Adverse Childhood Experiences

Be the Change

EITP ACEs & Trauma Informed Practice Project

Headline Findings from Training Needs Analysis for the Health & Social Care Sectors

June 2019


SBNI
Safeguarding Board
for Northern Ireland


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Introduction

The Safeguarding Board for Northern Ireland (SBNI) has been funded through the Early Intervention Transformation Programme (EITP) to deliver ACE Awareness and Trauma Informed Practice Workforce Development Training across health, social care, education, justice and the community/voluntary sector in Northern Ireland. The National Children's Bureau (NCB) is supporting this work with the SBNI. NCB has been commissioned to support the SBNI to determine the current levels of knowledge and expertise about ACE/trauma informed practice among practitioners working across health, social care, education, justice and the community/voluntary sector. This baseline of information will be used to inform training design and delivery.

An initial action in this project was the facilitation of stakeholder events for a range of different sectors. During May 2019, a total of 159 people from the health and social care sectors attended 5 events across each of the Health & Social Care Trust areas in Northern Ireland as the table below summarises:

Location	**Numbers attended**
Derry/Londonderry	21
Belfast	38
Lurgan	34
Bangor	27
Antrim	39
Total	**159**

Figure 1: Attendance at stakeholder events by location

A list of organisations and services within the Health & Social Care Trust areas represented at these events is included in Appendix 1.

The purpose of this report is to present headline findings from the training needs analysis (TNA) that relate to both the health and the social care sectors. This is one of a series of headline reports. Other headline reports covering the voluntary and community sector, housing, early years, Family Support Hubs, education and GPs are also being compiled. This report is laid out in the following sections:

- Section 1 details a profile of the participants who completed the TNA
- Section 2 provides a summary of participants' awareness and understanding of ACES, disaggregated by the health and social care sectors
- Section 3 summarises participants' awareness and understanding of Trauma Informed Practice, disaggregated by the health and social care sectors
- Section 4 explores Training and Workforce Development: Embedding ACES and TIP Practice and
- Section 5 concludes the report.

Section 1: Profile of Participants

A total of 95 people from the health sector and 37 from the social care sector completed TNA surveys at the events. The surveys explored a number of different aspects of ACES and TIP including, levels of awareness, training needs and applicability to current role. This headline report provides the data relating to each question and concludes with a summary of the discussion held at the workshop.

All percentages are given for those who answered each question. The following tables summarise the roles undertaken by respondents, number of years in those roles and areas in which their work is based, disaggregated by sector (please note: figures may not total 100% due to rounding):

Role	Health %	Social Care %
Front-line practitioner	64	73
Service manager	28	24
Administrative/Support Staff	1	0
Commissioner of services	2	0
Volunteer	0	0
Other	4	3

Figure 2: Respondents by role and sector

'Other' roles in these sectors include health improvement, coordinating evidence based practice, strategic roles influencing services and other sectors, learning and development and governance.

Years in current role	Health %	Social Care %
Less than 1 year	20	30
1-3 years	21	22
4-6 years	12	11
7-10 years	11	16
11+ years	36	22

Figure 3: Respondents by years in current role and sector

Area	Health %	Social Care %
All of NI	6	3
BHSCT	15	38
SEHSCT	24	5
SHSCT	17	11
WHSCT	11	27
NHSCT	25	16

**some participants chose two or more areas. 2 people from the health sector indicated that they worked in both the BHSCT & SEHSCT. Nobody from social care works in more than one area*

Figure 4: Respondents by area in which work is based by sector

Section 2: Awareness and Understanding of ACES

This section outlines the findings of the TNA in relation to awareness and understanding of ACEs, firstly from the health sector and secondly, from the social care sector.

2A: Awareness and Understanding of ACES in the Health Sector

Survey respondents were asked if they had heard of the term ACEs before the event. The majority (91%) indicated that they had heard of the term ACEs before the workshop, while 9% had not heard of the term.

