Lancashire Violence Reduction Network Trauma Informed Programmes

Evaluation Report 2021/22

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Abbreviations

ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BTH	Blackpool Teaching Hospital
CAF	Common Assessment Framework
CPOMS	Child Protection Online Management System
DP	Detained persons
DSL	Designated Safeguarding Lead
EHCP	Education Health and Care Plan
EMDR	Eye Movement Desensitization and Reprocessing therapy
L&D	Liaison and Diversion
LVRN	Lancashire Violence Reduction Network
PCSO	Police Community Support Officer
TAF	Team Around the Family
TI	Trauma Informed
VRUs	Violence Reduction Units

1. Executive summary

The Equitable Place Based Approaches to Health and Care (EPHC) team (part of the National Institute for Health Research (NIHR) supported Applied Research Collaboration (ARC) North West Coast) carried out an evaluation of four LVRN programmes of work (DIVERT; ED Navigators; Trauma-informed Education and Trauma-informed Training between October 2021 and June 2022. We spoke to 44 individuals and examined relevant data sets and documents to gather data for this report. The theoretical framework guiding the research was Normalisation Process Theory. This framework helped us to structure thinking and encourage exploration of issues that might otherwise not have been considered. Our aims for this evaluation were to: explore the extent to which staff from LVRN and partner organisations understand and implement trauma informed approaches and to identify training needs; explore how TI approaches support LVRN clients and explore how data collection systems can be developed and improved to support sustainable, long-term evaluation that result in improvements to LVRN service delivery.

We found evidence to support the implementation of Trauma-Informed (TI) principles as advocated by SAMHSA in all of the programmes of work. This was evident in the changes in language and approach to working with service users reported by participants. Participants valued LVRN leadership and resources. There was also a recognition that a multi-agency, joined up approach needs to be taken, if TI approaches are to be imbedded in practice. This could be achieved through raising awareness and promotion of the LVRN and TI approaches across organisations and professional groups.

TI coaches feel supported by Football Trust managers and staff from Divert. However, participants reported some lack of clarity around the role of the coaches and the purpose of their role. An example is that a police officer stated that they did not understand “what coaches did” despite having read an information leaflet on the Divert programme. Communication and collaboration between police and football trust staff could be improved by raising awareness of the Divert programme among custody suite staff and clearly articulating the role of coaches and how they will be working with clients. Coaches and football trust leaders felt that they would benefit from having time and space to reflect on and collectively share examples of best practice.

Participants who responded to the training evaluation questionnaire were least likely to agree with the statement ‘I have an increased understanding of how trauma presents in young women and girls and how frontline professionals’ response to this cohort may differ”. This statement links to one of the key aims of the DIVERT programme and national Home Office priorities and should be a priority area for enhancement within the programme.

Participants reported that those in the ED Navigator role were able to build on previous TI knowledge (for example working with the contextual safeguarding framework) and valued regular team meetings for support and reflection. They felt that there were opportunities for ED Navigators to carry out meaningful preventative work with clients and gave examples of engaging with schools around bullying policies, in addition to working with the police and agencies to support vulnerable people identified through the programme.

ED Navigators reported that training other staff working in hospital accident and emergency departments in trauma informed approaches to support identification and referral of patients who have been involved in violent crime would be beneficial and free some time that could be spent working directly with patients.

The evaluation team were able to engage staff employed by Blackpool Teaching Hospital, however the perspectives of staff working in Preston Royal and other early adopter hospitals is unfortunately missing.

Feedback from participants involved in the TI Education programme felt that the Covid-19 pandemic had hit schools particularly hard and affected the ability of school staff to engage with activities outside of their core area of responsibility, including engaging with trauma-informed training. Participants felt that this had affected ambitions to achieve a whole-school approach to being trauma-informed and unfortunately completely prevented some schools from engaging with the programme. However, the schools who did engage were able to complete tasks such as updating curriculum activities, family support and behaviour policies according to TI principles.

Participants reported that in the shorter term, working in TI ways had influenced their understanding and the way they dealt with children, describing changes in the way they interacted as “calmly” and “with respect”. It had also contributed to an increased awareness of the ways in which trauma affected parents and families of pupils and participants hoped that this would lead to better relationships developing with the schools.

TI training and workforce development reaches professionals from a variety of organisations and backgrounds, however, there were some commonalities and coherence in participants’ responses and discussions. Participants spoke positively about LVRN leadership and resources, including the self-assessment tool, and suggested that a community systems and partnership approach might be taken to ensure that all professionals working with vulnerable people are working in trauma informed ways. Barriers to professionals engaging in trauma informed training included limited capacity, challenges to existing professional identities and perceived lack of relevance to roles and responsibilities.

Participants were keen to access clinical supervision and support for those members of staff who are at risk of experiencing “vicarious trauma” through working with traumatised individuals, or who may have already experienced trauma in their personal or professional lives. Participants suggested that spaces be created where experience could be reflected on and best practice could be shared and that the LVRN counselling offer be promoted.

While we have achieved most of the evaluation aims, we do not have the perspectives of clients, patients, families, children and members of the public informing this report. This represents a clear gap in our data and limitation to the conclusions we can draw. However, we have developed some key principles for engagement with service users and intelligence around strengthening data collection systems. This evidence will be vital to supporting future research and evaluation.

2. Introduction

2.1. Background

In the United Kingdom (UK), the UK Government Home Office published its Serious Violence Strategy in 2018 DIVERT, encouraging a multi-agency, whole-system public health approach to violence prevention. The World Health Organisation’s 2014 Violence Prevention Alliance (1) advocates a public health approach, that “seeks to improve the health and safety of all individuals by addressing underlying risk factors that increase the likelihood that an

individual will become a victim or a perpetrator of violence" and suggests four steps to achieving this:

1. Identify the size and scope of the problem
2. Identify risk and protective factors
3. **Develop and evaluate interventions**
4. Widely disseminate effective practice

In 2019, the UK Government announced Home Office funding to assist with establishing Violence Reduction Units (VRUs) in 18 police force areas with the aim of reducing serious violence and its root causes (2). The VRUs public health or 'whole-systems' preventative approach to violence reduction includes:

- Multi-agency working
- Data sharing and analysis
- Engaging communities and young people
- Commissioning and developing evidence-based interventions (2).

As part of this public health approach, the government has stressed the role of *preventing* young people from adopting criminal behaviours and has identified experiences of trauma and adversity as potential predictors of at least one form of serious violence:

> *"Through understanding the impact of ACEs, we know there is increased likelihood of becoming a victim, becoming violent, becoming involved with hard drugs and excess alcohol and ending up in prison." (3)(p.61)*

In response, the Home Office stated it would support police forces to develop new models of preventative, trauma-based policing (3). Many of the VRUs have been working towards embedding a 'trauma-informed approach' through various interventions, for example, workforce development (staff training and awareness raising, changes to organisational culture), trauma-informed approaches through early interventions (for example, trauma-informed education), or development of trauma-informed interventions for young people involved in or at risk of violence (diversion and psychotherapeutic interventions).

The Lancashire Violence Reduction Network (LVRN) aims to embed trauma-informed (TI) approaches within their partnership organisations and workforce. The aim of TI practice is to ensure practitioners are informed and skilled in recognising the wide impact of trauma on the causes and effects of violent behaviour and to prevent the re-traumatisation of clients. (4)

The LVRN has adopted SAMHSA's (5) definition of trauma and their six principles fundamental to a trauma-informed approach. Trauma was defined as resulting from:

> *'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.'(5)*

The six principles are described below. The LVRN Organisational Development Toolkit suggests that to be trauma sensitive, organisations should explore these principles in their daily work and to become trauma responsive, to have begun to change the organisational culture to align with these principles.

Safety Ensuring safety of the individual. Throughout all organisations people accessing services and staff feel culturally, physically, and psychologically safe	**Trust** Organisational procedures and decisions are transparent, including providing timely, accurate and honest information about what is happening, what will happen next and why	**Peer Support** Enable people to feel valued, recognise their strengths, develop new skills, and become independent. Supporting them to identify peer support and mutual self help
Collaboration Understanding power imbalances and working to 'flatten the hierarchy' and make shared decisions. Ensuring empowerment, a voice and choice. Working with not to, in collaboration and with mutuality agree goals	**Empowerment, Voice and Choice** Promote choice. Recognise that every person's experience of trauma is unique and requires an individualised approach. Avoid re-traumatisation. Be conscious to prevent making people feel powerlessness	**Cultural, Historical and Gender Issues** Recognise trauma. Understand and be aware of history and taking the time to hear the influences and impacts upon life

2.2. The evaluation

2.2.1. Scope

The Equitable Place-based approaches to Health and Care (EPHC) theme, part of the National Institute for Health Research's (NIHR) Applied Research Collaboration (ARC) North West Coast were appointed by the Lancashire Violence Reduction Network (LVRN) in October 2021 to conduct an evaluation of four LVRN programmes of work:

- Adult DIVERT
- Emergency Department Navigators
- Trauma Informed Education
- Trauma Informed Training and Workforce Development

This report builds on the findings presented by Phythian (2021) and Quigg et al., (2021) who carried out evaluations of early implementation of TI approaches supported by the LVRN (6, 7). The content of these reports include: a summary of the strategic needs assessment and recommended strategic approaches; development of trauma-informed training and resources, engagement activities and overviews of the workstreams in operation to deliver on key aims and objectives. Please see the above reports for details of early implementation of TI approaches in Lancashire.

2.2.2. Evaluation questions and approach

The overall research question for our evaluation was: *How can the LVRN best support its staff and clients through incorporating a TI approach to their service delivery?*

The aims of the evaluation were:

- To explore the extent to which staff from LVRN and partner organisations understand and implement TI approaches and to identify training needs.
- To explore how TI approaches support LVRN clients
- To explore how data collection systems can be developed and improved to support sustainable, long-term evaluation that result in improvements to LVRN service delivery.

In addition, our findings, recommendations and key considerations for the development of further evaluation of the projects published in this report will contribute to the 4th step: *Widely disseminate effective practice.*

One challenge of evaluating discrete interventions that are linked by a unifying organisation and guiding set of principles is to identify elements that are universal and underpin the approach taken. For this work, we focused on TI approaches taken to reduce violent crime via the LVRN. We have identified Normalisation Process Theory (NPT)(8) as a useful framework to guide data collection and synthesise findings across this evaluation. NPT is a theory of implementation that has been used to support evaluations of complex interventions by exploring how new ways of working are embedded and normalised across groups of people and organisations. NPT focuses on four constructs: Coherence (understanding new ways of working); Cognitive Participation (linking new ways of working to existing knowledge), Collective Action (operationalising new ways of working) and Reflexive Monitoring (appraising and reflecting on new ways of working). Using a theoretical framework to guide research can be practical, help to structure thinking and encourage exploration of issues that might otherwise not have been considered.

The NPT constructs can be framed as a series of simple statements and questions which enable researchers to consider the social processes of implementing an intervention, or in this case, an approach. As such, the NPT framework is not a way of measuring an implementation, but a critical framework to think through the factors which may inhibit or promote a practice, intervention or approach. The NPT framework emphasises that an implementation should be understood as a dynamic process and as such is engaged in ongoing and interactive practices of accomplishment. The NPT framework enables a theorisation of the complexity of social systems through recognition of the way that implementations, such as the TI approach can be thought of as an “ensemble” of material and cognitive practices (9). Our topic guides for the interviews and focus groups used to collect the data for this report have been organised around NPT constructs (see interim report for examples of topic guides).

Here we give an overview of how the NPT constructs have supported our understanding of the data collected for this evaluation:

NTP domain	Examples of the types of questions that have guided our data collection analyses
Coherence has been used to understand how participants have attributed meaning to the TI approach in their community, including how they have made sense of the TI Approach and the work of the LVRN.	Do participants see the TI approach as a new and valuable way of working? Does it fit with previous ways of working? Do individuals understand what the approach requires of them? Do participants understand the role of the LVRN?
Cognitive Participation has been used to explore how committed people are to the approach and how working in trauma-informed ways fit with participants' existing value systems and understanding of their role.	Are participants willing/able to promote the TI approach? If they are willing, but not able, what are some of the barriers to cascading the information/approach to others? Is this where leadership is needed? Do stakeholders believe they are the correct people to promote and drive the TI approach? If they are not the right people, who is? Who is missing?
Collective action is the work people do together to enact TI approach and translate it into collective practices. Examples of the types of questions that have guided our data collection analyses are	How do trauma- informed approaches with the existing skills of the stakeholders involved? Do people have the right skills and training? Do people have confidence in the approach? Do they have the resources needed?
Reflexive monitoring describes how participants appraise their use of trauma-informed approaches in their work. Examples of the types of questions that have guided our data collection analyses are:	How do participants evaluate the worth of the LVRN and trauma-informed approaches? What are the benefits and possible costs? How do trauma-informed approaches work and for whom do they work? What are the barriers and facilitators to implementing trauma-informed approaches

2.2.3. Methods and analysis

The evaluation used a mixed methods approach. A total of 52 people from a range of organisations took part in interviews and focus groups. Secondary data was also analysed where it was available. Further details of the methods used can be found at the start of each case study. Tables showing data sources for each element of the evaluation and characteristics of participants can be found in Appendix 1& 2.

All interviews and focus groups were recorded: some were transcribed by the interviewer (where time allowed) and some by a professional transcriber. The transcripts were uploaded onto NVIVO 11, a data processing package, and coded against the NPT constructs and sub-themes. The quantitative data was analysed using Excel. Where quotations are included in the case studies, the reference number is for the interviewee or, for focus groups, the group as a whole. In a small number of cases the quotation is not referenced to protect anonymity.

2.2.4. Ethics

Ethical approval for the evaluation of DIVERT, TI Education and TI Training and Workforce Development was granted by Lancaster University's Faculty of Health and Medicine Research Ethics Committee on 14 February 2022 (FHM-2021-0631-RECR-1). NHS research ethics approval was not needed for the Emergency Department Navigators

element of the work: an authorisation for this service evaluation was provided by Blackpool Teaching Hospitals NHS Foundation Trust on 23rd March 2022 and Preston Royal Hospital on 24 May 2022.

The findings of the evaluation are presented in Section 2. Each of the four case studies begins with a description of the aims and processes adopted by the workstream, the sources of data for the case study and the data from the interviews and focus groups are presented using the NPT framework. A summary of activity information or secondary data for 2021/22 (where available) is contained in appendix 3.

