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Perspectives of Trauma Informed Care in public services: a framework synthesis and analysis

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Acknowledgements

Firstly, my sincere gratitude to my participants for taking the time and sharing your experiences with me. It was a privilege; I hope I have done you justice and that your voices continue to be heard.

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I dedicate this to survivors of trauma, in solidarity.

Foreword

There were some minor adaptations made to this project due to the Covid-19 pandemic. Originally it was planned that the Rivers Centre in NHS Lothian would be a third recruitment site. It was agreed by the author and research supervisors to no longer proceed with this due to the delays in ethical approval and the additional burden on clinical staff during the pandemic. Additionally, it was initially planned that participants would have a choice of whether they could attend interviews in person or remotely, by telephone or Attend Anywhere (an NHS based video messaging service). Due to the government restrictions and social distancing guidelines at the time, it was decided that this project would be carried out entirely remotely. Whilst participants were still given the choice of having an interview via telephone or video call, face-to-face interviews were not an option. The researcher also promoted this study by attending virtual team meetings in NHS Greater Glasgow and Clyde, as face-to-face meetings were not permitted. Fortunately, the project was able to continue as planned once these adaptations had been made.

Chapter 1: “Moving from control to collaboration” – a qualitative systematic review of stakeholders’ perspectives on the implementation of Trauma Informed Care across public services

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“Moving from control to collaboration” – a qualitative systematic review of stakeholders’ perspectives on the implementation of Trauma Informed Care across public services

Abstract

Introduction: There has been an increased focus over the past thirty years on recognising and responding to trauma. This has led to a shift towards developing trauma-informed policies and approaches across service settings, systems and jurisdictions in Western counties. Trauma Informed Care (TIC) has been found to improve service user experiences, enhance working relationships for staff and increase job satisfaction. This review aimed to synthesise stakeholders’ perspectives on the implementation of TIC across public services, as well as identifying barriers and facilitators.

Method: Six databases (EMBASE, PubMed (MEDLINE), PsycArticles, PsycINFO, Scopus and Sociological Abstracts) were electronically searched in September 2020. Reference lists were searched, and forward citation searches were conducted on the included papers. Results were analysed utilising best-fit framework synthesis, using the NHS Education for Scotland TIC framework.

Results: 1589 records were screened, and twelve papers were eligible for inclusion in the review and quality appraisal. Synthesis identified that stakeholders’ perspectives were captured by the TIC principles of safety, trust, collaboration, choice and empowerment. Multi-level community and systemic barriers were identified, including a lack of support for staff and vicarious trauma. Positive relationships, leadership, a commitment to long-term training and staff support were highlighted as key facilitators of TIC across services.

Conclusions: Stakeholders' perspectives reflected the principles of TIC, with individuals relating their experiences to the five core principles outlined above. Complex interacting factors were highlighted, including how professionals' prior training and systemic stressors can contradict a trauma-informed approach. Further research into TIC is needed, particularly focusing on client perspectives, TIC applied to staff and experiences of TIC across diverse cultures.

Background

There have been significant developments in understanding psychological trauma over the past thirty years (Wilson *et al.,* 2013). There is greater recognition of what trauma is and the impact of trauma on individuals, families and communities (Muskett, 2014). Trauma Informed Care (TIC) is based on the premise that people in contact with, and working in, public services may have experienced trauma, and this understanding needs to shape the way services operate, from an individual to an organisational level (Harris & Fallot, 2001). TIC is relevant to all human services, including mental health care, medical care, education and schools, forensic and justice settings, housing and social services (Havig, 2008).

Harris and Fallot (2001) proposed that five main principles underpin TIC: safety, trustworthiness, collaboration, choice and empowerment. Safety is understood as being both physical and psychological. Trustworthiness relates to transparency and consistency. Choice offers individuals control and personal agency, important in the context of trauma where individuals felt they had no control. Collaboration aims to re-address the inherent power imbalances that often exist within services and emphasises the need for clients to be actively involved in their care. Empowerment offers a strengths-based approach within a validating environment where people's voices can be heard. These principles underpin trauma-informed policies, across varying services and contexts, and are applicable to staff as well as clients (Center for Substance Abuse Treatment, 2014).

Research indicates strong links between traumatic experiences in childhood and experiencing distress in later life (Davidson *et al.*, 1991). Social determinants of mental health include poverty, racial discrimination and social exclusion (Silva *et al.*, 2016). Therefore services need to acknowledge both psychological and social factors in understanding mental distress and trauma (Dillon *et al*., 2014). Whilst TIC was initially applied to mental health services, other organisations are adopting this approach including health care, education, social services and criminal justice systems (Ko *et al., 2008).* When applied more broadly to public health settings, TIC aims to recognise the prevalence of trauma in the community and proactively take steps to avoid causing further distress and re-traumatisation (Hodas, 2006).

Trauma-informed services are not synonymous with trauma-specific services, which focus on working therapeutically with survivors of trauma, often using phase-based psychological interventions (Herman *et al.*, 2020). A trauma-informed service can be any service where it is recognised that people have experienced trauma and may find it difficult to develop trusting relationships with professionals and feel safe within organisations. Accordingly, such services are designed and delivered in ways that promote safety and trust and do not retraumatise those within it (Sweeney *et al.,* 2016). TIC is a strengths-based non-pathologising approach which emphasises that people develop coping strategies to survive trauma, and these strategies make sense within the context of their experiences (Rosenthal *et al.,* 2016). TIC aims to recognise and support the needs of persons who have experienced trauma (Harris & Fallot, 2001) and reduce practices that may be re-traumatising (Elliott *et al*., 2005).

Trauma-informed approaches are integral to the implementation of the knowledge and skills framework '*Transforming Psychological Trauma'* (NHS Education for Scotland, 2019), as part of the Scottish Government's commitment to develop a National Trauma Training Strategy. A systematic review of the limited research on TIC in mental health settings within the United Kingdom found that trauma-informed approaches are effective and can benefit clients and staff (Sweeney *et al.*, 2016). There is a lack of research into stakeholders' perspectives of implementing TIC, particularly in public services. Stakeholders include service users, clinical and non-clinical staff, managers, and collaborators. A review of stakeholders' perspectives could produce valuable insights into the factors that help and hinder implementation, which would inform policy and practice.

Aims

The primary aim of this review was to use a qualitative best-fit framework synthesis approach to capture the perspectives of key stakeholders in relation to the implementation of trauma-informed approaches in public services. The secondary aims were to identify any facilitators or barriers experienced by stakeholders when implementing trauma-informed approaches.

Method

Search strategy

In consultation with a subject librarian, it was decided that due to the relatively new concept and specificity of TIC, broad search terms should be used. This would maximise sensitivity and reduce potentially relevant articles from being excluded. The search term was “Trauma informed”. Before conducting the search, databases were examined for any existing qualitative reviews of stakeholders’ perspectives of the implementation of TIC in public services. None were found. The following six databases were searched for all dates up to 14th September 2020: EMBASE, PubMed (MEDLINE), PsycArticles, PsycINFO, Scopus and Sociological Abstracts. Forward citation searches of included articles were conducted and reference lists searched, no new eligible papers were identified. Before data was extracted, this review was registered with PROSPERO (ID: CRD42021254858).

Eligibility criteria

Table 1: *Eligibility criteria for the review*

Aspects of interest	Inclusion	Exclusion
Population sample	Human services (mental health community and inpatient, health, social services, education, police, community groups) Stakeholders (service users, patients, clients, health professionals, service managers) Worldwide	Private services
Context	Implementation of Trauma Informed Care policy/principles/training	Trauma approaches that are not defined as Trauma Informed Care policy Trauma-focused therapies Qualitative experiences of Trauma Informed Care that are not based in the context of implementation
Study type	Qualitative research Empirical research	Quantitative research Mixed methods Literature reviews Opinion pieces
Study aims	To evaluate the implementation of Trauma Informed Care	Aims that are not specifically focused on the implementation of Trauma Informed Care in organisations
Publication type	Peer-reviewed journal	Unpublished dissertation
Language	Written in English	Written in other languages

Framework synthesis

Best fit framework synthesis was utilised, in line with the principles described by Carroll *et al.* (2013). The results sections of the articles were manually extracted, and a line-by-line analysis of the data was conducted using NVivo software (released in March 2020). To increase reliability and rigour of the analysis, an independent rater (trainee clinical psychologist F.M.) coded a random selection of the articles and any differences were discussed until an agreement was reached. Examples of the coding can be found in

Appendix 1.1 and 1.2. Data were identified and coded according to the a priori TIC framework, an example of which is included in Appendix 1.3. Inductive thematic analysis (Braun & Clarke, 2006) was carried out on the data that could not be accommodated within the framework.

TIC Framework

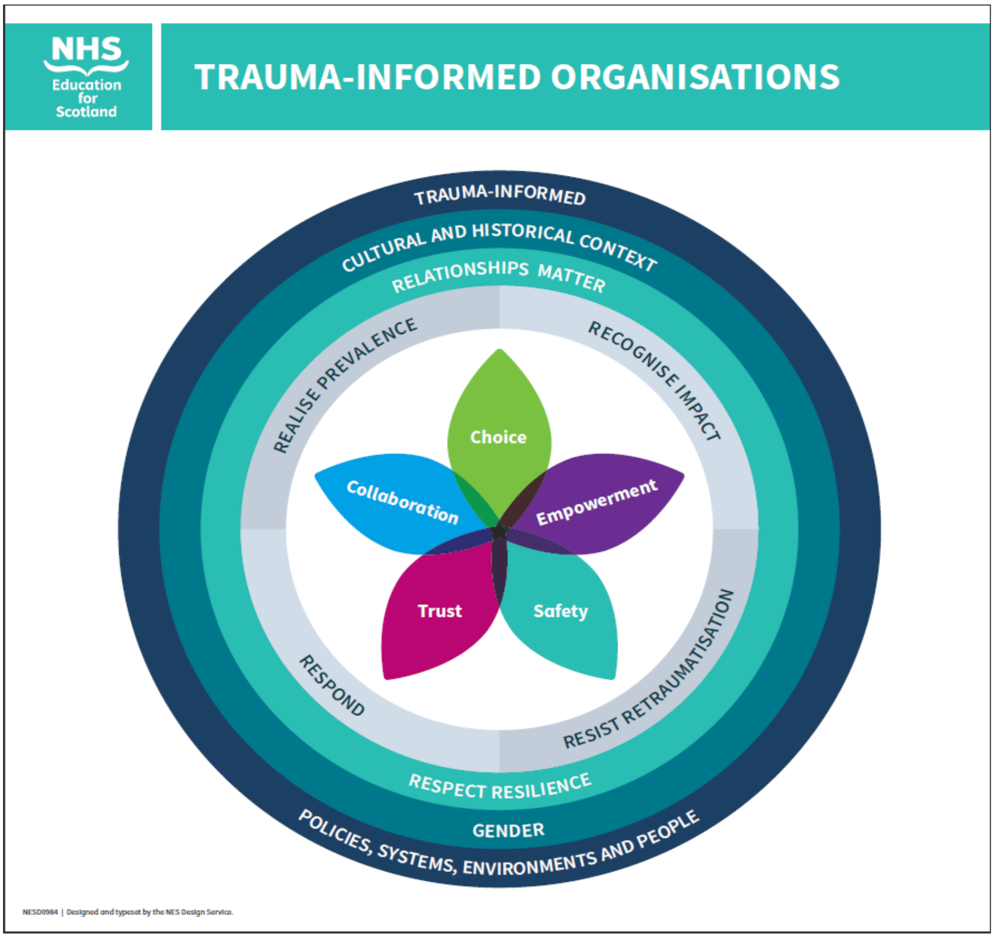

Figure 1. *Model for Trauma-Informed organisations* (NES, 2019)

