Scottish Government
Riaghaltas na h-Alba

Appendices to Evidence Review: Enablers and Barriers to Trauma-informed Systems, Organisations and Workforces

HEALTH AND SOCIAL CARE

social research

social research

Scottish Government
Riaghaltas na h-Alba

HEALTH AND SOCIAL CARE

Evidence Review: Enablers and Barriers to Trauma-informed Systems, Organisations and Workforces: Appendices

Contents

Appendix A: Classification of intervention effectiveness 2

Appendix B: Summary of the studies used to assess the effectiveness of the trauma-relevant predictors that bring the greatest changes to services, systems, and organisations 4

Appendix A: Classification of intervention effectiveness

Decision-making tools (classification of intervention effectiveness and an evidence of effectiveness decision tree) were used to inform how the evidence was synthesised for this review. These tools were developed for and initially implemented within the Scottish Government report What Works to Prevent Violence Against Women: A Summary of the Evidence. They have been adapted within this report to ensure a consistent and transparent approach to classifying the effectiveness of interventions to promote positive outcomes for staff and people with lived experience of trauma involved in different systems, such as education, child welfare, or the health system.

The decision tree leads to the following six categories of effectiveness. Appendix A provides definitions for each of these evidence.

It should be noted that the inconclusive category is distinct from the no effect category as it indicates either there is insufficient evidence to make a judgement on the impact of an intervention (e.g. only pilot evaluations available) or indicates the need for further research and evidence before conclusions can be drawn on the effectiveness of an intervention.

The decision making tool below has been used to determine effectiveness ratings throughout this report on what strategies to trauma-informed approaches work to promote positive outcomes amongst those involved in different systems.

Definition of the effectiveness categories used for analysis.

Adapted from Miller (2020).

Category: Effective

Definition: Evidence that the intervention is associated with a positive impact on the outcomes of staff working within different services, systems, and organizations, and people with lived experience of trauma involved in those systems, based on a moderate or strong evidence base. Due to the complexity of causality, an ‘effective’ intervention should be considered one that contributed towards improved health or wellbeing rather than one that single-handedly accounts for an increase in health or wellbeing.

Category: Promising

Definition: Findings were positive but not to the extent that they constituted evidence that an intervention was ‘effective’, this could be:

(i) in cases where an intervention has a positive impact on an intermediate outcome, rather than in improving health and wellbeing itself

(ii) where authors noted a positive change, but expressed doubts as to whether the intervention could confidently be said to have contributed to this (e.g. due to evidence being rated as “weak” or the other factors potentially having an impact).

Category: Mixed

Definition: Findings of individual article -

(i) An individual article that finds varied impact of a single intervention across research sites, or populations.

(ii) An article examining multiple strands of an interventions that finds some were effective/promising and others not.

Findings from a number of studies-

(i) Where there have been a number of studies and the results contrast – e.g. some found positive effects and some did not.

(ii) Similarly, a body of evidence that is mostly comprised of individual articles finding a 'mixed' impact of interventions would be considered 'mixed' overall.

Category: No effect

Definition: No evidence of effect (positive or negative) of the intervention on improving health or wellbeing or includes moderate or strong evidence found the intervention had no effect on improving health or wellbeing.

Category: Negative effect/ Potentially harmful

Definition: Evidence that the intervention is associated with worse health and wellbeing outcomes (e.g. worse than at the start of the intervention, or worse than for a control group).

Category: Inconclusive

Definition: Insufficient evidence to make a judgement on impact.

Appendix B: Summary of the studies used to assess the effectiveness of the trauma-relevant predictors that bring the greatest changes to services, systems, and organisations

EMPIRICAL STUDIES

Azeem et al., 2017 - Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital

Patient / population

Children and adolescents admitted in a state psychiatric hospital (N = 458).
USA.

Intervention

Staff training centred on six core strategies to promote trauma informed care within a child and adolescent psychiatric hospital. These strategies, based on NASMHPD guidelines for the reduction of restraints and seclusions, included leadership towards organizational change, use of data to inform practice, workforce development, use of restraint and seclusion reduction tools, improve consumer's role in inpatient setting, vigorous debriefing techniques.

Comparison / measures

Retrospective study based on the analysis of administrative data regarding number of seclusion/restraints episodes over three years. The study began a year after staff received trauma-based training.

Outcomes

In the final six months of the study, there was a marked reduction in the use of restraints and seclusions, compared to the first six months. More specifically, there were 93 episodes involving 22 children and young people in the first six months, and 31 episodes involving 11 children and adolescents in the last six months.