Levels of knowledge of ACEs and their impact

The following table summarises levels of knowledge by aspect in relation to ACEs for those in the health sector:

Extent of knowledge and understanding of the following:	**No, I don't know anything %**	**Yes, I know a little %**	**Yes, I know a lot %**
a. The prevalence of ACEs	11	66	23
b. The types of ACEs that a child may experience	5	51	44
c. Potential short-term and long-term effects of ACEs on children	3	59	38
d. How ACEs may affect brain development	14	48	38
e. How ACEs can affect a child's physical development	13	49	38
f. How ACEs may affect social and emotional skills development	2	59	39
g. Cultural differences in how children and families understand and potentially respond to ACEs	34	46	20
h. ACE triggers/reminders and their impact on a child's behaviour	14	59	28

Note: figures may not total 100% due to rounding

Figure 5: Levels of knowledge by aspect in relation to ACEs – health sector

As Figure 5 shows, there is considerable knowledge in the health sector in relation to the types of ACEs that exist, their prevalence, short and long terms effects and the effect on children's social and emotional development. There is a lot less awareness of how cultural differences might affect understanding and responding to ACEs and there is room for further awareness in relation to how ACEs affect brain

development, physical development and in terms of the impact of ACE triggers/reminders on a child's behaviour.

Understanding of parent/adult ACE history and its impact on parenting and response to services – Health Sector

The following table summarises levels of understanding of parent/adult ACE history and its impact for those in the health sector:

Awareness of parent/caregiver ACEs and their impact	**Yes %**	**No %**
I am		
a. Aware that many birth parents can have an ACE history	98	2
b. Knowledgeable about intergenerational cycles of abuse	82	18
c. Familiar with cultural issues that may impact disclosure of parents' ACEs and seeking treatment	68	32
d. Knowledgeable about the potential impact of past ACEs on a parent's ability to care for his/her children, potentially manifesting itself in mental health or substance abuse problems	90	10
e. Aware of how service providers' activities can trigger a parent's own ACEs history and affect a parent's response to staff and engagement with services	78	22

Figure 6: Awareness of parent/caregiver ACEs and their impact – health sector

As Figure 6 shows, almost all respondents in the health sector are aware that parents/caregivers can have their own ACE history that may impact on their ability to parent their children and that intergenerational cycles of abuse may exist. Less is known about cultural issues that may impact disclosure of parents' ACEs and seeking treatment and how service providers' activities might trigger memories of ACEs which may then affect how parents engage with service providers.

Participants were asked if they considered ACEs to be important in their current role. The majority (96%) of respondents from the health sector considered ACEs to be important to their current role. 4% were unsure. Reasons given for those who did see ACEs to be important tended to focus on the relevance to their current role - some as practitioners delivering services to adults and children/young people, many of whom have experienced ACEs, others as trainers within organisations. Some respondents who are managers also cited being able to support other members of staff who meet services users affected by ACEs on a daily basis.

Those who were unsure stated that they were new into posts and were still learning, or were unsure about, their current service and the interface with children and young people (i.e. their current service may not target children and young people specifically).

2B: Awareness and Understanding of ACES in the Social Care Sector

Survey respondents were asked if they had heard of the term ACEs before the event. The majority of those from the social care sector (94%) indicated that they had heard of the term ACEs before the workshop while 6% had not heard of the term ACEs.

Levels of knowledge of ACEs and their impact

The following table summarises levels of knowledge by aspect in relation to ACEs for those in the social care sector:

Extent of knowledge and understanding of the following:	**No, I don't know anything %**	**Yes, I know a little %**	**Yes, I know a lot %**
i. The prevalence of ACEs	8	68	24
j. The types of ACEs that a child may experience	5	46	49
k. Potential short-term and long-term effects of ACEs on children	5	59	35
l. How ACEs may affect brain development	19	54	27
m. How ACEs can affect a child's physical development	16	65	19
n. How ACEs may affect social and emotional skills development	8	62	30
o. Cultural differences in how children and families understand and potentially respond to ACEs	32	57	11
p. ACE triggers/reminders and their impact on a child's behaviour	19	59	22

Note: figures may not total 100% due to rounding

Figure 7: Levels of knowledge by aspect in relation to ACEs – social care sector

As Figure 7 shows, there is considerable knowledge in the social care sector in relation to the types of ACEs that exist, their prevalence, short and long terms effects and the effect on children's social and emotional development. There is a lot less awareness of how cultural differences might affect understanding and responding to ACEs and there is room for further awareness in relation to how ACEs affect brain development, physical development and in terms of the impact of ACE triggers/ reminders on a child's behaviour.

