REPORT

agenda
Alliance for Women & Girls at Risk

Centre for
Mental Health

A sense of safety

Trauma-informed approaches for women

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Acknowledgements

Executive summary

There is good evidence of a strong link between traumatic experiences and poor mental health. The more adverse events that occur in early life, the greater the likelihood of someone experiencing poorer mental health in later life. For women, trauma is frequently associated with experiences of abuse and violence – more than half of women who have experienced extensive abuse and violence across their lives have a common mental health condition like depression or anxiety. There is growing evidence that service responses need to be gender-specific to recognise and respond appropriately to gender differences.

This report explores how trauma-informed approaches for women are being implemented in a range of public services, the barriers to these approaches being delivered, and what more could be done to enable them to be more widely embedded. We surveyed services and conducted a number of visits to directly observe these services, as well as to talk to professionals and women who had accessed them. Services we visited worked across substance misuse, homelessness, mental health, the criminal justice system, and domestic and sexual abuse and exploitation.

Four themes emerged through our interviews and site visits:

- **Approaches to service delivery:** the services that seemed best able to adopt trauma-informed approaches tended to have a holistic approach to meeting women's needs; to prioritise relationships and peer support; and to create a sense of safety, choice and control.

- **Funding and commissioning:** many of the services we visited were delivering trauma-informed approaches under what was frequently described as precarious or "fragile" funding conditions, often through a number of different funding streams – creating challenges to delivering holistic support.

- **Organisational issues:** many organisations found it challenging to make the sort of cultural shift needed in order to start delivering trauma-informed services. Shifting a paradigm and changing a culture in this way is a long-term process.

- **Challenges for trauma-informed care:** these included the difficulty of bringing about a trauma-informed approach in an inherently traumatising environment, such as a prison.

There is a growing consensus about the value of trauma-informed services, and the picture is becoming clearer about their benefits. While there is still some way to go until these approaches are embedded, there is no evidence suggesting that adopting a trauma-informed approach causes any harm, so there is no risk to moving further in this direction.

For public services to become sustainably trauma-informed, large-scale changes will be needed to the ways that policies are created, commissioning is conducted and decisions are made at every level.

We recommend:

1. All public service providers, especially but not only health and social care, should have policies and strategies in place to support the development of trauma- and gender-informed provision.

2. The Department of Health and Social Care should include a requirement for trauma-informedness in the NHS Mandate.

3. The National Institute of Health and Care Excellence (NICE) should incorporate trauma-informed principles into the guidance it produces. Existing guidelines do not always take this approach and, as such, they miss the opportunity to support trauma-informed interventions and approaches in health care services.

4. All public service commissioning bodies should adopt trauma- and gender-informed commissioning principles for the services for which they are responsible. Commissioning frameworks should make achieving this goal an explicit expectation of a service when they commission it. Commissioners must recognise that developing and delivering trauma-informed approaches can be a significant undertaking, and should therefore sufficiently fund the time, resource and expertise to enable this and allow it to embed.

5. The Department of Health and Social Care and its arm's length bodies in England, and equivalent bodies in Northern Ireland, should look to developments in Scotland and Wales to support progress towards trauma- and gender-informed public services. In England, this will be vital if the Government is to fulfil the promise of the Women's Mental Health Taskforce.

6. The Department of Health and Social Care should lead a research and development programme in England to consolidate the evidence base and produce guidance and resources that support further consistency in approach. There is a significant role for Public Health England, Health Education England and NHS England in developing this, supported by academic institutions and research funders.

7. A definition and benchmark of trauma-informed approaches for women should be developed, to enable further standardisation of services and a recognition of how services and commissioners can assess quality. The Department of Health and Social Care and NHS England should play a central role in this, with the full involvement of other departments to which this could apply, including Ministry of Justice, Home Office, and Ministry of Housing, Communities and Local Government.

8. All inspectorate bodies (e.g. Care Quality Commission, Ofsted, HM Inspectors of Prisons and Probation) should inspect against the extent to which gender- and trauma-informed principles are being adopted and implemented.

9. Health Education England should ensure that training and development for the current and future health workforce incorporates trauma-informed principles. Public service employers should invest in training in gender- and trauma-informed practice for staff, particularly those working in front-line support, care and treatment roles.

1. Introduction

Background

"…whilst not all mental health is about trauma, all trauma is about mental health…"

(Clinical psychologist)

There is good evidence that there is a strong link between traumatic experiences and mental health. The more adverse events that occur in early life, the greater the likelihood of poorer mental health in later life (Bellis *et al.*, 2018). Traumatic experiences have a cumulative negative impact on mental and physical health. Having a history of trauma is associated with a range of poor outcomes, including attempted suicide, self-harm and longer and more frequent hospital admissions (e.g. Sweeney *et al.*, 2018).

For women, trauma is frequently associated with experiences of abuse and violence – more than half of women who have experienced extensive abuse and violence across their lives have a common mental health condition like depression or anxiety (Scott & McManus, 2016). Women and girls are significantly more likely to experience trauma in intimate relationships, at the hands of someone known to them and in a relationship where the abuser has power over them – such as physical strength, age or control over money, housing or access to children. This in turn can lead to women having little choice but to remain in the abusive and traumatic situation, meaning their experiences of trauma are closely connected in complicated ways to their own agency and relationships (Wilton and Williams, 2019).