The framework was based on the NHS Education for Scotland (NES) policy document '*The Scottish Psychological Trauma Training Plan'* (2019). This framework draws upon current research into trauma-informed organisations and is based on the five core principles outlined previously. The outer circles identify the broader, systemic factors needed for trauma-informed organisational change. This review used this model as an analytical framework to understand if it captured stakeholders' perspectives.

Quality appraisal tools

Rigour, transparency and credibility were considered using CASP (2018) Qualitative Checklist Criteria. The difficulty of developing a quality assessment tool to capture the methodological pluralism of qualitative research has been well documented (Guba & Lincoln, 2005.) Dixon-Woods *et al.* (2007) found little agreement in researchers' quality assessments of papers when comparing CASP to two other assessment frameworks. In addition, a checklist approach to quality appraisal does not distinguish the methodological quality from the transparency of the write- up, which is affected by the word limits imposed by journals (Walsh & Downe, 2006). Therefore, it was decided a priori not to use or report rating scores. Rather, the CASP topics were used to generate discussion between the lead researcher and an independent rater (trainee clinical psychologist, D.R.) to assess the overall strengths and limitations of the studies (Appendix 1.4 and 1.5) in keeping with the qualitative approach. There were small areas of disagreement relating to appraisal of rigour but following discussion consensus was reached and no further co-rating was required. In addition, the CORE-Q checklist (Appendix 1.6) was utilised to appraise the transparency of reporting (Tong, Sainsbury & Craig, 2007).

Reflexivity

It is recognised that the framework and the process of synthesis, and the appraisal of the articles, are subjective. In accordance with critical realist epistemology (Barnett-Page & Thomas, 2009), it is therefore essential to acknowledge that the findings will be influenced to some extent by the researcher's perspectives and experiences. At the time of this review, the researcher was conducting a qualitative study aiming to explore trauma survivors' perspectives within the context of the benefit system, using the TIC framework. The researcher kept reflective notes throughout the analytical process and utilised regular research supervision to reflect upon any bias and attempt to mitigate its impact on findings.

Results

Search process

The searches resulted in 2988 articles, after duplicates were excluded. 1589 records were screened, resulting in 63 full-text articles that were assessed for suitability against the eligibility criteria outlined in Table 1. Twelve studies met criteria and were included in the review. EndNote X9 referencing software was used to aid the lengthy manual screening process.

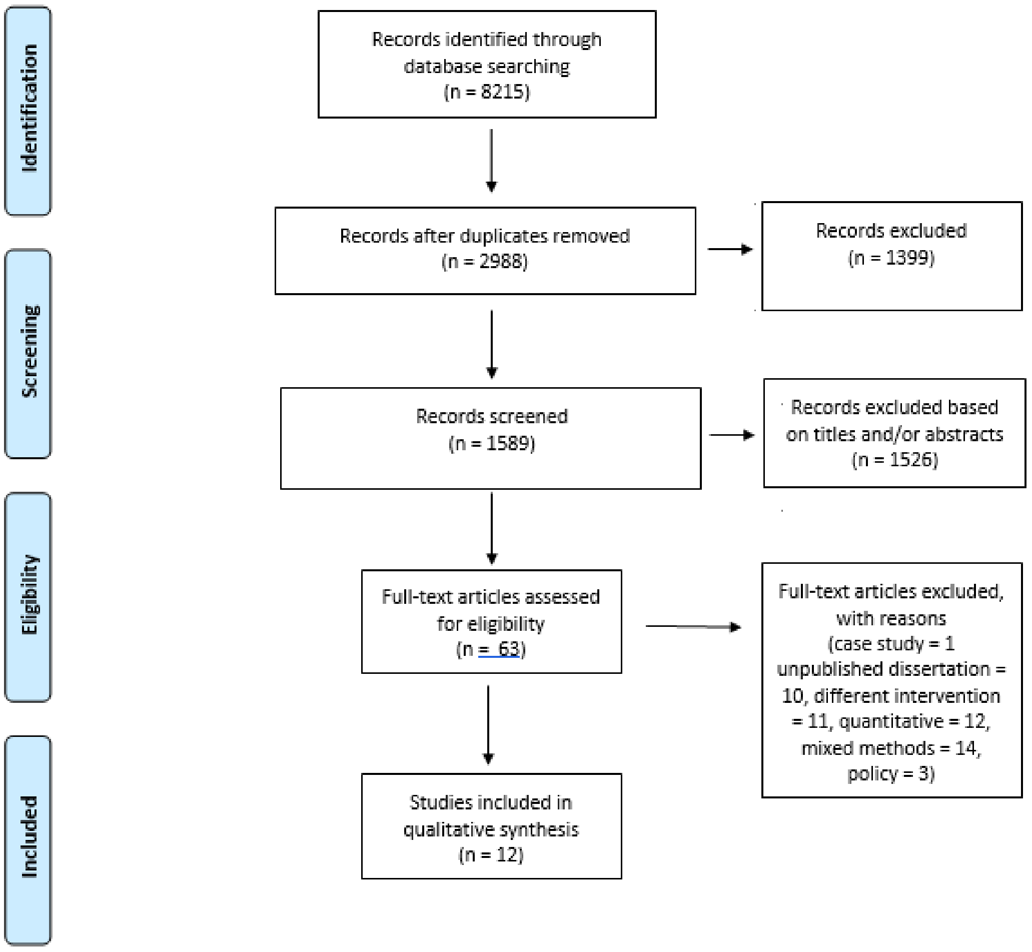

Figure 2. *PRISMA flow diagram* (Moher *et al.*, 2010)

Study characteristics

Twelve papers were included in the review, providing data for a total of 262 individuals. Of these 262, 45 were clients and 217 were staff or other stakeholders across a wide range of health and social care systems and contexts. All twelve studies were based in Western countries; ten were based in the USA, one in Canada and one in the UK.

***Table 2:** Comprehensive summary of the twelve papers reviewed in the quality assessment*

Authors & country	Primary aim & setting	Participants	Design & analysis	Key findings	Strengths	Limitations
Chandler (2008), USA.	To describe the experiences of staff in an inpatient mental health setting as they transition to a trauma-informed approach.	Purposive sampling. *N*=10 (8 nurses and 2 administrators)	Qualitative, interviews. Content analysis used.	Four key themes: • Changing perspectives; • Developing collaborative relationships; • Implementing safety measures; and • Prescribing educational resources.	Staff were recruited who worked in the service for a long period of time, so had experience of the transition to TIC. Trustworthiness of data was considered. Participants reviewed their responses. Quotes were included.	Researcher did not include own reflections or biases. Relationship with participants was not clear. Study limitations not given.
Drabble *et al.* (2013), USA.	To examine the implementation of a trauma-informed approach to assessment. To identify the barriers and facilitators related to trauma-informed systems change. Family drug treatment court (FDTC) setting.	Purposive sampling. *N*=12. Key informants representing the court and legal services (*n*=3), peer mentor (*n*=1), drug and alcohol treatment (*n*=2), child welfare and children's services (*n*=3), mental health (*n*=1), domestic violence services (*n*=1), and trauma consultants (*n*=1).	Qualitative, semi-structured interviews and historical analysis of project documents. Content analysis used.	Key benefits included increased awareness of trauma. Barriers included conflicting philosophies of different systems and systemic stressors. Facilitators included having trauma leaders and champions, commitment to training and peer mentors.	Interview guide and data gathering was described in depth. Quotes were included. Limitations discussed.	Ethical approval not acknowledged. Sample did not include a breadth of representatives for the FDTC.
Ezell (2019), USA.	To assess the implementation of a trauma-informed practice initiative in child protection services. To examine the challenges around implementation and capture experiences of secondary traumatic stress.	*N*=11. CPS agency director (*n*=1), a site manager (*n*=1), case investigators (*n*=4), casework supervisors (*n*=3), and benefits/licensing specialists (*n*=2). Participants aged from 20–55, median age of 40 years.	Qualitative, semi-structured interviews using a symbolic interactionist framework.	Trauma-informed practice reduced client distress and improved recidivism and placement outcomes. Implementation barriers included a lack of local resources for mental health referrals, broad socioeconomic barriers, inconsistent engagement from government stakeholders, and organisational stressors.	Ethical approval and written consent obtained. Analytical process described. Quotes included. Study limitations acknowledged.	How participants were approached was not made clear, researcher's relationship with participants not noted. Specific analysis not described.