Understanding of parent/adult ACE history and its impact on parenting and response to services – Social Care Sector

The following table summarises levels of understanding of parent/adult ACE history and its impact for those in the social care sector:

Awareness of parent/caregiver ACEs and their impact	**Yes %**	**No %**
I am		
f. Aware that many birth parents can have an ACE history	95	5
g. Knowledgeable about intergenerational cycles of abuse	89	11
h. Familiar with cultural issues that may impact disclosure of parents' ACEs and seeking treatment	59	41
i. Knowledgeable about the potential impact of past ACEs on a parent's ability to care for his/her children, potentially manifesting itself in mental health or substance abuse problems	95	5
j. Aware of how service providers' activities can trigger a parent's own ACEs history and affect a parent's response to staff and engagement with services	83	17

Figure 8: Awareness of parent/caregiver ACEs and their impact – social care sector

As Figure 8 shows, almost all respondents in the social care sector are aware that parents/caregivers can have their own ACE history that may impact on their ability to parent their children, that intergenerational cycles of abuse may exist and how service providers' activities might trigger memories of ACEs which may then affect parents' engagement with service providers. Less is known about cultural issues that may impact disclosure of parents' ACEs and seeking treatment.

Participants were asked if they considered ACEs to be important in their current role. The majority (97%) of respondents from the social care sector considered ACEs to be important to their current role. 3% (one person) were unsure. Reasons given for those who did see ACEs to be important tended to focus on the relevance for their work with vulnerable children and young people in various areas such as Looked after Children, adolescent mental health, adoption and fostering and family intervention. Some respondents work with adults who may be affected by ACEs experienced in their past. Others are trainers within their own organisations or managers who need to be able to support staff working with ACE affected service users.

The person who indicated they were unsure as to the relevance of ACEs did so as s/he works with older people who have mental health issues and a diagnosis of dementia. Cognitive impairment may, therefore, mean that such clients do not have a full understanding or awareness of ACEs in their past.

Section 3: Awareness and Understanding of Trauma Informed Practice

This section outlines the findings of the TNA in relation to awareness and understanding of trauma informed practice, firstly from the health sector and secondly, from the social care sector.

3A: Awareness and Understanding of Trauma Informed Practice in the Health Sector

Survey respondents were asked if they had heard of the term Trauma Informed Practice before the event. Over three-quarters (77%) indicated that they had heard of the term Trauma Informed Practice before the workshop, while 23% had not heard of the term Trauma Informed Practice.

The following table summarises the extent and knowledge of various aspects of TIP and its impact for those in the health sector:

Extent of knowledge and understanding of the following:	**No, I don't know anything %**	**Yes, I know a little %**	**Yes, I know a lot %**
a. What constitutes a trauma informed organisation	45	46	10
b. What is trauma informed practice	30	56	14
c. Impact of trauma on individual's physiological, neurological development and their social and emotional development	6	65	29
d. How to recognise trauma	16	66	18
e. How to respond in a trauma informed way	38	46	16
f. How to avoid re-traumatising service users	44	41	15
g. How to develop a trauma informed culture	54	37	10

Note: figures may not total 100% due to rounding

Figure 9: Knowledge and understanding of TIP and its impact – health sector

As Figure 9 shows, there are high levels of knowledge and understanding in the health sector of how to recognise trauma and the impact of trauma on individual development. However, significant gaps exist in relation to how to develop a trauma informed culture, what constitutes a trauma informed organisation, how to avoid re-traumatising service users and how to respond in a trauma informed way.

Participants were asked if they considered knowledge of TIP to be important in their current role. The majority (90%) of respondents from the health sector considered knowledge of TIP to be important to their current role. Reasons for this included the desire to provide more effective services to children, young people and families which have better outcomes, to support staff in their direct work with service users, to help create a trauma informed culture and promote trauma informed practice in their organisations.