There are also well-established gender differences in how women and men experience and respond to trauma. Women are more likely than men to experience psychological harm from trauma, and are more likely to develop 'internalising disorders' such as depression, withdrawal and anxiety following exposure to trauma (Wilton and Williams, 2019). Issues such as self-harm, eating difficulties and being diagnosed with personality disorders – closely associated with experiences of abuse and violence – are more common among women (Department of Health and Social Care, 2018).

There is growing evidence that service responses need to be gender-specific to recognise and respond appropriately to these gender differences. The case for a gender-specific response is set out by Wilton and Williams (2019) on behalf of Centre for Mental Health and partners. This describes the differences in women and men's experiences of trauma, and the importance of services responding in a way that takes these gendered experiences into account.

As well as recognising the wider impact of trauma and abuse, Stephanie Covington, a leading expert in the field of trauma-responsive work with women in prison, states that it is important to understand women's "experiences and the impact of living as a female in a male-based society" and that as a result, "gender awareness must be part of the clinical perspective…" (2008, p378).

Despite these links, and the developing field of gender- and trauma-informed approaches, evidence suggests mental health services do not always recognise or respond to women's trauma (Hopper *et al.*, 2010) and can even put their mental health at further risk – for example, through practices such as restraint, a lack of choice over their care, incidents of sexual assault or failing to recognise women's roles as mothers in the care they receive (Agenda, 2017; Sweeney *et al.*, 2018; Department of Health and Social Care, 2018).

There is, however, a growing awareness in policy and practice that change is needed. Initiatives such as work taking place in Scotland and Wales to develop a more trauma-informed public service workforce, as well as some local area approaches, highlight that there is leadership in this area. Equally, approaches taken internationally offer useful learning. In the United States, its national mental health services body SAMHSA (2014) has produced a manual for trauma-informed services and detailed online guidance.

Rationale for this report

This research was carried out by Agenda, the alliance for women and girls at risk, and Centre for Mental Health. Its aim was to explore how trauma-informed approaches for women are being implemented in a range of public services and the barriers to these approaches being delivered, and to consider what more could be done to enable them to be more widely embedded.

This report was produced in a context of wide developments in this area. The recent Women's Mental Health Taskforce, for example, brought together experts with the aim of defining and addressing priorities for improving women's mental health. The Taskforce, co-chaired by Jackie Doyle-Price MP, then Parliamentary Under Secretary of State for Mental Health, and Agenda's Chief Executive Katharine Sacks-Jones, demonstrated a clear need to take a more gender- and trauma-informed approach across the commissioning and delivery of services. The final report set out key principles for gender- and trauma-informed care, which it recommended should be applied across mental health services, as well as all public services likely to be in contact with women who are trauma survivors (see box 1) (Department of Health & Social Care, 2018).

Box 1: Gender and trauma-informed principles

(from the Women's Mental Health Taskforce final report)

- **Governance and leadership:** There is a whole organisation approach and commitment to promoting women's mental health with effective governance and leadership in place to ensure this.

- **Equality of access:** Services promote equality of access to good quality treatment and opportunity for all women, including LBTQ and BAME women.

- **Recognise and respond to trauma:** Services recognise and respond to the impact of violence, neglect, abuse and trauma.

- **Respectful:** Relationships with health and care professionals are built on respect, compassion and trust.

- **Safe:** Services provide and build safety for women, creating a safe environment that does not retraumatise. Services respond swiftly and appropriately to incidents that put women's safety at risk, including robust processes for reporting and investigating sexual abuse and assault.

- **Empowerment through coproduction:** Services engage with a diverse group of women who use mental health services to co-design and coproduce services. Services promote self-esteem, build on women's strengths and enable women to develop existing and new capacities and skills.

- **Holistic:** Services prioritise understanding women's mental distress in the context of their lives and experiences, enabling a wide range of presenting issues to be explored and addressed, including with a focus on future prevention. Services support women in their role as mothers and carers.

- **Effective:** Services are effective in responding to the gendered nature of mental distress.

(Department of Health & Social Care, 2018)

Being a trauma-informed service

This report follows on from *Engaging with complexity* (Wilton and Williams, 2019), a resource commissioned by the VCSE Health and Wellbeing Alliance, a partnership between the Department of Health and Social Care (DHSC), NHS England and Public Health England, and 21 national voluntary sector organisations and consortiums, following the conclusion of the Women's Mental Health Taskforce.

Trauma-informed practices move from asking "what is wrong with you?" to "what has happened to you?" They understand and respond to the high prevalence of trauma and its effects, as well as understanding that experiences of trauma can lead women to developing coping strategies and behaviours that may appear to be harmful or dangerous (Sweeney *et al.*, 2018).

Engaging with complexity (Wilton and Williams, 2019) sets out the evidence base about the ways in which women can experience and respond to trauma, some of the key principles to delivering services that respond to this, as well as some of the challenges to adopting a trauma-informed approach. As that report sets out, evidence shows there are a number of key components to trauma-informed services (see box 2).

The research also found four fundamental processes for a trauma-informed service, set out in box 3.

Box 2: Key components of trauma-informed services

- Trauma-informed services put people before protocols

- The service does not try to make women's needs fit into pre-specified boxes

- The service creates a culture of thoughtfulness and communication, and continually learns about and adapts to the individual using their service

- The service is willing and able to engage with complexity

- Trauma-informedness is a process and not a set of procedures.

