research in practice *for adults*

Frontline Briefing

Embedding trauma-informed approaches in adult social care

Dartington

www.ripfa.org.uk

Trauma matters. It shapes us. It happens all around us. It destroys some of us, and it is overcome by many of us. To ignore it is to ignore who we are in all our complexity.

(Filson, 2016)

Fire can warm or consume, water can quench or drown, wind can caress or cut. And so it is with human relationships: we can both create and destroy, nurture and terrorise, traumatise and heal each other.

(Perry and Szalavitz, 2017)

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

(Hopper et al, 2005)

No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest.

(Herman, 1998)

Five key learning points

1. People working in health and social care are likely to be working with people with significant trauma histories. Trauma is everyone's business.
2. Although trauma-informed approaches are an organisational change process, individual practitioners can cultivate trauma-informed practice, even when working within trauma-*un*informed organisations.
3. Trauma-informed approaches aim to do the opposite of the original trauma. These approaches empower people to move from powerlessness to personal agency, from fear to safety, from secrecy to transparency (Perôt, Chevous and the Survivors' Voices Research Group, 2018).
4. Trauma-informed practice with people relies on developing strong interpersonal and technical skills, and relationship-based practice.
5. Engaging in collaborative, mutual, healing relationships with survivors requires professionals in direct practice to attend to their own needs through comprehensive self-care and organisational support, including reflective supervision.

Introduction

This briefing provides an introduction to trauma-informed approaches. It suggests that trauma-informed approaches and relationship-based practice can help with a healing process for trauma survivors. It is important to note that people can and do recover following trauma. Through trauma-informed practice and collaborative engagement, survivors can harness the skills and overcome traumatic experiences.

Trauma-informed approaches are supported by organisational environments that:

- prevent re-traumatisation and vicarious trauma in practitioners and the adults they support
- foster healing and recovery.

Vicarious trauma is where a person experiences the impact of traumatic events as a result of working with a person who has directly experienced trauma. Practitioners working with people who have experienced trauma are therefore at risk of experiencing this phenomenon and so need supportive environments and working practices, such as reflective supervision, that enable them to emotionally protect themselves.

Nonetheless, individual practitioners can engage in **trauma-informed relationship-based practice** with the people they work with, based on a comprehensive understanding of trauma and its impacts. Individual practitioners have a vital role to play, with the right training and support, in promoting a trauma-informed culture.

The briefing is organised into four sections:

1) **The *why* of trauma-informed approaches**
   Understanding trauma and why it is everyone's business. **Page 4**
2) **The *what* of trauma-informed approaches**
   Understanding the basic principles. **Page 9**
3) **The *how* of trauma-informed approaches**
   Trauma-informed approaches and relationship-based practice. **Page 14**
4) **The '/' in trauma-informed approaches**
   Working with trauma. **Page 19**

Further reading

Trauma-informed approaches with young people: Frontline Briefing (Taggart, 2018)

The *why* of trauma-informed approaches: Understanding trauma and why it is everyone's business

Defining trauma

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) has produced a useful framework for understanding trauma which they describe as 'the three Es':

> *Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful, or life-threatening, and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing.*
> (SAMHSA, 2014)

First, a trauma **event** occurs - which may or may not be life threatening. The event might occur once or be a series of events that compound over time. Terr (1991) has described this as:

> **Type I trauma:** Referring to single incidents that can lead to Post Traumatic Stress Disorder (PTSD). For example, a car accident, sudden bereavement or violent attack by a stranger.
>
> **Type II trauma:** Referring to ongoing and repeated exposure to complex and compounding events such as [sex and] gender-based violence, coercive control, emotional neglect, abandonment, separation from family, gang violence or bullying.

Complex trauma is a term that has also been used to 'describe the experience of multiple chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature' (Van Der Kolk, 2005). These traumas occur in relationships and can radically alter a person's sense of self-worth, how they understand the world and their place in it, and their interpersonal relationships.

Some forms of trauma and adversity are so common that they have arguably been normalised. These can include **social and economic traumas** such as racism, homophobia, poverty and inequality. **Historical traumas** include the legacies of violence committed against groups, as with slavery and the holocaust (Blanch et al, 2012).

Second, people **experience** the same trauma event(s) in unique ways. The trauma will vary from person to person depending on a variety of factors, such as sex, gender, cultural beliefs, social supports, age and opportunities. However, common to many trauma survivors - particularly survivors of complex and developmental traumas - are ongoing and deep-seated feelings of guilt, shame and a lack of self-worth.

Trauma can undermine a person's trust in others. This may make it particularly difficult for people to trust figures who have authority or hold power in a relationship - for example, health and care practitioners, police, teachers and other professionals. This makes sense when you consider that Type II trauma typically involves one person having power over another. For those working with people affected by trauma, it means that trustworthiness must be proven.

Finally, the **effects** of trauma might occur immediately or in the future, and can last anywhere between a few weeks and a lifetime.

The impacts of trauma

Although some people may experience the effects of trauma over a prolonged period, healing can be nurtured through trauma-informed practice. This provides hope that, even in the most complex of circumstances, trauma-informed practitioners can support people to take steps to manage adversity and rebuild their lives.

Corrigan and colleagues (2011) have commented that 'threatening and traumatic experiences result in a bewildering array of cognitive, emotional and physiological symptoms'. The extent of impacts is, indeed, bewildering and there is a vast literature detailing the myriad ways that living with trauma can impact upon our individual, relational and social functioning.

Further reading

A summary paper on the effects of childhood trauma from a more psychiatric/psychological perspective can be found here: **www.traumacenter.org/products/pdf_files/Complex_Child_Trauma.pdf**

Impacts can range from difficulties in daily functioning to interpersonal relationships, physical and mental health, cognition (such as the ability to focus) and neurological development. The section on page 6 describes Adverse Childhood Experiences – also known as ACEs – research, which has found strong evidence of a population-level link between some forms of childhood adversity and multiple consequences in later life, ranging from the chances of receiving a custodial sentence to early death.

An emphasis of this briefing, however, is the relational impacts of trauma, as this is likely to influence how practitioners approach their work with traumatised adults. When thinking about the effects of trauma, it is helpful to see them less as symptoms of an underlying pathology and more as adaptive attempts to survive difficult circumstances.

