Trauma Informed Partnership
Leicester, Leicestershire and Rutland

Trauma Informed Leicester, Leicestershire and Rutland

Our Strategy
2023-2026
(Revised September 2024)

Contents

1. Introduction

This Strategy sets out our collective commitment to Leicester, Leicestershire and Rutland becoming a Trauma Informed area. It outlines our shared understanding, approach, and priorities for the next three years at which point this strategy will be reviewed and refreshed based on early progress. It has been developed following the Strategic Partnership Board (SPB)[1] agreeing a strategic intent to;

> 'work collaboratively across organisations and with communities to develop a Trauma Informed system which simultaneously aims to prevent childhood trauma and mitigate its harmful impact across the life-course'.

This was in recognition of the prevalence of trauma within and across communities, its known adverse impact on the emotional, psychological, and social well-being of individuals and communities and a shared understanding that many of the sources and consequences of trauma are preventable. The Strategy should be seen within the context of the wider work of the Strategic Partnership Board and its ambitions to prevent and reduce harm within and across our communities.

We recognise that the journey to become a truly Trauma Informed area requires cultural change across the system and an unwavering determination to address the systemic factors which contribute to the cycle of childhood adversity and trauma. A collaborative and courageous evidence-based approach which draws on the combined strengths of organisations and our diverse communities is essential. This strategy aims to ensure we collectively develop a coherent and consistent approach to understanding and responding to trauma and pursue prevention strategies which are most likely to achieve better outcomes for our children, families, and communities.

2. Our Shared Understanding of Trauma and its Impact

We know from multiple national and international studies that experiences of childhood trauma are common and widespread. One study found that 48% of the UK population reported having experienced at least one traumatic event before the age of 18, with 9% having experienced four or more (Bellis et al, 2014).

Given its prevalence at a population-level, it is important to arrive at a shared understanding of trauma and its potential impact. We have collectively adopted the following definition:

[1] The Strategic Partnership Board (SPB) is tasked with preventing and reducing violence and vulnerability across Leicester, Leicestershire and Rutland (LLR) applies a public health approach to tackling the root causes.

"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 individuals functioning and mental, physical, social, emotional or spiritual well-being" (SAMHSA, 2014:7)

Adverse Childhood Experiences

The most commonly used typology for childhood trauma is the 10 Adverse Childhood Experiences (ACEs). The term ACEs was first coined in 1998 by a study in USA, which referred to 10 traumatic experiences including five forms of child abuse and five "serious" family difficulties. These 10 experiences were found to increase the risk of a variety of negative social and health outcomes, and this was particularly the case when multiple ACEs were experienced in childhood (Felitti et al., 1998). Whilst this study first highlighted this link, there has been multiple ACE's studies conducted over different populations and demographics, all reinforcing the statistical link between adverse childhood experiences and future negative adult outcomes.

ACEs relating to child maltreatment

- Verbal Abuse
- Physical Abuse
- Sexual Abuse
- Emotional Neglect
- Physical Neglect

ACEs relating to family difficulties

- Parental Separation or Divorce
- Mental Illness
- Domestic Abuse
- Substance Misuse
- Imprisonment

Whilst these 10 ACEs are highly relevant and provide a useful initial focus, there is a much broader range of events which can be sources of trauma such as loss or victimisation. Trauma can also arise in communities through adverse environments because of structural factors such as poverty and discrimination (see figure 1).

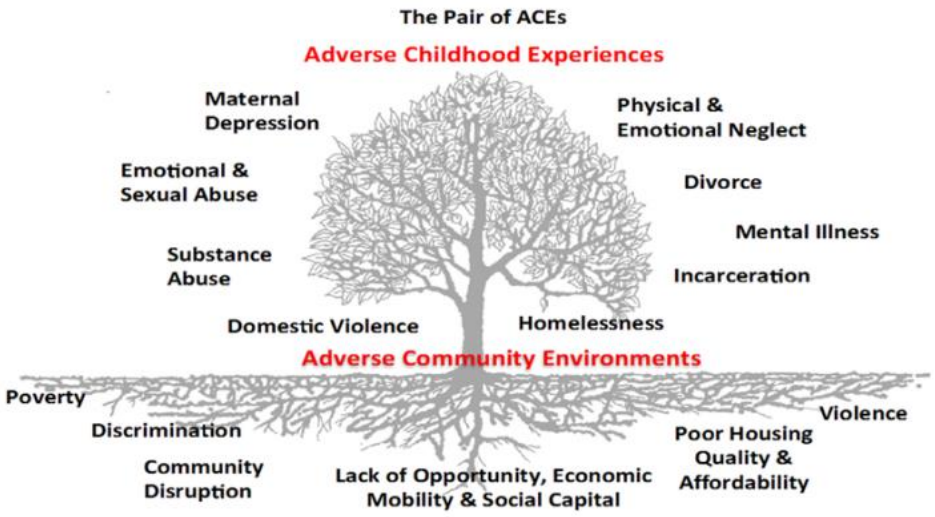


Figure 1 – Pair of ACEs Tree, (Ellis and Dietz, 2017)