(Wilton and Williams, 2019)

Box 3: Fundamental processes for a trauma-informed service

- Listening - Enabling women to tell their stories in their own words

- Understanding - Receiving women and their stories with insight and empathy

- Responding - Offering women support that is timely, holistic and tailored to their individual needs

- Checking - Ensuring that services are listening, understanding and responding in a meaningful way.

(Wilton and Williams, 2019)

This description of the characteristics and qualities of a trauma-informed service are entirely compatible with those of the American Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the U.S. Department of Health and Human Services that has led the way in developing guidance and principles around the delivery of trauma-informed approaches. The four overarching assumptions (box 4) and six principles (box 5) SAMHSA identify as being core to trauma-informed working are widely cited and help further to illustrate the difference between trauma-informed provision and 'traditional' mental health service provision, or that which is not trauma-informed.

In their research on the principles and implementation of trauma-informed services for women, Elliot and Colleagues (2005) developed a set of ten trauma-informed principles for women, and these have considerable overlap with those developed at SAMHSA (box 6).

Box 4: SAMHSA's four overarching assumptions behind trauma-informed approaches

1. **Realisation:** all people across the organisation have a basic realisation of trauma and can understand how trauma can affect the individual.

2. **Recognition:** all people across the service can recognise trauma symptoms and signs in clients, families, staff and others in the system.

3. **Responding:** the organisation responds to the individual's trauma by applying trauma-informed approaches in all areas (policies, procedures and practice).

4. **Resisting re-traumatisation:** of both clients and staff – for example, staff are taught how to recognise when organisational practices or something in the present may trigger painful memories and re-traumatise clients.

(SAMHSA, 2014)

Box 5: SAMHSA's six key principles of trauma-informed approaches

1. **Safety:** staff and service users should feel physically and psychologically safe.

2. **Trustworthiness and transparency:** relating to all organisational procedures.

3. **Peer support:** should be essential to the organisation.

4. **Collaboration and mutuality:** eliminating power imbalances and ensuring all parties involved have a role to play in achieving the end goal.

5. **Empowerment, voice and choice:** embedded throughout the culture of the entire organisation.

6. **Cultural, historical and gender issues:** overcoming cultural differences and offering a unique approach to each individual

(SAMHSA, 2014)

Box 6: Ten principles for trauma-informed services for women

1. Trauma-informed services recognise the impact of violence and victimisation on development and coping strategies.

2. Trauma-informed services identify recovery from trauma as a primary goal.

3. Trauma-informed services employ an empowerment model.

4. Trauma-informed services strive to maximize a woman's choices and control over her recovery.

5. Trauma-informed services are based in a relational collaboration.

6. Trauma-informed services create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance.

7. Trauma-informed services emphasise women's strengths, highlighting adaptations over symptoms and resilience over pathology.

8. The goal of trauma-informed services is to minimise the possibilities of re-traumatisation.

9. Trauma-informed services strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background.

10. Trauma-informed agencies solicit consumer input and involve consumers in designing and evaluating services

(Elliot *et al.*, 2005)

The evidence base for trauma-informed services

What this section and the previous *Engaging with complexity* report have demonstrated is that there is a growing body of evidence to support services adopting trauma-informed principles, and that there are tangible benefits, both to those who use services and those who work in them, not least in terms of better engagement. The research literature has, by and large, looked at the operationalisation of trauma-informed principles as a whole, but it is worth noting that the evidence base grows larger if we look at the evidence for each of the principles in turn, almost regardless of which set we choose from.

The evidence around how trauma-informed approaches can increase engagement is particularly strong. There is evidence that when

people have a say in their care and treatment, and when it is coproduced or co-designed, they are more likely to engage with a service (see Stubbs *et al.*, 2017). And there is evidence that employing peer support workers in mental health services alongside (not in place of) existing staff can increase engagement and can reduce the need for hospital admission (Trachtenberg *et al.*, 2013).

Whilst we should not really have to argue for the legitimacy of safety as a care principle, this is important for any vulnerable person seeking help and has both physical and psychological dimensions. And as the Mental Health Act Review demonstrated, people have not always experienced a sense of safety within mental health treatment (Wessely *et al.*, 2018).

Other research shows a range of positive impacts where trauma-informed ways of working have been established:

- Psychological safety: Service users feel emotionally safe and are able to build an appropriate, supportive relationship with staff (Clark *et al.*, 2007; Hopper *et al.*, 2010)

- Recovery and empowerment: Services reduce the risk of relapse (i.e. retraumatisation and or worsening of symptoms) (SAMHSA, 2010 cited in Kubiak *et al.*, 2017)

- Physical safety: Prisons that have implemented trauma-informed approaches see a decrease in violence in prisons; one US study of women's correctional facilities found a 62% decrease in prisoner assaults on staff, and a 54% decrease in prisoner-on-prisoner assaults (Benedict, 2014).

- Organisational: Services have better staff supervision, a safer environment, greater collaboration and team working, greater job satisfaction, less staff burnout and improved relationships between staff and service users (Damien *et al.*, 2017).

- Staffing: Services have improved service user engagement and are more cost-effective, as less money is spent on staff time for ineffective interventions e.g. missed appointments (Hepburn, 2017).

