducted a self evaluation of Moorside Primary School using the Trauma Informed Organisational Development Framework and Self and Peer Evaluation Toolkit as a guide. A peer evaluation was subsequently conducted by a trauma informed consultant. The assistant headteacher confidently cited descriptions of school policies, procedures, processes and practices as evidence to support the statements under all four phases. Whilst most of the trauma informed statements are fully developed, a few are in the process of being developed. For example, the school has recently devised a new monitoring form and has allocated staff time for data collection to evidence their trauma informed journey. The data collection process has led to targeted support for children who are not currently in receipt of tailored support (e.g. through pupil premium) but who staff recognise are potentially experiencing trauma related difficulties (e.g. absent parent and very quiet in class). The senior leadership team aim to implement a suitable supervision model to support the wellbeing of workers and lessen the potential prevalence and impact of secondary and vicarious trauma. Financial and logistical barriers are currently being addressed. Through completing the peer and self evaluation process, Moorside Primary identified current strengths and ongoing actions in the school's trauma informed practices.

Appendix 7: Glossary

Adverse childhood experiences (ACEs): The term ACEs was first coined in 1998 by a landmark population study (Felitti et al., 1998) to refer to 10 categories of abuse, neglect and family dysfunction in childhood used to predict a variety of poor adult outcomes. Since the original study was published, there has been widespread debate regarding the approaches used to prevent ACEs. It is also important to note that there are other negative child circumstances, beyond the original 10 listed, that can predict negative adult health outcomes (e.g. low birth weight, childhood disability, bullying and social discrimination). Furthermore, the link between ACEs and poor adult outcomes is not deterministic.

Critical thinking: Consideration of deeply held assumptions and questioning of accepted 'norms' and 'rules', not only the impact of our own roles, but also society's impact on people we work with and our practices.

Intersectionality: A term first coined by American scholar Kimberlé Crenshaw, that asserts that people are often disadvantaged by multiple sources of oppression, such as their race, class, gender, sexual orientation, religion and other categories of identity. Intersectionality theory argues that most sociological theories make the mistake of examining only one variable at a time (e.g. gender oppression or race oppression and so forth). The basic premise is that variables are not isolated but work in groups to create an intersecting or interlocking system of oppression.

Reflection: process of learning from experience and using it to inform future actions. Using reflection in a professional setting helps to develop and improve future practice.

Reflexivity: In contrast to reflection, reflexivity involves more than just recognising the importance of the past. Reflexivity can happen before, during or after events. It involves self-reflection to interrogate our beliefs, values and practices 'before and in action'.

Resilience: The notion of 'bouncing back' (Pooley and Cohen, 2010) or 'Ability to develop positively despite exposure to significant threat, severe adversity, or trauma that typically constitute major assaults on the processes underlying biological and psychological development' (EIF, 2020, p.22). The concept of resilience has been challenged by those who argue that we should take pro-social action to prevent trauma and change inequalities (e.g. poverty, social exclusion and poor housing) rather than mitigating their effects.

Strengths-based (or assets-based) approach: 'explores, in a collaborative way, the entire individuals' abilities and their circumstances rather than making the deficit the focus of the intervention' (Department of Health & Social Care, 2019, p.24).

Supervision: 'An accountable process which supports, assures and develops the knowledge, skills and values of an individual, group or team' (Skills for Care, 2007, p.5).

Case supervision: 'with workers or groups of workers to enable and support quality practice. A key aspect of this function is reviewing and reflecting on practice issues. This may include reviewing roles and relationships, evaluating the outcomes of the work and maximising opportunities for wider learning' (Skills for Care, 2007, p.5).

Clinical supervision: 'In some professions and occupations, alternative titles may be used, such as "peer supervision", "developmental supervision", "reflective supervision" or just "supervision", but generally clinical supervision is seen as complementary to, but separate from, managerial supervision, which is about monitoring and appraising the performance of staff. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice' (CQC, 2013).

Continuing professional development supervision: ensures workers 'have the relevant skills, knowledge, understanding and attributes to do the job and profess their careers. Constructive feedback and observation in practice should be part of the learning process for workers and supervisors' (Skills for Care, 2007, p.5).

Line management supervision: 'is about accountability for practice and quality of service. This includes managing team resources, delegation and workload management, performance appraisal, duty of care, support and other people-management processes' (Skills for Care, 2007, p.5).

Trauma: 'Trauma results 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 well being' (SAMH 2014, p.7). Sometimes 'trauma' is subdivided into 'single incident trauma' and 'complex trauma'. The term 'single incident trauma' is used to describe 'one off' events (e.g. a rape, assault or serious accident). On the other hand, complex trauma involves exposure to and the impacts of multiple traumas or trauma that persists over time (e.g. child neglect or domestic abuse).

Secondary trauma: is when another person's experience of trauma starts to affect you.

Trauma informed care, approaches and practices: Often the phrases trauma informed care, trauma informed approaches and trauma informed practice are used interchangeably, although there are subtle differences in their meanings.

Trauma informed care: This term and way of working originated in healthcare organisations. 'The primary aim of trauma informed care is to increase practitioners' awareness of how trauma negatively impacts children and adults and reduce practices that might inadvertently re-traumatise clients. Trauma-informed care also aims to increase practitioners' sensitivity so that users perceive them as trustworthy and feel safe to disclose traumatic experiences' (EIF, 2020, p.22).

Trauma informed approaches: Over the years, the terminology of trauma informed approaches has evolved, reflecting the wider relevance of trauma informed ways of working beyond healthcare services. Trauma informed approaches is a wider umbrella term for integrating understanding of trauma and its potential impact into policies, procedures and practices in schools, social care, the criminal justice system and other frontline services.

Trauma informed practices: These are about applying trauma informed knowledge in our daily work, how we conduct ourselves and the decisions we make.

Vicarious trauma: This can occur when a professional's perception of the world becomes distorted as a result of their area of work.

Care' typically refers to the provision of what is necessary for health, welfare, safety and protection. An 'approach' is about a way of dealing with a problem or situation. 'Practice' is about the application of knowledge about trauma.

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