Ezell *et al.* (2018), USA.	A pilot qualitative investigation, as part of a state-wide trauma-informed practice initiative, aimed at developing a better understanding of the implementation of trauma-informed practice and associated trauma-informed practice implementation procedures, challenges and spaces for improvement. Juvenile justice setting.	*N*=15. Probation officers (*n*=7), court referees (*n*=4), judges (*n*=2) and clinical therapists (*n=2).*	Qualitative, semi-structured interviews. Inductive thematic analysis.	Participants described preferring trauma-informed practice, noting growing inclinations to make mental health referrals instead of traditional (punitive) sentencing. Implementation barriers included limited access to local mental health resources, lack of buy-in from schools, government, and police, and issues maintaining professional boundaries. Recommended additional trainings on trauma-informed practice.	Analytical process described, including inter-rater reliability. Sample interview questions included. Results included quotes and tables. Limitations acknowledged.	Researchers' own reflections/biases/motivations not made explicit. This is particularly important as the researcher has done prior research in a similar area of interest.
Goldstein *et al.* (2018), USA.	Qualitative exploration of medical students' perspectives on a Trauma-Informed training course that addressed the health care needs of patients exposed to adverse childhood experiences.	*N*=20 (medical students). Convenience sample.	Qualitative questionnaires were analysed using content analysis.	The training improved the medical students' understanding of trauma and ability to recognise trauma responses. They learned how to respond sensitively to disclosures and identify resources to implement TIC in a medical setting.	The convenience sample was ethnically diverse, providing insights from individuals who are under-represented in research. The TIC training was comprehensively described. Inter-rater reliability considered. Themes presented clearly in a table. Limitations considered.	Sample not representative of medical students overall (the study only recruited those enrolled in the Race and Health Summer Institute). Participants completed self- report questionnaires, subject to social desirability bias. Researchers' relationship to participants not stated.

Keesler (2015), USA.	Understanding staff perceptions of a Trauma-Informed day programme for individuals with intellectual/developmental disabilities.	*N*=20 (staff members). Staff self-selected.	Qualitative semi-structured interviews were transcribed and analysed using constant comparative method. Part of a larger mixed-methods study.	Inductive analyses showed improved understanding of trauma, highlighting the five core TIC principles. Differences were associated with duration of employment and the presence of specialised training. Challenges with TIC emerged at different system levels: individuals, staff, management and inter-organisational.	The researcher's consideration of rigour and credibility explored, as well as the researcher's own bias. The TIC intervention described in depth, the sample demographics also present. Results were clearly set out with headings and quotes from participants, illustrating themes. Limitations described.	Ethical approval not mentioned (however, it was in the main study). Data was reported to not reach saturation.
Kusmaul *et al.* (2019), USA.	The aim of this study was to explore the lived experience of TIC in individuals receiving social services at different types of social service agencies.	*N*=26 (individuals receiving agency-based social services). Refugees (*n*=4), substance abuse (*n*=8), older adults (*n*=12), and maternal/child health (*n*=2).	Qualitative semi-structured interviews were analysed using multi-step content analysis.	Clients' experience of the TIC principles was influenced by the actions of other clients, and these experiences were either mitigated or hindered by actions of the agency employees. Agency policies either supported or enhanced their experiences. It was challenging for agencies to provide for all of the TIC concepts at the same time.	Methodology clearly outlined; ethical approval stated. The article was well presented with clear headings and themes supported by quotes from participants. Limitations outlined.	Reliability of the analysis was not noted. The researchers' own bias/reflections not included. Only a few participants interviewed from each type of agency setting.
Guevara *et al.* (2020), USA.	Exploring community practitioners' perspectives on Latinx families' engagement in trauma-informed services. Also understanding their own perceived barriers and facilitators to the implementation of TIC through a culturally responsive lens.	Professionals in the community. Purposive sample, *N*=10. Snowball sampling, *N=10.*	Qualitative semi-structured interviews, analysed using template analysis.	Themes that emerged from interviews captured societal, community and individual barriers to effective implementation. Multilevel barriers included socioeconomic circumstances, normalisation of trauma exposure and the transgenerational impact of trauma. Practitioners reported	Comprehensive detail of sampling and participant demographics. Interview guide described. Under-researched community. Analysis triangulation utilised. Participants' quotes included, to support	Researchers' relationship to participants not addressed. Sample included professionals from a wide range of agencies and the differences in experiences not explored.

				approaching their work using relationship-focused frameworks as facilitators to service engagement.	themes. Study limitations are acknowledged.	
Stokes *et al.* (2017), Canada.	To explore the understanding and experiences related to TIC among mental health nurses.	*N*=7 mental health nurses.	Qualitative, semi-structured interviews. Data analysed using constant comparison.	Participants' experiences of how they understood trauma and its effects on practice were grouped into four main categories: • Conceptualising trauma and TIC; • Nursing care and trauma; • Context of TIC; and • Dynamics of the nurse-patient relationship in the context of trauma.	Researcher described how they ensured trustworthiness of analysis, e.g. triangulation. The interview was piloted to assess coherence of the interview guide. Quotes from participants included to highlight themes. Study limitations are outlined.	Small sample size, no reasons given for why 18 individuals were contacted but only seven chose to participate. Inclusion of mental health/psychiatric nurses only.
Tompkins & Neale (2018), UK.	Exploring delivery of TIC in a women-only residential rehabilitation service, focusing on factors affecting how it is provided by staff and received by clients, particularly challenges experienced.	Clients (*n*=19), staff (*n*=15) and stakeholders (*n*=3*).*	Semi-structured qualitative interviews, thematic analysis used.	Trauma-informed treatment delivery was affected by recruiting and retaining a stable and trained staff team, developing therapeutic relationships and creating a safe and stable residential treatment environment'.	Good number of participants. Setting, recruitment, participant demographics and data analysis comprehensively described. Findings clearly outlined with quotes from participants. Limitations acknowledged.	Sample not ethnically diverse, most under 45 years and may not capture experiences of older groups from different ethnic groups. Researcher did not include their own reflections and bias.
Wall (2020), USA.	Exploring the impact of trauma on student behaviour and learning at a local elementary school; to identify Trauma-Informed Approach (TIA) educator supports; to ascertain the	*N*=9 (teachers).	Qualitative questionnaires (*N*=13) and interviews. Data was analysed	TIA helped students with emotional regulation, school functioning, confidence and relationship building. TIA focused on developing healthy relationships, sharing control and embracing a growth	Interview guide and approach to data analysis described. Results section organised into questions and themes, with quotes from	Small sample size. Does not state if reliability and credibility of the analysis was tested (e.g., did other researchers help with

	impact of a TIA on student functioning.		using content analysis.	mindset. Staff collaboration, engaging families and harnessing students’ resilience are key facilitators.	participants. Study limitations acknowledged, albeit briefly.	coding transcripts?). Researcher did not acknowledge own reflections or bias. Ethical approval not stated. Discussion section was short.
Wolf *et al.* (2014), USA.	Exploring whether social service agencies operationalise the TIC principles of safety, trustworthiness, collaboration, empowerment and choice.	10 focus groups (*n*=69) with different social service agencies and 6 individual interviews (*n*=6) with key informants.	Qualitative – focus groups and semi-structured interviews. Data transcribed and analysed using textual analysis.	Many of the organisations implemented TIC principles with clients, without knowing this was “trauma-informed”. TIC principles such as choice and empowerment did not fit staff experiences. This suggests that agencies are unaware that TIC applies to staff teams, as well as service users.	Researchers kept notes and used a script to ensure reliability of interview data. The focus group size was large and included a wide spectrum of agency workers. Ethical approval obtained. Participants’ quotes included, and the results section is formatted clearly.	Tape recorder did not record for three focus groups. The methodology not made clear, including the definition of “key informants” who were chosen for interviews. Not clear how the data was analysed. Different interviewers, which may have influenced participants’ experiences. Study limitations only briefly acknowledged.

Quality appraisal

All twelve papers included a clear rationale, background and aims of the research. All papers referenced ethical considerations, and all reported obtaining ethical approval except one (Wall, 2020). Most papers clearly outlined the recruitment strategy, data collection and analytic process. However, there was some opaque reporting (Wolf *et al.*, 2014; Goldstein, 2018), lacking detail and transparency when outlining the analytic process and epistemology of their work. Only one paper (Keesler, 2015) included thoughtful considerations pertaining to the authors' reflexivity, which strengthened the quality of the research and credibility of the analysis. Some papers described how they took steps to ensure trustworthiness of the analysis, such as using triangulation (Chandler, 2008; Ezell *et al.,* 2018; Goldstein *et al.,* 2018; Guevara *et al.,* 2020; Stokes *et al.,* 2017; Wolf *et al.,* 2014).

There was some variation in analytical methods, with most researchers using types of thematic analysis. Five articles used content analysis (Wall, 2020; Kusmaul *et al.,* 2019; Goldstein *et al.,* 2018; Drabble *et al.,* 2013; Chandler, 2008), two used inductive thematic analysis (Ezell *et al.,* 2018; Ezell, 2019), two used constant comparative method (Stokes *et al.,* 2017; Keesler, 2015), one used template method (Guevara *et al.*, 2020), one used iterative categorisation (Tompkins & Neale, 2018) and one used an unspecified 'textual analysis' (Wolf, 2014). Generally, the results were well presented and illustrated with relevant participant quotes, which demonstrated the richness of the data. Discussions were comprehensive, relating back to the aims of the research with most papers suggesting future areas of research. One paper (Goldstein, 2018) was very short, with fewer quotations from respondents included. All papers, except one (Chandler, 2008), acknowledged the limitations of their work. Despite methodological weaknesses identified in Table 2, the articles highlight valuable applications of TIC across public services. Generally, perspectives of TIC implementation are under-researched, and these papers provide insights into the factors that promote and challenge organisational change.

Framework synthesis

Best-fit framework synthesis found that the five TIC constructs captured stakeholders' perspectives in seven articles, as documented in Table 3. Five articles were more focused on barriers and/or facilitators of TIC implementation, which were captured using inductive thematic analysis. These themes will be described from staff and client perspectives.

Table 3: *Stakeholders' perspectives of TIC*

	Trust	Safety	Choice	Collaboration	Empowerment
Chandler (2008).	X	X	X	X	X
Drabble (2013).			X	X	X
Ezell (2019).		X		X	
Ezell (2018).			X	X	
Goldstein (2018).		X			
Keesler (2015).	X	X	X	X	X
Kusmaul (2019).	X	X	X	X	X
Guevara (2020).	X			X	
Stokes (2017).	X	X	X	X	X
Tompkins & Neale (2018).	X	X	X	X	X
Wall (2020).	X	X	X	X	X
Wolf (2014).	X	X	X	X	X

Trust

Trust was a theme in nine studies, where it was identified as being integral to delivering TIC.

Clients

Trust was fostered through the development of safe relationships, facilitated by good communication and active listening from staff. There was acknowledgement that clients in services had experienced interpersonal traumas and therefore may struggle to trust others, particularly if they had difficult experiences with services. In a learning disability setting, *"trust was perceived as the foundation of the entire programme" (*Keesler, 2015, p.7*).* This contrasts with how individuals with learning disabilities have historically been treated (Rich *et al.,* 2020). Kusmaul (2019, p.593) highlighted that "*elements of trustworthiness included delivery of services as promised, openness, and follow through*". The importance of transparency and consistency was expressed by clients in a range of settings and helped to promote trusting the service and staff. Additionally, confidentiality policies, information-sharing and informed consent were considered key areas for creating trust (Wall, 2020).