We also recognise that traumatic events and circumstances can occur (and re-occur) throughout adulthood and they can be jointly experienced by families and communities. We know that the relationship between the event, how it is experienced and its effects on an individual can be influenced by wider systemic, relational, and contextual elements. Although we cannot predict how an event might be experienced, we do know some of these interplaying risk or protective factors which will influence this (see figure 2).

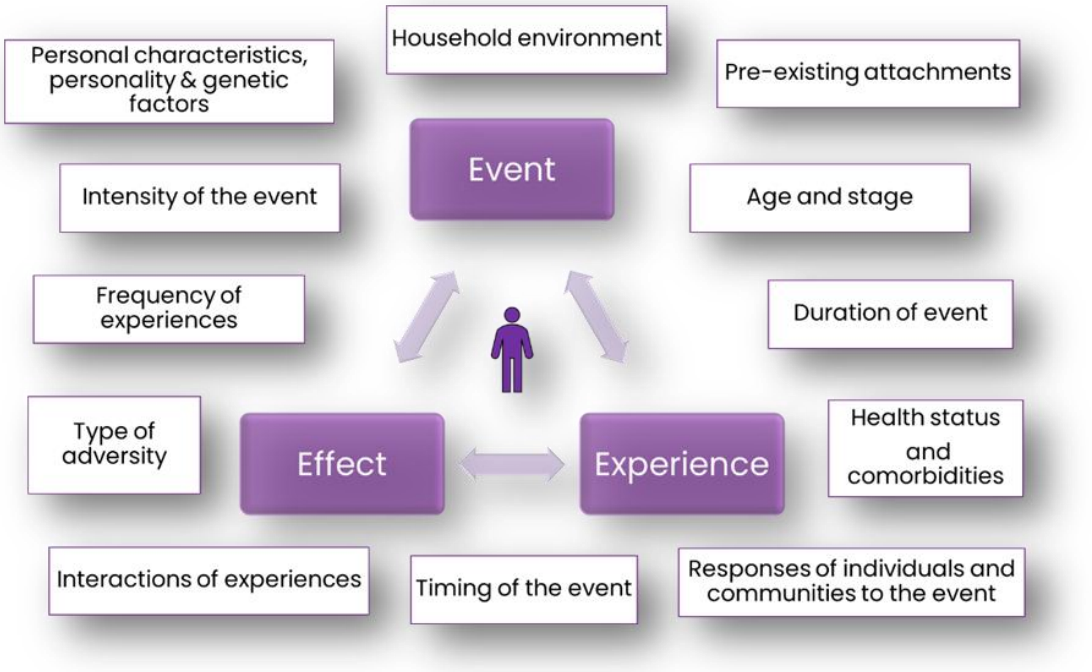


Figure 2 – The 3E's of trauma and the influencing factors affecting outcomes

Potential Impact

Adverse experiences in childhood have the potential to leave long lasting impacts across an individual's life-course.

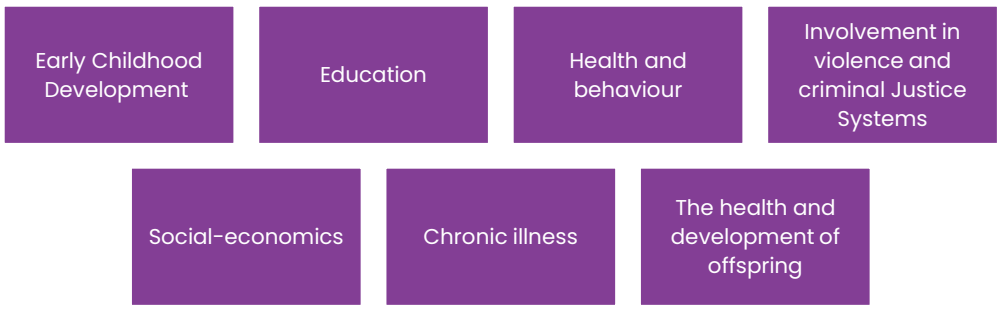


Figure 3 – Potential areas of impact across the life course (Bellis et al, 2023)