A key factor in the development of complex trauma in childhood is not being able to escape from the danger (Hyland et al, 2017). The interpersonal issues trauma survivors may face in adulthood - volatility, mistrust, avoidance of intimacy or engagement in inappropriate intimacy, as well as the more commonly cited 'Fight-Flight-Freeze' (Levine, 1997) and 'Friend and Flop' (Ogden and Minton, 2000; Porges, 1995 and 2004) responses - can all be made sense of as ways to survive dangerous situations.

Further reading

www.information.pods-online.org.uk/what-are-the-usual-responses-to-trauma

Importantly, people might not connect trauma event(s) to later impacts for a multitude of reasons. For example, they may not remember the event, might not want to see it as having impacted them, or might not want or feel able to disclose trauma experiences to others. One research study found an average delay of 16 years between trauma events and a person telling someone they had been abused (Read et al, 2006). This can mean that, whilst trauma might be impacting a person in significant ways, the events themselves are invisible.

Adverse Childhood Experiences (ACEs) research

Adverse Childhood Experiences (ACEs) research explores the scale and types of adversity experienced in childhood at a population level (Feletti et al, 1998; Hillis et al, 2000; Dube et al, 2003; Herman et al, 1997; Hughes et al, 2017). It does this by studying the impact of childhood adversity on a range of outcomes across the life course (see figures one and two on the following page).

Within the UK, large-scale ACEs research by Public Health Wales (2015) found that half of all adults self-reported that they had experienced at least one adverse childhood experience (for example, sexual abuse, neglect, an incarcerated parent, drug use in the home) before the age of 18, and one in seven experienced four or more.

Compared to those with no adverse childhood experiences, those with four or more adverse experiences are **twice** as likely to be diagnosed with a chronic disease, **six** times more likely to smoke, **fourteen** times more likely to have been a victim of violence in the last year and **twenty** times more likely to be incarcerated (Public Health Wales, 2015). Having four or more adverse childhood experiences places people at increased risk of **all** identified negative health outcomes compared to people without such experiences (Hughes et al, 2017), including risk of premature death (Brown et al, 2009).

This link between childhood experiences and subsequent adult health fits common sense understandings of the ways in which people are shaped by childhood experiences (Taggart, 2018). It means that people who have experienced multiple adversities are more likely to need support in life to overcome the impact of such adversity.

However, as with any body of research, critical appraisal is necessary. Locating ACEs in a wider social context is crucial, as is highlighting the intertwined impact of social and economic inequality. ACEs research highlights a correlation between childhood adversity and a range of outcomes in adulthood. As such, it cannot account for all potential factors impacting outcomes in adulthood. Finkelhor (2018) states that potential factors missing in the ACEs inventory may be involved. For example, alternative pathways contributing to social and health outcomes such as deprivation or poverty, have tended to be absent in ACEs research, though some research is now engaging with these wider issues (Kelly-Irving and Delpierre, 2019; Metzler et al, 2017).

In support of this The Power Threat Meaning Framework (Johnstone et al, 2018) highlights the link between social factors, such as poverty, racism, discrimination and inequality, plus traumatic experiences such as abuse or violence, with mental distress (Guthrie, 2018). This model locates causation firmly in the inequalities present in wider society, and in experiences of trauma, rather than within the individual.

Some authors also view the ACEs inventory as failing to account for some significant and well-established childhood adversities; for example, peer-rejection, bullying and discrimination (Finkelhor et al, 2012; Purewal et al, 2016).

There is evidence that the majority of people who have experienced ACEs do not develop related problems. ACEs, therefore, do not necessarily determine the health and social outcomes 'at an individual level the severity, timing, duration of stressful life events are likely to have different and heterogeneous consequences for health' (Kelly-Irving et al, 2013).

Whilst ACEs research may be a useful evidence-base for population level decision-making, some have argued that caution should be exercised in using the ACEs inventory as a tool in practice (as opposed to a research tool) as it has been described as an insufficient and ill-adapted tool for implementation at an individual level (Kelly-Irving and Delpierre, 2019). Notwithstanding the emerging critique of the ACES inventory, the ACEs research is valuable in understanding the need for structural change to support better access to health and social care services, and increase practitioner awareness of the impact of stressful life conditions.

It is important to remember that ACEs studies offer an empirical model for what may happen if trauma and adversity are not addressed. Engaging with these critical perspectives does not mean that the impact of trauma and adversity can be ignored. Trauma-informed practitioners understand that the existence of ACEs in a person's life may not negatively impact health and social care outcomes but, where there are negative consequences, there is still hope for a positive future. Relationship-based practice can significantly influence this trajectory, and recognising trauma and embedding safety can offer people other ways of living.

The images in the infographics below are re-produced from the work by the Robert Wood JF to illustrate ACEs research.

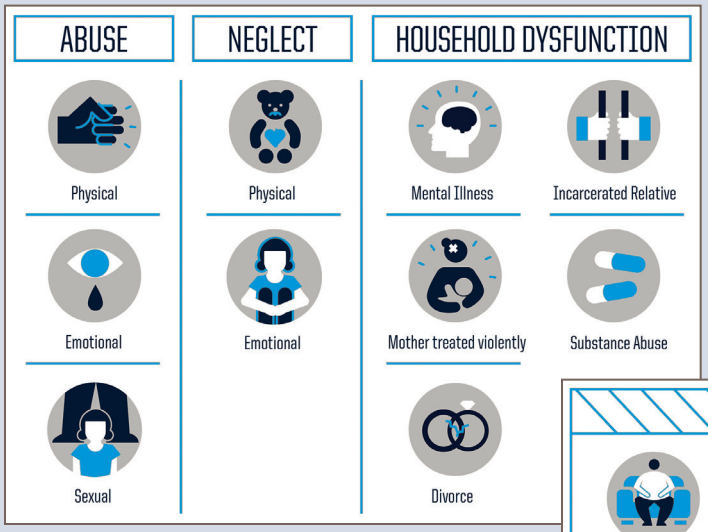

Figure one: The ten areas of adversity focused on in ACE studies

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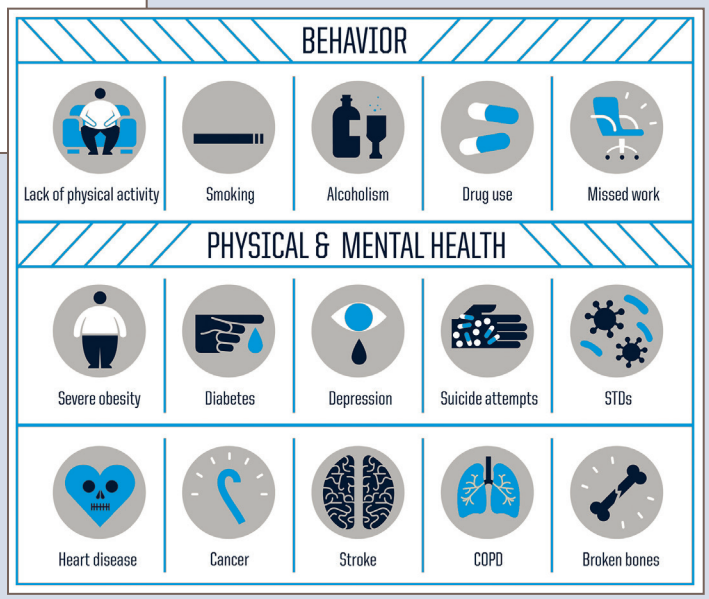