Staff

How trust was promoted in staff teams was mixed. It was more challenging for organisations to operationalise practices conducive to enhancing trust from a staff perspective. In a social service setting, Wolf (2014) found that although there were examples of ensuring trust between staff and clients, agencies had no established ways of ensuring trust among staff. Other organisations described how trust was established through staff relationships, which were promoted by team building and collaboration. Additionally, staff described that they "*experienced trust from leadership in the opportunity to make decisions rather than a top-down authoritative process*" (Keesler, 2015, p.7).

Safety

This theme was identified in nine studies. Physical and emotional safety were differentiated in the articles, highlighting the different ways safety was conceptualised and implemented in services. Overall, it was found that physical safety was promoted by policy, procedures and specific actions, while emotional safety was enhanced by relationships and responsivity. Safety was spoken about predominately in relation to clients; ensuring the safety of staff was only mentioned in relation to systemic stressors such as staffing levels.

Physical

Across services, policies and procedures were put in place to enhance physical safety and changes were made to the environment accordingly. The importance of keeping safety on the agenda at staff meetings was noted, particularly in busy staff teams where there was high turnover. Consideration was given to the need to create confidential spaces and for environments to feel friendlier and welcoming. Wall (2020, p.15) outlined the importance of "*eliminating triggers*" in schools, with staff paying close attention to the environmental stressors that can make students feel anxious, particularly if they have sensory needs, which is often the case for children with autism (Marco *et al*., 2011). Teachers being mindful of giving students more space, flexible seating and clearly accessible escape routes were identified as ways of promoting physical safety. Chandler (2008, p.367) also highlighted the need to modify the environment in a mental health inpatient setting to create a *"safe, soothing space"* for clients.

Stakeholders emphasised that clients in residential services needed to feel physically and emotionally safe during treatment, particularly in the context of clients' personal lives and living environments, which could be unsafe and unstable. Engaging in services became a safe, predictable space. It was described how "*structured daily routine and treatment* *timetable reinforced their sense of safety and contrasted with the insecurity and unpredictability of their pre-treatment lives*" (Tompkins & Neale, 2018, p.6).

Emotional

Chandler (2008, p.365) described how the 'traditional' treatment model in an inpatient mental health setting was based on staff having *"rigid control"* over patients. This could be experienced as punitive and re-traumatising, particularly the use of seclusion and restraint. Staff expressed how TIC had changed their perception of behaviours such as self-harm, previously considered 'manipulative', now understood as coping mechanisms. A *"shift in control"* – from staff to patients, was highlighted, which was part of a broader organisational change to *"a milieu-based focus on safety"* (p.365)*.*

Emotional safety was fostered by the "*caring attitudes of staff members and genuine interest in the needs of clients"* (Kusmaul, 2019, p.593). The concept of relational safety was a theme across all nine articles in which the broader theme of safety was identified. Emphasis was put on creating bonds between staff, clients and with each other. Tompkins and Neale (2018, p.6) outlined how "*having close relationships with staff who were caring, professional and available … were central aspects of feeling secure in the service".*

Staff and clients described how addressing emotional safety could be more challenging than physical safety. Stokes *et al.* (2017) highlighted ways of addressing physical safety could negatively impact emotional safety, for example, installing cameras. Difficulties perceiving what emotional safety might look like from a staff perspective were also brought up.

Choice

This theme was found in nine papers focusing on giving individuals' options, more freedom and flexibility to make decisions for themselves.

Clients

For clients, choice manifested in services adopting a more person-centred approach whereby individuals' wants and needs were recognised and prioritised. Rather than enforcing interventions or ideas, clients had freedom to decide for themselves and make their own choices. In judicial and social service settings, offering clients choice was more difficult because the inherent aims and service structures, for example, child protection. In a substance abuse setting, choice was characterised *"by programmes offered and the ability to choose which ones to attend."* (Kusmaul, 2019, p.594). Giving clients options was recognised as being a key element of promoting choice across services, whereas historically this was not offered.

Staff

Staff members reported being given more freedom and opportunities to make decisions by leadership. Staff across different agencies spoke of a shift in their thinking and having a greater understanding of trauma and how this influenced clients' behaviours. Staff described having "*more choice in how they could respond to challenging situations now they had a greater insight into trauma responses"* (Keesler, 2015, p.6). This included *"relinquishing control and offering flexibility",* which led to clients having a greater sense of agency and autonomy (Wall, 2020, p. 14).

Collaboration

This was a theme in 11 of the reviewed papers. There was overlap with collaboration and the other TIC principles, particularly empowerment and safety. Collaboration was interpreted in different ways across services and was often facilitated by choice. Staff perspectives on collaboration focused on developing collaborative relationships with clients, but also with each other. It was reported that team-working and good communication within organisations enhanced this.

Clients

There was limited reporting of client perspectives on their experiences of collaboration. One client, in a social service setting, described collaboration as "*having choice and a voice that was listened to*" and having support to meet goals that were meaningful to them (Kusmaul, 2019, p.594). For staff in a substance misuse service, enhancing collaboration meant actively involving clients in treatment plans and ensuring these were *"tailored with women at the centre"* (Tompkins & Neale, 2018, p.5). A paradigm shift for both leadership and staff, *"from control to collaboration"* (Chandler, 2008, p.370), was described in a mental health inpatient unit which had historically used control as a means of managing patients' distress. Moving to a trauma-informed approach meant a less restrictive approach, with an emphasis on compassion and collaboration.

Staff

Collaboration within staff teams was highlighted across eleven papers and was identified as a key factor in successfully implementing TIC. Collaboration was understood as being a fundamental aspect of good communication and teamwork, facilitated by building strong working relationships and regular team meetings. It was highlighted that "*always coming back to the table to discuss trauma-informed changes" (*Drabble *et al.,* 2013, p.106) was crucial in imbedding TIC into the organisation, particularly because of the time required to make changes. However, staff in a social service setting found it difficult to quantify their experiences of collaboration between themselves and clients, and also the sharing of power among themselves as employees (Wolf, 2014).

Empowerment

This was a theme across eight papers, with staff recognising that clients who used their services had historically been disempowered. From a staff perspective, empowerment was understood as clients having confidence, a voice and rights. Less of a focus was given to how empowerment could be applied to staff.

Clients

Client-centred planning was identified as a key value to promote clients to feel empowered in services. Staff in a judicial setting expressed how TIC fostered a strengths-based approach, recognising that parents in the court system know their child best (Ezell, 2019). A client in a social service context expressed how they felt staff *"recognised [their] strengths, skills and offered opportunities",* which was empowering (Kusmaul, 2019, p.595).

Across services, there was recognition of how power had operated in clients' lives and how systems could be disempowering. Addressing the inherent power imbalances within organisations was understood as a key facet to a trauma-informed approach. Empowerment was very much linked to control, and clients taking back control, which they historically were not afforded. In a mental health inpatient context, it was described how operating within a medicalised model of distress had created "*hierarchy of power",* which had been "*flattened"* since the implementation of TIC (Chandler, 2008, p.366).

Staff

Staff experienced empowerment through having greater options in how to respond to clients and how to react, and through effecting change in services and having access to training. In a learning disability setting, it was described how "*those in managerial positions affirmed that they listened to staff members, included them in decision making and encouraged them to* *identify solutions to emergent problems"* (Keesler, 2015, p.7). Across services that those in leadership positions who welcomed feedback from staff and took suggestions on board created a more empowering working environment.

Staff spoke of their role involving fostering hope and inspiration and how this contributed to better outcomes with clients, which increased their own job satisfaction and buffered the stress of their jobs (Ezell *et al.,* 2018). In a drug rehabilitation service, it was described how "*staff felt that strong therapeutic relationships were underpinned by an unfailing belief that women could recover from addiction and trauma. This belief helped women to trust staff and also enabled them to start to believe in their own ability to recover"* (Tompkins & Neale, 2018, p.5). Across services, the concept of staff instilling hope for clients created a greater sense of empowerment for clients and also within staff themselves.

However, it was reported that staff in a social service setting responded to an interview question about staff empowerment *"with a blank stare and no concrete answers*" *(*Wolf, 2014, p.118), a similar response to a question about the concept of collaboration. This raises questions about whether the terminology used is a barrier to understanding, or whether the TIC principles themselves are difficult to convey and apply practically in services.

Facilitators and barriers to TIC implementation

Inductive thematic analysis was used to identify the factors which facilitate, and are a barrier to, TIC implementation. These are illustrated in Table 4.

Table 4: *Facilitators and barriers of implementation of TIC*

	Facilitators					Barriers					
	Relationships	**Training**	**Leadership**	**Staff support**	**Reflective practice**	**Lack of leadership**	**Conflict of TIC constructs**	**Community resources & stigma**	**Prior training**	**Lack of staff support**	**Vicarious trauma**
Chandler (2008).	X	X	X	X	X						
Drabble (2013).	X	X	X	X					X	X	X
Ezell (2019).	X	X	X		X	X		X	X	X	X
Ezell (2018).	X	X	X			X		X			
Goldstein (2018).		X						X		X	
Keesler (2015).	X	X	X	X	X	X					
Kusmaul (2019).							X				
Guevara (2020).	X	X						X		X	
Stokes *et* (2017).	X			X	X		X			X	X

Tompkins & Neale (2018).	X	X	X	X	X		X	X
Wall (2020).	X	X	X		X			
Wolf (2014).		X	X		X	X	X	X

Facilitators

Relationships

The importance of relationships was expressed in nine of the reviewed papers, often in relation to the five TIC principles. Positive relationships between staff and clients, staff and leadership, and between inter-agency colleagues and stakeholders facilitated the implementation of TIC by increasing communication and trust between individuals and systems. Relationships between staff were understood as integral to a working environment that was conducive to trauma-informed organisational change.

The concept of relational safety was discussed, in recognition of the interpersonal harm clients had experienced. Therapeutic relationships between clients and staff were described as being *“at the heart”* of a trauma-informed approach (Guevara, 2020, p.7). Across services, there was an increased focus on nurturing relationships and prioritising these over *“behaviour focused approaches”* (Keesler, 2015, p.8). Relationships were based on trust and authenticity. This is exemplified by the below quotation from a client in a rehabilitation service:

“They’re [staff are] gentle, they’re loving, they’re firm, they make us laugh, they’re knowledgeable. You just feel, I just feel understood, I feel held, I’d feel loved, I feel like I can trust, trust them and feel like they really care.” (Tompkins & Neale, 2018, p.5).