Methodology

Centre for Mental Health and Agenda carried out this research to better understand what a trauma-focused approach for women might look like 'on the ground'; the barriers, challenges and potential benefits of delivering trauma-informed support to women; and how these approaches could be further supported and embedded. To do so, we surveyed services and conducted a number of visits to directly observe these services, as well as to talk to professionals and women who had accessed them.

To identify services that appeared to be offering trauma-informed and gender-specific therapeutic services for women, we carried out an initial online search. This search was informed by a search of the literature that specifically identified certain services. Further services were identified where their online

descriptions mentioned providing services for victims of trauma, or stated that they adopted a trauma-informed approach. Those which appeared to offer a women-specific offer were further explored. Those identified included public sector mental health services, psychological services and voluntary and community services.

We made contact with 24 services (out of a possible 35 identified) across England. This included an NHS Mental Health Trust that was attempting to introduce trauma-informed care across all its provision. We conducted telephone interviews with managers and practitioners from these services, to explore how they operated in a trauma-informed way.

We then selected nine sites to visit for more in-depth data collection. Services were selected from across the country and were delivered in different settings – public sector and voluntary and community, as well as women-only services, and those providing women-only programmes within a mixed trauma-informed service. Services we visited worked across substance misuse, homelessness, the criminal justice system, and domestic and sexual abuse and exploitation. When visiting services, we used both the SAMHSA and Elliot *et al.* principles to gauge the degree to which each service appeared trauma-informed. In most cases we were able to speak to both practitioners and women who used the services.

The types of services we visited included:

- Women's Centres (three in the Midlands, North West and South East)

- Women's only hostel (London)

- Specialist NHS Trauma service (South East)

- Prison-based trauma programme for women (South East)

- Counselling services – two, including one that provides residential care (South West and Yorkshire)

- NHS Trust (North East)

Through these interviews and site visits, some key themes emerged. These are discussed in the following section.

2. Themes from our survey and visits

Four themes emerged through our interviews and site visits:

1. Approaches to service delivery
2. Funding and commissioning
3. Organisational issues
4. Challenges for trauma-informed care

Approaches to service delivery

A number of clear themes emerged as to what both professionals and women using the services thought were key to working in a trauma-informed way. The services we visited that were best able to provide this were usually in the voluntary and community sector. It was notable that the services we visited in which the principles of trauma-informed care seemed most embedded were all Women's Centres.

Women who had used the services which we determined to be trauma-informed spoke positively of the benefits they received from the service:

"…It has helped us to recognise why we feel like how we do; we can understand ourselves more, trust people more and be more open…"
(Woman in a prison-based programme)

"…You don't have to go into depth about what actually happened but learn to understand it and find new coping mechanisms…"
(Woman using a counselling service)

The following key elements were identified as particularly important by both staff and women accessing the service.

Holistic and woman-centred

Being able to address a range of women's needs, therapeutically and practically, was identified as key to the delivery of a trauma-informed service. Women consistently stated that they wanted 'wrap-around' style services, and staff similarly talked about the value of 'one-stop shops' where women could access and remain engaged with a range of support under one roof.

"…services that have the ability to wrap around the individual and have the capacity to offer choice…"
(Staff member at a Women's Centre)

In addition to offering interventions (i.e. psychotherapies) that might directly target the impact of trauma on women, issues of debt, accommodation, parenting and a range of other issues experienced by women were also able to be addressed. Such services appeared to be able to offer an approach tailored to each woman, in recognition of the complex and multiple needs each woman may experience, and the differing coping mechanisms that may have been established in response to trauma.

"…the help covers every topic you could think of. It's good because you talk about issues you want to talk about, not what a member of staff wants to talk about…"
(Woman on a prison-based programme)

Women also reported that quite small things could make a significant difference:

"…If I arrive early, there is always someone to greet me, offering me a hot drink and a chat. They go that extra mile to try to understand and support you…"
(Woman using a Women's Centre)

Many women had poor experiences of using other services and were reluctant to be 'sign-posted' elsewhere as a result. For women experiencing a more complex range of needs, who may have had poor experiences of services previously, or been unable to access services because their needs were considered too high, this could be particularly important. This approach allowed women to be given a choice and prioritise what they wanted to address first, as described by this interviewee:

"…When the sessions first started, I was overwhelmed and didn't think I was ready. They gave me time to take a step back and to come back to therapy when I was ready. Other services… would have put me back on the long waiting list and I would have missed my chance…"
(Woman using a Women's Centre)

Relationships and peer support

A key element of trauma-informed approaches is the importance of fostering trusting relationships, and this was very evident in our visits. As one woman said:

"…The staff are amazing; they make you feel safe and as though you can trust them because they actually show an interest…"
(Woman using a Women's Centre)

Women also emphasised the importance of not having to "re-tell my story every time I go". Many beneficiaries' experience of other services, such as mental health services, was often of a lack of continuity of care. Each change in professional they are in contact with, for example a new psychiatrist, can result in women being re-assessed and having to re-tell their story yet again, which can have a significant negative impact:

"…Don't they read my notes? It's traumatising me every time I have to tell them about me…"
(Woman commenting on the experience of using a secondary mental health service)

"…you can't build up trust if the faces keep changing…and it's risky to build up trust if you can't be sure they will be there next time…"
(Woman commenting on the experience of using a secondary mental health service)

Both staff and service users felt that peer support should be available for all women accessing services and should be an integral part of the trauma informed service offer. It was felt that people with similar lived experience were often better placed to understand women's needs and provide support.