Figure two: Areas of increased risk across the life span identified in ACE studies

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Why 'trauma is everyone's business'

It is not possible to understand trauma-informed approaches without first understanding that trauma is everyone's business (Friskney, 2017; Thomson, 2018). Trauma is not only relevant to people whose work brings them into contact with known trauma survivors: instead, anyone whose work connects them to members of the public - whether as receptionist, outreach worker, domestic worker or another role - will inevitably come into contact with trauma survivors.

Health and care practitioners may also have experienced trauma themselves. Because being a trauma survivor impacts people's worldview, relationships, sense of safety, and ability to access and meaningfully engage with services, this will likely impact the way in which practitioners' relationships with adults unfold.

The legal and policy context

The Scottish government is developing a comprehensive trauma-informed training agenda that aims to raise trauma-informed competency across the public workforce in Scotland (for example, through NHS Education for Scotland, 2017). The national policy context for England and Wales is not as clear, although there is the Women's Mental Health Taskforce - which includes a set of principles on trauma-informed approaches, along with statements of how these principles are demonstrated (DHSC and Agenda, 2018). NHS England (2018) has produced a Strategic direction for sexual assault and abuse services:
www.england.nhs.uk/publication/strategic-direction-for-sexual-assault-and-abuse-services

The wider legal context for England and Wales includes:

- The ***Care Act 2014*** and the ***Social Services and Wellbeing (Wales) Act 2014***
  These include wellbeing principles and prevention, and create statutory duties to meet eligible care and support needs which support trauma-informed approaches.

- The ***Mental Health Act 1983***
  This outlines the legal position around mental health assessment, treatment and the rights of people experiencing mental health difficulties. The five overarching principles of the *Mental Health Act 1983* – and, in particular, purpose and effectiveness, respect and dignity, empowerment and involvement - all align with trauma-informed practice.

  Following the Independent review of the *Mental Health Act 2018*, which calls for changes in the law to increase the level of control people have over their care, there continues to be ongoing campaign activity to ensure this is further embedded.

  www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

- The ***Human Rights Act 1998***
  Articles three (right to freedom and protection from inhumane and degrading treatment), five (right to liberty and security) and eight (right to a private and family life) of this Act underpin the values of trauma-informed practice.

Further reading

For a more detailed analysis of the policy context in England, Scotland, Wales and Northern Ireland, see Bunting et al (2018).

The *what* of trauma-informed approaches:
Understanding the basic principles

Survivors' needs are too often not met. This could be for a variety of reasons:

1. Historically there has been a collective, societal failure to understand the scale of trauma in societies, particularly amongst people with health, care and support needs.
2. Survivors may have had experience of being let down by the institutions whose role is to protect them (for example, police, family courts), making it difficult to trust and engage with services.
3. Distress and extreme states are often viewed through a biomedical lens and interpreted as symptoms of a mental illness, a personality disorder, or the result of bad choices.
4. Services have historically been structured and delivered in ways that actively re-traumatise survivors through relationships that mirror the powerlessness of traumatic experiences.
5. Some services also focus on treating symptoms rather than creating healing environments, or on ensuring risk management rather than enabling safe, mutual and empowering relationships. (Sweeney et al, 2019)

Trauma-informed approaches aim to create environments that are conducive to healing and prevent re-traumatisation through comprehensive organisational change processes. Critically, individual practitioners can take steps towards trauma-informed practice, even when working within organisations where whole-system understanding of trauma is not embedded. For more on organisational change, see section 3 on page 14.

Four key assumptions in trauma-informed approaches

SAMHSA (2014) has described four key assumptions – **the 'Four Rs'** - that must be met for practice to be trauma-informed:

Realisation
Understanding the widespread prevalence and impacts of trauma on families, communities, organisations and individuals. Understanding that trauma-informed approaches are relevant to all services that work with people.

Recognition
Recognising the signs and symptoms of trauma in individuals, families, practitioners and others.

Response
Expecting the presence of trauma in the lives of people with lived experience and adopting working practices that do not re-traumatise. Fully integrating the principles of trauma-informed approaches in policies, procedures and practices.

Resist re-traumatisation
Taking steps to understand and actively avoid re-traumatisation.

Re-traumatisation can occur when a current experience triggers the same, or similar, emotional, psychological and/or physiological response as an original, traumatic experience. Whilst coercive behaviour is rarely deliberate at the individual practitioner level, arguably coercion is built into many public service systems and one of the most common forms of re-traumatisation is the replication of powerlessness that occurs when an adult's beliefs and choices are sidelined or ignored in coercive relationships.

Re-traumatisation may also occur when professionals make decisions on a person's behalf. Trauma experiences may be exacerbated where practitioners do not understand current responses as a triggering of past trauma. Consequently, at their most basic, trauma-informed approaches need to ensure that people are not re-traumatised through contact with health and social care services.

Principles of trauma-informed approaches

Perôt, Chevous and the Survivors' Voices Research Group (2018) have produced a draft resource *Survivors' Voices* - **www.survivorsvoices.org/charter** - with King's College London and the Welcome Foundation, which outlines principles for engagement with survivors. These include practice that:

- is safe
- is empowering
- amplifies the voice of survivors
- promotes self-care
- is accountable and transparent
- is liberating
- is creative and joyful.