Baetz et al., 2021 - Impact of a Trauma-Informed Intervention for Youth and Staff on Rates of Violence in Juvenile Detention Settings

Patient / population

Youth (N = 14.856) staying at two juvenile detention centres between 2012 and 2016. There were 3,213 young people residing in Facility A and 11.643 in Facility B. USA.

Intervention

Intervention based on two components. The first component was a trauma-informed training for staff following the Think Trauma curriculum. The second component was STAIR, a skill-building group program for young people in the facilities. A total of 331 young people completed STAIR, 190 from facility A and 141 from facility B.

Comparison / measures

Sociodemographic data was used to analyse the impact of the TIC intervention on rates of violence at the two facilities. Data included the rate of altercations and violent incidents between young people in the facilities. Measures were taken pre intervention, during the implementation of both components at facility A (2013) and at facility B (2014), and until 2016. The measures were expressed as the number of assaults and altercations per average daily population (100).

Outcomes

Results showed significant reduction in violent incidents at one of the facilities, but not at the other. The significant results were found at the facility where a larger population of young people had participated in the skill-building programme. These results might suggest that a threshold percentage of young people receiving the intervention might be necessary.

Barnett et al., 2018 - Developing, implementing, and evaluating a trauma-informed care program within a youth residential treatment center and special needs school

Patient / population

Staff working in a youth residential treatment centre and accompanying specialist school, as well as administrators working elsewhere in the institution, who participated in the voluntary training sessions and took part in a survey (N = 589 or 178). USA.

Intervention

A three-year multi-tiered trauma-informed program. The four tiers of the programme included 1) a pre-intervention needs assessment carried out with leaders and staff, 2) promoting leadership buy-in and planning with administrators, 3) staff training and coaching following a train-the-trainer format, and 4) ongoing training and reflective practice groups, staff rewards and evaluation.

Comparison / measures

An online platform was used to distribute two surveys amongst staff, 12 months into the programme sustainment phase. The surveys used were the Felt Safety Survey and the Trauma-Informed Skills Survey. Administrative data was used to analyse critical violent incidents including restraints and staff turnover.

Outcomes

There was a significant correlation between trauma knowledge and skills and the “dose” of staff involvement in training sessions and reflective practice groups. There was no correlation between staff training and reflective practice groups and safety or professional satisfaction. Critical incidents decreased by 22% during the intervention, and there were limited changes on staff turnover.

Bartlett et al., 2016 - Trauma-Informed Care in the Massachusetts Child Trauma Project

Patient / population

Leaders from the Trauma-Informed Leadership Teams (N = 32) participated in key informant interviews. Senior leaders from 20 community mental health agencies (N = 27) who participated in the learning collaborative in the first year of implementation, clinicians and clinical supervisors (N = 190) who completed an online survey, children (N = 326) and their parents, caregivers, or legal guardians, enrolled in the evaluation and received one evidence-based treatment.

Intervention

Implementation of the Massachusetts Child Trauma Project (MCTP), a state-wide trauma-informed initiative across the child welfare system and mental health network. The key components of MCTP are: child welfare staff trauma training, dissemination of evidence-based treatments, and systems integration.

Comparison / measures

Mixed methods implementation and child outcome evaluation. Evaluation focused on improvements on TIC after one-year implementation association between evidence-based treatments and reductions in trauma symptoms and improved behaviour six months after commencing treatment. Surveys (standardized and unstandardized), interviews, focus groups, records review, and child assessments were used for data gathering. The design of this formative evaluation is primarily descriptive. Evaluations took place after six months and one year of implementation.

Outcomes

After 1 year of implementation, Trauma-Informed Leadership Teams (TILTs) were essential for TIC implementation and systems integration. After approximately 6 months of EBT treatment, children had fewer posttraumatic symptoms and behaviour problems compared to baseline.

Barto et al., 2018 - The impact of a state-wide trauma-informed child welfare initiative on children's permanency and maltreatment outcomes

Patient / population

Children (N = 91,253) involved with the state child welfare system who had experienced maltreatment. Intervention group: N = 55,145, comparison group: N = 36,108. USA.

Intervention

Implementation of the Massachusetts Child Trauma Project (MCTP), a state-wide trauma-informed initiative across the child welfare system and mental health network. The key components of MCTP are: staff trauma training, dissemination of evidence-based treatments, and systems integration. The learning was supported by the creation of Trauma Informed Leadership Teams. These teams were comprised by leaders from the community and each of the two systems. One-year implementation period.

