# Event Analysis Report: *Compassionate Leeds*: Becoming a Trauma-Informed City

## Introduction

This report is a summary of an analysis about the *Compassionate Leeds* event which took place on 4th November 2021. Data came from observing keynote presentations, workshop presentations, and interactive content such as virtual discussions or written 'chat' in virtual meeting spaces, alongside written and visual documentation. The focus of this report is on the main themes arising from the day – these were the things that presenters and participants focused on, especially when thinking about what being 'trauma-informed' might mean for them in their work (and beyond).

## Values & Principles

There were some common words that people used to described what being 'trauma-informed' might look, feel, and sound like. These were values and principles that people felt should be fundamental to all the work that is done as part of *Compassionate Leeds.*


Also common within discussions were comments about what needed to change – what a trauma-informed city should *not* be. *Table 1* shows the most dominant themes that arose. I have organised these as existing on a continuum because most people recognised that these are aspirations to be worked towards, rather than things which can be achieved and completed.

*Table 1: Themes: Values and Principles of Being Trauma-Informed.*

| Letting Go Of… → | Cultivating… |
|---|---|
| Judgement | Curiosity, Compassion & Empathy |
| Shame & Pathologising | Normalising Struggle, Adversity & Distress |
| Siloed working | Collaboration |
| Gatekeeping | Inclusivity |
| Treatment Approaches | Healing Approaches |
| Trauma | Resilience |



Author: Dr Natasha Hardicre // December 2021

## Values and Principles Summary

Being trauma-informed means that services and organisations will assume that experiencing adversity and living with trauma is a possibility for **all** people and will therefore work towards reducing behaviours, practices and language which are shaming, blaming, or judgemental. Everyone will acknowledge that **adversity, struggle, and distress are normal** human experiences which should be met with **compassion** and **empathy** instead of judgement. Everyone will recognise that because of the things that have happened to them, some people live with trauma for which they need additional support, including specialist therapeutic input. However, services will endeavour to see and understand people **holistically** and not just as people presenting with 'symptoms' and/or problematic behaviours. Services will meet people with **curiosity** and **openness**, but without demanding transparency; people will not be forced to disclose traumatic events to access support.

Services will **work together** to meet people's needs, irrespective of whether people have received particular diagnoses. All services will shift from a focus on 'treatment' to an approach which promotes **healing**, even when trauma-specialist services are needed. This will involve centralising and prioritising **relationships** over organisational processes and recognising that healing is a process which takes **time.**

Everyone across the city will work together to prevent trauma across the life-course by cultivating **resilience** and enhancing **social and resilience assets** and providing **support** as early as possible, especially for children and young people and their families, and the people who care for people as part of their work. Organisations and services will be **safe** spaces for all people working in and using them.

# Thematic Summary

## Trauma: Definition, Causes, and Consequences

Throughout the event, multiple definitions of trauma were proposed and utilised, alongside causes and consequences described. There was an extremely high degree of congruence between people, including services working with different populations. This suggests that, for those people and services working in (or towards) being trauma-informed, a shared understanding of trauma exists. This appeared to lead to fruitful discussions in the workshops, especially because it minimised the need for detailed information-provision about trauma/causes/consequences. However, there was a common proposal that wider education and training about trauma was vital to Leeds (as a city and system) becoming increasingly trauma-informed, especially within the health, care, criminal justice, and education sectors. Increasing public awareness of trauma was also considered central in responding to and preventing trauma, now and in the future.

Commonly shared understandings underpinning discussions included:

- Adverse Childhood Experiences (ACEs) as a key contributing factor for trauma.
- Dose-response relationship between ACEs and poor outcomes was widely accepted.
- Trauma is often embodied and has both direct and indirect impacts on physical health.
- Adverse situation and experiences were/are common across the whole population – universal precautions ought to be taken.
- Some populations are at greater risk of ACEs and trauma – principles of universal proportionalism are therefore applicable.
- Many consequences of trauma should be considered features of developmental disruption, rather than disorder. Therefore, people and services should not rush to pathologise trauma.