Practice with 'people affected by abuse and trauma needs to look unlike and be the opposite of abuse - otherwise it can inadvertently replicate the dynamics of abuse and cause harm' (Perôt, Chevous and the Survivors' Voices Research Group, 2018). This means doing the opposite of what occurs when trauma is experienced - think about how practice can support people to move from powerlessness to agency, from fear to safety, from secrecy to transparency. Trauma-informed services are structured, organised and delivered in ways that promote safety and trust through implementation of the broad principles of the approach.

The table starting on the next page details nine principles of trauma-informed approaches and how good practice might feel to people.

Principles of trauma-informed approaches and their application
(Based on Sweeney et al, 2016, and Taggart 2018)

Principle	Description	Why?	How this might feel
Recognition of trauma	See through a 'trauma lens' by understanding potential links between current difficulties and past experiences. This includes being able to recognise the signs of trauma (for example, dissociation).	The majority of people in contact with health and social care services are likely to have experienced significant trauma which impacts current functioning. Having trauma recognised in appropriate ways can help survivors feel validated, safe and hopeful. Many people find it difficult to disclose. It can also prevent misdiagnosis and promote individualised support.	"I am being seen and believed."
Preventing re-traumatisation	Understand the way in which service policies (for example, around risk management) and power differences between practitioners and adults can re-traumatise all involved, and take steps to reduce re-traumatisation and vicarious trauma (see section 4 on page 19).	Re-traumatisation (sometimes known as iatrogenic harm) through contact with services is not uncommon and is often subtle. Practitioners are also vulnerable to re-traumatisation and vicarious trauma.	"They are not like the people that hurt me."
Cultural, historical, sex and gender contexts	Services should be culturally, sex and gender sensitive and appropriate, and recognise the role of intersectionality.	Different groups of people are likely to experience different forms of trauma. For example, on account of their sex or gender, race, sexual orientation, disability and so on. Cultural resources and taboos may mean that people respond to trauma in different ways.	"They thought about me as a unique person. Me as a *whole* person."
Trustworthiness and transparency	Decisions taken at individual and service levels should be open and transparent, with the aim of building trust.	Trauma is often defined by a sense of secrecy and betrayal, disrupting survivors' ability to form trusting relationships.	"When they say they will do something they do it."

Principle	Description	Why?	How this might feel
Collaboration and mutuality	Relationships should be collaborative and mutual, based on respect, trust, connection and hope. As with strengths-based approaches, there should be a clear move away from 'helper-helpee' roles which reinforce helplessness/power dynamics.	The inherent power imbalance between practitioners and survivors can mirror that of abusive relationships. Having experienced powerlessness in the past can lead to ongoing feelings of disconnection, hopelessness, mistrust and fear in the present.	"We are working through this difficult stuff together."
Empowerment, choice and control	Adopt strengths-based approaches that acknowledge the coping and adaptive skills survivors have developed in order to get to this point. Ensure people are supported to take control of their lives, and are able to make meaningful, genuine choices around their care and support.	To experience trauma is to experience an absence of control. Coping strategies are often critical adaptations that have enabled a person to make it through (for example, self-harm, heavy drug or alcohol use) but can be viewed negatively by practitioners.	"I am taking control of my life now."
Safety	Practitioners and people being supported should feel and be physically, emotionally, psychologically, socially and culturally safe. To achieve this, the above principles should be enacted, such as cultural, sex and gender sensitivity, competence, choice and control, transparency, and so on.	Experiencing trauma fundamentally disrupts a person's ability to feel safe at any given moment, with 'Fight, Flight, Freeze, Friend, Flop' - (Levine, 1997; Ogden and Minton, 2000; Porges, 1995 and 2004) mechanisms typically highly sensitised. People who identify as part of a minority group, for example LGBTQ+, may feel particularly unsafe in mainstream services.	"I feel like I can finally begin to trust people again." "It might be worth seeing if they're trustworthy." "I feel safe."

Principle	Description	Why?	How this might feel
Survivor partnerships	Organisations should work in partnership with survivors to design, deliver and evaluate services using co-production approaches. Peer support should be a fundamental part of any service.	Peer support and the co-production of services mean that mutuality, empowerment, collaboration and fairness/ justice become part of the response to trauma. Partnership working allows for control to be returned to the survivor, having been taken away in the original abuse.	"Meeting other people like me makes me feel less alone." "I am making a contribution to service development so things can be different for future generations." "My experience is valued."
Pathways to specialist trauma treatment (trauma-specific support)	Whilst all services supporting people who have experienced trauma should be trauma-informed, there still needs to be the option for survivors to access trauma-specific treatment from specialist services if they wish to. Survivors should be signposted to, and supported to access, trauma-specific treatments (where they desire). Services should cultivate good links with these trauma-specific organisations to facilitate referrals.	Survivors often find accessing trauma-specific support very difficult.	"I go somewhere safe to talk through and understand what happened to me."

The *how* of trauma-informed approaches: Trauma-informed approaches and relationship based practice

Having explored the *why* and *what* of trauma-informed approaches, this section explores *how* these approaches can be implemented in practice. Many of the core characteristics of a trauma-informed practitioner have the same qualities as relationship-based social work practice (for an overview see Turney and Ward, 2018). Whilst positive change can be achieved through individual practitioners adopting trauma-informed approaches, for large scale impact organisational change is also required.

The importance of organisational change

One of the distinctive features of trauma-informed approaches is that they require system change at an organisational level, as well as changes in the practice of the individual practitioner. This is because a trauma survivor's contact with health or social care services is more multi-faceted than their relationship with an individual practitioner. **A brief case example illustrates this point:**

> **Amy is a 23-year-old mother with experience of the care system. She was sexually abused by a trusted adult. She has been referred to Children's Services and Adult Mental Health Services because of concerns about her parenting skills and her mental health. On coming into contact with two sets of services Amy was asked to attend an initial psychiatric outpatient appointment, an assessment for psychological therapy, an initial Child Protection conference, a meeting with the Specialist Health Visitor, an assessment for a Mother and Baby group at her local Children's Centre and an appointment for her baby to attend a Paediatric consultation.**
>
> **Amy was also told she would receive regular visits by children's social care practitioners at her home. For any appointments she could not make, all of which were scheduled within a few weeks of each other due to the concerns for the child's welfare, she would need to reschedule by talking with receptionists. Some appointments, such as the Child Protection conference, were mandatory. At times Amy appears ambivalent and sometimes appears hostile to practitioners.**

As can be seen from Amy's scenario, it is difficult to imagine anyone being able to cope with this multitude of intrusive appointments, and being asked to reveal private aspects of their life to strangers on a daily basis. Add to this Amy being a young woman who has experienced sexual abuse from a trusted adult in childhood and it becomes clear how re-traumatisation can inadvertently occur through contact with services.