Comparison / measures

This study evaluated whether MCTP was associated with reductions in child abuse and neglect, improvements in placement stability, and higher rates of permanency during the first year of implementation. Children's demographic data, and administrative data were used to analyse the study outcomes. The administrative data covered information about total number of child maltreatment reports (substantiated or not), the total number of substantiated reports of any type of maltreatment, the total number of out-of-home placements including adoption, guardianship or returned home, and total number of days in placement during the programme.

Outcomes

After the first year of implementation, fewer total substantiated reports of maltreatment for children in the intervention group were registered. This included fewer physical abuse and neglect than the reported in the comparison group. Nevertheless, more maltreatment reports (substantiated and not) were registered for children in the intervention group, as were total out-of-home placements than children in the comparison group. Assignment to MCTP was not associated with increased kinship care or adoption rates. The results are promising and strengthen the importance of involving communities for the improvement of child welfare service delivery.

Connell et al., 2019 - Enhancing Capacity for Trauma-informed Care in Child Welfare: Impact of a State-wide Systems Change Initiative

Patient / population

Staff working across a child welfare system.
- Year 1: N = 233
- Year 2: N = 231
- Year 5: N= 185

USA.

Intervention

CONCEPT: multi-year initiative focused on enhancing capacity of the child welfare systems to provide trauma-informed care across the state of Connecticut. This initiative used a multi-component approach including workforce development, trauma screening, changes in policy, secondary traumatic stress supports, improved access to evidence-based trauma-focused treatments, and evaluation of the impacts of the program. Implemented across a 5 year period.

Comparison / measures

State-wide stratified random samples of staff working within the child welfare systems were used to assess changes in the system's capacity to deliver trauma-informed care. Data were assessed at three points in time. Areas assessed included staff perceptions of systems understanding and ability to use trauma-informed practices to support children, families and the rest of the workforce (years 1 and 3; Trauma System Readiness Tool; TSRT). In year 5 a reduced version of the TSRT was used and questions were included about 12 key CONCEPT components and staff perception and awareness of them, including their contributions to the improvement of the system's capacity to deliver trauma-informed care.

Outcomes

Significant improvements were observed across nearly all child welfare domains during the first three years of programme implementation. Domains included access to trauma-informed services, trauma supervision and support, or staff adoption of trauma-informed practices when working with families and caregivers. These results proved system-wide improvements in the system's capacity to provide trauma-informed care. Enhancements were sustained until the final year of implementation, and the collaboration between child welfare and health settings working on trauma-related behavioural was positively assessed.

Damian et al., 2017 - Organizational and provider level factors in implementation of trauma-informed care after a city-wide training: an explanatory mixed methods assessment

Patient / population

Professionals from non-profit organisation and government agencies (N = 90) working with people who have lived-experience of trauma. Agencies belonged to the Law Enforcement, Social Services and Health and Education areas in Baltimore City. USA.

Intervention

Comprehensive trauma-informed staff training and coaching delivered monthly citywide to different agencies. Training focused on educating participants and delivering support in the implementation of SAMHSA's TIC principles (safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural,

historical and gender issues). Learning activities included coaching, feedback sessions from trauma experts supporting trauma-informed practices within the different organisations, or monthly technical support.

Comparison / measures

Evaluation of the organisational culture and professional quality of life after TIC implementation. Data was gathered via survey before and after the training and analysed through multiple regression analyses. Semi-structured interviews were conducted with 16 participants and organisational and provider-level themes were identified.

Outcomes

Survey results showed improvements in organisational culture and staff satisfaction post training delivery, including participants perception of their burnout and secondary trauma-related stress. Interview results highlighted four main themes: adoption of more flexible and less punitive policies, implementation trauma-informed workspace design, increased awareness of own stress and needs for self-care, and increased sense of fellowship and empathy towards colleagues.

Diggins, 2021- Reductions in behavioural and emotional difficulties from a specialist, trauma-informed school

Patient / population

Primary and secondary school students (N = 18) attending a Specialist school for emotional and behavioural difficulties. The reasons students are referred to this school include disengagement, aggression and severe emotional issues. Australia.

Intervention

The ReLATE trauma-informed model: This strategy is uses school-wide trauma specific interventions to support students with higher needs for educational adjustment. The model includes staff training, establishment of a School Implementation Taskforce. This taskforce is comprised by an integral group of staff who lead implementation, supported by clear guidelines and ongoing support from consultants. Implemented over a 12-months period.

Comparison / measures

Outcomes were measured by using pre- and post-implementation data. These data were obtained through parents of the students who completed a standardised questionnaire as part of the intake process at the school (pre-intervention) and post-intervention questionnaire administered a year later.