- Relationships are central in both trauma-generation *and* healing – these relationships are often complex and sophisticated. Consequently, it is important to understand people within the contexts and relational systems within which they live.
- Trauma is inter-generational. This has both biological and social mechanisms – epigenetics, neuro-biology, and the impact of what could be thought of as 'inherited practices' were all referenced.
- Trauma is often complex and multi-layered, caused by events, series of events, and/or enduring conditions; experiences of trauma are dynamic. Service models which work within this paradigm can be beneficial at meeting peoples' needs as their experiences of trauma change over time. It also means that specialist services can be useful e.g., crisis services.
- Exposure to/witnessing other people's traumatising events, or the impacts of other peoples' trauma can be an adverse experience.
- 'Window of tolerance' was repeatedly referenced as a useful model for understanding 'undesirable' behaviour or 'conduct issues' and communicating this to others.
- Causes and consequences of trauma may be hidden and invisible. This may cause issues regarding whether it is 'disclosed' or not.
- The importance of a socially-mediated understanding of resilience as part of responding to and preventing trauma was considered essential. Many people in discussions were keen to emphasise the role of wider communities, including services, in providing and promoting social and resilience assets. People agreed that positive and healthy relationships and activities can act as protective factors against development of trauma, even when people experience adversity. Again, relational approaches were central to this, including delivering early interventions to families; providing more services, support, and resources within communities, especially so that people can help each other; actively promoting healthy relationships through education and support; and providing safe spaces where people can engage in activities which optimise physical, emotional, and mental wellbeing.

## Key Areas of Focus

Three key areas of focus were consistently discussed across the day: preventing and responding to adverse childhood experiences (ACEs); workforce well-being and the impact of trauma on the workforce; and on changing systems and institutions to respond compassionately to people living with trauma and facilitate healing, including access to appropriate interventions (where necessary).

First, focusing on children and young people (C&YP) and their families was emphasised throughout the day, particularly through preventing and reducing ACEs. Discussions emphasised work with children, young people, and their families – especially in the early years of life. Although there was some recognition that children and families were located within larger groups (such as communities, peer groups) much of the discussion focused on C&YP as individuals located within small relational groups, such as families. Optimising healthy childhood development by working with C&YP and their families was considered key, as well as providing help and support to C&YP who had experienced ACEs and/or were living with trauma. Lack of data on prevalence of people who have experienced ACEs/living with trauma who were in the city or accessing and utilising services was highlighted. The role of intentional enquiry was emphasised repeatedly, alongside the necessity of robust methods of recording and reporting data, including notification systems (e.g., Operation Encompass). Whilst many service providers and practitioners were responsive to principles of intentional enquiry, many expressed concerns about how this could work in practice and whether it would be onerous. It was agreed that this is something which needs to be addressed as this work is developed.

Second, workforce wellbeing was a key theme from the day. Many participants highlighted ways in which people delivering health, care, education, and support to people across the region are themselves dealing with trauma. Importantly, many emphasised the ways in which employing organisations failed to consider existing trauma; in some instances, people felt that organisations also generated trauma (or made existing trauma worse) through chronically challenging working conditions, lack of support, and non-compassionate policies and practices. A key theme from the day was that to be a 'trauma-informed city', organisations and services needed to prioritise workforce well-being and become trauma-informed from the 'inside-out'. Doing so will involve changing conditions and existing work processes to minimise risk of trauma, alongside providing time, support, and resources to people to help them deal with struggle, adversity, and distress when these are unavoidable.

Third, much of the day was spent describing and discussing ways in which services (and people within services) needed to change to move towards being more trauma-informed. Some people wanted more specialist services, especially for vulnerable people and underserved communities. Other people suggested a more open approach to service provision would be valuable; many services use diagnoses as a gatekeeper to access, which was felt to be problematic. Person-centredness was considered foundational to trauma-informed approaches and, importantly, this was desired at various levels.

Common feedback about existing challenges and opportunities for growth clustered around three levels. These are outlined below and represented diagrammatically in the models in the subsequent section.

- **Organisations and institutions**: particularly the need to become more person-centred and value-driven, rather than task-oriented and process-driven. Vitally, person-centredness was considered to include the workforce and not just service users. Many people felt that this will require service redesign and development; stronger and more robust programmes for staff development, wellbeing, and support; and more compassionate policies, especially when people do experience adversity, struggle and distress. Changing the conditions within which people work and live was considered fundamental to any approach that seeks to shift towards being more trauma-informed. Organisations and institutions mentioned frequently included schools, hospitals and health and care related facilities, and prisons and institutions for young offenders.
- **Small relational systems**: particularly families and small teams. These were often considered the key units for intervention. Within communities, families were promoted as key sites for early intervention and prevention, especially with regards to ACEs. However, workforce teams were also emphasised as important relational systems, especially for peer support and a space for reflexive engagement with work and the challenges contained within work.
- **Individuals**: This was the other key site for intervention and prevention, predominantly through teaching people about trauma, helping people to heal from trauma, and providing people with skills and resources to prevent trauma now and in the future. Interestingly, many people were keen to emphasise the ways in which individuals are socially-situated. So, although individuals were often considered a central 'unit' for intervention and support, people wanted to make it very clear that they did not think solving the problem of ACEs and trauma was simply about changing individual attitudes and behaviours. Whilst this was considered absolutely fundamental to trauma-informed work, many emphasised the necessity of understanding individuals within context, and then to change contexts in order

to influence individuals and outcomes. This is consistent with social ecological and public health approaches.