Whilst experiences at any age can lead to negative impacts, events, situations, or circumstances in early childhood can be more significant due to the vulnerability of a child's developing brain. The experiences we have from when we are conceived throughout our early lives can play a huge role in how we grow and development, both physically and emotionally. Reports such as "The Best start for Life" (DHSC, 2021) highlight the importance of the first 1001 days in a child's life. One reason for this is due to how early experiences shape the architecture of a child's developing brain and can cause it to become hardwired for survival. Repeated activation of the survival responses flight, fright and freeze can create a level of toxic stress which can lead to neurobiological changes in a developing brain and disrupt healthy childhood development (see figure 4). These changes can affect and present in individuals in a multitude of ways, which is why it is helpful to hold trauma in mind when thinking about behaviour.

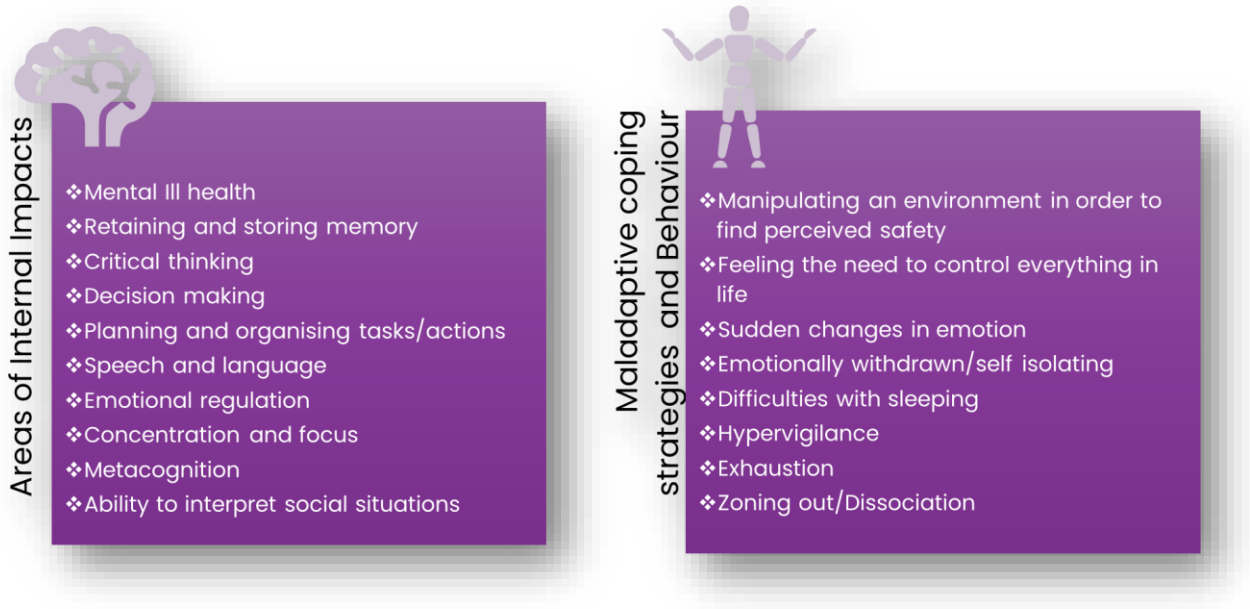


Figure 4 – Potential cognitive and behavioural impacts of ACEs

It is also this level of toxic stress, which is directly related to the physical health impacts of ACEs, this is due to the allostatic load which overtime "wears and tears on the body" (McEwen & Stellar, 1993). When considered across the life-course, the negative health and social impact of childhood trauma and in particular toxic stress can be far-reaching (see figure 5).