Outcomes

Improvements were observed in different emotional and behavioural domains, including behavioural difficulties, peer-problems and overall difficulties. Large effect sizes were reported over the 12-month period. New students demonstrated more positive adjustment and existing students showed non-significant positive adjustment. Positive results in the

area of Global Impact indicated that the benefits of the intervention expanded to home and social life, learning and leisure.

Galvin et al., 2021 - Residential Out-of-Home Care Staff Perceptions of Implementing a Trauma-Informed Approach: The Sanctuary Model

Patient / population

Residential care staff (N = 38) working across all levels of the MacKillop Family Services providing out-of-home care. Participants had roles like area managers, residential care coordinators, house supervisors, case managers, residential care workers, a principal practitioner, therapeutic specialists or clinicians, and one educator.

Intervention

The Sanctuary Model, implemented by the organisation as a gas an central Framework. The intervention was based on training caregivers and staff in different of evidence-based models based on strength-building, child-centred, family-focused approaches. These models included the “Therapeutic Crisis Intervention, Healing Matters, Eye Movement Desensitisation Reprocessing (EMDR), Therapeutic Life Story Work, Behaviour Support Planning and Power to Kids”.

Comparison / measures

A qualitative study was developed, based on six focus groups and three semi-structured interview conducted with residential care staff.

Outcomes

Enablers identified by participants include: social support systems and resources; shared trauma-informed knowledge and understanding; and leadership and champions. Barriers that impacted implementation included informal practice; lack of practice-based training; poor introduction to young people; and resources.

Hales et al., 2019 - Trauma-informed care outcome study

Patient / population

Staff (N=172) working at a medium-sized community-based organization providing services for people dealing with substance use, mental health difficulties and experiencing or at risk of experiencing homelessness. Clients using the organisation (N = 393).
USA.

Intervention

TIC intervention based on the recruitment of mentors, providing training for all staff, creating trauma champions roles, promoting reflective conversations to look at policies and practices, staff coaching, and delivering trauma information to clients. Mentors were programme directors and senior staff who aimed to create buy in and knowledge within leadership.

Comparison / measures

Data was collated pre-, mid-, and post-TIC implementation to assess its influence on staff and client satisfaction, client treatment retention and trauma-informed climate and trauma-informed procedures. Tools: Trauma-Informed Climate Scale (TICS); Trauma-Informed Organizational Self-Assessment; 5-point Likert-type staff satisfaction scale; 42-item instrument client satisfaction scale; administrative data.

Outcomes

Positive changes were observed after TIC implementation in the five outcomes assessed. These outcomes include workplace satisfaction and trauma-informed climate, and practices, which improved by moderate to large effect sizes. The outcomes corresponding to client satisfaction and number of planned discharges (indicator of treatment completion) improved significantly.

Jankowski et al., 2019 - Effectiveness of a Trauma-Informed Care Initiative in a State Child Welfare System: A Randomized Study

Patient / population

Ten child welfare offices matched and randomised to an early cohort (cohort 1 - intervention group; N = 77) or delayed cohort (cohort 2 - control group; N = 68) for the intervention. USA.

Intervention

New Hampshire Partners for Change Project. This interventions includes staff training, trauma screening, staff champions (“trauma specialists”), embedded consultative support for 3 months in each district office to support and maintain TIC practices. Subcommittee work to review and implement supportive system-level processes and policies was also carried out. Multipronged, five-year initiative.

Comparison / measures

This study assessed changes in self-reported practices and perceptions of staff working across the child welfare system. Assessment was conducted via a survey covering six domains: trauma screening, case planning, mental health and family involvement, progress monitoring, collaboration, and perceptions of the state’s overall system performance. Linear mixed modelling assessed the effect of the intervention.

Outcomes

The intervention group (Cohort 1) reported significant differences in the TIC domains of self-reported screening, case planning, and overall system performance. However, this was because the control group decreased their TIC practices, and not because of an increase for the intervention group. The hypothesis shared by the authors maintains that the intervention might have been what allowed cohort 1 (intervention group) sustain the TIC practices in a difficult situation (opioid crisis). Cohort 2 received the delayed intervention, which helped improve attitudes and behaviours toward trauma screening, case planning, and TIC system performance.

Lang et al., 2016 - Building Capacity for Trauma-Informed Care in the Child Welfare System: Initial Results of a State-wide Implementation

Patient / population

Child welfare staff working across a child welfare system. The sample size during the pre-intervention assessment was N = 223 and N = 231 following a 2-year implementation.

Intervention

A state-wide initiative in Connecticut to create trauma-informed child welfare systems. Strategies include workforce development, trauma screening, policy change, and improved access to evidence-based trauma-focused treatments. Initial implementation period (two years).