## Where

A common theme was the necessity of a trauma-informed approach within *all* services. However, there was agreement that there are some key spaces which are especially relevant (listed below). Many of these services are already working in (or towards) being (becoming) trauma-informed and people recognised how beneficial this work had been. People also felt that being trauma-informed needed to remain an intentional part of improvement agendas so that it becomes or remains a priority. It was felt that there were some services/spaces where a trauma-informed approach still needed to be embedded.

Spaces of particular importance:

- All education settings, including schools, college, and universities.
- All early-years practitioners, services, and settings.
- Criminal and Youth Justice Sector, including the Police Force and Prison and Probation Services.
- Specialist mental health services.
- Health and social care services.
- Specialist trauma and crisis services.
- All organisations working with vulnerable populations e.g., sex workers and people experiencing sexual exploitation; homeless people; people experiencing substance misuse and addiction.
- Organisations and services providing resources or support to people around the wider determinants of health and wellbeing e.g., housing, work/occupation, and finance etc.

## Models

Much of the content of the workshop from those delivering sessions was focused on existing work that had been, or was currently being, done towards being trauma-aware/informed; facilitating healing when people were living with trauma, its consequences, or were in crisis; and also preventing trauma through mediating A(C)Es. Many comments articulated perspectives on the ways people felt current conditions, processes and practices were not trauma-informed at multiple levels, including within organisations/institutions, small group, and individuals. People frequently articulated how they would like these things to change. Consequently, there are two models shown below on pages 7 and 8. The first illustrates many of the common critiques regarding how conditions, processes, and practices are either trauma-ambivalent or harmful. The second model communicates desired changes which people expressed throughout the day. Both models are organised around the three spheres articulated on page 4.