10% were unsure. Reasons for this included the possibility of one person's role changing in the future, not being sure of the differences between ACEs and TIP or needing to know more about TIP to make a judgement as to its relevance.

3B: Awareness and Understanding of Trauma Informed Practice in the Social Care Sector

Survey respondents were asked if they had heard of the term Trauma Informed Practice before the event. Almost three-quarters (74%) of those in the social care sector indicated that they had heard of the term Trauma Informed Practice before the workshop while 26% had not heard of this term.

The following table summarises the extent and knowledge of various aspects of TIP and its impact for those in the social care sector:

Extent of knowledge and understanding of the following:	**No, I don't know anything %**	**Yes, I know a little %**	**Yes, I know a lot %**
a. What constitutes a trauma informed organisation	50	42	8
b. What is trauma informed practice	33	50	17
c. Impact of trauma on individual's physiological, neurological development and their social and emotional development	8	72	19
d. How to recognise trauma	28	47	25
e. How to respond in a trauma informed way	39	44	17
f. How to avoid re-traumatising service users	44	36	19
g. How to develop a trauma informed culture	56	42	2

Note: figures may not total 100% due to rounding

Figure 10: Knowledge and understanding of TIP and its impact – social care sector

As Figure 10 shows, there are high levels of knowledge and understanding in the social care sector of the impact of trauma on individual development. However, significant gaps exist in relation to how to develop a trauma informed culture, what constitutes a trauma informed organisation, how to avoid re-traumatising service users and how to respond in a trauma informed way. What trauma informed practice is and how to recognise trauma are also areas where there is scope for greater knowledge and understanding to be built.

Participants were asked if they considered knowledge of TIP to be important in their current role. The vast majority (94%) indicated that they did consider that it was important in their current role, 3% (1 person) were unsure while another 3% felt it was not important. Reasons given by those who indicated that it was important included relevance to current role in direct work with families (children, parents and older adults), to better support staff teams working directly with families, to improve service development and to improve training for staff. The respondent who said they were unsure did so because they are not a front line practitioner, while the person who indicated that it was not important did so because they needed to know more about TIP.

Section 4: Training and Workforce Development: Embedding ACES and TIP

Training Received

The majority of health sector respondents (63%) and social care sector respondents (61%) indicated that they had not received training in relation to ACEs and/or TIP in their current organisation. 37% of health sector respondents and 39% of social care respondents had received such training.

14% (5 people) of social care respondents indicated that they had received training on ACEs and/or TIP from a previous employer and the corresponding figure for health respondents was 10%.

For some health sector respondents the training received was specifically on ACEs and their impact whereas for others similar knowledge was gained from other training such as the Solihull Approach, Safeguarding Training, the Family Nurse Partnerships, Signs of Safety or included as part of their initial professional qualifications. Some training was on the wider topic of trauma and trauma informed practice whereas other training was on specific types of adversity/trauma such as domestic abuse, the impact of the Troubles, mental ill-health or on topics such as resilience, with a few respondents mentioning seeing the 'Resilience' documentary that has been shown in a range of venues throughout Northern Ireland recently.

Some respondents (from both health and social care) reported that some of their initial professional training contained elements of ACE awareness and/or TIP. In addition, some training they had received was specifically on ACE awareness and

resilience. One respondent from each sector also mentioned training in Trauma Informed Practice. Training duration was mostly less than one day.

Although respondents were not asked about the sources of training, some volunteered this information and it ranged from inputs received as part of university courses, the Belfast Health & Social Care Trust, NSPCC, via BASW (British Association of Social Work), Dr Karen Treisman, private training providers to voluntary and community groups such as WAVE Trauma Centre, Women's Aid and Threshold.

Future Training Needs

This sub-section outlines the future training needs of the health and social care sectors in relation to ACEs and TIP.