"…Peer mentors are considerably valued here… as they offer the unique opportunity of shared experience…"
(Member of staff in a Women's Centre)

Women interviewed said that they valued working with peers with lived experience, either one to one or through peer groups. As one said:

"…Peers being facilitators makes it better. We all share similar experiences so can relate…"
(Women on a prison-based programme)

A sense of safety, choice and control

Another key element identified was the ability of a service to build a sense of safety for women. This could be influenced by both the physical environment of the service and by staff attitudes. It could be as simple as making a room look more welcoming and appealing, and less threatening, and by staff being pleasant and compassionate towards service users.

As one practitioner told us:

"Simply put, it does not cost anything to be nice; nor does it cost any more to paint a wall purple than it does to a paint a wall clinical green; or to remove posters from walls which may be threatening"
(Member of staff in a counselling service)

This also meant a service having an 'open door' policy or being delivered as a drop-in, where women were not forced to participate, but could just 'test out' the environment. This sense of safety also related to women's ability to come back to a service in future, and to prevent them from reaching crisis point if problems returned:

"…you shouldn't have to get really bad to get help…"
(Woman using counselling service)

"…Trauma has a long-term impact, so interventions for trauma need to be long-term, or to have an open-door policy…"
(Practitioner in an NHS service)

Having some control and choice in their 'treatment' and care was important to the women we spoke to and contributed to them feeling safe enough to address how trauma had impacted on them.

This was a particularly relevant facet of trauma-informed approaches for the women on the prison programme we visited, which was delivered as an optional service that women could choose to access if they wished. Both women and men in prison will sometimes have requirements to attend courses (often concerning behavioural change) as part of their sentence plan, and indeed the date of their release may depend on it. The importance of being able to access a trauma-informed service

on their own terms was therefore critical to a sense of agency and control. One woman attending the programme stated:

"…other services, like domestic abuse or substance abuse course[s], are a part of your sentence plan, and steered to meet targets. Being forced to do something is horrible…"

There is, however, a tension with being able to deliver a trauma-informed service in an environment which – by its very nature – limits women's choice and control. This is discussed in more detail later in the report.

Identifying the impact of trauma

Labelling service users as 'hard to reach', 'difficult to engage' or as having 'complex needs' can itself be retraumatising and stigmatising. We were told that women can internalise this label, leading them to think that their thoughts and behaviours are to blame, rather than seeing what has happened to them – and the trauma they have experienced as a result – as the fundamental problem to be addressed.

The experience of the women we spoke to was that it was often services themselves that were failing to meet needs or were 'hard to reach'. Many women had experienced repeated frustration in trying to seek help, often for years, which for many had compounded their problems by failing to provide them with the support they needed at an earlier stage. As a result, for many women their problems had become further established and even more difficult to resolve.

Funding and commissioning

Many of the services interviewed and visited were delivering trauma-informed approaches under what was frequently described as precarious or "fragile" funding conditions. Services in the voluntary and community sector were particularly reliant on varied and multiple sources of funding to enable them to provide the breadth in their offer that women said they needed and valued. Most of their funding was relatively short term so these organisations

felt they were "constantly battling to survive". One Women's Centre lead noted a parallel between the struggle to survive they faced as organisations and the structural inequalities many women face in their daily lives. Indeed, the inequalities that women experience were perceived as being reflected by the struggles faced by services. "We're operating in the same paradigm, mirroring the experiences of the women we work with."

In terms of the wider system and its ability to work in a more trauma-informed way, many public sector providers (for example mental health trusts) are commissioned through block contracts, with success largely based on volume of service delivery and an ability to achieve targets. These types of contracts tend to focus on targets such as numbers of new service users seen in a required period, or the number of attended appointments, rather than outcomes or the quality of a service.

This focus was often described through our visits as being counter to the holistic model of service delivery that women said they valued, and that practitioners said was essential to working in a trauma-informed way. It often affected the ability of a service to be innovative and to take risks. The focus encouraged providers instead to design processes aimed at achieving key performance indicators for individual commissioners in separate sectors, rather than those indicators of quality that a service user might value. This approach could even inhibit a service user's legal right to a choice over the service they receive (NHS Confederation, 2016). And it represents a structural barrier to offering holistic support while the commissioning of public health, health care, social care and other public services for people with multiple needs remains separate (Lowe and Plimmer, 2019).

In order to fully implement trauma-informed approaches that impacted on the culture of service providers, it was stressed that the culture of commissioning needed to change. As one practitioner said: "…Commissioning through a 'trauma lens' is what needs to happen, we need to build it into commissioning thinking as well as service thinking…"

Joint commissioning arrangements were seen as the route to addressing this. Areas such as Greater Manchester, where health and social care budgets are devolved and there are moves towards joint commissioning of services across the city region, were pointed to as leading the way in this type of approach.

Organisational issues

The Women's Centres we visited all appeared to be well established in delivering trauma-informed approaches. They had mostly operated to these principles for some time, frequently before the term was in common use in the UK.