Additionally, clients were supported to develop social networks in the wider community. In a mental health inpatient setting, there was a shift in policy from ‘no contact’ with patients after discharge to patients deciding for themselves if they wanted to continue the relationships when they had left the hospital. This policy change highlights freedom and choice within a relational context and was described as *“one component of creating a culture of safety”* (Chandler, 2008, p.366).

Training

Across all twelve papers, stakeholders spoke about how their experience of TIC had been generally positive. For staff, training provided them with a greater understanding of trauma, leading to increased recognition of trauma responses that clients present with. There was a new understanding of how trauma may present in individuals, when previously this may have been attributed to a medicalised view of a persons' 'symptoms'. In a judicial setting, a particularly powerful element of training was *"visualizations of trauma's morphological influence on the brain"*. This was noted as being "*a motivational talking-point used with families and external stakeholders, in stimulating buy-in" (*Ezell, 2019, p.7).

Staff reported increased sensitivity to identifying trauma, as well as greater confidence in responding. Staff described being able to recognise and understand trauma responses gave them greater empathy for clients, as described by a staff member in a judicial setting:

*"I look at what our parents go through and really try to put ourselves in their shoes and treat ... and it just makes us more aware of how we interact with our parents or how we talk to them or how we ask them to do things." (*Drabble *et al.,* 2013, p.101).

Importantly, commitment to long term training was identified by staff as a key facilitator of successful TIC implementation. Staff suggested follow-up days and spoke about the need for leadership to support and advocate for TIC initiatives*.* In a nursing setting, staff suggested *"integrating knowledge of trauma and TIC into existing nursing curricula, on both theoretical and practical levels"* (Stokes, 2017, p.6).

Leadership

Staff reported that whilst training in TIC was helpful in providing new perspectives in understanding trauma, good leadership was fundamentally important in ensuring this was carried out and modelled in services. This is demonstrated in Chandler (2008, p.366):

“The shift in perspective initiated by staff development was reinforced by role modeling of the nurse manager who deeply believed in trauma-informed treatment.”

Several services had assigned ‘trauma champions’ and leaders, identifying that change had to start from leadership level. Staff stressed the importance of formal commitment to TIC from leaders and stakeholders, emphasising that organisational change *“has to start at the top”* (Ezell, 2018, p.2).

Staff support

Five papers identified staff support as being a facilitator for TIC, acting as a buffer for burnout and vicarious trauma. Staff support was understood as a systemic approach involving adequate staffing ratios, frequent breaks, supportive management and colleagues and not working overtime. Self-care strategies were highlighted as being important in promoting staff well-being and were discussed in supervision. However, appropriate systemic supports had to be in place before individual strategies could be effectively utilised.

In an inpatient mental health unit, which successfully implemented TIC, it was noted *“cultural change takes both individual commitment and structural supports”* (Chandler, 2008, p.370). Policies were put in place to support staff, as there was an explicit acknowledgement that TIC applied to staff members as well as clients.

Reflective practice

In seven papers, staff reported that it was helpful to reflect on their practice. In an educational setting, it was expressed how staff “*must be attuned to their own dysregulation and frustration levels, observe their own triggers, and take action to proactively regulate their own emotions in a healthy manner”* (Wall, 2020, p.8). There was recognition of how the emotional wellbeing of staff could impact on clients, and vice versa.

Supervision provided a space for this in some services, which could help with boundary setting and protect against vicarious trauma. In a rehabilitation service, monthly mentoring and supervision was identified as helpful in developing confidence and skills with trauma-informed practice. Importantly, *“it had also provided staff with the chance to reflect on their individual and team working practices, including the need to protect their own emotional health in order to be effective in their roles”* (Tompkins & Neale, 2018, p.4).

Barriers

Lack of leadership

Four papers identified how a lack of leadership can be a barrier to TIC implementation. There was an unhelpful expectation that individual staff members were responsible for trauma-informed systems change, without any leadership or guidance. In a judicial setting, staff explained that *“when a manager doesn’t ‘buy into it’ … this mindset trickles down to staff”* (Ezell, 2019, p.8). This highlights the importance of team values-based approaches in implementing TIC, with all individuals within the system working towards a shared vision.

Additionally, there were complexities expressed pertaining to stakeholders having different perspectives, aims and values that may contradict a trauma-informed approach. This led to staff teams receiving mixed messages, and a lack of coherence and congruence to TIC policy and practice.

Contradictions of the TIC constructs

The interconnected nature of the TIC principles can create challenges for implementation (Bloom, 2010). Two papers highlighted policies that address one TIC construct might challenge or contradict another, for example increasing safety may decrease choice, and clients’ sense of empowerment. Several articles had respondents describe how operationalising the TIC constructs could be a source of distress for staff and clients, who were not used to having as much freedom and control. This was found during early stages of TIC implementation, when services were adapting to new ways of working:

"The nursing responsibility to ensure safety (of self and patient) led participants to also speak of a tension that exists in the provision of care in the context of trauma. A few participants explained how, at times, the staff's needs for personal safety could result in controlling practices, which might threaten their patients' perceptions of safety. As such, some participants described a 'conflictual relationship,' where there was a conscious realization that certain nursing acts designed to maintain safety might actually cause further trauma." (Stokes *et al*, 2017 p.5).

There was an identified need to acknowledge the complexity and challenges that are inherent in TIC implementation, particularly in services which historically disempowered those from already marginalised groups. In a learning disability context, it was important to understand how clients experienced institutionalisation and felt safe by the familiarity of more restrictive practices (Keesler, 2015). Giving clients more choice and freedom was experienced as new and frightening, demonstrating the need for services to be sensitive to clients' experiences and make changes at a helpful pace.

Community resources and stigma

A staff member in a social service setting asked, "*how do you tell a client who can't drive; they can't pay the Driver's Responsibility Act [fee]; they can't get insurance; they don't have a car. How do you tell them 'okay, be at counselling 3 times a week?'"* (Ezell, 2019, p.10). Socioeconomic disadvantage was identified as a barrier to individuals ability to access mental health support, due to fewer services and resources being available in areas of deprivation. Individuals living in areas with greater social deprivation were less likely to have access to transport or technology, which meant they were less able to access services even where available.

Two papers (Goldstein, 2018; Guevara, 2020) identified a need for TIC to be culturally competent, and reflective of the needs of diverse and marginalised groups. In a social service setting, a staff member described *“coming across some barriers where seeking help for mental health or just resources has a negative stigma to it”* (Guevara, 2020, p.77). Stigma was understood to be rooted in different cultural understandings, beliefs and attitudes related to mental health and trauma.

Prior training

Staff described how the principles of TIC could conflict with their professional trainings, particularly those who were trained in law enforcement or social work, described as a *“conflictual rub”* (Drabble *et al.,* 2013, p.105). TIC is still a relatively new concept, therefore established professional training and qualification routes may not include it in their curricula. In a judicial setting, *“there was prohibitive tension in moving from a system historically anchored to punitive justice to a system which sought to identify, understand, and address trauma to curtail delinquent behaviours” (*Ezell, 2018, p.10). Existing policies and procedures, as well as the purpose of services themselves, could be a barrier to implementing TIC.

However, one study in a social service setting described that “*clinicians who are abiding by the principles of social work practice are likely engaging in TIC, perhaps without labelling it as such*” (Wolf *et al,* 2014, p.118). There may be additional individual factors, such as individuals’ personal opinions and beliefs about trauma, which impact on their ability to work in a trauma-informed way irrespective of professional training.

Lack of staff support

Staff working in judicial and social service contexts highlighted the inherent stressors of their roles, due to heavy caseloads and working with complex families in areas of significant deprivation. Irregular team meetings, inconsistent communication with management and an expectation to work overtime were identified as negatively impacting staff. Additionally, a lack of solidarity, difficult interpersonal dynamics within the team and minimal opportunity for debriefing were described as preventing staff from feeling supported. Across the reviewed papers, the majority of staff perspectives focused on support for clients, and not how staff members themselves were supported.

Vicarious trauma

Vicarious trauma was experienced by some staff, particularly in services with high staff turnover and a lack of supervision. This was normalised in some services, with one staff member describing vicarious trauma as a *“systemic thing”.* They reflected that *“clients are regularly retraumatized over and over and over again by the system … but social workers and others working in the system are as well” (*Ezell, *2019,* p.18*).*

Staff noted that they could over-identify with clients’ stories at times, which could *“undermine their own wellbeing and ability to deliver the trauma-informed programme”* (Tompkins & Neale, 2018, p.4). This could lead to emotional over involvement and eventual burnout. Staff reported how listening to clients’ trauma experiences could be triggering of their own trauma.

Discussion

The review aimed to understand stakeholders’ perspectives on the implementation of TIC. The twelve papers spanned a range of diverse public services, but there were similarities found in stakeholders’ experiences. Stakeholders’ perspectives mirrored the principles of

TIC, with individuals relating their experiences to the five core constructs of trust, safety, choice, collaboration and empowerment. Staff described a shift in their perspective of how they conceptualised trauma, which led to an increased recognition of trauma responses in clients, greater empathy and avoiding practices which could cause re-traumatisation.

The five core TIC constructs were often viewed in a relational context, with staff and clients expressing the importance of these principles within their relationships. The importance of creating safe, compassionate relationships between staff and clients was a salient theme and highlights how relationships are at the heart of a trauma-informed approach (Sweeney, 2018). Relationships between staff and management were also discussed in some papers, with staff describing how teamwork and communication created a culture that had greater collaboration and opportunities for staff empowerment.

TIC was largely considered to be applied to clients, with staff finding it more difficult to give examples of how it could be applied to them. Research into implementing TIC has predominantly focused on its influence on clients, rather than staff (Morrissey *et al.,* 2005). There is some evidence indicating TIC is associated with increased staff retention, work commitment and staff performance (Hales *et al.,* 2017). This suggests that there needs to be a systemic understanding of TIC at leadership level, whereby the principles are applied to staff as well as clients.

There were complexities expressed pertaining to the TIC constructs, which could be conflicting when applied in services. By trying to create an environment that is physically safe, this could impact adversely on clients' emotional safety. It was also noted how giving more choice to staff and clients in organisations could cause anxiety, particularly if individuals were used to more restrictive, controlling practices. The findings suggest that clients' voices need to be heard when designing services and creating policies that are psychologically informed. Importantly, there is a need for policymakers and stakeholders to continually discuss and consider implementation challenges and solutions, particularly considering the often-found difficulties with TIC implementation in the early stages (Yatchmenoff *et al.,* 2017).