Reflective questions for practitioners working with Amy

Given what you know of Amy's trauma:

Q. How can you adapt your practice to develop a collaborative and trusting working relationship with her?

Q. How can you support Amy to manage the appointments with you and other services along with the other things she has to do?

Q. What can you do to feel confident that you are working with other practitioners to support Amy as effectively as possible?

A trauma-informed approach at a cross-organisational level would be able to plan what services Amy needs to attend with her baby, which are priorities and which can wait. It would also identify the key professional who can build a relationship with Amy to support her and assist her with safely navigating her way through the complex web of new relationships.

This organisational level change would include all professionals, including receptionists and administrators having an understanding of trauma-informed approaches and an understanding of the important message that Amy's response to support is not necessarily a sign of non-engagement but, more likely, a survival response - formed adaptively in childhood to help keep herself safe.

Relationship-based practice

One of the advantages of trauma-informed approaches is that they map onto relationship-based practice so, while working in a trauma-informed way might possibly feel new in some respects, there is much that will be familiar. **Carolyn Knight (2015) highlights four key themes:**

- Being trauma-informed does *not* require specialist trauma training.
- Social care practitioners should understand where their limits lie in working with trauma-related material.
- Social care practitioners and other professionals can attend to trauma and its impact without focusing on it.
- Practitioners should understand and validate current struggles in light of trauma and help the person to learn to live differently in the future.

Some connections between trauma-informed approaches and relationship-based practice can be seen in the following table:

Principles of relationship-based social care	Application to trauma-informed approaches
Social care multi-model can adapt to fit different contexts.	Flexibility to integrate psychological, social and political aspects of trauma and their impact.
The relationship is at the heart of intervention.	Interpersonal relationships are where much trauma occurs - relationships are also at the heart of healing.
Reflexive practice requires practitioners to reflect on their own histories and the impact this has on their practice.	Avoidance of re-traumatisation means not getting unconsciously pulled into abusive dynamics
Working with safe uncertainty - being responsive to changing needs.	Being able to make sense of, and respond but not react to, what may look like 'chaotic' presentations but are in fact trauma responses.
Commitment to social justice.	Recognition that many of the most marginalised people in society have experienced trauma and need to be treated as victims/survivors who are entitled to societal support, justice, safe housing and access to material resources, dignity and respect.

From Knight (2015); Taggart (2018); Bryan, Hingley-Jones and Ruch (2016); Hingley-Jones and Ruch (2016)

Asking about trauma and abuse

One reason many practitioners report lacking confidence in enquiring about trauma histories is because they feel concerned they may make it worse. Other factors relating to not asking about trauma and abuse histories include:

- more pressing present-day issues
- fear of vicarious traumatisation
- lack of understanding about how to manage hearing someone speak about the experience of abuse and not linking abuse history to the specific issues impacting on the person. (Young, Read, Barker-Collo and Harrison, 2001)

These are concerns that should not be dismissed or minimised, but ones that can lead to very low levels of inquiry into abuse histories (Xiao, Gavrilidis, Lee and Kulkarni, 2016) and a lack of responsiveness to someone expressing they have been abused (Read, Harper, Tucker and Kennedy, 2018). Practitioners with trauma-related concerns in their work may find section 4 on page 19 of this briefing especially helpful.

The Truth Project - **www.truthproject.org.uk/i-will-be-heard** - is a central strand of the Independent Inquiry into Child Sexual Abuse (IICSA), which is currently underway. The project involves adult victims and survivors of sexual abuse coming forward to the Inquiry to share their experience in a confidential and validating way in order to be heard, often for the first time, and to contribute to the knowledge base of the wider Inquiry.

As of October 2019, over 4000 adult survivors from England and Wales had shared their experience with the Truth Project. This arguably presents a societal shift in the visibility of childhood trauma and the willingness of many survivors to share their story when offered a safe and validating opportunity. It also opens up new possibilities for dialogue between adult trauma survivors and the professionals who work with them.

In recognition of the need for trauma-related knowledge and skills across the whole workforce, NHS Education for Scotland (2017) has produced a Knowledge and Skills Framework - **www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf** - to help guide people working in Scotland towards taking a trauma-informed approach. Despite being written with Scotland's policy perspective in mind, it is likely to be of benefit to those working in different nations within practitioner and senior roles - providing useful tips on how to work in a trauma-informed way at different levels of practice.

A key part of the framework highlights the need for practitioners to routinely enquire about trauma histories and the framework offers insights into how to do this in a safe and supportive way. It is critical that enquiries are done in a way that maximises the sense of control a person has over the process and minimises the risks of re-traumatisation. Equally, for those people who talk about their trauma history spontaneously, it is critical they do not feel shut down as this reinforces shame and silencing.

Sharing trauma history is a process, not an event. Survivors need a relational context where different forms of partial or full details of abuse *can be shared* if needed and for the conversation to be contained safely by the professional. Divulging trauma history may, therefore, happen over a period of time, at the person's pace, as they build trust in their relationship with the practitioner.

Routine enquiry is by no means a panacea. It should be undertaken with great care and skill on the part of the practitioner, and within a wider organisational trauma-informed framework. Without this, asking about trauma might exacerbate a person's sense of trauma – and can lead to professionals feeling under-equipped, and even vicariously traumatised.

Where trauma enquiries occur they should:

- Ensure that people feel heard.
- Be sensitive, timely and well-paced. Possibly open with something like: "Other people we work with here have sometimes had difficult childhoods, is that something you recognise in your own life?"
- Be optional - allow control over the process at all stages of the discussion: "Is it ok to ask about this?" and "Let me know when you have had enough of talking about this."
- Ensure people understand the limits to confidentiality before sharing their trauma history.
- Pay attention to the impacts of questions. Trauma survivors may convey distress non-verbally, for instance by losing concentration. Look for cues that the person is feeling anxious or distressed and respond to this. Remember that a person who appears unaffected may be in acute distress. Trauma survivors can be adept at presenting as robust and composed, which may or may not reflect what is going on internally and how they will cope after the conversation.
- Take a 'funnel approach' to inquiry (Read, Hammersley and Rudegeair, 2007). This involves introducing the topic of childhood history generally and then asking a series of increasingly specific questions that can get to questions of trauma without it coming 'out of the blue'. This approach incorporates positive experiences as well as more challenging ones. For example, the practitioner could begin by asking about childhood generally, then focus in on some specific positive memories - before going on to ask about relationships with family members, how discipline happened and other areas where relational harm may have occurred.
- Not initially ask for specific details about the trauma. Focus on the fact the person has just shared the information with you, how they feel about that, and whether they have shared it before and how that went. Check how the person is.
- Ask whether the person sees any connection between the trauma and their current difficulties.
- Ensure the person feels safe and grounded. This should include making plans with the person for how they will take care of themselves in the coming hours and days.
- Be translated into support. Something needs to be offered in response to a person sharing their trauma history. This should include authentic validation of what the person has expressed and a plan for how to follow up on it again at a specified time.