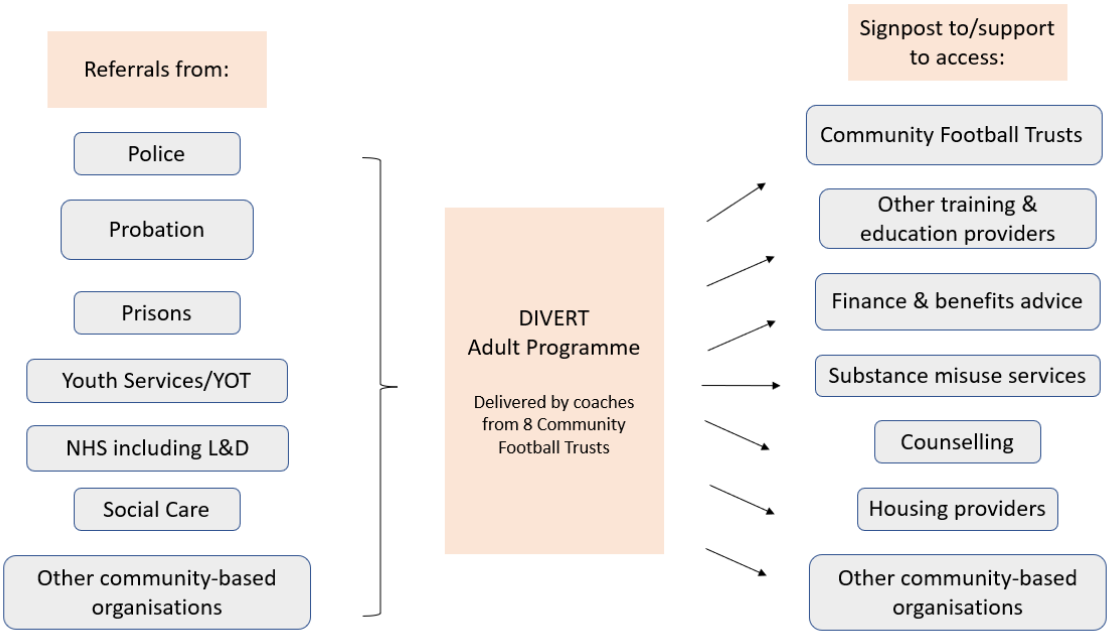
3. Findings

3.1. Case Study 1: DIVERT programme

3.1.1. Programme aims and processes

DIVERT Lancashire is based on an established model operated by the Metropolitan Police. In Lancashire the 'adult' DIVERT programme is a partnership between Lancashire Violence Reduction Network, New Era Foundation and eight local football community trusts. They work with 18-35 year olds who have been detained for violent offences, offering support to make positive changes in their lives, ultimately aiming to achieve a crime free lifestyle, improvements in wellbeing and personal development.

DIVERT coaches are trained in trauma-informed approaches and work holistically with clients. Coaches establish the client's assets, needs and objectives and assists them to access services and activities offered by the football trusts and other relevant providers: this support is available for as long as the client need it. Referrals come primarily from Preston, Blackpool, Blackburn and Lancaster custody suites although other routes are available as the figure illustrates. Clients are signposted/supported to access activities and support provided by a range of organisations. The chart below illustrates the range of agencies DIVERT has taken referrals from and those they signposted clients to or support them to access.



A logic model to describe the intended processes and outcomes for the DIVERT programme has already been developed by Quigg et al.,(7).

3.1.2. Data sources for this case study

Qualitative data for this case study comes from 7 interviews with DIVERT coaches (quotation references 101-104 below), a focus group with 7 football community trust managers (references 108-113) and 2 focus groups with a total of 8 police custody staff (references 120-121). The programme shared anonymised client and outcomes data and responses to a questionnaire sent to partner agencies in January 2022.

3.1.3. Findings from interviews and focus groups

Understanding the TI approach (coherence)

Individual understanding

The coaches have taken part in TI training and saw the TI approach as central to their role. It was a new concept to some who had found it challenging, one saying it had taken them out of their '*comfort zone'* and another that *'it challenges your thinking and the way you view situations*' (104). But it was seen as central to their 1-1 work with clients. One coach said,

> *'Obviously the trauma informed stuff is vital to what our goals are because a majority of the people that we work with, their background will have involved, at some stage, some kind of some kind of trauma' (105).*

They understood that past trauma *'probably led them* [clients] *to where they are today'* (101), impacted on their decisions and actions (104) and *'stops people from progressing'* in, for example, education and employment (102). Coaches talked about importance of *'building trust by being that positive person'* (101) and being non-judgemental (103). There was a view that being TI contributed towards understanding the importance of listening skills, understanding someone's situation, providing good quality support and *'not letting people down'*. In addition to individual trauma, two coaches spoke about trauma in the wider community: one said their locality *was '…struggling in a lot of ways that other areas aren't'* (107) and another spoke about high levels of unemployment, mental health issues, substance misuse and homelessness (106).

All of the football trust managers were aware of the TI approach, in some cases through previous work roles but more often via their connection with DIVERT. Sports organisations including the Premier League were also promoting the approach. One person suggested it also aligned closely with their DSL role. In contrast, the Police custody staff who took part in the focus groups were not aware of the LVRN TI approach, although one referred to knowledge of TI policing. They spoke generally about the vulnerability of detained people (DP) but had very little or no knowledge of the DIVERT programme and the type of work undertaken by the coaches: one custody officer said '*my experience of it literally is the (…) gentleman coming in, and sometimes one of his colleagues, doing what they do on their computer, asking us any questions they've got and then disappearing'* (121).

3.1.4. Collective understanding

During the focus groups, participants reflected on the level of understanding more widely within the football trusts, amongst staff in the custody suites and the agencies DIVERT was working with on a regular basis. There was limited discussion with clients about the TI approach.

Coaches suggested that the TI approach was '*filtering in*' to the wider football trust structures through their involvement with projects such as DIVERT. They spoke about changing attitudes towards the people DIVERT were working with and trust staff being more open to them not simply being a '*bad person'*. One coach suggested there was a real interest in extending awareness:

> *'I know at* [FOOTBALL TRUST8] we have committed to delivering the trauma informed training to all our staff so that's something that we're hopefully going to get done sooner rather than later … It's been received as genuine interest in terms of whether it could affect general practice across the Trust' (104).

One trust manager also highlighted the impact of community work staff had undertaken during the COVID-19 pandemic and suggested it had made the trust more aware of the relevance of a TI approach *'particularly with mental health and that kind of aspect'* (114). Trust staff had also been increasingly involved in other programmes underpinned by a TI approach including DIVERT Youth (necessitating attendance at CAF/TAF meetings) and United Together.

There were mixed reports from coaches about the extent of understanding amongst police officers. One coach said *'I think there is a degree of empathy towards a lot of people who are in custody by the police and they do get the trauma informed approach but same time I still think there's a lot who don't as well'* (105). The general view amongst the coaches was that further work was needed to promote DIVERT and the approach, although one said that some neighbourhood police officers were more aware and had referred to the trauma when making referrals to DIVERT. One police officer also differentiated between the custody and other officers

> *'We obviously know that when people see or are susceptible to violence at a young age, they're going to think that that is normalised behaviour and then they're going to exhibit that behaviour themselves (…) But as frontline officers, we're not really trained that much on it other than to look for the signs and symptoms of it when we're at scene but in custody it's a little bit different. We do the risk assessments all the time, but we don't really ask about trauma in childhood. We just ask the general questions about the health and wellbeing. So it's a little different' (121).*

There was an appreciation that many of the community-based organisations that coaches were working with were TI and one coach stressed that it was important that these partners were confident about

> *'…how we're trying to work. We're not police staff, we're all from different backgrounds (…) but we've all gone through that training, have been trauma informed. So, they know that they can trust us to continue the work that they may have started or they're willing to work with us because they understand that we've gone through that process and they've done the same as well' (103).*

Although DIVERT and other agencies are implementing TI practice there appears to be limited discussion of the TI approach with clients. Coaches gave different reasons for this, including for some *'it puts them* [clients] *in a bad place'* (106). But one coach qualified their hesitancy by suggesting there was a degree of reflection *'We just try and look towards the future. But then some of the clients will say, ah, this is probably why this is happened and then starts to figure out themselves'* (106). One coach suggested that talking with clients about underlying approach was not part of current work, but it might be something that coaches could support *'in different ways going forward'* (104).

Value of the intervention

All participants, including those who did not know much about DIVERT, agreed that the link with the football trusts was a useful facilitator for conversations with potential clients. It was suggested the trusts did not have the stigma attached to statutory organisations and the lack of formality made it easier to engage people who have 'experienced challenges in the past' (104). One police officer suggested the clubs involved gave the programme 'gravitas', so motivating involvement. Other factors identified as adding value to the intervention were the opportunity to take referrals from community-based organisations, before people arrived in custody; the breadth topics discussed and services that can be accessed; support that is 'tailored to fit' around individual needs; the relatively small number of clients attached to each coach providing an opportunity to build relationships; and the lack of a time limit on the provision of support.

3.1.5. Organisational engagement (cognitive participation)

Leadership

Leadership from the DIVERT programme manager, central LVRN team, and police VRN Sergeants were all valued. The DIVERT manager was described as *'the driving force'*, contacting police, local authorities, community safety partnership and other groups to *'get the message out there about what we do'*. The VRN Sergeants were seen having a role in introducing coaches to custody team: one coach said

> *'I think he is a well*-respected [colleague] So for him to come in and say why we are here and what we do and believe in it, I think that might change a lot of mindsets, so all right, if [POLICE SERGEANT1] says it's a good thing it must be a good thing' (101).

Another coach said *'… he's very keen on making sure we're being looked after in custody'* (105). But the police custody staff suggested from their perspective, the VRN Sergeant role could be developed further to increase awareness and understanding of LVRN activity and aid communication.

Legitimisation - are the right people involved?

The football trust managers highlighted that not all trusts had had the same experience in terms of getting key people onboard with the DIVERT programme. It was a challenge for at least one trust whose senior leadership initially *'didn't want to know, … didn't really see the benefit of it'* (112). They were particularly wary about the perceived level of risk involved in working with this client group, but it was suggested that the Designated Safeguarding Lead

(DSL) within the Trust was key to persuading senior leadership that experienced staff were involved and they understood how to do the work safely. The football trust managers also suggested that working with adults and the relatively small number of clients did not fit with the profile of the large volume activities that the trusts were used to. One said that it helped to change mindsets when they could demonstrate how DIVERT '*complemented'* other in-house programmes, including veterans' activities and their education/employability offer (108).

The police staff who participated in the focus groups were positive about the DIVERT programme and coaches in the custody suites in principle, even if they were not aware of them being there in practice. One compared DIVERT with Liaison and Diversion (L&D) saying *'we're used to initiatives like this'*. They felt they understood L&D because they had been there longer and there was more communication with them – they were '…*embedded in custody, they're there every single day. And they do say hello and give us updates on conversations they've had with the DP* (detained person)*'* (120). But there were questions about how the DIVERT related to L&D and initiatives such as Project Nova (offering support to veterans) and whether there was there an overlap.

In terms of acceptance, the experience of the coaches was mixed, although it they said this had improved over time. One coach said that there was a '*hierarchy'* in the custody suite and felt their presence was questioned *'…like who are you coming into my area?'* (101). Another coach said, *'I think what holds us back still is to break that wall of the police accepting us I suppose'* (105). One coach who felt DIVERT was now embedded in the custody suite put it down to relationship building, physical proximity (sitting with custody detention officers and Sergeant) and being based in a less busy custody suite.

In addition to working with police in the custody suites, coaches have adopted a range of methods to engage with other police units. Examples include inviting local PCSOs and police officers to meetings at the football club; patrolling with PCSOs and regularly attending neighbourhood policing team meetings. In addition, they have invested time building relationships with community-based organisations from whom they may take referrals or signpost clients to, particularly during the COVID-19 lockdown when face to face work was limited. The programme and some coaches have also built direct links with other parts of the criminal justice system including prisons, probation, youth offending, Offender Management Panels and are receiving referrals directly from them. One coach suggested the fact that coaches are adopting a trauma informed approach was a key facilitator their links with other services. Being based within the football trusts, however, could on occasions result in a distorted view about DIVERT's offer

> *'…some of them literally think all we do is sport and not the other aspects around the employment and stuff. So sometimes we've had to sort of repeat ourselves, remind them this is what we can do, this is what we can offer' (102).*

It was suggested that programme offer can become less clear particularly if organisation has heard about DIVERT from a third party.

3.1.6. Putting it into practice (collective action)

Policies and procedures to support the approach

As a new initiative, the TI approach was embedded in the DIVERT policies and procedures. These have also been adapted to meet programme needs, for example extending the age of clients to 35 years and taking referrals from other criminal justice organisations and community-based services to extend their reach and increase the number of referrals. Although the interviews and focus groups did not reveal areas where DIVERT policies and procedures did not support the intervention, one procedural issue was identified as the time the coaches spent in the custody suites. It was felt that they needed to be there to pick up referrals but that the time was unproductive if people who did fit the DIVERT criteria were not detained or they were not fit to be seen. It was suggested that this time could have been spent building relationships with existing clients and engaging them in activities: one football trust manager said

> *'It's important having that presence in the custody suite but at the same time we only get two days' worth of funding for our staff member so (…) having one day committed to the custody suite limits the time being able to spend doing the hard graft' (113).*

Someone else having this initial contact, however, was also seen as problematic:

> *'So we would expect or hope that if [COACH2] wasn't in custody, the custody staff, if there was a person in there 18 to 35, would give the leaflet to him on their behalf. But again, if it's coming from a police officer, how much are they going to take that on board compared to when it's our staff member in a football tracksuit?' (111).*

The football trust managers identified two potential areas where policies and procedures had been an issue. The first was with regards to safeguarding and risk assessments where their internal procedures differed from those in place for DIVERT. One trust manager said '*We have lone working policies and safeguarding policies that are scrutinized by DSL and Premier League but in a programme like this there was a lot of work that also had to go in and the Trust had to have a real buy in* (110). The trust managers suggested that the trusts had ultimate responsibility for the coaches, their policies and procedures were paramount, and they needed to have oversight of what the coaches where doing. One said,

> *'I have a quite hands on approach, making* sure that everything aligns with us effectively because if something was to happen and particularly when the coaches wearing the [FOOTBALLCLUB7] badge it would ultimately be in the newspaper saying [FOOTBALLTRUST7] employee XY and Z.' (114)

The second issue raised by some of the football trusts was the separation of DIVERT and DIVERT Youth. Some suggested that it would be more efficient if the coaches could work across the two programmes as they had higher demand for DIVERT Youth:

> *'I think with DIVERT Youth the difference we've found is that younger people are probably more motivated to engage or you can kind of get*

> *school, parents, YOT on board to try and encourage that engagement whereas the 18 plus it's purely their decision in custody if they want to engage and if they don't' (111).*

For the police staff, there was a general lack of awareness about DIVERT procedures and what was expected of them in relation to the programme. During the focus groups police staff asked, for example, whether their role was to identify which detainees they should signpost coaches to, or did coaches make their own decision based on information on the whiteboard? Did the coaches liaise with L&D about referrals? And if coaches did engage with someone, were they allowed to feedback *'relevant information'* about, for example, vulnerabilities. They also asked if they could refer people to DIVERT if the coach wasn't in the suite at the time. One custody officer contrasted procedures for DIVERT with those for Project Nova, the latter having a '*tick box on the risk assessment',* meaning all custody staff were aware of this programme.