The following table summarises interest in receiving training on different aspects of ACEs for the health sector:

Aspects of ACEs in which training would be welcomed (%) – health sector	
Cultural differences in how children and families understand and respond to ACEs	85
Cultural issues that may impact disclosure of parent ACEs and seeking treatment	84
The potential impact of past ACEs on a parent's ability to care for his/her children, potentially manifesting itself in mental health or substance abuse problems	83
ACEs triggers/reminders and their impact on a child's behaviour	83
How service providers' activities can trigger a parent's own ACEs history and affect a parent's response to staff and engagement with services	83
Potential short-term and long-term effects of ACEs on children	80
How ACEs may affect social and emotional skills development	79
Intergenerational cycles of abuse	78
How ACEs can affect a child's physical development	77
How ACEs may affect brain development	76
The types of ACEs that a child may experience	75
Parents' ACEs history	75
The prevalence of childhood ACEs	71
Other – please state	6

Figure 11: Aspects of ACEs in which training would be welcomed – health sector

The 'Other' aspect identified here was an interest in Train the Trainer training.

The following table summarises interest in receiving training on different aspects of TIP for the health sector:

Aspects of trauma informed practice in which training would be welcomed (%) – health sector	
How to avoid re-traumatising service users	89
How to respond in a trauma informed way	86
How to develop a trauma informed culture in my workplace	86
How to become a more trauma informed practitioner	85
How to respond in a trauma informed way	84
How to recognise trauma	80
How to create a trauma informed organisation	79
The impact of trauma on individual's physiological, neurological development and their social and emotional development	77
Other – please state	5

Figure 12: Aspects of TIP in which training would be welcomed – health sector

The 'Other' aspects identified by respondents in relation to TIP training include self-care for staff, the role of different professions in supporting service users' organisations (e.g. Sure Start), using TIP in a managerial role, how trauma can present diagnostically and how to focus on what happened as opposed to labels and Train the Trainer training.

The following table summarises interest in receiving training on different aspects of ACEs for the social care sector:

Aspects of ACEs in which training would be welcomed (%) – social care sector	
How service providers' activities can trigger a parent's own ACEs history and affect a parent's response to staff and engagement with services	86
Cultural differences in how children and families understand and respond to ACEs	86
The potential impact of past ACEs on a parent's ability to care for his/her children, potentially manifesting itself in mental health or substance abuse problems	84
Cultural issues that may impact disclosure of parent ACEs and seeking treatment	81
ACEs triggers/reminders and their impact on a child's behaviour	78
How ACEs may affect brain development	78
How ACEs may affect social and emotional skills development	76
Potential short-term and long-term effects of ACEs on children	73
How ACEs can affect a child's physical development	73
Parents' ACEs history	73
Intergenerational cycles of abuse	70
The types of ACEs that a child may experience	70
The prevalence of childhood ACEs	62
Other – please state	14

Figure 13: Aspects of ACEs in which training would be welcomed – social care sector

'Other' aspects identified here included the impact of the conflict, intergenerational ACEs experience, how ACEs present in adult life, dementia "delusions" among older people (is this remembering hidden ACES from their past?), Age to Stage training and how to help with trauma during a crisis or with drug/substance misuse.

The following table summarises interest in receiving training on different aspects of TIP for the social care sector:

Aspects of trauma informed practice in which training would be welcomed (%) – social care sector	
How to become a more trauma informed practitioner	95
How to respond in a trauma informed way	92
How systems can become more trauma sensitive	89
The impact of trauma on individual's physiological, neurological development and their social and emotional development	86
How to avoid re-traumatising service users	86
How to develop a trauma informed culture in my workplace	86
How to recognise trauma	78
How to create a trauma informed organisation	73
Other – please state	3

Figure 14: Aspects of TIP in which training would be welcomed – social care sector

'Other' aspects identified here included trauma history and skills in working in care planning.

Summary of the discussion on the roll out of training with delegates

At each of the events, delegates discussed existing workforce development opportunities and challenges to the implementation of TIP as well as the drivers and project support offers that might need to be in place to make this happen. At three of the events, presentations were made reflecting personal and professional development journeys and developments in specific services and/or geographical areas relating to trauma informed practice. These presentations were from the following:

- Sheena Funston, Acting Head of Health Improvement, Western Health & Social Care Trust, who presented on the developments in the WHSCT area.
- Gavin McGee who presented on the MACE (Multiple Adverse Childhood Experiences) Project. This is a cross-border EU-funded project involving key stakeholders in health and social care from Northern Ireland and their counterparts from the Republic of Ireland.
- Jackie McMaster from the CAMHS service, Belfast, who reflected on the journey Beechcroft has undertaken to become a more trauma informed service.