Asking about abuse is not necessarily straightforward for the survivor. They might not:

- be able to untangle the threads and communicate what's happened to them in an understandable way
- understand that what they have experienced is abuse
- remember any abuse
- want to risk being re-traumatised by talking about it
- want to repeat their life history again and again.

Interpersonal and technical skills

This briefing has emphasised that trauma-informed approaches require organisational as well as individual level changes. Busy practitioners may, therefore, benefit from guidance about what do to in practice. **The following is a quick guide for trauma-informed practice** based on some collaborative work by a medical doctor and a survivor peer support trainer (Seaman and Cochran, 2018).

- **Environment**
  Who is sitting where and is the person in control of their exit?
- **Body positioning/Language/Self-awareness**
  Sit in a way that is not confrontational and use shared language.
- **Ask permission, ask permission, ask permission**
  Before any new enquiry check the person is still happy with the conversation.
- **Listen for, and reflect, underlying needs**
  What does the person want or need from this conversation? What is its function for them? If they don't know, help them figure that out.
- **Listen for, and reflect, underlying values**
  What is important to this person? What cultural, spiritual and moral values do you need to consider when offering help?
- **Acknowledge strength and avoid (and, if not possible, always explain) professional jargon**
- **Help people find their feet, and help their feet find the ground**
  Top Tip - facilitating the person to be present in the here and now can support them to stay in the current moment and avoid dissociating back to the trauma.
- **Treat people as partners**
  Engage collaboratively with survivors in order to harness the skills that have already helped them survive and overcome traumatic events. That resilience is there and can be tapped into.

The '/' in trauma-informed approaches:
Working with trauma

> *...to stand as witness to the extent and horror of people's accounts of pain and suffering is to encounter and experience fear, despair, loss and rage.*
> Coles (2014)

Consistently stated in the literature is that any attempt to work with people in a trauma-informed way ideally needs to have a similarly trauma-informed organisational structure for supporting practitioners to do this complex, demanding and, at times, distressing work (Bloom, 2017; Sweeney et al, 2016).

Trauma histories among practitioners

There is evidence, albeit focused on children's social care, that suggests health and social care professionals have higher rates of traumatic experiences in their own lives, when compared to the general population (Esaki and Larkin, 2018). This is one reason many practitioners choose to enter helping professions and their experiences can be an asset in their work with their survivor clients (Black, Jeffreys and Hartley, 1993).

Recognising and exploring that professionals, like all people, may have experienced adversity and trauma can help to deconstruct unhelpful and binary 'us and them' mentalities which act as barriers to the meaningful connections that are a core feature of trauma-informed practice (Hingley-Jones and Ruch, 2016). Practitioners may encounter survivors with similar stories to their own and this can lead to an enmeshed state where the practitioner struggles to demarcate where their story ends and the other person's begins. Routine discussion with practitioners through trauma-informed supervision is key, as this is supportive of practitioner wellbeing.

Vicarious trauma

Irrespective of whether or not individual practitioners have a trauma history, there is a risk of vicarious trauma in working with survivors. Work with people who have experienced trauma may involve hearing about traumatic events and this can result 'in cognitive shifts in beliefs and thinking that occur in social workers in direct practice with victims of trauma' (Newell and MacNeil, 2010). In addition, working with survivors can also lead to practitioners witnessing extreme emotions and behaviours that can be directly traumatising (Ford and Blaustein, 2013).

If unprocessed, these cognitive shifts can lead to a vicarious trauma response, which may mirror the features of post-traumatic stress disorder (PTSD); nightmares, intrusive thoughts, avoidance and emotional dysregulation; leading to practitioners' illness, burnout and turnover amongst professionals (Newell and MacNeill, 2010). It is, therefore, essential that, in developing trauma-informed services, practitioners' wellbeing and support are attended to so that they are able to safely undertake the work with survivors required of them.

As the NHS Greater Glasgow and Clyde *Trauma-informed Practice Training Needs Assessment* (2018) recommends:

> *The literature and our research emphasises the risk of vicarious trauma amongst practitioners who regularly work with service users who are survivors of trauma. This includes a combination of well-structured support and supervision in services, and empowering and enabling practitioners to engage in self-care.*

Reflective supervision

Supervision is a vital aspect of work in health and social care settings – however, it often means quite different things in practice. Trauma-informed organisations combine the key elements of core supervision practice and knowledge from vicarious trauma and burnout literature. **The elements listed below are designed to mirror the qualities of the relationships trauma-informed practitioners employ with adults receiving support**:

- Separate from, although not replacing, management supervision.
- Regularly scheduled and prioritised by all parties.
- Agenda collaboratively constructed but led by supervisee.
- Strengths-based approach which also makes space for training and development needs.
- Acknowledgement of ambivalent and difficult feelings around working with trauma - awareness of signs of vicarious traumatisation.
- Separation of practitioner experiences from adults with care and support needs.
- Non-blaming wider organisational culture or, at least, recognition that this is what is needed.
- Understanding interpersonal experiences with survivors in the context of trauma.
- Infusion of hope, as well as acknowledgement of difficulties.
- Other forms of self-care discussed and consideration of impact of work on practitioner home life allowed for.
(Based on Newell and MacNeill, 2010; Earle et al, 2017)

Conclusion

This briefing has highlighted a range of issues facing many people accessing adult social care that can be understood in part through their trauma histories. A key message is that many of the difficulties people face are not problems to be eradicated but are adaptive strategies to survive which people may need support to change. Using a trauma lens to support people to understand why they are struggling to live how they want to, and developing a shared recognition through relationship-based practice, is often the first step in the practitioner and survivor beginning a process of change together.