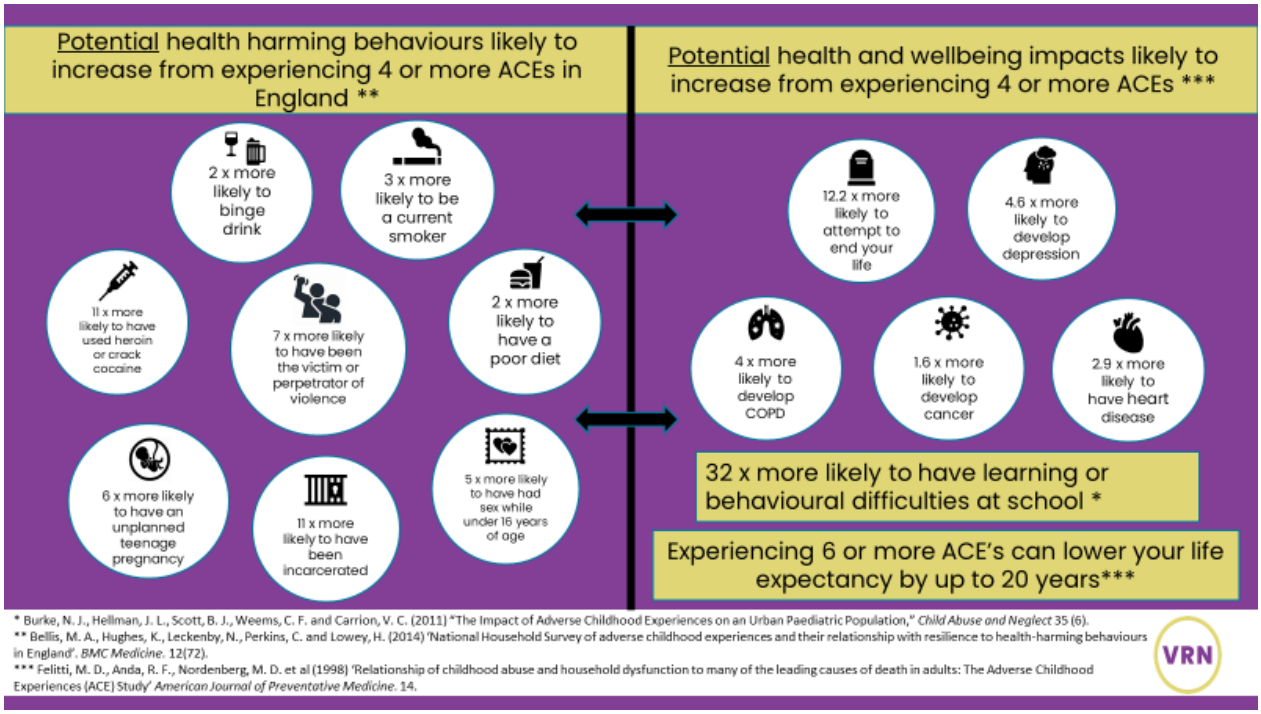


Figure 5 – Potential health and wellbeing Impacts of ACEs

Whilst the human costs are far-reaching, the financial costs of childhood trauma are also significant. One study estimates the annual financial cost of ACEs in England stands at £40.6 billion a year, when looking at risk factors and causes of ill health (Hughes, Ford, Kadel, et al., 2020). It is the multiple and potentially far-reaching human costs of trauma alongside these economic impact which underpin our collective determination to prevent their occurrence and mitigate their impact. We do however recognise that experiences of trauma do not always result in negative outcomes. Most of the available research was conducted at population-level and therefore should not be used to predict outcomes for individuals. However, we do recognise that each traumatic experience a child has in their life has the *potential* to impact them biologically, psychologically and behaviourally.

Importantly, whilst there has been an increased focus on the significance of childhood adversity there is growing research around the role benevolent childhood experience can have as protective factors against adversity. (Narayan, 2018). Of particular note from a prevention perspective, is that many sources of childhood trauma occur within the context of relationships. Importantly, relationships also hold the key to prevention; for example, the availability of a trusted adult and other positive human connections can act as 'buffers', positively influencing how the event is experienced by the child and mitigating negative effects and impact.

3. Our Principles and Approach

Our partnership is a wide-ranging and complex system of organisations and communities with diverse purposes, histories, culture, and language. Our commitment to our shared principles (see figure 6) is therefore important to provide a foundation and continuous guide in our journey to become a Trauma Informed area. The golden threads between all our six principles are relationships and communities – two crucial human contexts in which to build resilience, prevent trauma and mitigate its impact.

Our Shared Principles

Figure 6 – Our Shared Principles based on SAMHSA, 2014

To provide a framework for our journey, we have also developed a shared approach which draws on and adapts the 4R's developed by SAMHSA (2014). Centre-stage in our approach is prevention and most importantly striving to prevent trauma from occurring wherever possible.

Figure 5: Our shared approach

Being a Trauma Informed area requires us all to **realise** the prevalence of trauma and the widespread impact it can and does have on individuals, families and communities.