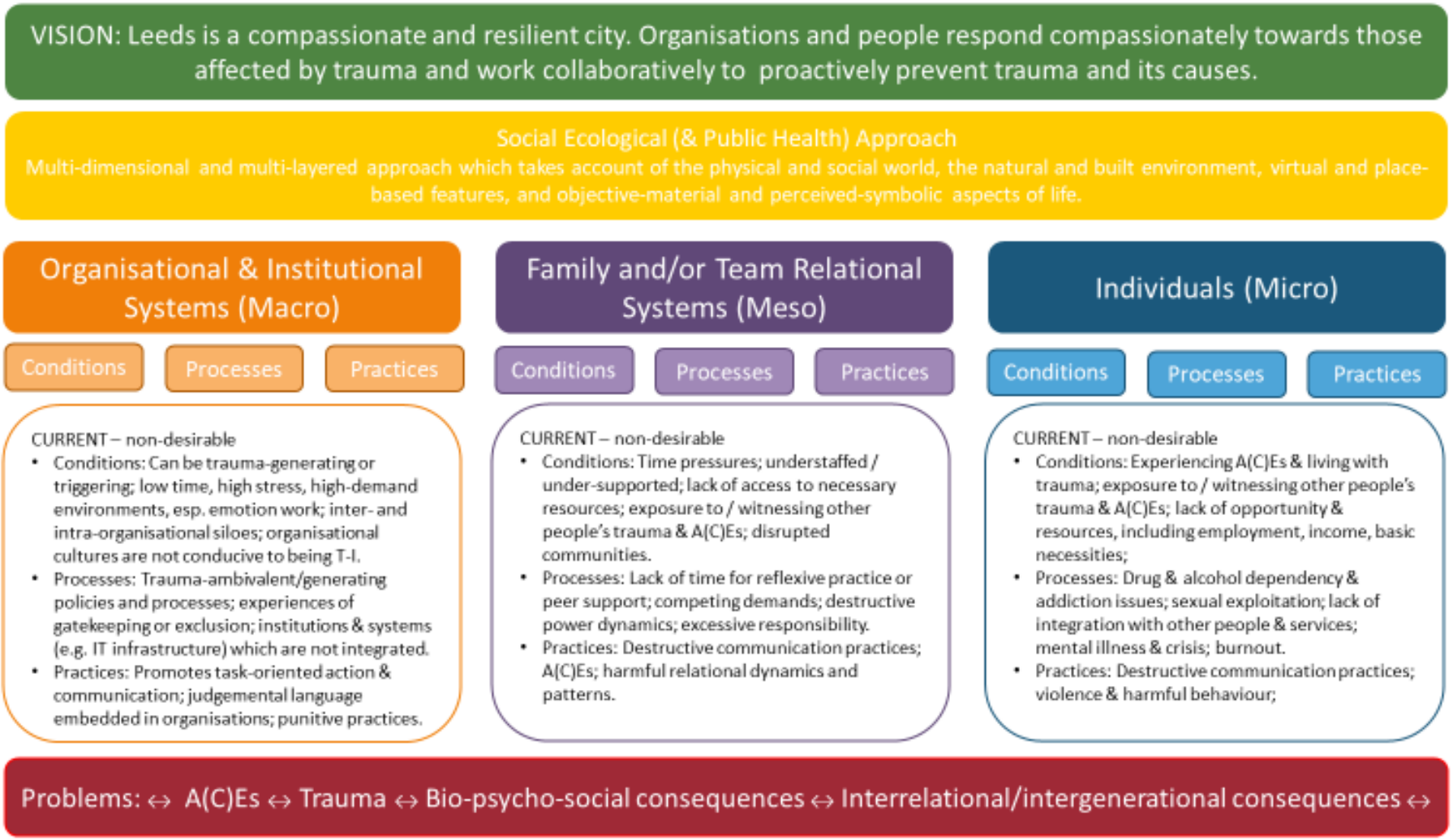
## Conclusion

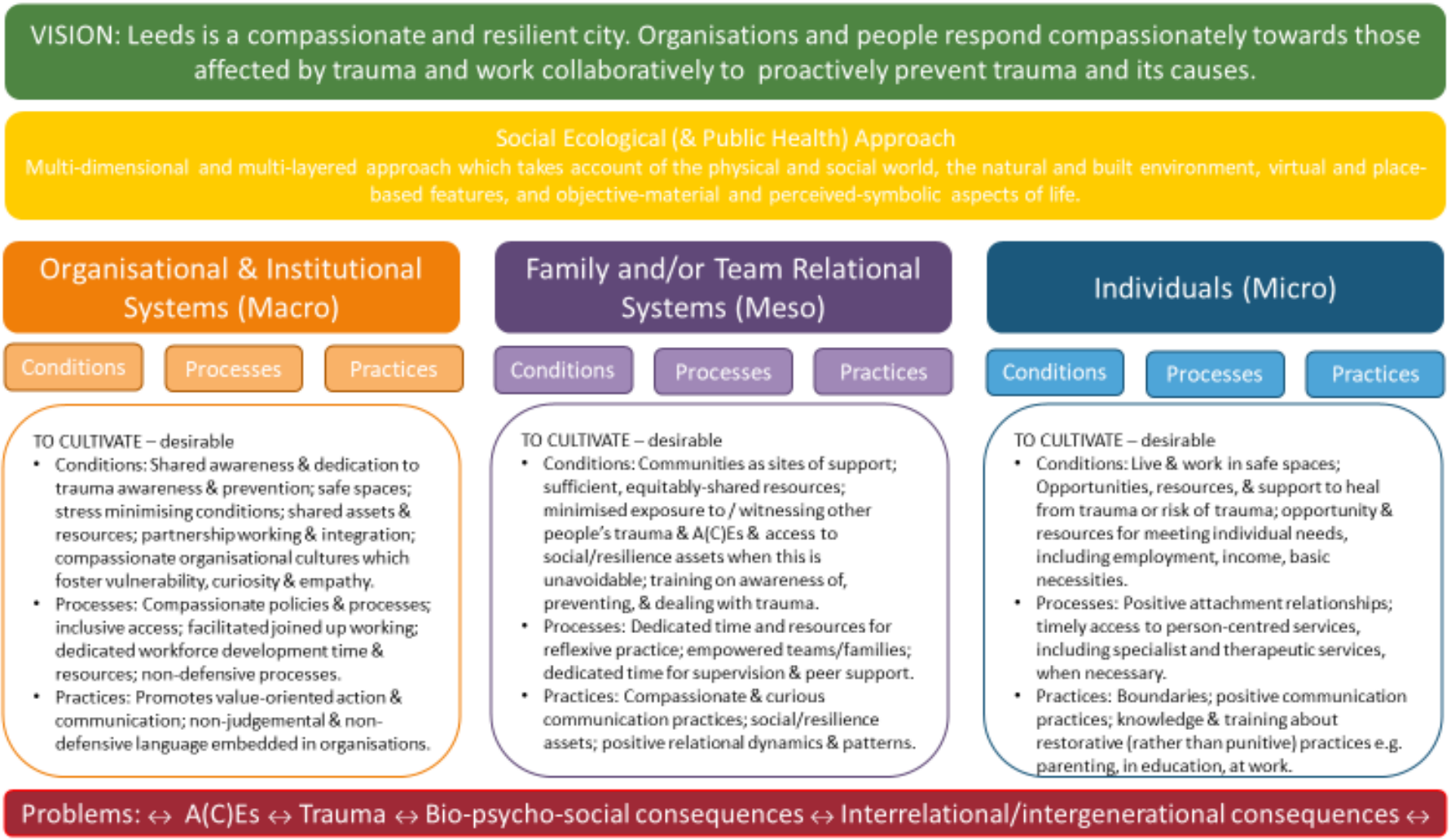
The themes and models presented in this document are based on the event and are therefore an artifact of the discussions had by the people having them – they themselves are socially and culturally situated and mediated. Nonetheless, they represent the ways in which a collection of people, many of whom were and are invested in trauma-informed approaches as a vehicle for social