Feedback from all 5 events has been organised under the following headings:

- Where does the ACE agenda fit in to workforce development?
- How can trauma informed practice happen within your role/organisation?
- What additional supports do you need to make this happen?

Where does the ACE agenda fit in to workforce development?

There was a variety of responses in relation to where delegates at the events felt that ACE training fitted best. There was a sense that people know about ACEs but do not use that term. Various delegates stated that they have been working with ACEs 'knowledge' for years but the language has changed.

Some felt that it should be part of safeguarding training, others that it should be included in the induction programmes within organisations. A number of delegates across disciplines felt that all undergraduate/qualifying courses for those working with children, young people and families should have ACE awareness integrated into them. This could also help to create common language across disciplines.

Many delegates felt that ACE training needs to be mandatory and that the mode of delivery should be primarily face to face. While there is potential in developing e-learning or e-training, this should be for a complementary product and should be video focused and interactive.

Some delegates felt that a number of existing training and education programmes and practice initiatives already have elements of TIP built into them. These include the Family Nurse Partnerships, the Solihull Approach, the work in CAMHS teams, some social work training, training provided by the Recovery College and Foyle Women's Aid. Learning from the Sanctuary model was also discussed.

There was a call from some for the training to be multi-disciplinary as it was felt that this would enable participants to learn from each other, share knowledge and also build relationships with other disciplines. However, others felt that the initial training should be stand alone and discipline-specific in order to create buy in, confidence and change.

Some suggested looking at already existing training such as Signs of Safety, Think Family and Solihull Approach and see if these could be built upon. There were some caveats to this, though, as the limitations of Signs of Safety were raised. Avoiding saturation is important for staff or disciplines, e.g. midwifery or social work, where there have been other large scale changes already to training/approaches.

In relation to Tier 3 Leadership Training, it was felt that it may be beneficial to have representation from across organisations within each level of management. Some participants felt that Assistant Directors may not know what is realistic on the ground. Having representatives from all levels to interact and think of implementation on a range of levels/services would, therefore, ensure that there was a strategic

approach to, as well as practical implementation of, such training. These representatives could become practice educators or development leads.

It was felt that showcasing the learning about change across all services (including older people's services and mental health services) has great potential for practitioners' learning and development. However, it was also felt that training alone is not necessarily the only place where the ACE agenda fits into workforce development – there is a need to embed it in practice, to 'walk the walk'.

How can trauma informed practice happen within organisations?

Some delegates have reservations about ACEs and the checklist, including the potential for unintentional exclusion or traumatisation. An understanding that TIP is much more than ACEs is also important.

It was felt that TIP needs to have buy in from everyone – frontline practitioners as well as managers and that a cultural shift was needed to really embed this approach within some organisations.

Practical ideas, such as doing a 'walk through' (as outlined by Covington)[1] to ascertain if TIP is indeed already happening and to identify areas for further development, were discussed.

Communication and language was a recurring theme among delegates. This encompasses the following:

a) the need to develop common language across disciplines about trauma

b) ensuring that all staff have the vocabulary to confidently hold the conversations that are necessary in order to address trauma with service users (including parents, as well as children and young people) and

c) developing the skills to get messages about trauma across in creative ways that will be well received.

There is potential for children and young people, adults and families with experience of ACEs to be involved in developing practice and training and recognised as 'experts by experience'.

[1] Covington, Stephanie (2016): Becoming Trauma Informed. Tool Kit for Women's Community Service Providers. Part of the One Small Thing Initiative www.onesmallthing.org.uk, Center for Gender and Justice, California. www.centerforgenderandjustice.org

What additional supports do you need to make this happen?