The caveat to greater police involvement, however, was that it did not *'get in the way of what we're there to do in the 1st place'* (120). The lack of clarity in DIVERT procedures in the custody suites was perhaps explained by the differing attitude of two coaches – one said they ask the custody staff '*Are we OK to borrow one of your staff members just to open up the cell doors for us. That's literally the end of their role'* (101) whilst another was keen for police staff to be more engaged and suggested:

> *'the only way you build up that relationship is by talking and explaining what you're there for, what you do and it's got to the point now where when I'm not in, DIVERT's still being spoke about by staff and L&D (…) in custody, so they still talk about DIVERT to the people that come through custody even when I'm not in and they know that they can refer to me. Then it's not just me, DIVERT's is not just something when I'm in custody' (103).*

Workforce support

DIVERT coaches receive support from both the DIVERT programme manager and their football trust manager: this dual provision did not seem to be an issue and there was positive feedback from the coaches about both. Some coaches also received joint supervision sessions, in part to ensure there were no '*crossed wires'* – one football trust manager suggested that since this had happened, *'it has got a lot better, and I do tend to touch base with our coach a lot more than I had done previously'* (110). The football trust managers said they needed to know about their coach's caseload with a particular view to safeguarding and several coaches said they would go to their football trust manager with any safeguarding issues. One coach said: *'although we're seconded to DIVERT, we are part of the community trust, we wear the club badge, and the trust is our place of work. We are allowed to wear the badge so that we need to be responsible to them'* (103).

Resources

DIVERT coaches identified the needs of clients as including support to access employment, education or training; assistance with substance misuse; mental health and wellbeing; housing and homelessness; financial or benefits advice; and social networks. Coaches argued that it was important for the client to prioritise their needs and the coach to identify

resources to meet them. One coach said '*it's about sorting the basic things out first (…) we'll do little like baby steps with him so that they're not feeling a bit overwhelmed by it all'* (106).

Once in post, the coaches spent time becoming familiar with local service providers and building links with them. Some suggested this was aided by their location in an established football trust with one saying their Trust

> *'…probably have one of the best understandings of the local community and have already a pre-existing network of contacts (…) They're already a trusted resource so when we're approaching a college, if we're just approaching as a new programme, say DIVERT wasn't attached to the football trusts I think there would be a lot more questioning of well, who are you? What are you doing? But when you come at it from a football club approach (…) they know the people that we work with, there's mutual connections between the organisations' (104).*

The larger football trusts themselves also have a wide range of resources and activities that DIVERT clients can access and their venues were identified as relaxed meeting spaces. One coach highlighted how important the football trust provision could be:

> *'I'll introduce people slowly because a lot of them suffer from anxiety, mental health, depression. So getting into a completely new thing is hard enough so if I told them 'you've got to go to this college', then I don't really want to do that, but if I can introduce people at the football club or the community trust, then they start to feel at ease and that's how we can get them into education and traineeships' (106).*

A number of resource issues, however, were identified, including long waiting times and finding an appropriate service, particularly to address mental health issues that may be associated with trauma. One coach described '*getting passed from pillar to post ... and being asked why can't this person make the phone call?'* (105) when they were making enquiries on a client's behalf. Coaches said they often had to engage clients in other activities whilst waiting for the necessary professional input. Homelessness and housing were also mentioned as issues where finding solutions was difficult and on occasions, coaches had to leave the client to find short-term accommodation through their own support networks. Another identified gap was the lack of a budget to support client activities: this was particularly an issue for smaller football trusts where there were fewer internal resources available. A football trust manager contrasted this with DIVERT Youth where coaches do have a budget.

3.1.7. Reflection and future evaluation (reflexive monitoring)

Measuring and recording outcomes

The coaches use View and an Excel spreadsheet to record information about clients and outcomes. The DIVERT programme manager and administrator are currently looking at data quality issues and whether there are better ways of recording and storing information. Although the coaches were positive about the data collection systems training they received, some did see this element of their role as a '*daunting'* and a time consuming task. There was

also a suggestion that whilst Views was good at recording 'solid' outcomes such as getting people into work, there were also significant 'soft' or intermediate outcomes like starting to leave the house, speaking to mum or dad, increased confidence, improved wellbeing or engaging with a service that might be missed because the focus was on the end point. One coach also said there may be an information gap in recording things that had not worked so well: '*from my experience we do tend to record a lot of the positive stuff so maybe if there's a way of easily collecting challenges and setbacks and recording them'* (104). There was a recognition that both quantitative and qualitative data was required and served different purposes: for the football trusts and for the programme as a whole, both stories and 'hard facts' were required.

For the football trusts, there had been a challenge to not simply look at the number of people the programme was working with, a more traditional measurement for their organisations. One trust manager said:

> *'…on other projects we tend to be focused on numbers so we will have a target to aim for. I think it took a bit of getting used to our end with DIVERT that this is more quality, a concept that was a very different way of working at first, that's what we've got our head around over time' (109).*

They were positive about attitude of LVRN and programme management who they said had not been frightened to argue the case for quality over quantity and also lead a data clean-up which will look like the number of cases has reduced:

> *'I feel like as a group in Lancashire supporting fewer numbers but actually hitting those outcomes rather having 30 people on a caseload but actually you see them once every few weeks and how much impact can you make on their life when you see them an hour a month? So I do think definitely for us quality over quantity is working' (111).*

<u>Outcomes for clients</u>

DIVERT coaches record client outcome including facilitated support into treatment services, housing, financial/benefits advice, volunteering opportunities and community based activities and a broader 'improved wellbeing' (illustrated above). Information on reoffending is not currently collected but it has been suggested that this could be done manually.

The coaches suggested that the process of talking to clients about outcomes was very positive. One explained it was important for client to recognise what they have achieved, one said

> *'The big bonus in his realising that they're doing it even though we're supporting, putting the pieces in place for them. But at the end of the day, they've got to get up in the morning and go to a course and go to work (..). It's them, they're doing it' (103).*

And for some clients, celebrating and recording intermediate milestones was as important as one coach explained:

'a lot of the outcomes have been like getting them into housing, getting them into employment, getting into traineeships (…) But as well, I've got a few that suffered badly with anxiety, they might not want to leave the house or the hostel so getting them into community activities where they're interacting with people, that's a massive outcome for them' (106).

It was evident from questionnaire responses that professionals from partner organisations also recognised these 'softer' outcomes, citing, for example, the value of DIVERT activity in building a meaningful relationship, positive role modelling, support to attend appointments and engagement in constructive activities.

Whilst DIVERT and the football trusts shared information about outcomes for clients (particularly positive ones), police staff said they were not aware of the activities that DIVERT clients were engaged in or the subsequent outcomes, but they were interested in knowing more as one custody officer explained:

'the reality is we don't know what the outcomes are because we're not in that loop. So it would be nice to know because it's always good to know that the effort you put in to facilitate all this is actually coming to a fruitful end' (121).

Outcomes for organisations

The coaches and football trust managers spoke about attitudinal change within the Trusts as a result of the DIVERT input. It was suggested that people were becoming more openminded: one coach said

'…when we've got events on they are welcome, the same as everyone else. We've given volunteer opportunities to people. We've given education opportunities to people off the programme, and we've even got some of the clients into work through the Trust, which I don't think would have happened two years ago or pre DIVERT, I think it's definitely challenged some automatic responses' (104).

One trust manager also referred to a local employer who was a club sponsor now having a policy of offering an interview to DIVERT clients seeking employment.

The input of a DIVERT coach was also seen as an advantage to community based organisations. One coach spoke about a housing organisation *'… giving people a chance that they might not give them without the backing of the programme or without the support of coaches'* (104). Partner organisations who had referred to DIVERT said the support offered had enabled clients to attend appointments and one said it was 'crucial' in one person's smooth transition from custody to the community and their maintaining links with the probation service. The fact that it meant that an individual had access to more frequent one-to-one support was also recognised.

In terms of outcomes for the police, there was one comment from a football trust manager which suggested the police were recognising the impact of the programme:

'I think the custody sergeants now we're aware of what we can do and from our experience in [TOWN6] there were two or three that we've worked with who were becoming regular offenders that they don't see anymore. So I think they're see the value in terms of actually not seeing those regular faces pitching up on a Sunday or Saturday after a night out. So again I think they see that we have made a difference to their workload which obviously, it's the ultimate gain' (110).

Communal reflection

The coaches have a weekly DIVERT team meeting for information sharing and one coach said it was an opportunity for reflection. Another coach mentioned their '*innovation panel'* to discuss the programme and its direction *'what can we do to make this programme as good as it can be (…) how can we improve what we do'* (101). No-one else mentioned this but another spoke about longer meetings where they have targeted specific issues or challenges, '*to gain an understanding from different trusts or different people on what their challenges are and how we could overcome it and how we can move it forward collectively rather than people just people struggling individually*' (104). Not all of the coaches seemed to be involved in these meetings as one suggested that *'themed meetings (…) where we could discuss certain things would be good'* (105). Where there is more than one coach operating from a custody suite, there was an opportunity for casual conversation when they overlapped. Two coaches worked alone and so did not have this opportunity, although they had linked up informally.

The football trust managers had met together when DIVERT was being established but had not done so recently, instead meeting individually with the programme manager. They appreciated the focus group as a chance to get together to talk about the programme:

'The one thing that's quite nice today is actually sitting with all the other trusts. Since DIVERT launched where we did sit initially with everybody, we haven't done that since really because all of our coaches have gone off and they're all working in different pockets of Lancashire on different programmes with different referral numbers' (110).

Recognising there were differences across the county, the trust managers suggested it would be beneficial to get together to:

'…share best practice, what are some of the issues that are coming out of certain areas, how we can all learn from each other because we've already said London is completely different to Lancashire but equally [TOWN1] is completely different to [TOWN6]. So, we're all going to have different needs and issues but actually we can probably still take something from each area and learn from some of the young people we work with' (111).

The trust managers also spoke about meeting with London DIVERT, a useful learning experience but they clearly felt there were big differences between local needs and subsequent mode of operation that needed to be stated and recognised by the Home Office. One manager said:

'So should you get the Views up for London and the Views up for us it does look like completely different programme in terms of [quantitative] outcomes (…). It's really important that we're not just having those conversations, they are then taking it to VRN and they're then having those conversations and saying actually we feel that this programme is more valued by doing this. We feel that we are shaped by this, and they've not been frightened to think flipping heck, we need to keep up with London because that's who gets funded, and we need to do that.' (114)

Implementing trauma-informed principles

The LVRN Organisational Development Toolkit suggests that to be trauma sensitive, organisations should have begun to explore the six principles of TI practice in their daily work, and to become trauma responsive, to have begun to change the organisational culture to align with these principles. The following quotations are illustrative examples of statements made during the evaluation about practice that supports these principles:

Safety	Coaches were aware of the need for clients to feel physically and psychologically safe: *'I'll introduce people slowly because a lot of them suffer from anxiety, mental health, depression. So, getting into a completely new thing is hard enough so if I told them 'you've got to go to this college then', I don't really want to do that. But if I can introduce people at the football club or the community trust, then they start to feel at ease and that's how we can get them into education and traineeships'* (106). There were also conversations about safeguarding policies and practice: '*We have lone working policies and safeguarding policies that are scrutinized by DSL and Premier League but in a programme like this there was a lot of work that also had to go in and the Trust had to have a real buy in'* (110).
Trust	Building and maintaining trust with the client was important: *'Ultimately, the aim is to reduce reoffending. But obviously it's not as simple as that. I think the main aim to reduce reoffending is to build trust with all these people, building trust by, you know, being that positive person. But a lot of these people haven't had that. Just having that ability to be able to say that we're here for you if you need us'* (101) '*I think it's down to the way we approach people, the way we speak to them and how we make them feel, whether we made him feel like we*

	are someone that can be trusted, as someone who's interested in helping, or whether we make them feel like we're someone that's getting paid between 9 and 5' (104)
Peer support	Coaches described activities where clients could meet other people with lived experience: *'So they can say like here's what I did to get out of this and they can help each other. So, I think probably the main thing is just helping them access that support network'* (101)
Collaboration	Coaches worked with client to come up with a plan of action: *'I'll say what do you want us to do first? What do you feel like you need most at the minute? And then we'll work off that, we'll tick through that work' (101)*
Empowerment, voice and choice	The importance of developing resilience was recognised: '*the most important thing is just improving that mental wellbeing because that can just give them the confidence to go out there and get a job. I might not have done anything else apart from improve his confidence, but then he could then go out and do that off the back of it'* (102)
Cultural, historical and gender issues	Football Trust managers suggested there were cultural differences within the county that needed to be reflected in the programme's way of working: *'…we've already said London is completely different to Lancashire but equally [TOWN1] is completely different to [TOWN6]. So, we're all going to have a different needs and issues but actually we can probably still take something from each area and learn from some of the young people we work with' (111)*

3.2. Case Study 2: Emergency Department Navigators

3.2.1. Programme aims and processes

The Emergency Department (ED) Navigator programme aims to prevent violence-related admissions to hospital amongst children and younger adults (aged 10-29 years) and to support patients who have attended hospital as a result of a violence-related incident. The LVRN funded programme has been based at Blackpool Teaching Hospital and the Royal Preston Hospital and during 2021/22, additional funding from the Home Office Teachable Moment initiative (67% of the total ED Navigator budget) enabled the service to be extended to include Lancaster and Morecambe, Blackburn and Burnley. From 2022/23 onwards, the LVRN will fund the programme in Blackburn, Blackpool, Lancaster, Preston.

In Blackpool, the ED Navigator is a nurse and is based in the ED. The first contact with patients is usually in the hospital, although if the ED Navigator is not on duty, suitable patients will be contacted by telephone. The ED Navigator will offer to complete a health needs assessment with the patient and following discharge will provide a bespoke service to support patients, including helping them to access community-based services. The ED Navigator is based in the safeguarding team and undertakes more work by telephone (see *below). A total of 547 patients were reached at Blackpool Teaching Hospitals in 2021/2022 via the LVRN funding stream (and 901 people via the Teachable Moment funding – the latter included 185 people in Preston).

A logic model to describe the intended processes and outcomes of the ED Navigator programme has already been developed by Quigg et al., (2021, p37).

3.2.2. Data sources for this case study

Qualitative information for this case study comes from 3 interviews with ED Navigator programme staff from Blackpool Teaching Hospitals Trust (quotation references below 2011, 2012, 2013). Staff from Preston were invited to take part but did not respond to the invitation to participate.

3.2.3. Findings from the interviews

Understanding the TI approach and ED Navigators (coherence)

<u>Individual understanding</u>

A trauma informed (TI) approach was identified as a longstanding mode of operation for the programme management. ED Navigator programme staff referenced '*looking at adverse childhood events'*, being aware of '*cycles of violence*' and the importance of being part of a contextual safeguarding framework where violent incidents are seen against the backdrop of an individual's home, school, on-line and neighbourhood relationships. As one participant explained, they '*think outside the box about what's brought this person here. It's not just as easy as "Oh, they've been in the wrong place at the wrong time," that happens but it's not often like that (…) It's what's going on in the outside world for that person…'* (2011).

In addition to a TI approach with patients, the programme has identified the need to understand vicarious trauma and its impact. ED Navigator staff had attended vicarious trauma training which addressed '…*how to deal with some of the things that we're seeing and how to try and keep that at work and not take it home with you or not let it impact the way that you're working'* (2013). This participant had found the training beneficial and suggested it was something that should be considered for all staff who were working with people who had or were experiencing trauma.