Comparison / measures

Stratified random samples were used to evaluate system readiness and capacity to deliver trauma-informed care. Staff completed a pre-intervention assessment and a two-year follow-up implementation evaluation.

Outcomes

Significant improvements were observed in trauma-related knowledge, practice and collaboration across most areas assessed, including supervision, behavioural health, or access to evidence-based practice. This suggests a positive impact of the intervention on readiness, capacity to provide trauma-informed practice and care across the system, and towards a trauma-informed cultural and organisational change. Greater improvements were reported by frontline staff than by those in management positions.

Lotty et al., 2020 - Effectiveness of a trauma-informed care psychoeducational program for foster carers - Evaluation of the Fostering Connections Program

Patient / population

A total of 79 foster carers (intervention group N = 49 and control group N = 30) within the national child welfare agency. Ireland.

Intervention

Fostering Connections program, a trauma-informed psychoeducational training for foster carers. The intervention was delivered over 6 weeks in 3.5-hours experiential sessions. The intervention was delivered to groups of foster carers in a community-based organisation.

Comparison / measures

Evaluation of the effectiveness of the programme using the Strengths and Difficulties Questionnaire (SDQ). This tool measured the foster carers' knowledge about trauma-informed foster care, tolerance of negative behaviour, fostering efficacy and children’s

emotional and behavioural problems. Assessment measures were analysed at baseline, 6 weeks and 16 weeks after completion and 15 months after the intervention.

Outcomes

Results show significant improvements in foster carers' understanding of trauma-informed fostering, tolerance of negative behaviours, and fostering efficacy. Effect sizes ranged medium to large and persisted over 15 months.
Significant improvements were also observed in children's emotional and behavioural problems after 15 months, with a small effect size.

Murphy et al., 2017 - Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative

Patient / population

Children aged six and older (N = 1499) in "out-of-home" placements across a large, private child welfare system from January 2011 (one year before implementation) to December 2014. USA.

Intervention

Implementation of Trauma Systems Therapy (TST) in a private child welfare system. TST was based on providing trauma training for all staff embedding the model across the whole system and continuous evaluation of children's emotional and behavioural functioning and regulation. Three-year implementation.

Comparison / measures

Assessment focused on the longitudinal associations among implementation of TST and children's well-being (functioning, emotional regulation, and behavioural regulation) and placement stability. Administrative data about children's wellbeing, placements stability and TST dosage (extent to which staff in the inner and outer circle of children were trained in TST) were used.

Outcomes

The implementation of TST was associated with children's improvements on emotional and behavioural regulation and functioning, and greater placement stability. Results indicate that all members of children's care teams were equally important and positive effects were produced by their exposition to TST, regardless of how close they work with the child.

Perry and Daniels, 2016: Implementing trauma-Informed practices in the school setting: A pilot study

Patient / population

Different stakeholders involved in a pilot school for children ranging from Pre K through Eighth grade. Participants included teaching staff and administrations (N = 32), families (N = 19), and students (two classes of fifth grade and two classes of sixth grade; N = 77). USA.

Intervention

The New Haven Trauma Coalition, focused on addressing the negative effects of trauma and stress on the mental health and social outcomes of families and school children. The intervention used three Direct Services components: Development, Care Coordination, and Clinical Services. Teaching staff and administrations received training, families were involved in care coordination teams, and students participated in a three-day workshop series. Implemented over a school year.

Comparison / measures

The outcomes evaluated, as outlined within the logic model include: School staff and/or community members learn about trauma sensitive practices; students requiring trauma-informed support are identified; schools implement systems to provide trauma-informed services to students; and students learn skills in how to cope with current symptoms and how to respond to future stress. A satisfaction survey post-training (for staff) and post-workshop (for students) was administered.

Outcomes

Most staff (97% of respondents) were satisfied with the training received, found it useful (94%) and noticed their knowledge about trauma had increased (91%). Participants reported that they now had skills to improve their self-care (38%) and to lower stress in the classroom (47%). Positive changes in communication between families and schools were reported, leading to wider community support. After attending the psychoeducational workshop, students learned to recognise stress, relax, and worry less. They started thinking how to expand their support network. However, lower benefits were observed in students capacity to trust others.

Racine et al., 2021 - Maternal-Child Health Outcomes from Pre- to Post-Implementation of a Trauma-Informed Care Initiative in the Prenatal Care Setting: A Retrospective Study

Patient / population

Women (N = 601) receiving prenatal care at a low-risk maternity facility. A group (N = 338) received trauma-informed care and another group (N = 263) received standard care (provided before staff received trauma-informed training). Canada.