Key areas in which additional resource or support is required were identified as including:

- Time: releasing staff for training, peer review, debrief, self-care and supervision; having more direct contact with clients over longer periods of time
- Skills: enhancing capacity across the workforce and acknowledging practitioner wisdom rather than possibly 'deskilling' staff
- Staff: sufficient staffing levels in key disciplines; addressing workforce gaps especially in North West and rural areas; managing staff turnover
- Collaboration: multi-agency approaches, systems and provision
- Wellbeing support: for staff to identify, mitigate or manage vicarious trauma and compassion fatigue
- HR and administration systems which can support change
- Acknowledgement of ACEs specific or particular to Northern Ireland, i.e. transgenerational impact of the conflict; suicide; mental health; children in care
- Focus on transitions: particularly from children's to adult services
- Bring in less typical services: adult; disability; older people; GPs

Section 5: Conclusion

Levels of awareness of ACEs are slightly higher than those for TIP for both health practitioners and those from social care. There is, however, a huge appetite from both sectors to know more about both of these areas, to develop practice and to embed TIP into their organisations. Participants acknowledged that doing so requires a cultural shift, support from those leading organisations and buy-in from across the workforce. Training can certainly contribute to this and indeed there is already much that can be built upon. Other considerations include adjustments to workload, time for adequate support and supervision, addressing workforce gaps and much more multi-disciplinary work across sectors to fully realise the ambition of making trauma informed practice the norm.

Appendix 1

Organisations and services within HSCTs represented at the Health and Social Care Stakeholder Events

16+ Team
Addictions
Adoption Support Team
Adult ADD Diagnostics Team
Adult Disability
Adult Mental Health
Adult Social Care
Adults Primary Mental Health
Alcohol & Drug Service
Autism Teams
Autism/CAMHS
Belfast HSCT
Belfast Recovery College
Bryson Care Ards and North Down
CAMHS
Children & Young People's Service (CYPS)
Children's Autism Intervention Team
Children's Disability
Children's Mental Health
Children's Occupational Therapy
Children's Psychological Services
Children's Services (Gateway)
Children's Social Services Learning and Development Team
Community Children's Nursing
Community Children's Service SCNS
Community Forensic Mental Health Team
Community Mental Health Team
Community Mental Health Team - Older People
Community Midwifery
Crisis Resolution Home Treatment Team
Daisy Hill Hospital Emergency Dept
Discharge Hub
Drink Wise Age Well
Early Intervention Support Team
Early Years
Eating Disorder Youth Service
Emergency Care/Departments
Family Group Conference
Family Intervention Service Westbank
Family Nurse Partnership
Family Placement Team
Health & Social Care Board/Western
Childcare Partnership
Health Improvement
Health Improvement PHA
Health Visiting
Hospital Learning Disability Adult and Children's Service
HSCNI
Kinship Foster Team
Larne Parental Support Team
Learning Development and Governance
Maternity Services
Mental Health - Holywell Hospital
Mental Health for Older People's Service
Mental Health Services Older People
Multi-Disciplinary Team within GP Practices
Neonatal Intensive Care
Northern Health & Social Care Trust
Nursing and AHP Directorate - PHA
Orthoptic (Eye team)
Paediatric Complex Needs Team
Paediatric Occupational Therapy
Pain Management Programme
Parenting Partnership
Personality Disorder Services
PH+SD
PHA - Nursing and AHP Directorate
Portadown Health Visiting Team
Portadown Family Intervention Team
Primary Care and Older People's Services
Primary Mental Health Team
Prison Healthcare

Promoting Wellbeing
Public Health Agency
Public Health Agency - Nursing and AHP
Rapid Assessment Interface and Discharge Mental Health
Regional Integrated Support for Education in NI (RISE NI) NHSCT
Royal Belfast Hospital for Sick Children
Safeguarding Children
Safeguarding Children Nurses
Scaffold
School Nursing
School Nursing/NINES
SEHSCT
SHSCT
Signs of Safety Implementation Team
Social Services Learning, Development & Governance
Social Wellbeing Clinic
Start360
Sure Start/Speech and Language Therapy
Training and Employment
Unscheduled Care
Well Mind Hub
Western Childcare Partnership
WHSCT
Women & Children's Directorate, Family Support
Workforce Development and Training