It requires everyone to be able to **recognise** the signs and symptoms of trauma for example how social and health-harming behaviours are often coping strategies designed to survive past and/or current adversity and overwhelming circumstances.

It is also about **responding** as a whole system prioritising healthy and safe relationships and physical environments and providing tailored support and opportunities further reduce risk factors and strengthen protective factors and offer recovery opportunities. A strength-based approach which recognises and **promotes** resilience is critical to the success of our responses.

Most importantly, a Trauma Informed system seeks to **prevent** harm, recognises that many adverse childhood experiences are preventable in the first place and it is always possible to mitigate the negative impacts of trauma across the life-course. An important part of our approach is actively preventing re-traumatisation by avoiding practices which can be triggering and painful for those who have already experienced trauma.

Risks and protective for childhood trauma and adversity are often complex and can be interlinked and interwoven between individuals, relationships, communities as well as societal contexts (see figure 7). Therefore, we have chosen to take a public health approach to preventing and mitigate the long-term harm, through reducing risks and increasing protective factors (see appendix 1).

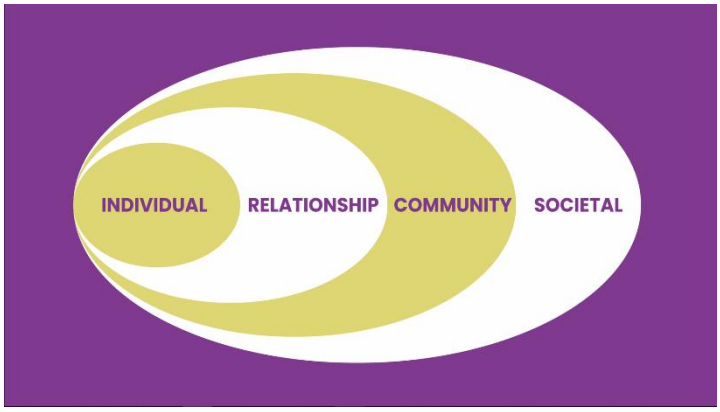


Figure 7 – Public Health Ecological Model

In order to prevent trauma and is negative impacts we need to ensure our strategies, policies and practice support children growing up in safe and nurturing environments. Where trauma does occur, we need to pursue opportunities to intervene early to pro-actively reduce risk and mitigate the potential impact of trauma and develop strategies

which support long-lasting recovery for those who have experienced trauma. We therefore need to think and act across all levels of prevention as outlined below.

Levels of Prevention	
Primary Prevention	The prevention of traumatic events and experiences from occurring in the first place through tackling the root causes and creating the conditions for healthy and safe relationships and communities.
Secondary Prevention (Early Intervention)	Pro-actively reducing the risk and mitigating the impact of trauma including the strengthening of protective factors to lessen the potential negative and long-lasting impact of trauma.
Tertiary Prevention (Recovery)	Provision of tailored support and specialist care to enable people to recover from trauma to reduce the on-going impact and prevent re-traumatisation.

Consistent with a public health approach we will draw on the best available research and practice in developing and implementing strategies and interventions. The CDC (2019) endorse six evidence-based strategies which are known to support the prevention and mitigation of adverse childhood experiences and we will draw on these across the system in strengthening our collective response. Many of these strategies sit within the work of existing partnerships including the Strategic Partnership Board, Safeguarding Children Partnerships, Health and Wellbeing Boards, Community Safety Partnerships and the Violence Reduction Network (see appendix 2)

Strategy	Examples
Promoting social, behavioural, and environmental norms that protect from ACEs	• Public awareness and education campaigns • Relational approaches to behaviour management • Bystander approaches (Mentors in Violence Prevention) • Men and boys as allies in prevention • ICON – Babies cry, you can cope
Strengthening families and their economic supports.	• Healthy Child Program • Children's Centres/Family Hubs • Attachment based interventions • Enhanced Midwifery and antenatal services • Parenting programmes/attachment-based interventions Strengthening household financial security • Family-friendly work policies • Family and child related benefits/grants/entitlements (i.e, Healthy start vouchers, Sure Start maternity grant, FEEE)
Supporting learning and development of life skills	• Social-emotional learning programs • Safe dating and healthy relationship skill programs • Community/classroom-based interventions • Enrichment programmes

Building positive relationships with children and young people through activities.	• Mentoring programs • After-school programs • Community based youth groups • Relational based approaches within education
Responding to reduce immediate and long-term harm.	• Enhanced primary care and specialist secondary care • Victim-centred services • Counselling and therapeutic approaches • Interventions to reduce toxic stress • Trauma-Focused mental health approaches • Family-centred treatment for substance use disorders • Improving access to specialist interventions • ACE specific response programmes

Whilst these are some of the known examples of system wide prevention, we will continue to learn what works locally through monitoring and evaluation. We also recognise interventions that address multiple risk factors at the same time or combine a range of strategies may increase benefits and cost savings (Bellis et al, 2023). Organisations such as The Early Intervention[2] Foundation and the Youth Endowment Fund[3] offer sources of evidence informed information that may be helpful on our local journey.