Public sector organisations and some voluntary and community sector organisations, however, reported that they found it challenging to make the sort of cultural shift needed in order to start delivering trauma-informed services. Moving towards a trauma-informed approach involves changing how all members of staff work, including managers, clinicians, reception and other staff. Shifting a paradigm and changing a culture in this way is a long-term process.

As one service manager told us:

"Staff have found it difficult to switch over to working in a trauma-informed approach… Becoming trauma-informed is a long process, it takes time to change people's attitudes."
(Service manager)

One voluntary sector service discussed how they had gradually shifted to a more trauma-informed culture of care. This involved the introduction of trauma champions in each department, who had a role in monitoring the physical environment and the perception of staff by those who use the service. They had involved women with experience of the service in this process.

Providing specific trauma-informed approaches for women within a broader trauma-informed service

The move to full "trauma-informedness" involves all aspects of a service undergoing a process of change, from the senior leadership, staff training and the physical environment, to considering how all aspects of a service operate. This includes the experience 'front of shop' (e.g. reception), referral processes, and assessment and treatment.

As part of this project we visited an NHS mental health trust that is attempting to become entirely trauma-informed. In order to support this, the strategy has had full buy-in from the senior management team, as one would expect given this ambition. Senior management within the trust see their move to a trauma-informed approach as improving the quality of the service and in satisfaction among those who use it. At present this service has not taken a gender-specific approach, but sees this development as a future part of this process once they have fully embedded trauma-informed ways of working.

Separate to this project, one of the authors visited an NHS secure mental health service on a mixed ward, where most of the clinical team were keen to develop a trauma-informed approach to care. People who spoke to the author confirmed how difficult it was to move to a trauma-informed approach without full buy-in from all clinicians, but even more so without the active support of management and senior leadership.

Those who had achieved the transition to a trauma-informed service told us that buy-in from clinical and other staff involves a gradual "winning of hearts and minds". It also requires a concerted effort to ensure that changes to becoming trauma-informed involve a minimum of additional burden. In these cases, a growing programme of largely informal education on the benefits of trauma-informed working and the development of local toolkits has been most successful. Departmental and service champions play a significant part in this reforming of services. These champions act as influencers and their credibility within services adds to the potential for buy-in from other staff. Collectively, these champions mean there is a team effort and ensure any change is embedded and sustainable.

Challenges for trauma-informed care

Creating trauma-informed environments in women's prisons

One of the environments in which there has been much discussion about trauma-informed approaches in recent years is prison. The UK charity One Small Thing has set out to change the culture of both women's and men's prisons, in part through training both staff and peers in trauma-informedness. Their approach seeks to create an environment working to improve women's lives whilst in prison and to avoid causing more harm by failing to respond to them in a trauma-informed way.

One of the sites we visited was a women's prison attempting to apply a trauma-informed intervention. Female prisoners could voluntarily participate in a programme to help them address and cope with their past traumas, and women we spoke to who had taken part were very positive about its benefits. As one woman told us, the need for services (including prisons) to recognise trauma and its impact is vital:

"If an animal bites and keeps whining, there is something wrong with that animal. That should be translated into people: if someone who is usually in a happy mood is being destructive, moody or unhappy, it isn't simply that this person has an attitude; something is going to be wrong. Staff who have been trained in trauma-informed approaches are recognising that now and it's making all the difference…"
(Woman on prison-based programme)

The response to this shift was deemed by staff to have had positive results. One member of prison staff told us:

"…One lady had self-harmed for 12 years and always blamed herself. She realised what happened to her wasn't her fault, removed the self-blame and learnt other coping strategies…"
(Prison staff member)

Women we spoke to did, however, highlight the challenges posed by attempting to deliver trauma-informed interventions in a prison.

Women mentioned the disruptions caused by the environment in particular and stressed that the whole of the prison needed to be trauma-informed in order for effective trauma-informed interventions to be offered. Women were also concerned that prison itself had the potential to re-traumatise and potentially undo the good work the programme had done:

"…There are constant interruptions which is annoying. You just get started on a course then you have to stop. There is no consistency…"
(Woman on prison-based programme)

"…Staff supervising the group should not be disturbed so that the group can carry on. You start to bond with the women in your group, then time passes, and it starts to fracture. By the time you meet again it's a bit awkward and takes longer getting back into the swing of it…"
(Woman using a prison-based programme)

There were also some concerns that, despite the positive impact they may have experienced from participating in the programme, the benefits would be lost if they did not get further support after they were released.

This is a naturally a huge challenge for a prison to address. Within the custodial environment, daily acts associated with imprisonment that could act as triggers to re-traumatisation are common, including restraint, being handcuffed, isolation, being searched, loud noises and the smell of disinfectant.

One US review of trauma-informed programmes in both male and female custodial settings concluded that this approach was both possible, and that it could help such settings achieve their core aims more effectively (Miller and Najavits, 2012: p6):

"…There is sometimes great reluctance to open the trauma 'can of worms' given the prison environment and the limited clinical resources. Yet trauma informed correctional care and staff training can go a long way toward creating an environment conducive to rehabilitation and staff and institutional safety…"

Working with victims of trauma versus being trauma-informed

"It becomes something a service is, rather than what services do."

(NHS manager)

It was apparent from our interviews and visits that it is possible to provide a service for victims of psychological trauma, offering evidence based 'treatment', but still not be a fully trauma-informed service, especially if we reflect on the principles outlined earlier in the report. Some services we contacted worked with both women and men who had experienced trauma, sometimes exclusively so, but did so within what might be described as a 'traditional' health offer.