change, equity, and justice, share a common understanding and framework for challenging existing problematic processes and practices and making positive changes for all people.

In sum, the main findings of the days are that:

- Being trauma-informed is the business of all, including large systems, small relational systems, and individuals. Intentional work to cultivate growth in each of these spheres will therefore be necessary to bring about change.
- Making positive and sustainable changes to the contexts and conditions within which people are born, live, work and age are crucial to improving outcomes. Likewise, changing processes, including policies and enduring patterns of behaviour, will be important in ensuring that both organisations and people are value-led.
- People need education, help, support, and resources to bring about changes within their own lives and the lives of others. This will look different for everybody and approaches should therefore be flexible, adaptable, and person-centred. For some, this may involve specialist provision of (dedicated) services; for others, it could involve personal development such as improving skills to maximise their wellbeing or positively impact on their relationship with others, for example.
- More awareness and knowledge about ACEs and trauma is considered to be valuable for everyone, especially the universal nature of the problem. An approach is needed which communicates the universality of the problem; designs services and helps people to act in ways consistent with universal precaution; and at the same time provides targeted support for the people most at risk and those living and struggling with trauma.


VISION: Leeds is a compassionate and resilient city. Organisations and people respond compassionately towards those affected by trauma and work collaboratively to proactively prevent trauma and its causes.
Social Ecological (& Public Health) Approach
Multi-dimensional and multi-layered approach which takes account of the physical and social world, the natural and built environment, virtual and place-based features, and objective-material and perceived-symbolic aspects of life.
Organisational & Institutional Systems (Macro)
Conditions
Processes
Practices
CURRENT – non-desirable
• Conditions: Can be trauma-generating or triggering; low time, high stress, high-demand environments, esp. emotion work; inter- and intra-organisational siloes; organisational cultures are not conducive to being T-I.
• Processes: Trauma-ambivalent/generating policies and processes; experiences of gatekeeping or exclusion; institutions & systems (e.g. IT infrastructure) which are not integrated.
• Practices: Promotes task-oriented action & communication; judgemental language embedded in organisations; punitive practices.
Family and/or Team Relational Systems (Meso)
Conditions
Processes
Practices
CURRENT – non-desirable
• Conditions: Time pressures; understaffed / under-supported; lack of access to necessary resources; exposure to / witnessing other people's trauma & A(C)Es; disrupted communities.
• Processes: Lack of time for reflexive practice or peer support; competing demands; destructive power dynamics; excessive responsibility.
• Practices: Destructive communication practices; A(C)Es; harmful relational dynamics and patterns.
Individuals (Micro)
Conditions
Processes
Practices
CURRENT – non-desirable
• Conditions: Experiencing A(C)Es & living with trauma; exposure to / witnessing other people's trauma & A(C)Es; lack of opportunity & resources, including employment, income, basic necessities;
• Processes: Drug & alcohol dependency & addiction issues; sexual exploitation; lack of integration with other people & services; mental illness & crisis; burnout.
• Practices: Destructive communication practices; violence & harmful behaviour;
Problems: ↔ A(C)Es ↔ Trauma ↔ Bio-psycho-social consequences ↔ Interrelational/intergenerational consequences ↔



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