As an illustration of how this partnership between practitioner and survivor can work in practice, the following quote from a number of survivor researchers and activists emphasises that, while it is important that services offer a trauma-informed culture, it is survivors themselves who need to lead the way in bringing about both individual and systemic change:

> *It is through validation (the act of believing) that a climate of support and recognition for victims and survivors of sexual violence and abuse is created. Our core belief, and one that is worth repeating, is that the expertise about what we need to heal lies with us.*
> (Sweeney et al, 2019)

Five key questions for reflection

1. How has trauma traditionally been identified and worked with in your organisation?
2. What types of trauma are you and your service better at working with? What types do you struggle with?
3. Which aspects of trauma-informed approaches are your service already doing effectively?
4. What are the areas of development for you and your service in developing trauma-informed work?
5. What are three things that need to change about your service for you to be able to work in a trauma-informed way?

Further reading

As the world becomes more trauma-informed, work to do (Becker-Blease, 2016): **www.tandfonline.com/doi/full/10.1080/15299732.2017.1253401**

References

Blanch A, Filson B, Penney D and Cave C (2012) *Engaging women in trauma-informed peer support: A guidebook*. Rockville, MD: National Center for Trauma-Informed Care. Available online: **www.nasmhpd.org/sites/default/files/PeerEngagementGuide_Color_REVISED_10_2012.pdf**

Bloom S (2006) *Human service systems and organizational stress: Thinking and feeling our way out of existing organizational dilemmas*. Philadelphia, PA: Trauma Task Force.

Brown D, Anda R, Tiemeier H, Felitti V, Edwards V, Croft J and Giles W (2009) 'Adverse childhood experiences and the risk of premature mortality'. *American Journal of Preventive Medicine* 37(5), 389-96.

Bunting L, Montgomery L, Mooney S, MacDonald M, Coulter S, Hayes D, Davidson G and Forbes T (2018) *Evidence review - developing trauma-informed practice in Northern Ireland*. Belfast: Safeguarding Board for Northern Ireland and Queen's University.

Corrigan F, Fisher J and Nutt D (2011). 'Autonomic dysregulation and the Window of Tolerance Model of the effects of complex emotional trauma'. *Journal of Psychopharmacology* 25(1), 17-25. DOI: 10.1177/0269881109354930

Department for Health and Social Care (DHSC) (2018) *The Women's Mental Health Taskforce Final Report*. London: DHSC.

Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH and Anda RF (2003). 'Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences Study'. *Pediatrics* 111(3), 564–572.

Earle F, Fox J, Webb C and Bowyer S (2017) *Reflective Supervision: Resource Pack*. Dartington: Research in Practice. Available online: **www.rip.org.uk/resources/publications/practice-tools-and-guides/reflective-supervision-resource-pack-2017**

Elliot D, Bjelajac P, Fallot R, Markoff L and Glover RB (2005) 'Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women'. *Journal of Community Psychology* 33(4), 461-77.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP and Marks JS (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experience (ACE) study'. *American Journal of Preventative Medicine* 14(4), 245-248.

Figley CR (1995) 'Compassion fatigue as secondary traumatic stress disorder: An overview' in Figley CR (ed.) *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner/Mazel.

Filson B (2016) 'The haunting can end: Trauma-informed approaches in healing from abuse and adversity' in Russo J and Sweeney A (eds.) *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*. Hay-on-Wye: PCCS Books.

Finkelhor D (2018) 'Screening for adverse childhood experiences (ACEs): Cautions and suggestions'. *Child Abuse and Neglect* 85, 174-9.

Finkelhor D, Shattuck A, Turner HA and Hamby SL (2012) 'Improving the adverse childhood experiences study scale'. *Archives of Pediatrics and Adolescent Medicine* 167(1), 70-75. Available online: **http://dx.doi.org/10.1001/jamapediatrics.2013.420**

Ford JD and Blaustein ME (2013) 'Systemic self-regulation: A framework for trauma-informed services in residential juvenile justice programs'. *Journal of Family Violence* 28, 665-677.

Freyd J (1998) *Betrayal trauma. The logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.

Friskney R (2017) *Barnardo's Scotland response to Transforming Trauma: The draft trauma knowledge and skills framework*. Ilford: Barnado's Scotland. Available online: **www.barnardos.org.uk/2017.05.02_barnardos_scotland_trauma_framework_comments.pdf**

Guthrie L (2018) *Person-centred approaches to mental health: Frontline Briefing*. Dartington: Research in Practice for Adults. Available online: **www.ripfa.org.uk/resources/publications/frontline-resources/personcentred-approaches-to-adult-mental-health-frontline-briefing-2018**

Herman D, Susser E, Struening E and Link B (1997) 'Adverse childhood experiences: Are they risk factors for homelessness?' *American Journal of Public Health* 87, 2, 249-255.

Herman J (1998) 'Recovery from psychological trauma'. *Psychiatry and Clinical Neurosciences* 52: S98–S103.

Hillis S, Anda R, Feletti V, Nordenberg D and Marchbanks P (2000) 'Adverse childhood experiences and sexually transmitted diseases in men and women: A retrospective study'. *Paediatrics* 106, 1.

Hingley-Jones H and Ruch G (2016) 'Stumbling through'? Relationship-based social work practice in austere times'. *Journal of Social Work Practice* 30:3, 235-248. Available online: **https://doi.org/10.1080/02650533.2016.1215975**

Howard A, Parris S, Call C, Becker E, Razuri E, Purvis K and Cross D (2015) 'An examination of the relationships between professional quality of life, adverse childhood experiences, resilience and work environment in a sample of human service providers'. *Children and Youth Services Review* 57, 141-148.

Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, Jones L and Dunne MP (2017) 'The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis'. *Lancet Public Health* 2(8).

Hyland P, Murphy J, Shevlin M, Vallieres F, McElroy E, Elklit A, Christofferson M and Cloitre M (2017) 'Variation in post-traumatic response: The role of trauma type in predicting ICD-11 PTSD and CPTSD symptoms'. *Social Psychiatry and Psychiatric Epidemiology* 52: 727-736. Available online: **https://doi.org/10.1007/s00127-017-1350-8**

Johnstone L and Boyle M with Cromby J, Dillon J, Harper D, Kinderman P, Longden E, Pilgrim D and Read J (2018) *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Kelly-Irving M and Delpierre C (2019) 'A Critique of the Adverse Childhood Experiences Framework in Epidemiology and Public Health: Uses and Misuses'. *Social Policy and Society* 18(3), 445-6.