In these settings, while the service might work with victims of trauma, we could see minimal or no evidence of the kinds of ways of working we would expect to see in a trauma- or gender-informed service. The waiting areas did not necessarily feel safe, there were sometimes lengthy waits before any offer of help was made, service users were placed in a general reception area (used by the whole hospital) and the staff were not trained in offering a trauma-informed service. There was also little evidence of coproduction or collaboration, one of the core principles of trauma- and gender-informed services identified by the Women's Mental Health Taskforce (Department of Health & Social Care, 2018). Appointments were for formal assessment and therapy; some did not allow self-referral, offered appointments by letter, and operated a 'two strikes then out policy'

(i.e. if appointment letters were not responded to then the assessment or treatment offer was withdrawn). This was in contrast to other settings where the emphasis was on providing a safe space, the ability for women to drop-in, working at the women's pace, offering choice on what interventions they might utilise and focusing on strengths and resilience building.

Perceived lack of evidence or shared definitions

We heard from a number of the professionals that we spoke to that the perceived lack of an accepted empirical evidence base posed a challenge to the continued roll out of these services. Concerns were also raised that not having a widely understood definition of how trauma-informed services should be delivered led to wide variations in approach and practice. Similarly, the lack of a commonly shared evaluation tool meant services struggled to demonstrate the impact of their work, and commissioners found it hard to understand the difference between the approach or outcomes of different services.

In order to better embed trauma-informed approaches, it was suggested that a shared understanding of their positive impact, and an ability to measure and evaluate this, would be of benefit. This would enable services that describe themselves as trauma-informed to demonstrate that they are achieving measurable positive differences to the lives of the women they work with, and how these compare to the outcomes of traditional service offers.

3. Discussion

"It is not about being specialists in trauma, but about being confident to talk about it, and to manage and support survivors"

(Practitioner in a Women's Centre)

Psychological trauma is unique, and so are women's responses to it. It affects individuals differently, and different groups may be subject to different forms of trauma. Women often experience psychological trauma through intimate or family relationships, where the perpetrators of behaviours leading to trauma are closely connected to them and often hold a strong degree of power over them – such as controlling access to their children or finances. This can mean that women are unable to leave the situation causing the trauma, which can further compound the harm they suffer.

Services that aim to respond to women's trauma and its presentations must take account of women's gendered life experiences, as well as the ways in which trauma might have made an impact on their lives. Scott and McManus (2016) found that one in every 20 women has experienced extensive abuse and violence across their lives, compared to one in 100 men. Many can go on to experience other problems in their lives: of women with experiences of extensive physical and sexual violence, a third (36%) have attempted suicide, a fifth (22%) have self-harmed and a fifth (21%) have been homeless. Women with these experiences are also eight times more likely to be drug dependant than women who have experienced little to no violence or abuse (Scott and McManus, 2016).

As a result of the trauma they experience, women can develop coping mechanisms or behaviours as a response that services can interpret as being 'difficult to engage with'. The consequences of trauma may overlap, such as struggling with both addiction and mental health problems, which can lead to women being excluded from some services due to their thresholds or exclusion criteria. The impact of trauma can also mean that women have difficulties developing trusting relationships with professionals intending to support them.

Those who have been psychologically traumatised usually have multiple and complex needs and may require support or intervention from different agencies. Given the high prevalence of trauma and abuse in many women's lives, the need to respond appropriately is critical for mental health services, but also has implications for wider services which trauma survivors might engage with, such as drug treatment, criminal justice, housing or children's social care. Such services can have negative impacts on women if they do not take into account the fact that these women have been psychologically traumatised. Trauma-informedness and trauma-appropriate responses need to be widespread across these agencies.

There are challenges for both policy and practice in responding to this kind of complexity in a woman-centred way. This is not straightforward for services and commissioners, and it requires significantly rethinking current provision. Changes are needed at all levels of the system to enable further appropriate support to be delivered.

Delivering trauma-informed provision means ensuring that fundamental processes are established so that services are listening, understanding, responding and continually checking what they are doing (Wilton and Williams, 2019). This means ensuring that systems, policies and staff training are in place so that staff are aware of women's gendered experiences, are trained to ask about experiences of violence and abuse, and can respond effectively. It means providing a context that is safe, one where the service recipient has control over the service they receive and the environment it is provided in. Evidence suggests that a gender-specific service often means creating a single-sex environment with only female staff. Women who have accessed both mixed- and single-sex provision routinely express a preference for gender-specific, single-sex services.

An additional challenge is the different views women and men can have about whether trauma-informed services should be single-sex. The men Centre for Mental Health has spoken to for other projects often state a preference for mixed settings. Like many women, men have often become traumatised due to the actions of other men, and can therefore find an all-male setting threatening. The women we spoke to for this research, as well as others we interviewed elsewhere, almost exclusively expressed a preference for all-female settings. This too presents challenges for services trying to develop an appropriate response for all people with experiences of trauma. Despite this, however, it is clear from the literature and from the women we have spoken to that first and foremost, trauma-informed services have to feel safe and respond to gendered life experiences. As such, this will often mean a single-sex setting.