3.2.4. Collective understanding

It was argued that the services that ED Navigators work with were '*rooted'* in the TI approach: services highlighted were youth offending, social care, Child and Adult Therapeutic Services and a community based project The JJ Effect. But the value of the LVRN rolling out the TI approach across the county to practitioners who are less aware was acknowledged.

The ED Navigators regularly see police escorts in the hospital and converse with them about their role. They cited an increasing understanding from police staff and a link being made with other programmes: one participant said

> *'I'll explain to them my role and then they're like, "We've got DIVERT. We've got Liaison and Diversion. We've got various different processes in place where we're learning about trauma-informed practice." I know especially the younger ones that are coming in … have more of an understanding about the trauma background and don't just to jump on the fact that he's arrested because he was causing criminal damage, or she was in a fight. It's nice to know they're actually thinking outside the box themselves.' (2013)*

One participant suggested that ED staff were a group that needed to be more TI. It was suggested that one outcome of this would be for them to understand why they needed to ask patients for and recording more information if the ED Navigators were not present. The pressures on hospital staff as a result of the COVID-19 pandemic has delayed awareness raising with this group of staff but this is currently being planned. In the meantime, when the ED Navigators are in the ED, it was suggested that their pink uniform makes them stand out and other staff have asked them about their role. Navigators are thus able to raise awareness through their one to one contact with hospital staff, particularly with the charge nurse before they approach patients.

Another sector that was identified as needing to think in a more TI way were schools. In supporting school age children, the ED Navigators have questioned the attitude adopted and tried to encourage staff to consider why a child was behaving in a particular way:

> *'…it's like you're having to challenge that. Why are they being nasty to other children? What's making them do that? Is it because they're feeling vulnerable? Are they trying to fit in? Are they trying to make friends? There's so many different reasons and I get that education are busy and they've got hundreds of kids in a school to deal with, but at the same time, they're there to safeguard the children. It's working with them and challenging them as well and making sure they are aware of the trauma-informed approach' (2013).*

They described their work with schools where children were struggling and parents did not know where to turn. One person said

> *'I think it's really important that we target certain schools that aren't following bullying policies. When we can see a school that's constantly coming in with bullying issues, then work needs to be done in that school around bullying, following policies correctly (…) we have had some real battles with some schools around, "No, we're dealing with it, we don't want it reporting to police." It's absolutely crazy. That's something we could definitely work on improving.' (2012)*

Value of the intervention

The presence of the ED Navigator in a hospital setting was seen as opportunity to engage with an individual at a point in time when they were vulnerable but in a safe space and with someone they could trust. The ED Navigator service was seen as providing capacity for engagement at that *'reachable and teachable moment.'* (2011). One participant explained that the process of relationship building starts at this point:

'…clinical staff don't have the time to support them emotionally and to find out the bigger picture of what's going on and if they're going to be safe to leave the department. Have they got support out there? That's where we come in and I think it makes a massive difference. Just so that they know they've got someone to actually listen to them.' (2013)

It was also argued that ED Navigators have an opportunity to engage with people involved in violent incidents before they are in contact with the police or turn up in custody, thereby avoiding another potentially traumatic experience.

Employing nursing staff and basing them within the ED were seen as key elements of the programme. It was suggested that nurses could pick up on '*more subtle presentations*' and identify whether an injury was likely to be accidental. Being NHS staff was also seen to facilitate their communication with other health professionals, enable them to accompany patients to appointments and advise on other health issues or injuries after discharge.

Underlying the intervention, especially moving forward, was the use of data to establish the 'problem profile' so the ED Navigators service could be provided at times and in locations where the need was greatest.

3.2.5. Organisational engagement (cognitive participation)

Leadership

The ED Navigator Programme is overseen by the LVRN Health Lead. Their experience of contextual safeguarding and a range of initiatives related to serious violence were seen as key to their role in the development and oversight of the programme. The delivery of the same ED Navigator service across the county, the '*fidelity of the model'*, was also seen as a core principle for the programme's leadership, a principle influenced by similar provision in other areas of the county (particularly in London and Glasgow), and other services such as the Independent Sexual Violence Advisers (ISVAs).

Involving the right people

As highlighted above, the participants from Blackpool THT believed firmly that the ED Navigators should be NHS staff and based in the ED. One person said 'You've got to understand the ED and you've got to be accepted in the ED and hold your own. And it's, you know, they're a 24/7 team, they deal with lots of things. You've got to be there and be one of them' (2011). It was also suggested that the ED Navigator's presence in the ED enabled other staff to see how they interacted with patients, thereby modelling TI practice. And an ED Navigator involved in the evaluation suggested that some nursing staff were now taking onboard the TI approach:

> *'I have recently had, in children's ED, good responses from some of the nurses. They're getting more involved in asking specific questions and trying to (…) think outside the box. I had one this today, for example, she'd put a safeguarding alert on (…) She had a discussion with me prior to me going in and she said, "There's just something I don't feel is right. I don't think he's necessarily opening up and telling us the full story, X, Y and Z." He's come in with a thumb injury but she's thinking outside the box and to her it's not just a thumb injury, which was really positive because obviously, that's what we're looking out for as well.' (2013)*

But it was argued that there was still some way to go before ED staff were TI and also understood the importance of collecting the information that the ED Navigators required. One participant said it would be '***massively beneficial'*** if other ED staff asked more questions so that vulnerable patients could be identified without the ED Navigators having to do the time-consuming task of reviewing all of the people who attend the ED when they were not present. It was hoped that awareness raising sessions, delayed by the COVID-19 pandemic, would facilitate greater proactivity.

The location of the ED Navigators within the contextual safeguarding team was seen as advantageous, both as a foundation for the way of thinking about an individual's circumstances (particularly with the family context) and with their close links with services such as Child Exploitation and Youth Justice.

The ED Navigators casework necessitates engagement with a range of community-based services including GPs, sexual health, mental health and substance misuse services, dentists, housing providers, social care, victim support, schools etc, many of whom, it was argued, were already working in a TI way. Participants highlighted the need to ensure that all of the professionals they were referring patients to were TI and were not only cognisant of the most recent injury but also about patient's history. Other services not adopting a TI approach could have a subsequent impact on the support required from the ED Navigator as one person illustrated:

> *'Like a young man that had been stabbed several times, I worked with him because there was a police investigation, and his anxiety was really bad. Getting him to the appointments, he was struggling, being discharged from mental health because he couldn't get to the appointment, but they weren't looking at the fact that he was too scared to get to the appointment. We will support with things like that until they're in a better place and they don't need us anymore.' (2013)*

3.2.6. Putting it into practice (collective action)

Policies and procedures to support the approach

The two areas of policy and procedure raised by participants related to safeguarding and patient referrals. Patient and staff safety were key considerations to the operation of the ED Navigator programme. Their patients are vulnerable children and adults and include people who fear for their life: this particularly impacted upon where they felt able to meet with the ED Navigator, how they could travel to appointments and activities, and the nature of support they and often their family required. Working collaboratively with other providers to avoid or reduce re-traumatisation is also an important safeguarding consideration. For the ED Navigator staff, assessing the level of risk for each case and taking action to mitigate risk is central to their practice as one participant explained: *'A couple of weeks ago, (…) I went out all day doing joint visits because they are high-risk cases, so we go in twos.' (2012)*

The ED Navigator programme does not have a referral process for wider ED staff to refer to the programme. The work began during the COVID-19 pandemic, and it was felt that ED staff did not the capacity to '*fill in another form'*. Consequently, the ED Navigators view all attendances that occur when they are not present, and follow-up by telephone any cases that appear to be appropriate or they are unsure about. But the participants stressed the importance of the ED Navigator being present in the ED at peak times *'…to capture when the attendances arrive, which is obviously anti-social hours. It's not a Monday to Friday, 9 to 5 job this because that's not when serious violence happens.'* (2011).

> *'Being in the hospital and having timely conversations with patients were seen as key facilitators to engagement 'I think definitely that (…) the initial talk and greet with them and getting to know them and to know our service and what we're about. Really, I think that is so imperative to how we can support them moving forward and building that rapport with them initially.' (2013)*

Workforce support and skills

It is acknowledged that working with such a vulnerable group and in high risk situations required considerable support and supervision. Managers described the availability of support when staff were working out of hours, for example, comparing it with a social worker duty system:

> *'…they're dealing with really significant injuries in cases and it's not easy to deal with. So they could be on shift at ten o'clock at night dealing with a case and yes, you've got ED staff there to support you, but it's not really quite the same. They're dealing with the injury where we're dealing with the whole emotional and contextual package of what's going on, which can bring out a lot more. They can think, "What can I do with this?" and they call me. They probably have supervision every other shift, to be honest, but that's fine'.*

The ED Navigator manager also accompanies ED Navigators undertaking casework if required, explaining that it *'…supports my staff physically, not just in a supervision way (…) Sometimes if they've difficult cases and they'll be having a bit of a wobble and I'll go and do*

a shift with them and support them.' This was also seen as a way of maintaining consistent levels of practice. Each case open to an ED Navigator is discussed at individual supervision sessions and '*ad hoc'* supervision whenever it is needed. The team also have a monthly team meeting during which an ED Navigators can bring a case to discuss.

The ED Navigator involved in the evaluation particularly valued the informal support that was available saying

> *'We do have regular supervisions. Once or twice a month, I think it is. But it feels like more because we're always able to contact our manager. It's very open-door policy because obviously, because of what we're seeing and what we're witnessing and we are working on our own on a shift, it does get overwhelming at times. But we've always got our manager to speak to. We've got other people within the team we're able to talk to. But definitely really good support.'*

Managers were also aware of the impact that this work could have on staff and vicarious trauma training has been provided.

The medical training of the ED Navigators was seen as a key element of the programme, as described above. In addition to the skills that the Band 7 nurses brought with them, ED Navigators have also received additional training to support them and their patients including vicarious trauma training and more recently 'knife savers' training. Both of these were attended with colleagues from the Blackpool Contextual Safeguarding team.

Resources

ED Navigators work with patients to support their access to a range of health, social care and third sector resources, depending on each individual's situation and needs. They will also work with other family members whose health and wellbeing is affected by the assault – one participant said: '*if you don't sort out the issues within the family then how are you supporting the victim? Sometimes we'll have a victim of violence but then there's a lot more going on (…) you have to look into the family and if they need referring to social care for extra support and things like that.'* (2012)

Mental health services post hospital discharge were identified as a key resource requirement as one participant explained:

> *'I think our initial thing is making sure that they do have that support because obviously, it's traumatic what they're coming in with and we can refer to places such as Supporting Minds, and Minds Matter and services that are out there for mental health and anxiety and post-traumatic stress. We can refer but it's not going to be next day delivery (…). They're going home and potentially having flashbacks or nightmares or anxiety and worrying. So, it's just to make sure they've initially got that support straight away. That's my first concern.' (2013).*

Some additional funding had been accessed by the programme to enable a small number of patients to receive cognitive behavioural therapy and 'eye movement desensitization and reprocessing therapy' (EMDR) to address ongoing mental health issues and a provider has been identified to provide therapeutic sessions for children. One to one sports sessions were available through the JJ Effect, a sports and knife crime project.

In assessing the needs of each case and the input required, one consideration is whether patients or family members are already connected to particular services. Care was taken to avoid duplication and re-traumatisation as one participant explained with reference to mental health services:

> *'So instead of us both seeing them at different stages, and them having to re-tell the story, re-go through what they've already just been through (…) is there something we can do to work together to say, "I'll do it? They've come in with a mental health concern, so I'll touch on it though and I will discuss X, Y and Z." Or can you do it, and vice versa.' (2013)*

This may result in patient not needing this particular input from an ED Navigator or requiring support to re-establish their connection with another service. It was suggested that being a health practitioner facilitated these links: '*So I think we're quite highly respected in that way and the appointment is usually made without an issues.*' (2012)

There is also no limit on the length of time that patients can access support from the ED Navigators, in part because an individual's needs and the input of other service will change over time. One person described the need for flexibility as an individual's initial needs have been met but there has been a change of situation: '*We do get patients or parents contact us again and say you know what, this has happened but he's not sleeping now he's having flashbacks, or this is happening or it's getting worse. They can always contact us.'* (2013)

A further resource engaged by the programme was preventative. Outreach was undertaken in problematic locations identified via ED Navigators cases as one participant explained:

> *'Information is key because then we can target those areas with outreach work, which we do where police and licensing, council, social care, health go out on a Wednesday and Friday evening and disrupt those places. Only this weekend a park was highlighted that will be targeted now for nasty assaults taking place (…) we need to look at disrupting and being proactive.' (2012)*

The ED Navigators reported limitations in their capacity to deliver the service. Although staff cover each other's sites if they are on annual leave, cases routinely build up and the high number of ED attendances made keeping up patients '*taxing and demanding*'. For the periods that the ED Navigators were off-site or not working, they needed to check the data recorded about each attendee to assess whether they fit the programme's criteria – this was a time consuming task and described as '*something that we really need to look at.'*

Reflection and future evaluation (reflexive monitoring)

Measuring and recording outcomes

The ED Navigator programme have an initial assessment of need and 'follow-up' templates to record 'what services we referred to, what work we're doing with them. And obviously, if it's not going well and they're not engaging, how we're going to resolve that.' (2013)

Separate forms record the needs of and work with families. This work is seen as an essential element of the ED Navigator programme but not one that was recognised by the Home Office in the Teachable Moment fund reporting. One participant said

> *'…so you're working with a person and our numbers will look like we're working with a person who was the victim of violence, but actually it's much wider and then you start linking in with social workers and everybody else around the family, mum's mental health worker, some of the cases are really quite complex.' (2011)*

One Home Office target mentioned, and one participant questioned whether it was appropriate, referred to returning to full time education: it was suggested that there may be other more suitable options for young people who might have been out of school for a significant length of time.

The programme also produced '*patient stories'*, including recorded versions to communicate needs, activity and outcomes. The ED Navigator said it was important to show the breadth of their work through these case studies that are shared with external organisations, including funders:

> *'I try and give a mixed, genuine representation of what our struggles are, as well as our success so that people from the outside can think it's not just plain sailing and going out referring people, or taking them out for McDonalds, or doing X, Y, Z. It's genuine, hard work we are doing but it's for the greater good of impacting the children and young people and adults. I suppose future generations as well.'*

It was suggested that the process for recording informal feedback from patients and families in particular could be improved: 'It's something we don't capture at the minute. They send us lots of messages, text message and things and say these things but it's not being captured as well as it could be at the minute so that's something we're looking at.' (2012)

Outcomes for clients

During the interviews there was limited discussion of specific outcomes individuals who had accessed the ED Navigator service. One that was mentioned were positive outcomes for some of the patients with ongoing mental health issues who had accessed the EMDR therapy pilot. The Teachable Moment annual report refers to improved outcomes for individuals including 'physical recovery from a violent injury, access and supported to substance misuse and sexual health services, improvement in emotional health and well-being and a speedier recovery to return to education, thinking about training opportunities, reintegrating with peers and support with wider family dynamics and tensions.'

It was acknowledged that it can be difficult to get information from people who decide to disengage but it was suggested that they may have got what they wanted out of the service and no longer felt they needed support.