Intervention

Multi-layered TIC initiative based on selecting and training a trauma peer champion, training physicians and staff offering primary care, promoting patient awareness of mental health and trauma, using standardised screening of ACEs and mental health symptomatology. Two-years long study.

Comparison / measures

Evaluation of differences in health during pregnancy and offspring birth outcomes when receiving TIC or standard care. Data (demographic details, health and pregnancy risks, an birth outcomes) was obtained via retrospective file review.

Outcomes

There was a modest association between the TIC implementation and reduced child birth difficulties: 70.45% showed no risks after implementation, compared to 63.5% before implementation. There was no association between the TIC intervention and increased health risks for mothers or infants.

Singh et al., 2020 - Trauma-informed and relational approaches to service provision: building community-based project capacity to respond to interpersonal violence through a national initiative.

Patient / population

Service providers trained as 'Connections facilitators' (N = 27) working within 14 community organisations focused on supporting mothers and children with experience of interpersonal violence. Canada.

Intervention

Intervention called “Building Connections: Supporting Community-Based Programs to Address Interpersonal Violence and Child Maltreatment”. This intervention incorporates trauma-informed and relational principles, training in trauma-informed concepts and the delivery of the intervention, the creation of 'Connections facilitators' who delivered the intervention, and a community of practice.

Comparison / measures

Open-ended interviews with 27 service providers or Connections facilitators. The interviews focused on participants experience in the intervention, their reflections about this process and the way in which their practice had change as a result of their participation in the intervention.

Outcomes

Participants reported four main areas of change at individual, organisational, and community level. The first area is awareness, related to positive changes in attitudes about interpersonal violence, or trauma knowledge gained. The second area is competency, where changes took place around the practical implementation of trauma-informed knowledge. The third area was collaboration, related to working with other organisations to

deliver services to families. The fourth area was safety, which involved changes to create welcoming and safe spaces.

Tabone et al., 2020: Examining the effectiveness of early intervention to create trauma-informed school environments

Patient / population

Young school children in Trauma-Informed Elementary Schools (TIES) and non-TIES classrooms (N = 74). These classes ranged from pre-K, Kindergarten, and first grade. USA.

Intervention

Trauma-Informed Elementary Schools (TIES) programme. Components include a resource liaison (therapist) to support teachers in recognizing and responding to trauma indicators, parent and teacher training, classroom consultation, and therapeutic intervention. The intervention took place during a school year and impact was evaluated at the end of that year.

Comparison / measures

Comparison between TIES classrooms and non-TIES classrooms using the CLASS tool, which is an observation-based scale that assesses various components of classroom quality and interactions. CLASS measures the overall classroom, not specific students. Specialised CLASS observers, unaware to group assignment, directed the observations and carried out measurements.

Outcomes

Significant improvements were reported in the TIES classrooms. These improvements took place in the three outcomes evaluated: emotional support (teacher sensitivity, classroom climate), instructional support (concept development, quality feedback, language modelling), and classroom organisation (clear teacher's behavioural expectations and effective strategies to prevent negative behaviour). Non-TIES classrooms showed non-significant improvements. Significant differences were found within- and between-group.

LITERATURE REVIEWS

Avery et al., 2021 - Systematic Review of School-Wide Trauma-Informed Approaches

Context

Literature review focused on school-wide trauma-informed models. It covered four studies which implemented these models within disadvantaged, predominantly African American populations with high need in low socio-economic areas. All studies from the USA.

Interventions covered

Four school-wide TIC heterogeneous models were identified. These models shared some core elements such as trauma-informed staff training, organisational and practice changes, and trauma-screening.

Models: The Healthy Environments and Response to Trauma in Schools (HEARTS) model (Dorado et al., 2016); The Heart of Teaching and Learning (HTL) model (Day et al., 2015); The New Haven Trauma Coalition (NHTC) (Perry and Daniels, 2016); The Trust-Based Relational Intervention (TBRI) model (Parris et al., 2015).

Measures

Different measurement tools were used, and school administrative data about behavioural incidents was commonly used to assess outcomes (Day et al., 2015; Dorado et al., 2016; Perry and Daniels, 2016). Some also evaluated trauma symptomatology, school engagement (Dorado et al., 2016) and students' perception of teacher supportiveness (Day et al., 2015).

Main results

HEARTS model: significant improvements in student engagement, incidents, physical aggression, suspension rate, improvement in trauma symptoms (CANS scale).
HTL model: significant pre-post-test difference for PTSD score indicating medium positive effect (CROPS–PTSD), self-esteem and school climate didn't change significantly.
TBRI model: incidents of aggressive and disruptive behaviour decreased 'markedly', staff reported improved school culture, increased positive mood and countenance among staff and students.
NHTC: pilot study, no overall findings (individual elements evaluated separately).