Various barriers to implementation were identified, including systemic stressors such as lack of staff support and leadership which in turn increase the risk of staff burn out (Newell *et al.,* 2010). Staff working with people frequently exposed to trauma may experience vicarious traumatisation (Baird & Kracen, 2006). Strong leadership support has been found to mitigate against vicarious trauma (Strolin-Goltzman *et al.,* 2020), and was also found to be a key facilitator for TIC implementation. Systemic considerations such as balanced workloads (Cunningham, 2003) and reflective supervision (Sommer, 2003) can provide a space for workers to consider the impact of their work on themselves and promote healthy boundary setting. Preventing vicarious trauma in staff is key ingredient of trauma-informed organisational practice (Menschner & Maul, 2016), which further strengthens the need for staff to receive trauma-informed supervision.

Key facilitators identified included having strong leadership and trauma champions in services and a commitment to long-term training. The findings illustrate that responsibility to create and sustain change cannot be put on individuals alone. Policies, leadership and training need to be the foundation of a meaningful commitment to shifts in service delivery. It was highlighted how the mandates of systems and professional training and qualification programmes can be built on fundamentally opposing philosophies to TIC. This raises questions about how the TIC values can be implemented in services from a grassroots level. There is a need for governments and policymakers to recognise the value of a trauma-informed approach in public services and provide the funding and commitment to training to embed TIC in services, affecting change on individual and systemic levels.

Strengths and limitations

This review encompassed a wide range of public services, with different structures, objectives and populations. Whilst this provided valuable insights into perspectives across organisations, the nuances and idiosyncrasies of particular systems were explored in less depth. In addition, the papers included in this review mainly encompassed the perspectives of staff, so the valuable reflections and experiences of clients may have been missed. Grey literature was not included in the review, so any useful insights contained in such documents were not captured.

To enhance reliability an independent rater coded a selection of articles and co-rated papers as part of the quality assessment. The researcher also kept reflective diaries and utilised regular supervision, to mitigate the potential impact of personal bias on the findings.

The researcher found the TIC framework challenging at points, as it separated constructs into discrete categories when it is arguably best understood holistically (Bloom, 2010). The deductive framework synthesis meant that themes were assigned to categories that were established a priori. However the broader, systemic aspects of the framework lacked detail and inductive analysis was needed to capture specific systemic factors.

It is important to note that most organisations in this review were based in the USA, and all twelve in Western countries. This over-representation of USA and western samples has important implications for the generalisability and transferability of findings to other contexts including both high income but also low- and middle-income contexts. Additionally, the particular TIC framework utilised for this review was designed for use in Scotland. Whilst it incorporates the Harris and Fallot (2001) principles that underpin trauma-informed practice internationally, there will be nuance in how these are applied across services and countries.

Clinical implications and research recommendations

Given the relevance of TIC currently (Collin-Vézina, 2020), it would seem pertinent to ensure organisations in the public sector have access to quality training and that the values of those in leadership positions align with the TIC principles. This review highlights the need to ensure staff working in the public sector, with people who have experienced trauma, receive regular supervision. This review also raises questions about how the principles of TIC could be interwoven into other professional trainings and the implications of this.

Further quantitative and qualitative research should evaluate implementation of TIC taking into account important ecological considerations including levels of implementation. For example systems to promote implementation including leadership, and the involvement of staff and recipients and of services in informing and shaping the methods and outcomes evaluated. Future qualitative research into the implementation of TIC from the perspectives of clients, and TIC applied to staff, would be important. Next phase research into the barriers and facilitators experienced at the implementation stage focused on specific services (e.g., mental health, criminal justice, education) could provide valuable learning for stakeholders. Additionally, research exploring TIC constructs in diverse cultures and communities would be welcome.

Conclusions

Stakeholders' perspectives mirrored the principles of TIC, with individuals relating their experiences to the five principles of trust, safety, choice, collaboration and empowerment. Staff mainly understood TIC in relation to clients, less so how the principles applied to them. There were complexities experienced when implementing TIC, including how professionals' prior training and systemic stressors can contradict a trauma-informed approach. A lack of leadership and support for staff and vicarious trauma and staff burnout were identified as barriers. Strong leadership, a commitment to ongoing training, staff support and positive relationships with clients and staff were key facilitators to successful implementation.

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Chapter 2: “It’s like the Sword of Damocles” – A Trauma Informed Care framework analysis of individuals’ experiences of Personal Independent Payment (PIP) assessments

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Plain Language Summary

“It’s like the Sword of Damocles” – A Trauma Informed Care framework analysis of individuals’ experiences of Personal Independent Payment (PIP) assessments

Background: People who claim benefits in the UK may experience feelings of shame and humiliation, made worse by austerity measures (Garthwaite, 2014). Personal Independence Payment (PIP) replaced Disability Living Allowance (DLA) in 2013, with the new benefit being more difficult to get. People who have a diagnosis of Post-Traumatic Stress Disorder (PTSD) have described the process as being distressing and panic-inducing (The Guardian, 2016). While Trauma Informed Care (TIC) was developed to help public services better support people who have experienced trauma (Harris & Fallot, 2001), at present there is little research into TIC in the benefit system.

Aims: The study aimed to understand to what extent people feel that the process of PIP assessment fits the principles of TIC. It also aimed to find out more about people’s experiences of claiming PIP after they have been through trauma.

Methods: Twelve people who had experienced trauma were interviewed about their experience of attending a PIP assessment. Participants were all over 18 years of age, were attending therapy in NHS services for trauma-based difficulties and had attended a PIP assessment in the last three years. A method called framework analysis was used to make sense of the findings.

Main Findings and Conclusions: People’s experiences were found to be the opposite of the principles of Trauma Informed Care. An alternative framework was created, which captured what they described. The five themes that made up this alternative framework were: harm, distrust, rigidity, intimidation and powerlessness. These results suggest that attending PIP assessments can be re-traumatising to claimants and could make their mental health worse. Further research is needed to explore how things could be improved.

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Abstract

Introduction: Over recent years there has been a growing body of research highlighting the distress experienced by claimants when being assessed by the benefits system. There has also been a greater acknowledgement of trauma in society and the myriad ways this can impact individuals, groups and communities. In recognition, there has been a call for relevant organisations to adopt policies in line with Trauma Informed Care (TIC). There is little research into the benefits system from a TIC perspective. It is hoped that the present study will contribute to the emerging evidence base for the application of TIC in broader public services, as well as giving voice to individuals' experiences of the benefit system.

Objectives: The primary aim of the study was to understand to what extent, based on participants' experiences, the process of PIP assessment fits the principles of TIC, using a framework produced by NHS Education for Scotland. There were two secondary aims: firstly, to identify what other experiences participants describe that are not captured by the TIC framework, and secondly, to explore the limitations of the framework for understanding participants' experiences.

Method: Twelve participants were recruited from community mental health services in two NHS Scotland health boards. Participants were receiving therapy for trauma and had attended a PIP assessment within the last three years. Semi-structured interviews were audio recorded and transcribed verbatim. Framework analysis was used to develop a working framework, onto which the data could be mapped.

Results: Participants' experiences were found to contrast with the principles of TIC. So pronounced was the distinction that an alternative framework was deduced from the data, comprising of five key themes: harm, distrust, rigidity, intimidation and powerlessness. The constructs of the two frameworks are best understood as dynamic and interrelated, as opposed to distinct categories. PIP assessments were found to be re-traumatising and having an adverse impact on claimants’ mental health.

Conclusion: Participants’ experiences of PIP assessments were understood as being harmful and re-traumatising. Further research is needed into making PIP assessments trauma-informed, as well as exploring assessors’ perspectives and experiences. Providing training to benefits staff working in Scotland, as part of the National Trauma Training Programme, is recommended in order to improve claimants’ experiences and reduce distress.

Introduction

There is an increasing amount of research exploring the impact of austerity measures on mental health (Edmiston *et al*., 2017). Shame and humiliation may be experienced by individuals who are engaged in the benefits system and have been affected by changes due to austerity policies (Garthwaite, 2014; Samuel *et al*., 2018). The experience of ongoing shame and humiliation has been found at the core of many forms of psychological distress and increases the risk of depression, particularly in individuals who are socially isolated (Thibodeau *et al*., 2011).

In the United Kingdom, Personal Independence Payment (PIP) replaced Disability Living Allowance (DLA) in 2013. The qualifying criteria became narrower, making it more difficult to claim (Machin, 2017). PIP is usually conditional upon a medical assessment, which is conducted by a registered health care professional. Nearly 50% of individuals claiming PIP have a mental health condition (Department of Work and Pensions, 2018) yet there is a concern that the assessments are overly medicalised and do not capture claimants' experiences of mental health (Baumberg *et al*., 2015). Claimants have reported the assessment process as being geared towards physical disability, not mental health difficulties (Shefer *et al*., 2016).

Qualitative research findings suggest that attending PIP assessments can be distressing for claimants (De Wolfe, 2012). Significant fear of contact from the DWP has been described, with participants' "*fear of the brown envelope"* dominating their lives (Garthwaite, 2014). Additionally, the assessment process itself was described as depressing due to the focus on an illness model and limitations, which was contrary to individuals' desire to adopt a strengths-based view of themselves (Gillespie & Moore, 2016). Claimants reported feeling that they were not treated with respect or sensitivity, both in encounters with benefits officials and in the wider benefits system (Bauld *et al*., 2012).

The process was felt to be particularly insensitive to the needs of those with mental health difficulties (Hamilton *et al*., 2016). A participatory social welfare study, using qualitative methods, found that claiming benefits for mental health-related difficulties is "*humiliating, isolating and frightening*" for claimants, creating a sense of powerlessness (Ploetner *et al*., 2019). Prior studies have produced similar findings; claimants described anxiety and even dread of attending assessments (Barr *et al*., 2016) and reported the assessment process as making them feel suicidal (Saffer *et al*., 2018). Assessments were described as re-traumatising as claimants were asked to talk about intimate experiences without emotional support (Shefer *et al*., 2016). Beyond formal research, personal experiences of those attending a PIP assessment who had a diagnosis of Post-Traumatic Stress Disorder (PTSD) have reported them as being highly distressing and panic-inducing (The Guardian, 2016), with assessors lacking empathy and not having a trauma-informed approach (Hutchinson, 2018).