Outcomes for organisations

Data in the Teachable Moment report suggests that more than 90% of patients who have received support from ED Navigators have not reattended the ED. It was acknowledged that

it would be useful would be to look at this figure over different time periods to identify the extent to which this positive outcome is maintained. The programme lead also spoke about planned research with other similar programmes to identify characteristics of people who do/do not reattend ED.

Another stated aim of the programme is to reduce anti-social behaviour and serious violence. Although no data were available, the disruptive outreach work in response to ED Navigator intelligence is likely to be contributing to a positive outcome for criminal justice services. As one participant explained, where appropriate, ED Navigators will encourage information sharing with the police or an intermediary, although there were risks associated with this:

> *'So it's up to the young person, but sometimes things have to be reported to the police and they understand that, but sometimes they can be reported to Crimestoppers or anonymously and it doesn't have to be the young person. Sometimes you don't want to expose the young person because they would be identifiable, who's given them significant information about maybe drugs or something. So actually, it's good that it's a third party or via a different route' (2011)*

Communal reflection

The monthly team meeting was identified as a forum where ED Navigators meet and can bring cases for communal discussion and advice: this was also the place where staff could share ideas, identify new trends and suggest practice improvements. The Programme lead meets with a national group of 32 Trusts at the Royal London Hospital every 6 weeks to *'check-in'*, talk about progress, new developments etc.

Implementing principles of TI practice

The LVRN Organisational Development Toolkit suggests that to be trauma sensitive, organisations should have begun to explore the six principles of TI practice in their daily work, and to become trauma responsive, to have begun to change the organisational culture to align with these principles. The following quotations are illustrative examples of statements about practice that support these principles:

Safety	Patient and staff safety were core issues for the ED Navigator programme: *'I think that's one of the main things, allowing them to feel safe in our care and that, unless it's a safeguarding risk, we're not going to share information with other people. They don't have to feel scared about sharing information with us but just need to know that they're safe, and making them feel that they are worth, and they are going to be listened to in ED. Like I said before, it's so fast paced, and they've not got the time, the clinical staff, to sit there and listen to the emotional concerns and how they're feeling.' (2013)* *'We don't want to duplicate our role with anyone because obviously with the mental health team we see some similar patients. So instead of us both seeing them at different stages, and them having to re-tell the story, re-go through what they've already just been through, and*

	they're traumatised anyhow, is there something we can do to work together to say, "I'll do it? They've come in with a mental health concern, so actually I'll touch on it and I will discuss X, Y and Z." Or can we do it, and vice versa, is it that they've come in with a violence-related assault, but actually they've got underlying mental health conditions. Instead of having to re-traumatise them, can we work together collaboratively to reduce that?' (2013) *'I always do joint visits with my practitioners for any high-risk cases. A couple of weeks ago (…) I went out all day doing joint visits because they are high-risk cases so we go in twos.' (2012)*
Trust	Once trust had been established, the Navigators were keen to show the patient that they were going to be there to support them: *'I also found, in particular some who have never been able to trust anybody in their lives, and I mean they trust can trust nobody, they're really trying you out and to test you. So I don't want to hand them over to somebody else or sign post them. We want to take them, we genuinely care and are interested in you and we want to try to help. So we take to sexual health, we take to benefits, we take to training'* (2011)
Peer support	Supporting the family so they could support the patient: *'…if you don't sort out the issues within the family then how are you supporting the victim? Sometimes we'll have a victim of violence but then there's a lot more going on. We want to know that because it can't just be the victim, you have to look into the family and if they need referring to Social Care for extra support and things like that.'* (2012)
Collaboration	Navigators are making progress in encouraging other staff to take a more TI approach: *'I have had some, recently, in children's ED, good responses from some of the nurses. They're getting more involved in the asking of specific questions and trying to (…) think outside the box.'*
Empowerment, voice and choice	Choice in decision-making was important: *'it's important to listen to their reasons and work around how they feel best. I think that's always been the same and we encourage that* [meeting] *where they feel most comfortable. Sometimes the child will want to come out in the car with you, but they won't want to go into McDonalds with you ... If they want to go through the drive-through and then just sit in the car and chat to you, that's okay, it's whatever is best for them, wherever they feel most comfortable.' (2012)*
Cultural, historical and gender issues	Acknowledging patients' personal histories: '*I think it is about looking at adverse childhood events and things like that and thinking outside the box about what's brought this person here. It's not just as easy to look at, "Oh, they've been in the wrong place at the wrong time," that happens but it's not often like that. It's more around the contextual safeguarding (…). It's what's going on in the outside world for that person, you might be safe at home but you're not safe when you go out.' (2011)*

3.3. Case study 3: Trauma-informed Education

Programme aims and process

The stated aims of this workstream are to increase resilience in children and young people, reduce exclusion rates, increase attendance, and raise attainment. Eight schools were invited to join Lancashire Trauma-informed Schools' Network Pilot: the schools in one area were chosen because police data highlighted concerns about exploitation. The other schools were ones with whom the TI Education Lead had a contact who had expressed an interest. The pilot was about finding a model of TI mentorship and coaching, so invitation was felt to be the best route.

The first meetings with schools took place between March and June 2021. The plan was for targeted work to take place in each school following an internal audit. An action plan would then be developed and work undertaken with input from the LVRN Education lead. Further support from the LVRN could include:

- Trauma-informed (TI) training, mentorship and coaching.
- Access and signposting to relevant resources.
- Support to share and develop resources and materials.

3.3.1. Data sources for this case study

The eight schools identified as being part of the Lancashire Schools Pilot were invited to take part in the evaluation. The qualitative information for this case study comes from focus groups with a total of 20 people (school leaders, pastoral and classroom staff) from 3 schools (quotation references below 301, 302, 304). Of the remaining five schools:

- Two schools initially agreed to take part in 1-1 interviews but did not respond to follow-up contacts.
- One school declined because they had not yet been involved in the pilot, saying they could not give any meaningful feedback.
- After attempts to reach named contacts failed in one school, an appointment to speak to the head was made but cancelled: the school did not respond to subsequent emails.
- There was no response to the invitation and follow-up email from one school.

Data on absence, exclusions and attainment (the first two are measures used by the Home Office) has also been collected from Government statistics for the eight pilot and comparison schools.

3.3.2. Data from pilot and comparison schools

Comparison schools in Lancashire/Blackpool were selected by the research team as requested in the LVRN's Invitation to Tender. The criteria used were that they were the same Ofsted rating and had had a similar number of pupils; a similar % whose first language is not English and % eligible for free school meals any time during past 6 years. The tables in Appendix 3 illustrate this data for the LVRN pilot and comparison schools (Table 1), absence, exclusions and attainment data for the pilot and comparison schools (Table 2) and the average absence, exclusions and attainment data for Lancashire, Blackpool and

England (Table 3). A number of factors, however, make it difficult to draw meaningful conclusions from this data at this stage including:

- a lack of information about the start date and extent of TI Education activity in the pilot schools;
- any initiatives linked to TI practice in the comparison schools;
- the timeframe for the data as absences, exclusions and attainment were impacted by COVID-19 lockdowns and there are gaps in the DFES data gaps.

This data does, however, provide a useful baseline and starting point for further discussion. It can also be followed up on and used to monitor comparative changes over time.

3.3.3. Findings from interviews and focus groups

Understanding the TI Education approach (coherence)

Individual understanding

Whilst the TI approach was new to some staff, the majority has some awareness of TI practice before the LVRN input. They suggested it was a *'natural progression'* from previous work including on ACEs, *'the make-up of the brain'* with particular reference to ADHS/ASD, emotional coaching, and links with the police and domestic violence incidents via Operation Encompass.

The input from the LVRN, however, had highlighted or reinforced aspects of TI practice. There was a greater appreciation of the individuality of the experience of trauma and that what is traumatic for one person may not be to someone else – but it is *'not just a bad day'*. For others it highlighted that a child's needs cannot be addressed in isolation and have to be seen within the context of their home situation which may include issues such as financial difficulties, parental mental health problems, substance misuse or domestic violence. Staff spoke about working with parents who *'might often have their own trauma'* and in one school referred to the inter-generational trauma and the hope that '…*being understanding and empowering children at this point will break that cycle'* (302).

Staff spoke about increased self-awareness and suggested the training had reinforced the impact of speaking to children in a considered way, '*calmly'* and '*with respect'*. One participant said: '…*we just understand what's going on more. We just don't judge any children. We just think right this could be happening at home, why you're behaving like that'* (304). The LVRN input had also enhanced participants' understanding of the physical impact of stress and trauma and given them confidence to put the TI approach into practice: they felt it was evidence-based and they knew the *'theory and logic behind it'* (302).

A whole-school approach

In some schools the first LVRN input was with pastoral staff but there was an emphasis on the needs for all school staff attending training to achieve consistency and ensure practice was reinforced across the school '*so parents understand that every class teacher is going to have the same approach towards their family'* (304). With reference to pupils, one participant said the LVRN input had encouraged that cohesion *'as we've all had the same training at the same time, children will hear the same types of language being used so they feel comfortable and supported by everyone rather than just individuals*' (302).

In addition to pastoral and teaching staff, one school had included governors, and another was going to involve lunchtime staff in awareness raising sessions. Two schools were planning events for parents, one of which would also include pupils, so they were '…*hearing messages together (…) in a non-threatening environment'* (301). There was also a hope that a whole school approach would improve relationships with parents:

> *'They'll see that we've got that awareness as well, and if they can see that we've had the same training they have maybe they'll start to open up more and there's more of a discussion (…) and it's not a taboo subject then. They'll go, "Okay, I've been struggling with this" and we can then help them in whatever way we can. I think those barriers of we're the teachers and they're the parents, we're not looking down on them (…) we're all here for your child ultimately' (302).*

Only one school spoke about groupwork with children, but another stressed the importance of this, in part to make children aware '…*of why certain individuals have these boltholes and things, without going into details. It's a tricky process*' (302).

But not all of the school staff had yet attended TI training events and it was suggested there was some resistance from staff who were *'more ritualized in their practice'* and staff who saw a TI approach as children '*getting their own way'*. One school said it was *'…a huge thing trying to change the mindset of some members of staff that have been here a long time, to get them out of that constant word of consequence'* (301). Another school drew a distinction between pastoral staff who adopted a *'nurturing and motherly'* approach and some in the wider school who '*don't get it'* (304). Participants suggested that rolling out the TI approach would take time but would be assisted by staff who were committed to the approach '*modelling'* their behaviour and language.

3.3.4. Organisational engagement (cognitive participation)

Leadership

The LVRN TI Education lead was respected for their recent practical experience, knowledge and style of delivery, but it was recognised that the external facilitation had to be combined with an internal readiness as one participant explained:

> *'So because we know it (LVRN input) is coming from a point of it works in practice, it's been a lot easier to take as an approach. But because of the ethos of the school, we've been receptive to that technique anyway, because it ties in with what we're looking to provide anyway as a school' (302).*

Participants spoke about their own school leaders as role models and the input of the LVRN as encouraging a formalisation of the approach: '*I think* (school leaders) *have driven the process and it's the way they work. They've rolled it out to us, they've drip fed us through the years but then it's making it more official really'* (302).

Are the right people involved?

The staff involved in the focus groups saw the TI approach as an appropriate fit for their work with pupils in the classroom, the wider school and also informing their interaction with families. Speaking about their contact with families, participants suggested a more TI approach had aided their conversations about difficulties pupils were having saying '*I think I'll get more knowledge about home life so you just know what they're going through and why maybe they behave the way they do at certain times'* (301). Another school explained the relevance of this work: '*I'm for getting schools involved and us being more aware about what's going on with the children out of school and what impacts on the children for their learning and their emotional well-being coming into school' (304)*.

In two schools there was a suggestion that pastoral staff were more engaged with the TI approach than classroom staff. One teacher said:

> *'As classroom staff we'll kind of mention it, raise it once or twice then after we'll go straight to pastoral. We won't make any issue. We'll have a chat with the pastoral staff and they will kind of sort something out so it doesn't become a big confrontational behaviour issue in class' (301).*

But in contrast, view of the group which consisted entirely of classroom staff was that as pupils need to be settled and feeling they were in a safe environment in order to learn, this was a key part of their role. One teacher said:

> *'I don't think anybody thinks that our jobs are just simply to tell them information and for them to learn (…) We spend a lot of time with these children so it's right that we are aware of this and that we know how to deal with things, and strategies, because your teacher training doesn't give you enough ammo (…). Whereas something like this, where you've got something to fall on, you've got a bit of theory behind it, you've got lots of people who are informed to talk to, if you're new in the job, the profession, you're starting on a front foot for the children' (302).*

The special school involved in the pilot saw the TI approach as being especially relevant to their practice as all of their pupils have an EHC Plan and some are also looked after or on the Child Protection Register. One participant said *'the drive was out there to be able to put all these things in place to help those children that have got those ACEs and how to overcome that*'.

Engaging others

The roles of some staff brought them into contact with local service providers and there was some suggestion that other agencies should be more TI. Particular reference was made to a social housing provider with one person saying '*for it* (TI approach) *to work properly, I think it needs to be embedded across all the agencies'* (304). This school had recently established bi-weekly meetings with the housing provider's community and reinforcement officers to discuss issues and share information. They also wanted to share practice and learning with other local schools, one person saying, '*for me it's not just about our school, it's about the*

whole of the community in [TOWN7]'. Getting the high school involved was also a priority for them *'because all the good work that goes on here gets undone a little bit when they go to high school'* (304): they suggested the high school did not have the same family focus or nurturing approach and that primary schools.

3.3.5. Putting it into practice (collective action)

Policies and procedures

The LVRN TI Education lead helped each school develop an action plan. This external perspective was valued as one participant explained:

> *'…it's really key to have somebody from outside because they're able to look at our school in a different way. I think because we are part of the school, we can't see things that she sees. She's given me some really key things to work on' (302).*

One area identified for development for all of the schools was their behaviour policies and practice. One stated that 'our behaviour policy wasn't particularly trauma-informed and some of the ways we went around dealing with some behaviours were not the best practice ever' (301). Changes have included policies with a greater focus on relationships and what the school can do to encourage 'behaviour for learning' with behaviour plans becoming more 'child-led' and with greater consideration of 'what the child needed from us'. The schools also identified a number of proactive ways in which pupils struggling with trauma might be identified. These approaches were wide-ranging and included:

- A TI register of children to consider whether they could help or approach children in different ways and look out for '*triggers'*.
- Using the annual meeting with parents/carers about the child's EHC Plan to look at each child's needs in relation to traumatic experiences.
- Pastoral staff attached to specific year groups, allowing for long-term relationships with a cohort of children and families.
- The potential use of packages such as CPOMS/Trackit Lights/Boxall/PIVOTS to identify changes in behaviour.
- Ongoing involvement in Operation Encompass so they are aware of incidents of domestic abuse attended by the police.
- Changes to the PSHE curriculum so issues can be discussed in a TI way.

Workforce skills and support

The LVRN TI Education lead was still delivering training in each school and staff spoke positively about its content and the mode of delivery, both of which they felt was strengthened by her recent practical experience. Participants also explained that, in addition to the LVRN input, they had previously or were currently involved in related training on, for example, ACEs, emotional coaching, sensory training and TeamTeach (positive behaviour management). The general view was that the combination of events had increased their understanding of children's behaviours and provided advice around topics such as language and techniques for working with children. Having received in-school TI training, one newly qualified teacher identified TI practice as a significant gap on his university course.