Bailey et al., 2018 - Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings

Context

Organisation-wide therapeutic care models, encompassing the whole organisation, from the CEO to all workers including administration staff. Out of home care organisations.

The participants who participated in these studies were varied, including preschool and school-aged children Arvidson et al., 2011, females in two residential programmes aged 0

– 21 (Hodgdon et al., 2013, children and their caregivers (Hodgdon et al., 2016), staff working with young people (Kramer, 2016; Rivard et al., 2005). All studies from the USA.

Interventions covered

Attachment Regulation and Competency framework (ARC) (3 studies), Children and Residential Experiences programme (CARE) (1 study), The Sanctuary Model (3 studies).

Measures

Research designs and analysis were diverse. These included: a naturalistic programme evaluation and t-tests comparisons pre- and post-scores using the Child Behaviour Checklist (CBCL; Arvidson et al., 2011); a naturalistic study using data from the National Child Traumatic Stress Network dataset analysed using multi-level regression (Hodgdon et al., 2013); a semi-structured naturalistic design based on a 16-week ARC implementation, results were analysed using correlations for children and parents outcomes and multilevel regressions for the rest of outcomes (Hodgdon et al., 2016). The rest included a multiple baseline interrupted time series (Izzo et al., 2016); a qualitative study based on group observations, content analysis of administrative data, focus groups and interview with staff (Kramer, 2016); and comparison group design, measures taken at baseline, and after 3 and 6 months (Rivard et al., 2005).

Main results

The ARC studies reported drop in CBCL t-scores, increase in permanent placements (Arvidson et al., 2011), lower PTSD symptomology, externalising and internalising behaviours, and the use of restraints (Hodgdon et al., 2013), lowering of Child Mental Health Symptoms and care-giver stress (Hodgdon et al., 2016). CARE outcomes: declines in behavioural incidents (aggression towards staff, property destruction, runaways) (Izzo et al., 2016). Sanctuary model: seclusions reduced, patient satisfaction surveys improved, staff demeanour towards children more positive, lowered incidence of violence (Bloom et al., 2003), ameliorated symptoms of complex trauma (Kramer, 2016), improvements in treatment environment (e.g. support, safety), youth coping skills and sense of control over environment (Rivard et al., 2005). Risk of bias was high and authors conclude that despite the scarce evidence, this review gathered promising results about the positive impact of trauma-informed interventions on children in the welfare system.

Berger, 2019 - Multi-tiered approaches to trauma-informed care in schools: A systematic review

Context

Review of 13 studies exploring multi-tiered approaches to trauma-informed care in schools. Studies worked with a variety of participants, including students and school and hospital staff (Cicchetti, 2017), 30 refugee youth learning English (Ellis et al., 2013), or 81 preschool children receiving early interventions (Holmes et al., 2015).

Most studies were developed in the USA, except for three, that were based on Chile (Garfin et al., 2014), Bosnia (Layne et al., 2008), and Australia (Stokes and Turnbull, 2016).

Interventions covered

The focus of this review was the alignment of trauma-informed interventions and tiered school-level and support programmes. The main features of the interventions reviewed include: either training or the promotions of engagement with staff and families; the delivery of social/emotional curriculum for all students; and identification and intervention strategies with high-risk students or referrals to mental health services.

Measures

Different designs and assessment measures were used in these studies. Some examples include: pilot follow-up study, with measures of sense of belonging, or monitoring of program fidelity (Ellis et al., 2013), pre- and post-intervention measuring PTSD symptoms and trauma symptoms) (Hansel et al., 2010), or a qualitative study based on semi-structured interviews with early years educators, Head Start teachers and administrators working with refugee communities (Hurley et al., 2013).

Main results

Findings include positive improvements in student academic achievement and behaviour using qualitative methods and behaviour rating scales (e.g. ASEBA and BASC-2), and reduced depression and PTSD symptoms (Depression Self-Rating Scale and UCLA PTSD Index).

Bunting et al., 2019 - Trauma Informed Child Welfare Systems-A Rapid Evidence Review

Context

All studies focused on the child welfare systems, and were develop din the USA. There is variability in the populations and sample sizes involved in the different studies. Still, all included children or young people, most times with their caregivers (birth families, and foster or adoptive parents).