[2] The Early Intervention Foundation provide a guidebook which provides information about programmes that have been evaluated and shown to improve outcomes for children and young people. http://guidebook.eif.org.uk/

[3] The Youth Endowment Fund Toolkit provides an overview of existing research on approached to preventing violence affecting young people. https://youthendowmentfund.org.uk/toolkit/

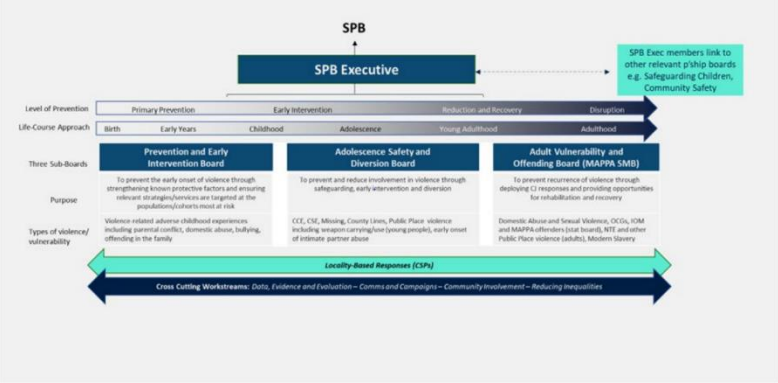
4. Our Strategic Priorities

Our five strategic priorities simultaneously focus on developing Trauma Informed policy and practice through raising awareness, investing in the development of volunteers and staff and building Trauma Informed organisations as well as ensuring there is sufficient focus on pursuing strategies and building resilience in the pursuit of prevention. They are:

1. **Increase Awareness and Understanding**
   We will raise awareness and understanding about trauma, it's prevalence and impact and how everyone can play a role in preventing trauma, mitigating its impact, and avoiding re-traumatisation.
2. **Develop and Deliver Prevention Strategies**
   We will identify and pursue prevention opportunities across the system and develop and strengthen strategies which contribute to safe, stable, nurturing relationships and environments for all children, families, and communities.
3. **Equip and Support Our Workforce**
   We will enhance the knowledge and skills of our workforce and provide on-going support so they can adopt a Trauma Informed approach in their everyday practice.
4. **Support Organisations to become Trauma Informed**
   We will develop, agree, and implement a common self-assessment framework to guide organisations in their journeys to become Trauma Informed and to ensure an evidence-informed, consistent approach is adopted within and across organisations.
5. **Build Resilience in Partnership with Communities**
   We will collaborate with families and communities, strengthening assets and co-producing solutions to build resilience and our collective ability to prevent trauma and mitigate its impact.

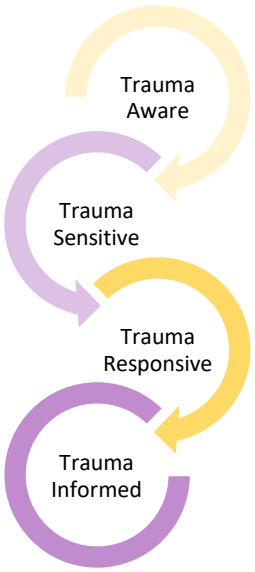
5. Governance and Delivery

Governance for this Strategy is provided through Leicester, Leicestershire and Rutland's Strategic Partnership Board and more specifically the sub-board Prevention and Early Intervention (PEI), as outlined below. The work will, however, span the whole SPB structure as well as other relevant partnerships and Boards given its relevance to all stages of the life-course.