The growing understanding of personal and vicarious trauma, combined with the experience of the COVID-19 pandemic, resulted in the schools re-considering staff wellbeing issues. Methods of staff support include formal structures such as employee assistance schemes and a 'Pulse' wellbeing monitoring system. Informally staff spoke about mutual support and school leaders communicating their appreciation and understanding of the impact incidents can have on staff. One participant explained how things had changed in their school:

> *'If we've had a very stressful day, you don't feel on edge if you need to go home at 3:00 o'clock (…) to be able to look after ourselves. I think that's definitely being recognised within school through being more trauma-informed and looking after each other as well as our own well-being. If you can see a member of staff struggling you will take over in that classroom a little bit more and will say, you go and take 5 minutes, get yourself a cup of tea. I'll stay here. You know, I think for us to be able to look after the children we've got to look after ourselves, haven't we?' (304)*

Resources to a support TI approach

Resources identified as part of the schools' TI approach to supporting children and their families were wide-ranging. They included developing emotional literacy and tools so pupils can explain how they are feeling; the creation of or improvements to safe spaces or 'dens' in the school to make them attractive and comfortable retreats; children having access to a school therapy dog; additional hours for staff working with families (including during school holidays); the provision of breakfast, after-school and holiday clubs; and an app (Class Dojo) being made available to children during the COVID-19 pandemic so they could contact the school. The exacerbation of family issues caused by a lack of resources was also highlighted and schools frequently, for example, requested and distributed donations from staff, charities and supermarkets.

Schools had also created new links with organisations such as those providing victim support for young people and counselling services. But participants more frequently spoke about gaps in external services to address children's needs, combined with a lack of information and poor communication. Long waiting times for services such as CAHMS were highlighted and communication with agencies such as Children's Services, school nursing, health visiting and mental health teams was identified. In some cases, this resulted in the school attempting to fill the gap *'So we have to try and do things ourselves that to mirror what CAHMS would be doing'* (301). One participant spoke about the suspension of Safeguarding Cluster Meetings during the COVID-19 pandemic: these were seen as a useful forum for information sharing about new initiatives, service changes etc. Schools also anticipated a significant issue with their lack of capacity to undertake additional tasks which were now required of them, in particular to undertake social care family assessments.

3.3.6. Reflection and future evaluation (reflexive monitoring)

Measuring and recording outcomes

Several different tools and systems were identified that were used to describe and record staff's TI work with children and families. These included annual EHC Plans where particular behaviours linked to trauma could be identified and the 'family star' where staff could work with families to identify needs and assess progress. Systems mentioned included CPOMS,

Arbor, Boxall, ScholarPack and Pivots but it was not always clear how they are being used and it did not appear that any were currently being used to inform or monitor TI practice. One participant explained that staff capacity was an issue:

> *'I'm going to be really honest with you, we are that busy that sometimes it's impossible to be able to record the impact that has on it. I think for us we see that the children start to come to school more regularly, they don't talk about as many issues, you can see in the children's personal presentation (…) and the feedback generally from the children (…) it's a bit more like that gut feeling. I know that's not helpful to Ofsted because they want hard evidence and a measurable target but you know it's a very fast paced job and I'm just happy for my staff just to record the positives and negatives on CPOMS so that I can look at the graphs very quickly to see what's going wrong' (304).*

The conversation in another school also suggested they are struggling to identify relevant outcomes, with one person saying:

> *'A lot of it will be anecdotal, won't it because (…) you can skew data in any way you want, can't you? If you want to and try hard enough. I think just listening to staff and how they're finding differences in how the children are getting on, I think that's always going to be a major part of actual impact' (302).*

All the schools referred to the production of case studies to record processes and outcomes. One school had produced then as part of their LVRN work and another used them for staff reflection. The third school suggested they may produce case studies to identify '…*where they were, how they've improved, has it had impact, that sort of thing'* (302) They also suggested that they could look at family groups as they moved through the school to see if the approach was working:

> *'Hopefully, as we can address the problems, they will filter down through the family. So the issues that might have arisen with the older siblings will become less of an issue with the younger siblings. Obviously, trauma can affect the whole family. It can affect certain children or certain individuals, but I think a tangible way of looking as well, at how it's making an impact on the family is how we're noticing the changes in the family as they're travelling through school' (302).*

Other suggestions for monitoring outcomes including using CPOMS to look at the language staff use, ScholarPack to look at academic progress for particular children where trauma has been identified and the use of safe spaces or Dens (although they would need to be clear about whether greater use or less use is a positive indicator). Using the feedback at parents evening or via parental and pupil questionnaires was also mentioned.

Outcomes for parents and children

Caution must be exercised in looking at outcomes during the disrupted period of the COVID-19 pandemic, but staff suggested that their approach during this period, which includes being more TI, had resulted in improved attendance, a reduction in exclusions, improved

academic achievement, targets being met in EHC Plans and improved relationships with parents/carers. The reasons given for these improvements include:

- Being more proactive about getting children into school and approaching parents in a more collaborative way, with less of a *'blame culture'* (301).
- After the disruption of COVID-19, children are '*starting to enjoy coming to school again'* – teachers identified that their approach was calmer and the way they were behaving impacted on the children (302).
- One school said they now *'do all we can'* to find alternative provision or keep a child in school rather than sending them home.
- Building better, more trusting relationships with parents/carers was seen to result in '*difficult conversations'* being more likely to have positive outcomes.

Outcomes for the school

A number of outcomes for the teachers and the school were identified as a result of them adopting a more TI approach. They suggested that a greater awareness of the TI approach had not resulted in a wholesale change but pointed to a calmer school environment '*It's obviously what we did have in place already is kind of working and it's just tweaks that are going to have a longer-term effect and help us individually, I think'* (302). In one group participants suggested that it had changed the way that the teachers think about the behaviour of particular children, and this had had an impact on the way they spoke to them, about them, and on their own wellbeing:

> *'The biggest change for me is the conversations we're having between staff. Staff room, sacred four walls, go in and vent about different children. You don't hear the "Oh that child is doing this, that and the other and I'm tearing my hair out with this." You feel your own stress levels aren't as (pause) we still obviously have our stresses, we still moan, we're teachers (…). But you're not having those conversations about the individual children because you've understood it, you've dealt with it in your mind, and then you've moved on instantly. So as staff, I feel a benefit in that sense' (302).*

Communal reflection

Both formal and informal modes of reflection or appraisal were identified. On a formal level, participants referred to weekly staff meetings which usually had space for discussions about individual children if there were particular concerns or a child needed pastoral support. In one school, however, these were usually cases where there were safeguarding issues rather than children impacted by trauma. One school said they had a half-termly 'reflective staff meeting' where case studies are discussed:

> *'so we'll look at what is working well, what could we have done and get everybody buying into it so that everybody is responding to those children in the same way. And that is really important. So that reflective practice and timetabling that into your school every six weeks is really important' (301).*

The reflection that did take place was more regular but informal via conversations between staff about their work with specific children and families. A member of the pastoral staff at one school said:

> *'I think we are quite a reflective team to be fair and we do reflect daily, half daily and when we work together will say could we have done that any better, what went well for us, what went wrong and, you know, if it has gone wrong, we will say, Oh my gosh, we didn't really handle that very well did we? What can we do to make that better?' (304).*

It was not apparent whether patterns of behaviour or practice were being identified through these individual conversations and to date there did not appear to have been much sharing of practice with other schools. The impression given was that it was still early days for the pilot schools. One participant said that they thought the head possibly had had informal conversations with other but said looking forward '*I think that was the hope that we'd be able to inform or advise others'* (302)

Implementing principles of trauma-informed practice

The LVRN Organisational Development Toolkit suggests that to be trauma sensitive, organisations should have begun to explore the six principles of TI practice in their daily work, and to become trauma responsive, to have begun to change the organisational culture to align with these principles. The following quotations are illustrative examples of statements about practice that support these principles:

Safety	Participants discussed the importance of pupils having safe spaces and feeling safe: *'It's nice when kids feel they've got a safe environment that they can openly talk to you about it as well. You know, pretty much all the classrooms in and around school (…) for a lot of these kids it can be a safe haven. It's good for them that they feel that they've got the confidence that they can approach not even their own class teacher, but there's a number of staff they could approach. You know, they build good relationships with staff'* (302)
Trust	Bring in 'external' agencies was seen as problematic: *'…if we need early help and support in the community it's got to be consent based and parents don't want to consent to it. It takes us a long time to convince parents to win them round you know, because ultimately, they will come to us as a school because they trust us because we look after their children and we have that relationship with them, but they won't consent. They don't want anybody else in because again, that stereotypical 'they're going to take my children away''* (304)
Peer support	Not specifically discussed
Collaboration	Work with families is being view differently: *'It's changed my way of speaking about the attendance. Maybe rather than just saying it's the law, your children must come to school, more personal, it's better for you, they're better here, you've got your break. Then as a family, you know, they're less stressed in the evening'* (301)

Empowerment, voice and choice	Looking to build resilience in children: *'…if children are struggling, making them aware of how they can deal with it themselves. Not us always saying, "take yourself off to there." If they know how to do it – provided we've got the spaces – it's like an agreed process then. The children feel safe, we're obviously aware of where they are and why it's happening. Not only does it keep everyone in the loop together, it becomes a process then that's two way.* (302) *'…we try to give every child lots of tools to take away with them because sometimes we can't change what goes on at home with all the services in the world. We're never going to change some of those things. But what we need to do is maybe give the children tools to be able to deal with situations when they've left school and know how to resource things and what goes on in the community, where they can get help and support from'* (304)
Cultural, historical and gender issues	Importance was attached to understanding the community in which the children are living: *'It'll take a while to embed it across the school. But yes, I think the message is slowly getting through. I think the majority of staff are looking at the bigger picture now [PARTICIPANT3041] and I were born and bred in [TOWN7]. So we understand our community, we understand the issues that are here. Others aren't. But it's trickling through, I think'* (304)

3.4. Case study 4: Trauma-informed training and workforce development

3.4.1. Programme aims and processes

This workstream focuses on developing the trauma-informed (TI) skills-base of professionals. The workshops aim to support a system wide approach that examines new ways of identifying adults who have experienced multiple childhood traumas and puts in place support to prevent ongoing and inter-generational problems.

In 2021-22 workforce development training has been offered to multi-agency groups and included basic awareness raising, sessions for leaders and managers and a 'Train the Trainer' programme. Training and awareness raising has also been delivered to staff from particular sectors: the police, education, the third sector and health. Additional training has been funded by the LVRN e.g., Research in Practice on-line '*Practical Application of TI Knowledge'* for Blackpool Adolescent Service.

LVRN describe the '*key deliverables'* of the in-house training as to:

1. Enhance participants understanding of underlying trauma that could contribute to an individual's risk of involvement in serious violence and crime.
2. Enable participants to put in place more effective interventions to address the impact of underlying trauma.
3. Better able participants to collaborate and intervene more effectively as a result of a developed shared language and understanding of the impact of trauma.
4. Increase participants ability to recognise adverse experiences and trauma and understand how these may interfere with a child or young persons' ability to form trusting relationships with frontline professionals.
5. Increase participants awareness of how to avoid practices that might inadvertently cause further trauma, preventing the individual from accessing appropriate support.
6. Increase participants understanding of how trauma presents in young women and girls and how frontline professionals' response to this cohort may differ.

The participants in the evaluation attended the Leaders and Managers training. The stated aims of that workshop were for participants:

- To gain insight to why we want to move towards a TI Lancashire.
- Develop awareness, knowledge and confidence in the areas of Trauma, TI Practice and Reflective practice.
- Begin to develop ideas to how this relates to your role, service or organisation and what meaningful changes can be made.
- To raise awareness about the Organisational Toolkit and peer assessment process.

3.4.2. Data sources for this case study

A total of 64 people who signed up for Leaders and Managers training in August and October 2021 were contacted by email and invited to join a focus group. Seven people agreed to take part. To accommodate the times they were available, 1 paired interview (ref 401), 1 focus group (402) and a 1-1 interview took place (403). Participants worked in a range of sectors including local government, health, education and the third sector.

It has not yet been possible to arrange a group with police staff although arrangements were being made to talk to a group of neighbourhood officers who had attended LVRN TI training. All participants were offered a shopping voucher as a thank you for their time: the police fieldwork was delayed because there was a question about whether police officers could be offered this voucher.

The LVRN provided anonymised responses from 214 participant feedback forms and quantitative data including the number of events and number of people attending (see Appendices 4.1 and 4.2).

3.4.3. Findings from the interviews and focus groups

Understanding the TI approach (coherence)

Individual understanding

The professionals who took part in the evaluation were all aware of the TI approach before they attended the LRVN training. Sources of knowledge included their professional and clinical training, being based in specialist services (e.g., perinatal mental health) and previously attending ACEs workshops.

Most of the participants spoke about the TI approach as encompassing both a staff and service user perspective. One person explained this dual aspect in the following way:

> *'So we've got a kind of double whammy going on, of potentially staff that have experienced trauma, we've also got service users who have experienced trauma historically, but then actually might be going through it at the moment as well' (403).*

Another professional, however, suggested their organisation was currently thinking almost exclusively about the staff perspective, saying they *'…haven't considered it from a patient experience and the systems that we use, but it's a good question to ask actually, maybe one that we should spend some time thinking about*' (401). The focus group conversation appeared to have alerted them to this.

Participants also described their understanding of the subjectivity of trauma and the underlying characteristics required by professionals adopting a TI approach, including compassion and empathy. One person said:

> *'I think everybody should be trained in the impact of trauma and what that can mean for someone. And that trauma is very subjective. What might be traumatic to me might not be to you. It goes back to those really basic values around respecting difference and tolerance…' (403)*

One person stressed the importance of colleagues being supportive of each other, offering them '…that unconditional positive regard that we would offer to a client if they were seeking out help and understanding' (402).

Collective understanding

Attending the LVRN training had encouraged the participants to think about their organisation's procedures and attitudes towards trauma. For some this was as part of a structured self-assessment and/or the delivery of training. It was clear that although the people who had attended the training felt they were TI, some of their organisations were at the start of a journey. One person said that as a service provider, their aim was for staff to recognise *'…that actually people do present in different ways based on their life experiences*', but although optimistic, they felt there was some way to go. They said:

> *'We are literally at stage one where we're just sharing the information, but the idea is that obviously we'll complete all the different steps and then I think it will be a trauma-informed organisation and it will just be part and parcel of one of our values' (401).*

In contrast, other participants said there was a collective understanding of TI practice within their organisations because it was part of their mandated training and/or family history and trauma was an integral part of case discussions. Others said they and their colleagues had become more aware of the TI practice as a result of co-location with services where it was embedded. One area identified where increased understanding was needed, however, was vicarious trauma. One person said that when delivering the Train the Trainer package, they found staff hadn't considered the impact, particularly on their physical health, of working with '*complex individuals'*.