Interventions covered

Review exploring the evidence relating to the organisational change processes required to implement trauma-informed care at a whole systems level within community-based child welfare settings. It covers a total of 21 papers reported on evaluations of 17 trauma-informed interventions. Common features of those interventions include training (the most common component), many included trauma screening and evidence-based trauma treatments, and some included on-going staff support, staff self-care. Many were part of broader, organisation-wide trauma-informed implementation strategies with leadership buy-in and strategic planning, a number mentioned changes to policies, processes and/or data systems, a number mentioned engagement of service users, none mentioned changes to the physical environment.

Measures

Different research designs and measurement tools were identified. Some of these included preliminary implementation and follow-up assessment using a multi-method approach and

tools like the Child Behaviour Checklist (CBCL); surveys distributed amongst foster families (formerly or currently licensed) or adoptive families to explore their perceptions about the quality of trauma-informed approaches regarding mental health series, children's' needs and parent satisfaction; or a longitudinal study based on structured interviews with young people and their caregivers, using standardised tools and looking at caregivers strain and behavioural difficulties, anxiety, and depression in young people.

Main results

Findings indicate methodological weaknesses. However, the authors conclude that there is preliminary evidence supporting the efficacy of trauma-informed approaches in improving the mental and emotional well-being of children served by community-based child welfare services. There is also potential to reduce caregiver stress and improving placement stability.

Fondren et al., 2020 - Buffering the effects of childhood trauma within the school setting: A systematic review of trauma-informed and trauma-responsive interventions among trauma-affected youth

Context

A review of trauma-informed and trauma-responsive interventions among trauma-affected youth in school settings. The populations involved in the different interventions varied in age, covering a range from children in the first year of primary education up to 15-year old adolescents. These children had experienced different types of trauma, for example, related to war, natural disasters, accidents or to multiple trauma. The studies were based in different countries including Japan, Israel, Lebanon, Turkey, the USA, or Palestine.

Interventions covered

This review focused on evaluating the current literature developed about trauma-informed care at school level, looking at interventions that provide trauma-responsive care within schools. Four of the studies identified looked at multi-tier TIC approaches, mostly involving school-level training in combination with group-based intervention/prevention along with individualised services, (Dorado et al., 2016, Holmes et al., 2015, Perry and Daniels, 2016, Shamblin et al., 2016).

Measures

The studies reviewed measured a series of different outcomes, including PTSD, depression, grief, hope, anxiety, discrimination, separation anxiety, wellbeing, somatic complains, or social competence.

Main results

Results indicate that most research focuses on one tier of intervention, whereas very few studies tried to integrate different tiers to evaluate their effectiveness. Additionally, only one of the studies reviewed was experimental in nature. Therefore, the authors conclude that there is no sufficient experimental evidence at the moment to gather confidence in the effectiveness of these programmes.

Purtle, 2020 - Systematic Review of Evaluations of Trauma-Informed Organizational Interventions That Include Staff Trainings

Context

Different populations were included in the studies reviewed here. These include young people admitted to a psychiatric hospital or staff working in psychiatric hospital, mental health providers working within the child welfare system, children served by child welfare systems and staff working within those systems, or staff and students in a primary school. Sample sizes ranged from 40 to 11.913. Most studies were developed in the USA.

Interventions covered

Systematic review of organizational interventions that included a "trauma-informed" staff training component across different organisations. Interventions varied and included a one-year learning collaborative, which included training on trauma-informed practices and treatments, a half-day training on making trauma-informed changes to practices, or a school-wide training strategy and consultation to identify students' needs, drive culture change and deliver school-level trauma-focused treatments.

Measures

The most commonly used design was based on single group pre-test, post-test. Five were randomised control trials, and one followed a quasi-experimental design using a non-randomised comparison group.

Main results

Out of the 23 studies identified, 8 assessed the effects on client outcomes. Five out of these 8 found significant outcomes improvement. The authors conclude that trauma-informed interventions seem to be more impactful when they include other components, such as policy changes, in addition to training.
The author concludes that the strength of the evidence is hindered by methodological weaknesses, including short follow-up periods or non-standardised use of assessment tools.

How to access background or source data

The data collected for this social research publication cannot be made available by the Scottish Government for further analysis as the Scottish Government is not the data controller.

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

This document is also available from our website at www.gov.scot.
ISBN: 978-1-80525-979-4

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for
the Scottish Government
by APS Group Scotland
PPDAS1309122 (06/23)
Published by
the Scottish Government,
June 2023

GSR
GOVERNMENT SOCIAL RESEARCH
Social Science in Government

Social Research series
ISSN 2045-6964
ISBN 978-1-80525-979-4

Web Publication
www.gov.scot/socialresearch

PPDAS1309122 (06/23)