From our brief review, the services we visited that appeared to be best received by women, and that seemed most capable of supporting women's needs, were Women's Centres and women-centred services in the voluntary and community sector. These services all attempted, mostly successfully, to provide holistic support through a 'one-stop shop' offer that women described as being essential to meeting their needs. This type of service was often delivered in partnership, bringing together specialist provision and reducing the number of services a woman had to engage with separately. This 'wrap-around' support, and the capacity for a woman to drop in or return to a service when they needed it, was key to engaging with women at their own pace. The women we spoke to emphasised that choice and control over their care were key elements to their feeling safe, which in turn was critical to addressing the impact of psychological trauma.

Typically, these types of service were able to deliver the range of support that they provided by accessing multiple funding streams. Most sources of funding were short-term, however, sometimes one-off grants. This could lead to staff turnover, instability and lack of continuity, as services struggled to maintain appropriate levels of provision. There are also challenges in claiming to offer a one-stop-shop model, when particular elements of service provision have had to be scaled back due to reductions in funding. The funding environment that many trauma-informed services for women inhabit is fragile.

A further challenge to achieving more holistic and trauma-informed service delivery is the separate nature of funding streams for the various different services involved. Multiple commissioners have responsibility for meeting the needs of women who have experienced psychological trauma and suffer its impact. This approach risks siloed and uncoordinated provision. For public sector organisations that we visited, challenges centred around this kind of 'traditional' commissioning and the need to meet contractual key performance indicators, which could limit creativity and make it difficult to offer flexibility and choice for women.

There are also challenges in delivering in settings which are inherently triggering, for example within prisons and some health care settings where women's freedom, choice and control are significantly limited.

Scotland has taken significant steps to ensure that all public sectors workers, regardless of what agency they work for, have at the very least a basic awareness of trauma. Those with a care or treatment role have more extensive training. In Scotland, and particularly Wales, there is a recognition of the impact of adverse events during childhood, and therefore a

particular emphasis on prevention, resilience building and early intervention. The population size and multiple commissioning agencies (numbering in their hundreds) in England make the situation all the more complex.

Whilst there is a growing recognition among services of the need to adopt a trauma-informed approach, it is also clear that commissioning agencies, such as clinical commissioning groups, local authorities and Police and Crime Commissioners, need to support the development of such approaches. In short, there is a need for 'trauma-informed commissioning' that is integrated and recognises the needs of the people it commissions services for, setting service specifications based on these principles, and commissioning accordingly. Becoming a truly trauma-informed service requires not only a shift in the entire culture of an organisation, but across the entirety of public services, those who commission them and those who develop policy. Given the multiplicity and complexity of need, both service provision and commissioning need to be better joined-up across different siloes of decision making and funding. This type of approach could be further supported by clear guidance or a commonly shared evaluation tool that would provide a collective understanding of what good trauma-informed provision looks like in practice.

4. Recommendations

There is a growing consensus about the value of trauma-informed services, and the picture is becoming clearer about their benefits. While there is still some way to go until these approaches are embedded, there is no evidence suggesting that adopting a trauma-informed approach causes any harm, so there is no risk in moving further in this direction. In order to do so, and to take account of the barriers and limitations highlighted through this research, we recommend the following:

1. All public service providers, especially but not only health and social care, should have policies and strategies in place to support the development of trauma- and gender-informed provision.

2. The Department of Health and Social Care should include a requirement for trauma-informedness in the NHS Mandate.

3. The National Institute of Health and Care Excellence (NICE) should incorporate trauma-informed principles into the guidance it produces. Existing guidelines do not always take this approach and, as such, they miss the opportunity to support trauma-informed interventions and approaches in health care services.

4. All public service commissioning bodies should adopt trauma- and gender-informed commissioning principles for the services for which they are responsible. Commissioning frameworks should make achieving this goal an explicit expectation of a service when they commission it. Commissioners must recognise that developing and delivering trauma-informed approaches can be a significant undertaking, and should therefore sufficiently fund the time, resource and expertise to enable this and allow it to embed.

5. The Department of Health and Social Care and its arm's length bodies in England, and equivalent bodies in Northern Ireland, should look to developments in Scotland and Wales to support progress towards trauma- and gender-informed public services. In England, this will be vital if the Government is to fulfil the promise of the Women's Mental Health Taskforce.

6. The Department of Health and Social Care should lead a research and development programme in England to consolidate the evidence base and produce guidance and resources that support further consistency in approach. There is a significant role for Public Health England, Health Education England and NHS England in developing this, supported by academic institutions and research funders.

7. A definition and benchmark of trauma-informed approaches for women should be developed, to enable further standardisation of services and a recognition of how services and commissioners can assess quality. The Department of Health and Social Care and NHS England should play a central role in this, with the full involvement of other departments to which this could apply, including Ministry of Justice, Home Office, and Ministry of Housing, Communities and Local Government.

8. All inspectorate bodies (e.g. Care Quality Commission, Ofsted, HM Inspectors of Prisons and Probation) should inspect against the extent to which gender- and trauma-informed principles are being adopted and implemented.

9. Health Education England should ensure that training and development for the current and future health workforce incorporates trauma-informed principles. Public service employers should invest in training in gender- and trauma-informed practice for staff, particularly those working in front-line support, care and treatment roles.

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Trauma-informed approaches for women

Lauren Bear, Dr Graham Durcan & Jessica Southgate

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