Although time and resources were identified as obstacles to the rolling out TI practice across organisations, the most frequently mentioned barrier was a perceived lack of relevance. One participant said:

> *'…the barriers will be that they don't see why we need to have a trauma-informed approach. We are not working with people who are in recovery from substance misuse, offenders or ex-offenders etc. It's making them understand that this is for everybody and anybody. It's not just a particular group of people' (401).*

Another person suggested that that the promotion of a system-wide approach could encounter resistance because it was seen as '*entering professional territory'* where '*professional identities and things like that can be a little bit threatened'.* (403)

Value of the LVRN intervention

The LVRNs promotion of the TI approach, however, was viewed positively. One person said it had *'…brought all that to the forefront again. It allows you to kind of have that recap and refresh'* (402) and another that it had added something new, for example it had drawn attention to the language being used in professional practice. The LVRN training was also valued for the community-wide perspective, the timing of the intervention and its multi-agency approach. The vision of a multi-agency and county-wide approach was welcomed, with one participant suggesting it could provide clients with a more consistent service:

> *'(it) puts us in a good position as a trauma-informed organisation to raise our expectations of others, to ensure that people aren't just getting one good level of service from one organisation, instead that a really good level*

of trauma-informed service is available throughout all the services which they might encounter, whether or not that's statutory or non-statutory, whether that's education or children social care, adult social care, (…) trauma-informed being a baseline level of support which people can expect' (402)

Other people suggested a system-wide approach provided a critical lens through which to assess the actions of others. There was an element of validation for professionals and their awareness provided an opportunity to ask pertinent questions. One person said: *'…it gives that emphasis and the reason why we want people to alert their professional curiosity that sometimes you think well, why didn't you ask that question about the past? I think they feel a bit more confident in doing that now.'* (402)

Although not widely discussed in the focus groups, one participant highlighted the promotion of community engagement which was apparent in the LVRN training. They were enthusiastic about sharing the TI approach more widely, saying a '*big message*' they took away from the Train the Trainer course was that:

'…this is to influence communities and to have everybody trauma-informed as opposed to being necessarily an organisational focus (…). If we can have communities that are trauma-informed, then we can start to support each other in a much more appropriate way as neighbours and friends and colleagues and family members, everything as opposed to a work-based ethos really. It's a great vision, I'm very supportive.' (401)

The timing of the LVRN intervention was also seen as being useful. This was stated with reference to the changes in children's social care, resulting in school staff in particular needing to be TI as they were '*having to be more hands on and pick up those early pieces of work and the preventative stuff':* the participant who regularly worked in schools, suggested they '*can see the weaknesses'* in current levels of awareness and skills. They said they would have liked to see more school staff at the LVRN training, but they were unaware of the TI Education workstream. Another participant said the promotion of the TI approach coming after the stresses of the last two years was timely. They suggested an element of '*compassion fatigue'* had surfaced: *'it was just another person who was turning up that was frustrated or not able to communicate in a way that they perceived was helpful'*. They felt that the LVRN rolling out a county-wide approach could '…*start to build compassion again and remind people why they came into services in the first instance.'* (401) Clearly the principles of the TI training were seen as being relevant to staff as well as service users.

3.4.4. Organisational engagement (cognitive participation)

Leadership

Participants were positive about the LVRN and its leadership. One person said:

'I think the vision to have the county trauma-informed is brilliant and its high aspiration for anyone to declare. But the people who are driving it forward are definitely the right people and you sense that when you're actually participating in the training as well' (401).

But some participants suggested the LVRN need to have a higher profile, pointing towards a general lack of awareness about the Network and its activities. One said, *'when you talk about VRN, people don't even know who they are, they have not really heard of VRN'* (401). Another person suggested *'it needs to be much wider than just the police'* (403). It was also clear that participants who knew about the TI Workforce activity did not know about other LVRN programmes that were directly relevant to their work, such as TI Education.

Engaging others with the approach

The focus group participants all appeared to be committed to the TI approach and, often with colleagues, were actively engaged in promoting the approach within their own organisations and with external partners.

Three participants spoke about promoting or delivering training within their own organisation, one of whom had used the self-assessment toolkit. Participants also referred to the need to encourage organisations they regularly worked with to be more TI and that how the TI approach was presented was key:

> *'…it's not something they've come across or think about really. So to start introducing this approach, they sort of look at you daft. But when you can sit down and talk to them properly and give them an example, suddenly it's like, 'oh, if that's what you mean'. It's just simplifying, isn't it? I think when you start talking about a trauma-informed approach a lot of people think about injuries, don't they? As in a physical injury or recovery from that type of thing. So that's been interesting that some of the partners do have that 'what are you talking about?' (401)*

This organisation could be viewed as an early adopter: they explained that they were working in Blackburn where there was a '*big push on ACEs'* and they are now trying to influence other organisations, including funders, '*getting them trained up so they understand and they ask the right questions, (…) thinking in the same way'* (401). They suggested there was a need for people who were TI to talk to partner organisations about their current practice and what they could do. They had found it was '*having a good impact. They've all found it really interesting which so far is really good for us*.' (401). One social care professional had identified the need for schools they worked with to be more TI and so did the Train the Trainer course so they could deliver TI training in this setting. They said that it had been '*successful'*.

The promotion of a county-wide approach, as described above, was enabling TI professionals to be feel '*justified'* in engaging those who were less so in '*challenging conversations'*. One person suggested they were doing this before but now felt more certain in their approach: *'I feel like I've got the training behind me to kind of back it up and go, you know, it's real research, an informed approach and it's what's best for that young person. It should be about that client's lived experience.'* (402)

3.4.5. Putting it into practice (collective action)

Policies and resources

The participants came from a wide range of organisations and there was not capacity in the focus group to speak about policies and resources that were specific to each person's area

of practice. One participant, however, spoke about the value of the LVRN self-assessment toolkit as a way of engaging with others in their organisation to look at their workforce, policies and practices. They said:

> *'…without the self-assessment tool this would have been a lot harder for me to drive this. It was really handy having that set out and actually looking at where we are as an organisation and working through it with the training team. So having that buy-in with the core people who influence how training rolls out across the 12 month period.' (401)*

Recruitment and risk assessment are both covered in the self-assessment tool. One participant suggested that TI practice should '*become part and parcel of how we recruit and who's involved in the services.'* Another said the TI training had led them to reflect on the purpose of their risk assessments and the way they were undertaken:

> *'My question (…) would be why am I doing this? What's the outcome? What's the outcome for me? What's the outcome for the young person? Is it a positive outcome? Are we going to retraumatise that young person as a result of putting them through this process? Is the end going to justify the means I suppose. As a result of this training, I've tried to ensure that the process is as gentle and kind and empathetic as it can be so they get something from it opposed to them just being pushed through a process.' (402)*

Workforce support

Support for staff and volunteers who had experienced trauma and for staff working with clients who had or were currently experiencing trauma were discussed in the focus groups. One person drew particular attention to staff or volunteers who were engaged because of their lived experience:

> *'…you'd have a team member become absolutely strong. They'd be brilliant. (…) Then you suddenly see them start to sort of dip really and even some would have a minor blip and then you'd have to sit down and think, hang on, what's going on here?' (401)*

Participants described staff counselling services that had been available for some time but also new 24-hour provision that staff could access whenever they needed to. Several people questioned whether there was enough support for professionals exposed to *'vicarious trauma'*, including people undertaking vocational courses:

> *'A more trauma-informed approach would be to focus on students' wellbeing and how they are with the work and create more of those spaces where people can process the trauma that goes with working with this client group. Not that they're not a great client group to work with. (…) I think in order to help staff to do it better we probably need to support them better.' (403)*

Workforce training and skills

The participants referred to new TI training that was proposed or had started to be rolled out within their organisations, in one case by Mental Health First Aiders. For some the COVID-19 pandemic had delayed progress as the preferred method of delivery was face-to-face so they could identify possible distress amongst participants. One person said '*we don't really know what's going on in somebody else's life (…) if there was somebody looked like they were struggling or mention that they were struggling for whatever reason, we could make sure we supported them'* (401). It was suggested that all staff needed to be included so that there was a common understanding and approach. Staff being prepared for each conversation was stressed by one person:

> *'I suppose when we're thinking about trauma (…) we've got very few opportunities to catch someone and if we're present when we can catch them in school for example, I think, like you say, that first conversation could be really positive on especially when there's one of our trained practitioners available.' (402)*

One person talked about the particular importance of including reception staff in TI training as they may be having the first contact, are making decisions about who to pass a person on to and may also be hearing about traumatic events. Other participants had not considered this group but agreed when the reasoning was presented.

The resources provided in the LVRN Train the Trainer event were well received, although one person suggested it was going to be a challenge to select which elements they were going to use: they felt sessions needed to be tailored to different groups to ensure it had an impact. Another point related to the ability of vocational training providers to update their curriculum to incorporate a TI approach. One participant suggested that there might be the desire or willingness to make changes but that universities were '*not very agile'* and it would take time to make the necessary systematic changes to key courses. The value of inviting people with lived experience to contribute to training, including on vocational courses, was also highlighted, although it was argued this needed to be done in a structured and supported way.

3.4.6. Reflection and future evaluation (reflexive monitoring)

Measuring and recording outcomes

In general, participants found it difficult to articulate outcomes that they could attribute to practice within their organisations being more TI. One person said:

> *'We have been doing it for many years and to suddenly highlight that all because we've got a trauma-informed approach this is a result, you couldn't just put it down to that (…) to sort of have that person who's suddenly on that pathway, they've got the resilience in place, they've improved their lifestyle and they're happy again. For me that's right but that's not just down to it being a trauma-informed approach, it's part of it, but definitely could never put it down to just that alone.' (401)*

Another participant made a similar point in thinking about their conversations with service users. They said:

> *'I talk to my young people all the time, and that's how we would measure how we're doing, what impact we're having, how that young person is feeling. I don't know whether they would have an awareness to say, Oh yeah, it was a trauma-informed approach that helped me more though. So I think it would be difficult to pinpoint as an overall service…' (402)*

Some participants, however, did refer to systems that their services had for recording outcomes and others suggested they were currently considering what outcomes were pertinent to their TI approach and how to record them. But most comments about outcomes were very general in nature as this information extracted from the conversations illustrates:

Possible outcome	**Suggested reasoning for it indicating the approach was TI**
Timely service delivery	'…participation and someone feeling as though it's again the right support in the right place at the right time' (402)
Enabling and empowering service users	*'…it feels as though when we're using our trauma-informed practice, it ensures that we're not kind of prescribing things, we're enabling and empowering people to make their own decisions about what they want to happen next and then offering them freedom and capacity.' (402)*
Improved communication	'Our aspiration (…) was actually re engage people's compassion and empathy and understanding and how they communicated with people who wouldn't necessarily present in a way that some people considered appropriate. So our aspect was more around how taking some time to think about somebody else from that perspective might improve the communication with them, but I do definitely think it's something we need to go away and spend some time thinking about.' (401)
The 'lived experience of the organisation'	'…qualitative stuff around relationships and just the feel of the organisation, the kind of lived experience of the organisation and what it was like to receive a service there or to work there and to feel valued and appreciated, that your needs are going to be met, if there were difficulties that there would be somewhere to go with those difficulties. (403)
Influencing other providers	'If we can get the leisure trusts who are out there doing the health checks, etc. and the clubs, even the community clubs that we very much work closely with, if we can get them thinking differently and that approach, then for us it's a success.' (401)
Improved workforce data	Including staff sickness, absence and retention (403)

Communal reflection

During the conversations about communal reflection about TI practice, participants focused on the forum they currently had for professional conversations, suggesting that TI practice was or could be incorporated in these forums. Most frequently mentioned spaces were

supervision and team meetings. 'Reflective practice learning circles' which were part of at least one organisation's processes, and conversations with families when a case closes were also seen as spaces where a TI approach could be discussed and good practice identified (402). One participant spoke about the possibility of using a recently formed 'practice group' where professionals discuss cases, saying:

> *'It's interesting to hear that some of the practice nurses really genuinely don't know how to deal with something, what approach to take. So having other services there who are a little bit more experienced with the approach seems to be helping because all it's making them go away and think about it' (402).*

It was also suggested that '*informal conversations'* should be used to keep TI practice at the forefront of people's minds (although it was stressed that not everyone has yet received TI training). In some vocational education settings, there are student-led case discussions. One person speculated whether these discussions being used in a more TI approach would

> *'…focus on students' wellbeing and how they are with the work and create more of those spaces where people can process the kind of trauma that goes with working with this client group. Not that they're not a great client group to work with (…) It's just in order to help staff to do it better we probably need to support them better.' (403)*

One person suggested an area on the LVRN website could be a TI community of practice where people from different organisations could share their experiences of TI practice and ask questions (401).

Principles of TI practice

The LVRN Organisational Development Toolkit suggests that to be trauma sensitive, organisations should have begun to explore the six principles of TI practice in their daily work, and to become trauma responsive, to have begun to change the organisational culture to align with these principles. The following quotations are illustrative examples of statements about practice that support these principles:

Safety	Questioning the appropriateness of a risk assessment process: *'My question certainly within my organisation would be why am I doing this? What's the outcome? What's the outcome for me? What's the outcome for the young person? Is it a positive outcome? Are we going to retraumatise that young person as a result of putting them through this process? Is the end going to justify the means I suppose, and I guess as a result this training I've kind of tried to ensure that the process is as gentle and kind and empathetic as it can be so they get something from it opposed to them just being pushed through a process'* (402)
Trust	The potential impact of early conversations was recognised:

	'It's about your approach, isn't it? I think that those initial conversations are the most important ones because they're the ones that have that impact in terms of building that report and that trust with you as to how much information they want to disclose.' (402)
Peer support	Not specifically discussed
Collaboration	Importance of all staff being TI: *'I suppose when we're thinking about trauma and trauma informed practice, we've got very few opportunities I think to catch someone and if we're present when we can catch them in school for example, I think, like you say, that first conversation could be really positive on especially one where there's one of our trained practitioners available to them'* (402) Respect as an element of the relationship with the service user: *'I talk to my young people all the time, and that's how we would measure how we're doing, what impact we're having, how that young person is feeling. I don't know whether they would have an awareness to say, Oh yeah, it was a trauma-informed approach that helped me more though. So I think it would be difficult to pinpoint as an overall service, trauma-informed is more respectful, isn't it?*' (402)
Empowerment, voice and choice	Empowerment at an individual level: '(TI approach)…*helps us best understand the needs of their clients and offer the right support, right place at the right time. (…) it feels as though when we're using our trauma-informed practice, it ensures that we're not kind of prescribing things, you know, we're enabling and empowering people to make their own decisions about what they want to happen next and then offering them freedom and capacity.' (402)* One of the few examples where someone spoke about the involvement of service users in TI service development: 'Y*oung children that have been in the care system have been part of our executive safeguarding board meetings to see how they want services for them and how they felt when they've been involved with services. We've done a lot of work around the 16 to 18 year olds especially that have been in care or on wards and how we work with them so they're not traumatised' (402?)*
Cultural, historical and gender issues	Previous experience of trauma is part of case discussions: *'When we have our allocations meeting with children social care managers to discuss cases that get referred to us (…) we do talk about the trauma that these families might have gone through, the history of DV sexual violence, birth trauma. (…) The discussions we have seem to be very beneficial and I think it's something that we do automatically now, so whether that training has helped, I think it probably has.' (402)*

4. Discussion

The overall research question guiding the evaluation of the four programmes of work was; *"How can the LVRN best support its staff and clients through incorporating a TI approach to their service delivery?"* We have found evidence to support the implementation of SAMHSA's TI principles (5) in each of the four workstreams we have evaluated, which suggests that there has been some success in the implementation of TI approaches to violence reduction in Lancashire. Here, we discuss our findings for each of the programmes of work, exploring barriers and successes and identifying commonalities in approach that could define and unify the LVRN TI offer.