There has been increased recognition that systems can serve to harm and re-traumatise individuals who have a history of trauma, for example by restrictive practice, coercion, withholding information and inadvertently triggering the re-enactment of early traumatic experiences (O'Hagan *et al*., 2008). This has led to a call for such services to acknowledge the social and psychological factors in the development and maintenance of distress (Dillon *et al*., 2014) and to develop trauma-informed approaches which acknowledge the impact of trauma and resist re-traumatisation (Hodas, 2006).

Trauma Informed Care (TIC) was developed in recognition of the prevalence of trauma and need for services to become more trauma-informed to support individuals (Harris & Fallot, 2001). It is relevant to all public services, including medical care, mental health services, education, criminal justice and social care (Cole *et al.*, 2013). Trauma-informed services are not designed to treat symptoms related to trauma; rather, they are services where staff are aware of, and sensitive to, the importance of creating a safe space and relationships with individuals, no matter what their role (Jennings, 2004).

NHS Education for Scotland (NES) is an education and training body in Scotland, providing training to NHS workers and broader public services. In 2016, The Scottish Government commissioned NES to develop a programme entitled '*Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce'*, as part of a wider plan to develop a National Trauma Training Strategy. The Trauma- Informed Practice level of the framework outlines the knowledge and skills required by everyone in the Scottish workforce, including the benefits system. The framework is based on existing TIC literature and further informed by service user experiences, with five principles identified: safety, trust, collaboration, choice and empowerment (NHS Education for Scotland, 2017).

There is currently no research into TIC being implemented in the benefits system in the UK. The present study therefore aims to explore of experiences of PIP assessments, from the perspectives of those who have experienced trauma. At the time of writing, the benefits process is being devolved from the UK Government to the Scottish Government and a comprehensive re-design of the entire process is underway in Scotland. It is hoped that this research can provide valuable insight into how a trauma-informed approach might be applied. Due to Covid-19, many people are accessing the benefits system for the first time and the number of PIP applications have reached the highest level in history (DWP, 2021). Further research into individuals' experiences of PIP assessments is therefore timely and crucially important to ensure assessments accurately capture the needs of claimants.

Aims

The primary aim of the study was to understand to what extent, based on participants' experiences, the process of PIP assessment fits the principles of TIC. There were two secondary aims: to identify what other experiences participants described that are not captured by the TIC framework, and to establish the limitations of the framework for understanding participants' experiences.

Methods

Design

This study utilised a qualitative design to explore individuals' perspectives of attending a PIP assessment through the lens of TIC, using semi-structured interviews.

Interview

At proposal stage (Appendix 2.1), an interview topic guide was developed (available at: https://osf.io/pqmbs/) to reflect the aims of the research. The TIC framework was used to highlight key areas and to develop the questions in the topic guide, to allow participants to reflect on the key TIC constructs. Open-ended questions were utilised to flexibly prompt subject areas for discussion.

Care was taken to ensure that this research was conducted in line with the principles of TIC. This included being transparent about what the interview would cover in the Participant Information Sheet. The lead researcher was mindful about checking in with participants throughout the interview process, attuning to possible distress. Reflecting and summarising participants' responses, to ensure a shared understanding, was also present throughout all interviews.

Ethical considerations

Ethical approval was obtained from the NHS West of Scotland Research Ethics Committee REF: 20/WS/0161 (Appendix 2.2) and the NHS Research and Innovation departments in NHS Greater Glasgow and Clyde (GG&C) REF: GN20MH492 (Appendix 2.3) and NHS Lanarkshire REF: L20118 (Appendix 2.4).

Procedure

Twelve semi-structured interviews were conducted by the lead researcher between February – May 2021, lasting between 35 – 90 minutes. The mean interview duration was 50 minutes. Interviews took place over the telephone or Attend Anywhere (an NHS-based video messaging platform), due to restrictions on face-to-face contact in the context of the Covid-19 pandemic.

Participants' demographic details were not collected to ensure participant anonymity. Clinician and Participant Information Leaflets (Appendix 2.5 and 2.6) were emailed to team leads in community mental health services in NHS Greater Glasgow & Clyde and NHS Lanarkshire Boards, to circulate in their teams. The lead researcher also attended virtual team meetings, to promote the study and answer any questions. Clinicians contacted the lead researcher via email when a potential participant expressed interest in taking part and gave consent to pass on their contact details. The lead researcher then contacted participants, explaining the study and providing them with a Participant Information Sheet (available at: https://osf.io/pqmbs/), which was discussed with the participant. Participants completed consent forms online or were sent paper copies if they did not have internet access. Interviews were recorded using an encrypted audio recorder and participants were assigned pseudonyms to ensure confidentiality. Field and reflective notes were kept electronically throughout the process and informed the analysis.

Participants

Twelve participants were recruited from community mental health services in NHS GG&C and NHS Lanarkshire. Participants were all over the age of 18, had attended a PIP assessment in the last three years and were currently accessing psychological therapy for post-traumatic difficulties. A sample size of 10–16 participants is in line with previous qualitative doctoral theses where Framework Analysis has been used (Artis, 2013; Xanidis, 2020).

Data analysis

Interviews were audio recorded and transcribed verbatim. Framework analysis was carried out in line with the seven stages as outlined by Gale (2013): transcription; familiarisation; coding; developing a working analytical framework; applying the analytical framework; charting data into the framework matrix, and interpretation. Line-by-line coding of the transcripts was carried out using NVivo software (released in March 2020).

The researchers' field and reflective notes were also considered throughout the analytic process. During the data familiarisation stage, the researcher became aware that participants' experiences were linked to the TIC principles, but in what appeared to be an antithetical way. Examples of coding can be found in Appendix 2.7 and 2.8. Development of the framework can be found in Appendix 2.9 and 2.10. The working framework was therefore developed from the emergent themes in the data, before being applied to the entire dataset. The data were then charted into a framework matrix (Appendix 2.11).

Rigour

Rigour of the analysis was enhanced through transparency of the analytic process. The researcher's supervisors provided feedback on a coded transcript and the development of the framework throughout the analytical process. To promote transparency of reporting, the researcher utilised the COREQ checklist (Appendix 2.12).

Framework

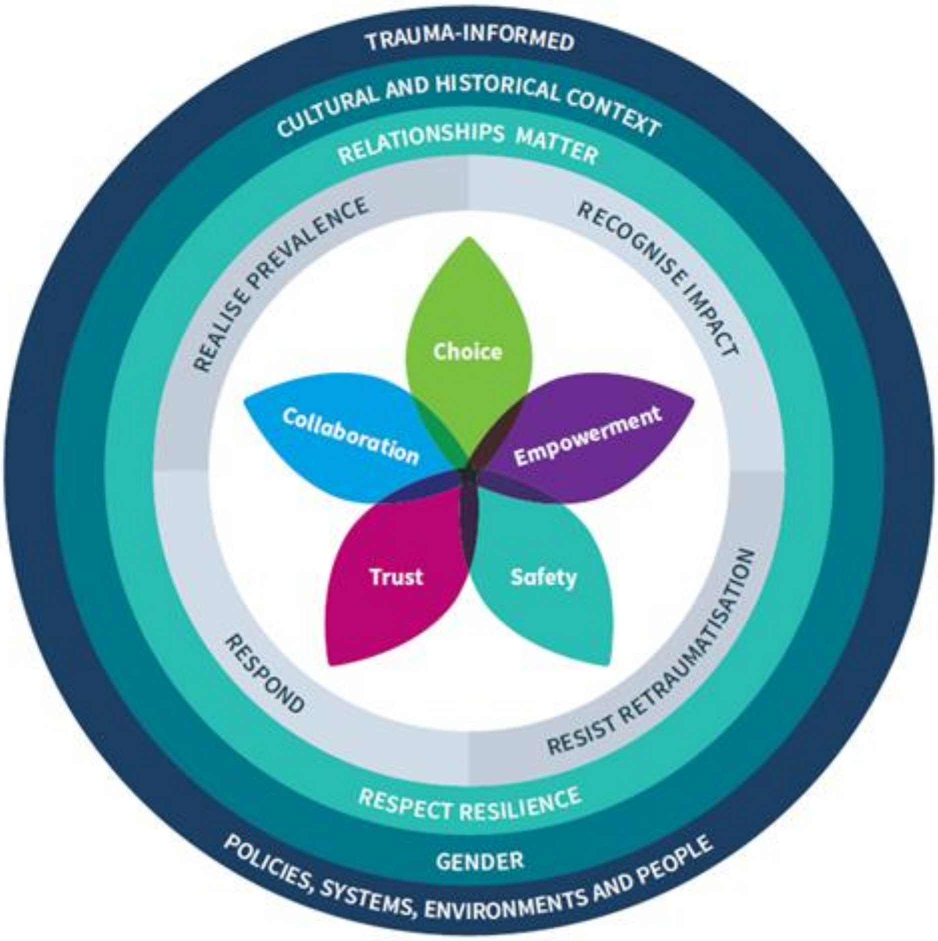

Figure 1. *Trauma-informed organisational change model* (NES, 2019)

The TIC framework as defined by this study is based on the NES policy document '*The Scottish Psychological Trauma Training Plan'* (NHS Education for Scotland, 2019), which draws upon the current literature and evidence base for trauma-informed organisations. A summary model is shown in Figure 1. The outer circles depict the broader systems, cultural and historical contexts. This study will focus on the five central principles of TIC at the centre of the model: choice, collaboration, trust, safety and empowerment. These principles underpin trauma-informed approaches, as outlined by Harris and Fallot (2001). These five constructs will be the framework which informs the interview topics and subsequent analysis for this study.

Epistemology

The epistemological position of this study was critical realism, whereby the researcher sought to understand participants' experiences whilst recognising the influence of the broader social and political context (Danermark *et al*., 2002).

Reflexivity

The lead researcher is a trainee clinical psychologist, who has personal and professional experiences of trauma. Given the subjective nature of qualitative research (Polkinghorne, 1995), this process is therefore influenced by the researcher's own perspectives and values, including political beliefs. In recognition of this, a reflective diary, field notes and supervision were used to reflect upon personal biases and mitigate the impact of this on the analysis.

Results

Framework analysis indicated that the overarching theme of participants' responses was re-traumatisation. Participants found the assessment process triggering and distressing, at times reminding them of when they had been abused. The loss of power, control and safety participants' experienced during the PIP process replicated the dynamics of prior traumas (Zgoda et al., 2016), causing psychological harm to participants.

Participants' experiences were best captured in the following main themes: harm, distrust, rigidity, intimidation and powerlessness. These themes contrasted with the original TIC framework (Table 1); an alternative framework was therefore created and applied.