6. Measuring Progress and Impact

As highlighted in the introduction to this Strategy, becoming a Trauma Informed area is a journey which requires long-term system-wide commitment and effort. During this journey different parts of the system will move at different paces and in different ways. To provide a structure for understanding and measuring our overall progress we will refer to and utilise four commonly referred to phases. These will also form the basis of our organisational self-assessment to assist partner organisations to continuously assess their progress. These are:



Trauma Aware: We have increased understanding across the system about trauma, its prevalence and impact

Trauma Sensitive: We have secured commitment and are preparing for lasting change through understanding and planning how we can incorporate our approach and principles across the system

Trauma Responsive: We are starting to be able to demonstrate how we are preventing and responding to trauma in relation to staff and those who use our services

Trauma Informed: We are routinely preventing trauma and our approach and principles is evident in our everyday practice with children, families and communities. We are evaluating our work and can evidence impact

Our ultimate aim is to prevent the causes and sources of childhood trauma through pursuing prevention activity which will contribute to a long-term impact. To plan, monitor and measure this we will develop and continuously review a Theory of Change (ToC) and embed processes which will enable us to monitor and evaluate our impact.

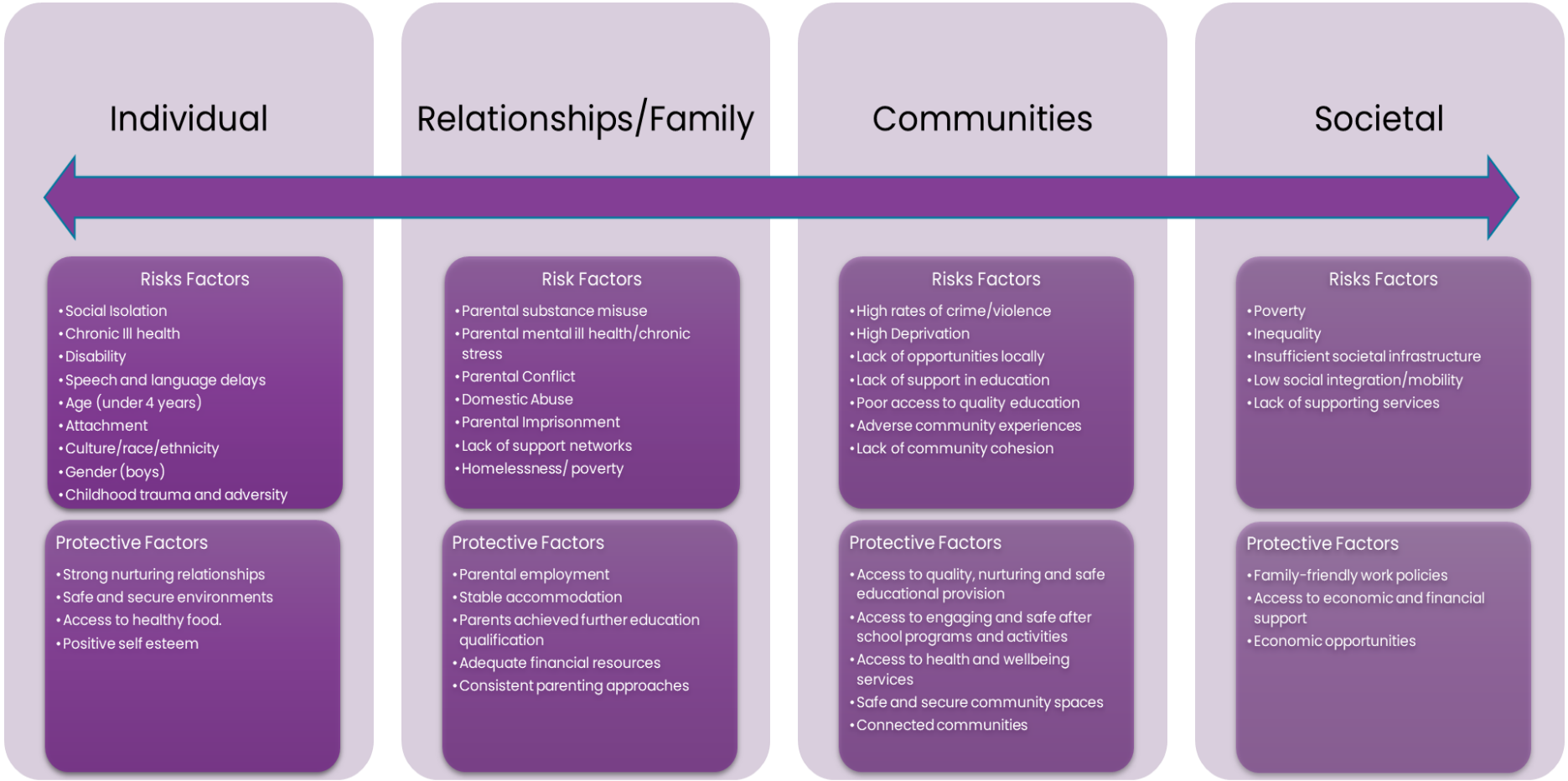
We recognise that importance of involvement from children, families, staff, and communities as their experiences are critical to whether we are making progress in our ambition to be Trauma Informed. This will be embedded in the organisational self-assessment framework.