The DIVERT programme has had some success in recruiting and training staff from the football trusts to work in TI ways and this is supported by those with leadership roles. TI coaches feel supported by Football Trust managers and staff from DIVERT. However, participants reported some lack of clarity among police staff, particularly those working in custody suites, around the role of the coaches and the purpose of their role. An example is that a police officer stated that they did not understand "what coaches did" despite having read an information leaflet on the DIVERT programme.

Communication and collaboration between police and football trust staff could be improved by raising awareness of the DIVERT programme among custody suite staff and clearly articulating the role of coaches and how they will be working with clients. Coaches and football trust leaders felt that they would benefit from having time and space to reflect on and collectively share examples of best practice. If introduced, it might be helpful if some joint sessions were to be organised with staff from policing to help troubleshoot any issues, share best practice and promote awareness raising of developments in the role.

Participants who responded to the training evaluation questionnaire were least likely to agree with the statement *'I have an increased understanding of how trauma presents in young women and girls and how frontline professionals' response to this cohort may differ".* This statement links to one of the key aims of the DIVERT programme and national Home Office priorities. Introducing or enhancing specialist workforce training in understanding and responding to trauma in women and girls should therefore be a priority area of consideration.

The evaluation team experienced some challenges around collecting data from the ED Navigators programme. We were able to engage staff employed by Blackpool Teaching Hospital, however the perspectives of staff working in Preston Royal and other early adopter hospitals is unfortunately missing.

Useful data has been collected and utilised to inform strategic planning around staffing, targeting locations and times where ED navigators would be most effective. Unfortunately, we were unable to access routinely collected data and case studies carried out from Blackpool Teaching Hospital to analyse for this evaluation and triangulate with the qualitative data. However, we have managed to gain insights into other data sources that might be used to inform future evaluations (discussed further in the next section).

Participants reported that those in the ED Navigator role were able to build on previous TI knowledge (for example working with the contextual safeguarding framework) and valued regular team meetings for support and reflection. They felt that there were opportunities for ED Navigators to carry out meaningful preventative work with clients of all ages and gave examples of engaging with schools around bullying policies, in addition to working with the

police and agencies to support vulnerable people identified through the programme. The ED Navigator staff we interviewed highlighted that a particularly time-consuming task was to go through patient records to identify eligible people to engage with. They felt that training other staff working in hospital accident and emergency departments in trauma informed approaches to support identification and referral of patients who have been involved in violent crime would be hugely beneficial to the success of the programme and free some time that could be spent working directly with patients.

Unfortunately, the evaluation team had experienced some barriers to accessing participants and data from the TI education programme. Feedback from schools that did not participate suggested that the Covid-19 pandemic had hit schools particularly hard and affected the ability of school staff to engage with activities outside of their core area of responsibility, including engaging with trauma-informed training and the evaluation team. Another challenge was the greater role schools were being expected to play in family assessments and support in the face of funding cuts and conflicting priorities. One long term solution to the roll out of a TI approach was to include TI practice in teacher training curriculums, which could ensure that the education workforce would eventually take a similar approach as partner agencies, in their interaction with pupils and parents and, in the long termer, strategic decision making.

Participants reported that in the shorter term, working in TI ways had influenced their understanding and the way they dealt with children, describing changes in the way they interacted as “calmly” and “with respect”. It had also contributed to an increased awareness of the ways in which trauma affected parents and families of pupils and participants hoped that this would lead to better relationships developing with the schools. Changes in language also played a role in the enactment of TI approaches in practice, with staff who had been trained modelling trauma sensitive language in the hope of influencing those who had not undertaken TI training.

As TI training and workforce development activity reaches professionals from a variety of organisations and backgrounds, it is challenging to coherently capture how the programme is being implemented in practice due to the complexities of various individual and organisational responsibilities and structures. However, there were some commonalities and coherence in participants’ responses and discussions.

Participants spoke positively about LVRN leadership and resources, including the self-assessment tool, and suggested that a community systems and partnership approach might be taken to ensure that all professionals working with vulnerable people in a given geographical area were all working in trauma informed ways. However, some felt that more promotion and awareness-raising around the profile of the LVRN and trauma informed training needed to be done to engage a wider range of professionals. Barriers to professionals engaging in trauma informed training suggested by participants included limited capacity, challenges to existing professional identities and perceived lack of relevance to roles and responsibilities.

Some of our findings were consistent across groups of participants and applied to all workstreams. These included the value attributed to LVRN leadership and resources. There was also a recognition that a multi-agency, joined up approach needs to be taken, where staff working with vulnerable people in specific areas all need to working in TI ways, if TI approaches are to be imbedded in practice and effective for the people who most need support. There is a clearly identified need to raise awareness and promote the LVRN and TI

approaches across organisations and professional groups to promote engagement with the training on offer.

A key issue for many of the people we spoke to for the evaluation is clinical supervision and support for those members of staff who are at risk of experiencing "vicarious trauma" through working with traumatised individuals, or who may have already experienced trauma in their personal or professional lives. Specialist counselling services are available for some staff working in TI ways so perhaps this could be promoted and offered more widely. Many participants suggested that spaces be created where experience could be reflected on and best practice could be shared. That might be facilitated by the LVRN as an organisation, or encouraged within partner organisations.

If TI approaches are to be universally adopted, our findings suggest that TI approaches should be routinely taught in undergraduate, post graduate and professional training programmes. The LVRN and partner organisations could support this by promoting TI approaches for trainee teachers, police officers, health care professionals, social workers and other professions who are preparing students to work with vulnerable communities and individuals.

Strengths and weaknesses of the evaluation

The research design facilitated the engagement of a range of professionals and Normalisation Process Theory was a practical device to help structure thinking and encourage exploration of issues that might otherwise not have been considered. Nevertheless, it important to note that a wide range of stakeholders have contributed and have brought different views and insights to the evaluation. The range of methods used to collect data have added to the diversity of views and the richness of the information. The researchers conducting the evaluation were independent of LVRN and there was also learning between this and the LVRN communities evaluation which started later, but included some parallels in data collection.

The short timescale for the evaluation meant that some people may not have been able to participate before the fieldwork had to be completed. There were also some gaps in the data collected and participants from key organisations (e.g. Fleetwood High School). These issues were exacerbated by the ongoing impact of the COVID-19 pandemic: professionals were still working under extreme pressure, particularly those working in schools and health services. The pandemic also meant that in some cases, involvement with LVRN programmes had been restricted, therefore individuals may have felt that they had little to offer in the way of feedback. A final limitation was that secondary data about programme activity was not always available.

Our aims for this evaluation were to: explore the extent to which staff from LVRN and partner organisations understand and implement trauma informed approaches and to identify training needs; explore how TI approaches support LVRN clients and explore how data collection systems can be developed and improved to support sustainable, long-term evaluation that result in improvements to LVRN service delivery. While it appears that we have achieved most of these aims, we do not have the perspectives of clients, patients, families, children and members of the public informing this report. This represents a clear gap in our data and limitation to the conclusions we can draw. Although not within the remit of this work, we explore engagement with service users in our next section that focuses on data collection systems and future evaluations.

5. Data collection systems

In this section we discuss data collection systems that can be developed and improved to support sustainable long term evaluation that results in improvements in service delivery including:

- Involving service users in future research and evaluation (responses from participants in this evaluation).
- Data collection and use of data (including ensuring data quality, reporting, sharing, reflective practice)
- Links with big data sets
- A questionnaire to evaluate TI training (given difficulties in engaging some staff in evaluation work, a brief tool to evaluate changes over time is suggested).

Involving service users in research and evaluation

Drawing on data collected using the methods outlined above, we have identified some principles and suggestions for future research and evaluation of programmes of work supported by LVRN and Trauma-informed Lancashire

Involving service-users is imperative, but we need to be sensitive

It is crucial to involve service users in the design and development of evaluation studies, in addition to including them as research participants. It is however important that this involvement does not re-traumatise or excessively burden vulnerable individuals *"It could be damaging for some people to revisit a very low point of their life … if they have come so far and they've put that behind them"* (DIVERT 101)

Some participants believed that involvement in research might be empowering, particularly qualitative research which provides the opportunity for people to tell their personal stories "*really empower them and support them in their journey'* (TI Training 402). However others believe that recruiting people with whom they have an established therapeutic or professional relationship could jeopardise the trust in the relationship patients *'It takes all this time to get this trusted relationship with the ED Navigator. They won't trust social worker. They won't trust police. They won't trust anybody. And also we risk the relationship breakdown.'* (ED Navigator 2011)

The benefits and drawbacks of using gatekeepers and advocates

One approach might be to adopt a gatekeeper or advocate approach, where professionals make a judgement about the suitability of the people they are working with to engage in research and evaluation before recruitment *'people that have been in the programme for a good amount of time and have already started to address some barriers. It would definitely be beneficial to understand their views and understand what has or hasn't worked well for them and what could be done better.* (DIVERT 104). This approach appears practical and introduces a layer of safeguarding. However, the strategy may not work for people who have dropped out or not engaged with services. Moreover, research ethics committees tend to encourage researchers to avoid any recruitment practices that may involve a sense of obligation on behalf of the participant and professional relationships with unequal power

dynamics therefore these issues should be considered when designing recruitment pathways.

Make involvement in research and evaluation meaningful

All research should have clear purpose and plan to use any data collected in a meaningful way before attempting to engage service users: *'… it's what we do with those voices. And if we're willing to reflect as a service and what we need to make better, that can be a really powerful thing to do. Whereas I suppose if it's just doing it for the sake of it, we do people a disservice in listening but not doing anything about it*.' (TI Training 402). Research ethics committees also consider it unethical to collect data from participants without analysing and using it for the purpose specified (known as data hoarding).

Consider safeguarding measures

Although a DIVERT coach suggested it may be necessary to have a member of staff present while interview or focus groups take place, this may not be practical (e.g. data collection may take place out of normal working hours) or ethical (presence of the professional may influence the responses of the participant). One solution would be to ask the participant what their preference would be and ensure that the researcher was experienced and trained in TI approaches. A risk assessment would need to be carried out and a plan in place for signposting to support if necessary.

Make involvement accessible

Participants in this study felt that a choice of venues and approaches would be important to ensure that service uses could easily be involved in research and feel comfortable doing so. Suggestions included face-to-face options in accessible and familiar venues and opportunities to be involved remotely/online. Both focus groups and one to one interview should be offered to suit the preferences of individuals. Other suggestions provided were written feedback, recorded conversations with professionals, parental questionnaires alongside school reports and app-based surveys. One professional suggested observational methods could be considered: '*I think possibly just a walk-through observation to have a feel of the school. I mean, for an outside agency to come in just to have a feel of the school and what's happening'* (TI education, 302)

Ask service users what works for them

Participants from the TI Training and Workforce Development programmes cited existing service user groups who have lived experience and young people in care who were part of safeguarding board meetings who might provide further insight into how to best involve other people with lived experience.

Consider how we thank participants for their time

Participants felt that offering shopping vouchers to thank people for their time spent participating in research would be appropriate, however others said they would be happy to participate free of charge. Some restrictions may be imposed by the Home Office position with regards to incentives for individuals who have committed a criminal offence (financial incentives only in exceptional circumstances?). Government guidance in general appears to be compatible with incentives. More information is available in *Finding participants for user research - Service Manual - GOV.UK (www.gov.uk)*.

6. Data collection and use of data

We have been able to start the process of collating a list of data linked to the programmes of work covered in this evaluation. When completed, this could be utilised in future research, along with informing the ways in which existing data collection systems should be strengthened. The indicators identified/data available to date and some suggestions for development can be found in Appendix 4.

During the course of the evaluation, we were able to analyse data that was shared by some of the programmes. Once we started to ask questions about what the data was saying about practice it became clear that it was not being used in this way on a regular basis: this is part of the process of attaching value to the data. Further work is required to consider what information is being collected, what it says about activity and practice and how it relates to the aims, objectives and performance indicators that have been set for each area of work.

It is also important to share activity and outcome information with other professionals who are involved in each programme of work, such as custody suite staff for DIVERT, emergency department staff for ED Navigators). This has the potential to increase their understanding and encourage them to become more invested if they see it is having an impact. As funders, the LVRN should also be aware of activity and outcomes of each programme, and it would enable greater reflection on practice at a strategic level.

At a programme level, reflective on the activity and outcomes data can enable, for example, the identification of differences by location, skill set of workers, resources, approach of organisations adopting a TI approach: current reflection largely appears to be about individual cases as part of individual supervision or practice groups. It is also clear that data can be used to inform preventative activities – one example is the ED Nav location of incident data being used to inform outreach activity: whether there are other areas where data can be used in this way should be considered.

In line with the LVRNs promotion of the Principles of TI Practice, another area which deserves greater reflection is how these are embedded across organisational processes and practice. Although there were clear examples of participants practicing in accordance with the principles of TI practice, there less reference to ‘peer support’ and ‘cultural, historical and gender issues’ than the other principles.

There are also reflective questions for specific areas of LVRN activity, the answers to which could increase understanding of what works and assist in the roll out of the programme. In the case of TI Education for example, reflective questions may include: What does a whole school approach look like? Can elements of ‘good practice’ in working towards a whole school understanding and purpose be identified? How can everyone be equally invested (leaders, teachers, pastoral staff, children, parents, governors, lunchtime staff) to avoid an ‘us’ (those who get it) and ‘them’ (don’t get it/haven’t been invited) mentality. And what is the impact of a whole school approach?

Links to big data sets

Our ARC Northwest Coast colleague at Liverpool University has identified the following national data sets that could be used in future evaluations. We are able to collaborate with our colleagues on identifying and accessing this and other large datasets.

- ONS summary level data that includes knife crime - https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables
- The Ministry of Justice Data First platform https://www.gov.uk/guidance/ministry-of-justice-data-first

Wellbeing literature and questionnaires

In our original proposal, based on the ITQ provided by the LVRN, we stated that we would research and identify suitable questionnaires to be used to gather data on:

- Wellbeing of professionals who have undertaken TI training
- Changes in behaviour and practice of those who have undertaken TI training

Findings from our rapid review of current literature in this area are in Appendix 6.1.

There is limited research/evidence on how best to measure the impact of trauma-informed practice on police staff wellbeing, however, one pilot study conducted by Grove and O'Connor(10) identified the Professional Quality of Life Scale (ProQOL). Please see Grover and O'Connor's report(10) and Appendix 6.1 for further detail.

Two validated questionnaires that could be considered to evaluate TI training are:

- COM -B questionnaire to assess behaviour change in professional practice (11) (Appendix 6.2).
- NOMAD instrument to assess adoption of new ways of working (12) (Appendix 6.3)

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