Kelly-Irving M, Lepage B, Dedieu D, Lacey R, Cable N, Bartley M, Blane D, Grosclaude P, Lang T and Delpierre C (2013) 'Childhood adversity as a risk for cancer: Findings from the 1958 British birth cohort study'. *BMC Public Health* 13(1), 767.

Levine P (1997) *Waking the tiger: Healing trauma.* Berkeley, CA: North Atlantic Books.

Metzler M, Merrick M, Klevens J, Ports K and Ford D (2017) 'Adverse childhood experiences and life chances: Shifting the narrative'. *Children and Youth Services Review* 72, 141-9.

Newell JM and MacNeil GA (2010) 'Professional burnout, vicarious trauma, secondary traumatic stress and compassion fatigue: A review of theoretical terms, risk factors and preventive methods for clinicians and researchers'. *Best Practice in Mental Health* 6(2), 57-68.

NHS Education for Scotland (2017) *Transforming psychological trauma: A knowledge and skills framework for the Scottish workforce.* West Port, Edinburgh: NHS Education for Scotland in partnership with Scottish Government.

NHS England (2018) *Strategic Direction for Sexual Assault and Abuse Services: Lifelong care for victims and survivors - 2018-2023.* London: NHS England. Available online: **www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf**

NHS Greater Glasgow and Clyde (2018) *Trauma Informed Practice Training Needs Assessment. Final report and supporting action plan.* Glasgow: NHS Greater Glasgow and Clyde. Available online: **www.tiny.cc/l568fz**

Ogden P and Minton K (2000) 'Sensorimotor psychotherapy: One method for processing traumatic memory'. *Traumatology* 6(3), 149-173.

Perôt C and Chevous J (2018) *Turning Pain into Power: A Charter for Organisations Engaging Abuse Survivors in Projects, Research and Service Development.* Available online: **www.survivorsvoices.org/charter**

Perry B (2005) 'Maltreatment and the developing child: How early childhood experience shapes child and culture'. *The Inaugural Margaret McCain lecture (abstracted), McCain Lecture Series.* London: The Centre for Children and Families in the Justice System.

Perry D and Szalavitz (2017) *The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook - What Traumatized Children Can Teach Us About Loss, Love, and Healing.* 3rd edition. New York: Basic Books

Porges S (1995) 'Orienting in a defensive world: Mammilian modifications of our evolutionary heritage. A polyvagal theory'. *Psychophysiology* 32, 301-318.

Porges S (2004) 'Neuroception: A subconscious system for detecting threats and safety'. *Zero to Three* May 2004, 19-24.

Purewal SK, Bucci M, Gutiérrez Wang L, Koita K, Silvério Marques S, Oh D and Burke Harris N (2016) 'Screening for adverse childhood experiences (ACEs) in an integrated pediatric care model'. *Zero to Three* 37(1), 10–17.

Read J, Hammersley P and Rudegeair T (2007) 'Why, when and how to ask about childhood abuse'. *Advances in Psychiatric Treatment* 13, 101-110.
DOI: 10.1192/apt.bp.106.002840

Read J, Harper D, Tucker I and Kennedy A (2018) 'How do mental health services respond when child abuse or neglect become known? A literature review'. *International Journal of Mental Health Nursing*.
doi.org/10.1111/inm.12498

Read J, Mcgregor K, Coggan C and Thomas D (2006) 'Mental health services and sexual abuse: The need for practitioners training'. *Journal of Trauma and Dissociation* 7, 33-50.

Ruch G, Turney D and Ward A (2018) *Relationship-Based Social Work: Getting to the Heart of Practice* (5th edition). London: Jessica Kingsley Publishers.

SAMHSA (2014) *SAMHSA's Working Concept of Trauma and Framework for a Trauma-Informed Approach*. Rockville, MD: SAMHSA, National Centre for Trauma-Informed Care (NCTIC).

Sara G and Lappin J (2017) 'Childhood trauma: Psychiatry's greatest public health challenge?' *Lancet Public Health* 2(7): PE300-E301.

Steptoe A, Marteau T, Fonagy P and Abel K (2019) 'ACEs: Evidence, Gaps, Evaluation and Future Priorities'. *Social Policy and Society* 1-10.
DOI: 10.1017/S1474641900019

Sweeney A, Clement S, Filson B and Kennedy A (2016) 'Trauma-informed mental healthcare in the UK: What is it and how can we further its development?' *Mental Health Review Journal* 21(3), 174-192.
DOI: 10.1108/MHRJ-01-2015-0006

Sweeney A and Taggart D (2018) 'Editorial: (Mis)understanding trauma-informed approaches'. *Journal of Mental Health* 27(5), 383-387.

Sweeney A, Perôt C, Callard F, Adenden V, Mantovani N and Goldsmith L (2019) 'Out of the silence: Towards grassroots and trauma-informed support for people who have experienced sexual violence and abuse'. *Epidemiology and Psychiatric Sciences*.
DOI: 10.1017/S2045796019000131

Taggart D (2018) *Trauma-informed approaches with young people: Frontline Briefing*. Dartington: Research in Practice. Available online:
www.rip.org.uk/resources/publications/frontline-resources/traumainformed-approaches-with-young-people-frontline-briefing-2018

Terr L (1991) 'Childhood traumas: An outline and overview'. *American Journal of Psychiatry* 148(1), 10-20.

Thomson L (2018) *Trauma is everyone's business. An exploration of the challenges and opportunities for Trauma-Informed Practice amongst female populations within custodial settings*. Ilford, Essex: Centre for Youth and Criminal Justice and Barnado's Scotland.

Van der Kolk BA (2005) 'Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories'. *Psychiatric Annals* 35(5), 401-408.

Wales PH (2015) *Welsh Adverse Childhood Experiences Study*. Cardiff: Public Health Wales NHS Trust.

Wilton J and Williams A (2019) *Engaging with complexity: Providing effective trauma-informed care for women*. London: Mental Health Foundation and Centre for Mental Health.

Yiannoullou S (2019) *Independent Review of the Mental Health Act: NSUN's response*. London: The National Survivor User Network (NSUN). Available online:
www.nsun.org.uk/news/independent-review-of-the-mental-health-act-nsuns-response

Young M, Read J and Barker-Collo S et al (2001) 'Evaluating and overcoming barriers to taking abuse histories'. *Professional Psychology: Research and Practice* 32, 407-414.

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