7. Review

This Strategy will be reviewed on an annual basis in line with the Strategic Partnership Board's annual review process.

8. Appendices

Appendix One: Risks and Protective Factors for ACEs



Appendix Two: Existing Partnership Boards

Partnership Boards	**Purpose**
Strategic Partnership Board	Chaired by the Police and Crime Commissioner for Leicestershire, the Strategic Partnership Board's (SPB) core purpose is to: *"provide system leadership and the strategic coordination required to prevent and reduce violence and vulnerability across Leicester, Leicestershire and Rutland. "* SPB Exec also has three sub-boards which deliver the VRN's priorities: The Prevention and Early Intervention Board; the Adolescence Safety and Diversion Board; and the Adult Vulnerability and Offending Board.
Safeguarding Children Partnerships	To ensure that local services work together to protect children at risk of harm by develop policies and procedures that local services must follow. The partnership is responsible for overseeing the Multi-Agency Safeguarding Children arrangements in response to the Children and Social Work Act 2017 and as required by the government guidance Working Together to Safeguard Children 2018.
Health and Wellbeing Boards	Health and Wellbeing Board have a joint responsibility to develop and deliver health and wellbeing strategies through partnership working. For the purpose of achieving better health, wellbeing, and social care outcomes for the local population and Improving the quality of care for those encountering health and social care services.
Community Safety Partnerships	A collection of organisations with the responsibility for the delivery of safety communities' objectives locally. Including the following: ➢ Reducing re-offending and substance-related crime and disorder ➢ Protecting those considered to be most vulnerable in the community ➢ Reducing anti-social behaviour ➢ Increasing public confidence in local crime and disorder services.
Violence Reduction Network	An alliance of groups, organisations, and communities determined to prevent and reduce serious violence locally. The purpose of the network is to build an inclusive, collaborative, and courageous network to tackle the causes and consequences of violence.

Appendix Three: Glossary of Trauma Informed Terms

Adverse Childhood Experiences (ACEs)

Refers to an American study by the Centre for Disease Control and Prevention in 1998 which highlighted the relationships between traumatic experiences in childhood and the long-term mental, physical, and social outcomes in adulthood.

Toxic Stress

A term to describe repetitive and prolonged activations of the stress response systems which has been linked the disruption of healthy physical development and maladaptive coping strategies in individuals.

Allostatic load

"The wear and tear on the body" which accumulates from repeated and prolonged exposure to chronic stress (McEwen & Stellar 1993).

Child Maltreatment

"Child maltreatment is the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust or power" (World Health Organization, 2022).

Chronic Illness

An illness that is prolonged for at least 6 months. Studies have found an increase in ACE's scores increase the potential risk of having chronic illness, diseases, and syndromes in later life. For example, Lung disease, heart disease, diabetes, chronic fatigue, and cancer (Bellis et al, 2023).

Social-economics

The study of the relationship between social behaviour including factors such as income, education, family structure, occupation and ethnicity and economics. Research has shown that social inequalities can influence the prevalence of childhood adversity and trauma and reduce individual and community resilience (Walsh D, McCartney G, Smith M, et al, 2019)

Resilience

The capacity to use healthy coping strategies to manage and recover from difficulties, setbacks, and challenges in life.

Communities

A group of individuals who live in the same area or have a particular shared characteristic that connects them.

Trauma Aware

Individuals, services, or organisations have an understanding and awareness around the prevenance and impacts of childhood trauma and adversity.

Trauma Sensitive

Individuals, services, or organisations are trauma-aware and can integrate this understanding and knowledge into some of the context of their practice.

Trauma Responsive

Individuals, services, or organisations can recognise and respond to trauma to reduce its impacts and promote resilience and protective factors for individuals, families, and communities.

Trauma Informed

A whole system culture which is infused with Trauma Informed principles that seek to prevent ACEs, promote resilience and protective factors and reduce the impacts for individuals, families and communities.

Trauma Informed System

When individual or collective organisations can demonstrate and maintain awareness, sensitivity, and responsiveness to ACEs across all areas of service delivery.

Appendix Four: References

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