Table 1. *TIC principles and main themes found in participants' data*

TIC principle	**Theme found**	
Safety	Harm	***Re-traumatisation***
Trust	Distrust	
Choice	Rigidity	
Collaboration	Intimidation	
Empowerment	Powerlessness	

Rather than the TIC framework reflecting participants' experiences, it was discovered that the framework 'refracted' them (Olive, 2021) meaning that they were in oppositional contrast to the principles of TIC. Figure 2 is a graphical representation of the alternative framework (Trauma blind framework), which was derived from the themes in the data.

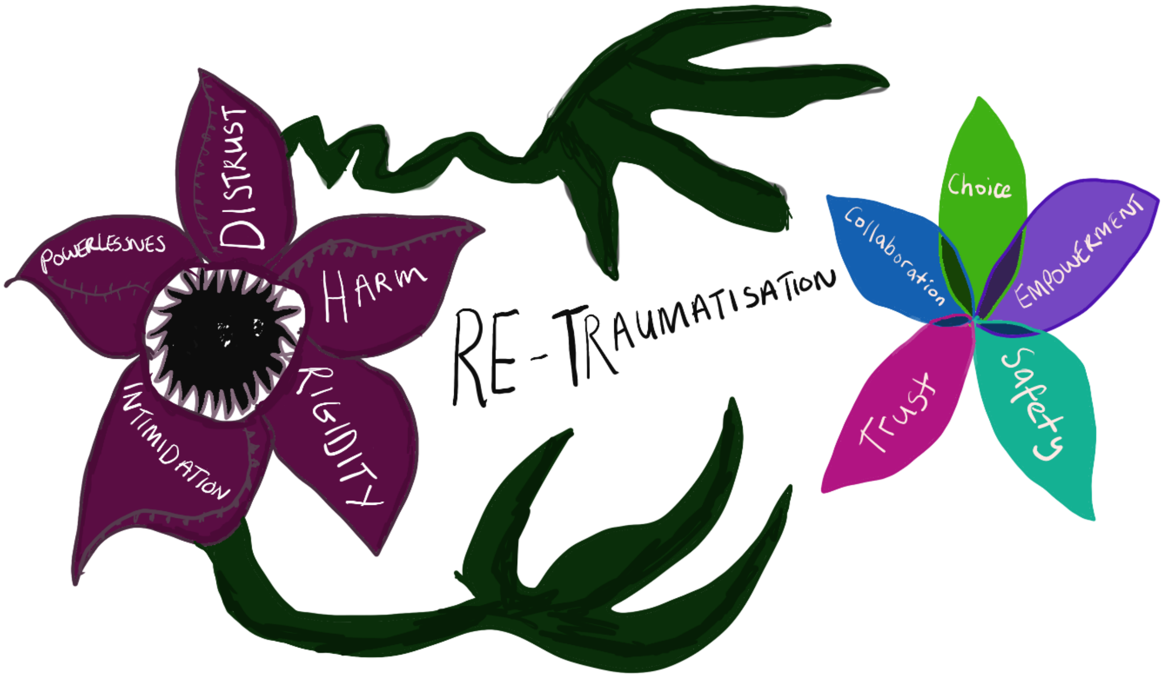

Figure 2. *The alternative 'Trauma blind' framework contrasted with the TIC framework*

Inductive coding suggested sub-themes which informed the main themes, these are illustrated in Table 2.

Table 2. *Main themes and sub-themes of participants' data*

Main theme	Sub-themes
Harm	• Anxiety • Distress • Humiliation • Adverse impact on mental health
Distrust	• Lack of transparency • Not feeling believed • Distrust of assessor • Distrust of other claimants • Distrust of system
Rigidity	• Inaccessibility • Lack of flexibility • Tick box exercise • Robotic assessor
Intimidation	• Threat • Surveillance • The dreaded brown envelope • Austere environment • Feeling on trial • Hostile dynamic with assessor
Powerlessness	• Lack of control • A rigged game • Dehumanisation

- Intrusive questions
- Getting help from professionals

These constructs and themes are fluid and interlinked, with each impacting on the other.

Harm

Participants described how engaging with the benefit system was harmful to their mental health, exacerbating feelings of anxiety, worry and stress.

Anxiety

All participants conveyed how anxiety provoking they found the PIP assessment process. From filling in the paperwork to attending the assessment to waiting for the outcome, the uncertainty and worry coloured their lives, making it difficult to see beyond it. One participant described, "*it just hangs over you – it's like you can never really focus on your mental health and look towards the future" (*Christine, p9, ln369*).* A palpable sense of immobility was described, of not being able to move forwards in life whilst being entangled in the PIP process.

Distress

Ten participants expressed finding the assessment to be distressing, describing how they became tearful, overwhelmed and confused during it. One participant described how he would *"rather go to prison…or get another cancer operation*" (Ross, p4, ln117) than attend another assessment. A few participants found the experience so distressing and re-traumatising that they experienced suicidal thoughts after the assessment. Two participants described attempting to end their life following the assessment.

*"There was a possibility I might have done something stupid… and I have not felt that way in years. That bad… that's how bad he made me feel and that seems ridiculous. That that is literally how bad he made me feel, he made me feel so worthless. And I dread going through this again, I hate it, absolutely hate it." (*Susan, p2, ln74*)*

Impact on mental health

Participants described the assessment process as actively detrimental to their mental health, which impacted them beyond the assessment itself due to the uncertainty of the outcome and associated anxiety. Emma expressed the exhaustion she felt after she attended the assessment: *"I mean the times I've been for these assessments, I've come out and spent the next 3 or 4 days in a stupor and that's God's truth, it's a horrible experience." (*P2, ln42*)* Another participant described the impact of being in the system as "*in a way it almost stifles any chance of your recovery" (*Jack, p8, ln311*),* highlighting again how the process can thwart their recovery journey.

Humiliation

A strong theme of humiliation was constructed from many accounts. Ross (P5, ln170) described the benefits process as resulting in a situation where he *"felt like a beggar"* and this theme was further exemplified by Jack (P4, ln155): "*It's an absolute assault on your dignity."* A complex interplay of factors created a sense of shame and humiliation in participants, from the personal questions they were asked about toileting, the unpleasant physical environment, to the interactions with staff in the building:

*“I was really going through a bad time and I really didn’t want to be amongst a lot of people. You know how when you sit in the waiting room… so they had sat me in a chair in a corridor. Um... I found it quite humiliating as there were no chairs… it was just let’s drag this chair and I’ll sit on it. I remember this girl, woman, came up to me via like a notice board... and she came right up close to my face and spoke to me as if I had a hearing problem. You know... it was that slow kind of ‘are…you...okay’... and I felt really felt humiliated...” (*Emma, p1, ln6*).*

Distrust

Distrust was a salient theme throughout all 12 interviews. Distrust of the assessment process, assessors and the wider system was conveyed, as well as the feeling that participants themselves were treated with scepticism and not believed. The distrust was pervasive, creating a sense of participants having to prove they were worthy of receiving PIP. There was also a marked sense of suspicion towards other claimants, creating a divide between claimants – those perceived to be deserving or undeserving of the benefit.

Lack of transparency

The broader assessment and decision-making process was perceived as cryptic and confusing. Participants conveyed a sense of confusion as to what they would need to provide to be considered eligible to receive PIP:

*“You have no way of knowing how they are assessing what you’re saying and recording it. Do you fill out any kind of form… you’re asked to sign a form, but you don’t know what you’re signing… It’s not clear what information they require from you to prove your claim. They don't tell you what they need, they just expect that you're going to automatically understand and know what that is.” (*Lucy, p8, ln317*)*

The assessment questions were perceived as unclear and confusing, with several participants describing how the same questions were worded in different ways, throughout the assessment.

Not being believed

Five participants described that they did not think their assessor believed their experiences of mental health and trauma. The PIP benefit not being awarded for the problems they were struggling with reinforced the sense of being disbelieved and invalidated.

*"It's so belittling, because basically they don't believe you. And it's hard enough, when you've got mental illness, to get a diagnosis and get help... And it's just… it makes you so… it makes you so upset, but angry at the same time, because it's like, when you get, when it comes back, and you have zero points, you're like, they've clearly didn't believe a word I said, because if they did, they would have at least given me some, but they gave me nothing. And so obviously, you know, they have to think I'm lying. And that's just… I just think, what do you need me to do?" (*Susan, p5, ln208*)*

This was reminiscent of other distressing times in participants' lives where they had not been believed. Mariah (P3, ln83) described the negative impact on her mental health from disclosing past self-harm and suicide attempts to her assessor, and this not being reflected in their report or the assessment outcome:

"It makes me feel a lot worse. Because it makes me feel as if they don't believe me… like I've done past self-harm and past attempted suicide. I've told her all this and it's like it goes in one ear and out the other. It's like you go that deep to somebody, to tell them about your struggles. And it's like they just shut it away to the side."

Ten participants expressed how the assessment appeared to demand some kind of material proof of their mental health difficulties. The differences between physical and mental health were highlighted, and how the PIP assessment was geared towards medical health conditions. Participants conveyed how their mental health experiences were not identified or understood, leaving them feeling like they weren't believed.

*"With mental health… it's as if they don't believe you. Because they cannot see it. You need to have something physically wrong with you, like a visible illness. But because it's in your head, and they can't see it, they don't believe it." (*Mariah, p4, ln125*)*

Six participants described an incongruence between how they were feeling during the assessment, and the report they received, which described their mental state at that time. Lucy (P6, ln220) exemplified this experience:

"They were perhaps not understanding… that even though I might not have been exhibiting, clearly exhibiting signs of stress, or distress, actually what's going on under the surface… it's complex and emotional. But the person I'm speaking to is just a medical practitioner I guess."

The nuances of distress often went unnoticed, particularly lesser- known trauma-based responses such as dissociation and appease (Van der Kolk, 1996). Such responses can be more difficult to detect, particularly without training in trauma.

Distrust of other claimants

Three participants expressed views that other claimants were "*at it*", that they were able to "*play the system*" – creating a sense of a divide between the deserving and the undeserving, which was maintained by the wider system. Katie explained how the narratives in the media had influenced their perception of other claimants:

"Because there's so many people, obviously, there's so many people trying to work the system everywhere. And I've heard so many different stories about disability living allowance and PIP and people saying trying to get on that you know, and saying use a walking stick, you hear everything you know. And I do, I feel that maybe that's that much of it that maybe

*the powers that be they've got to try to root these people out, because it's not right… but to the detriment of the people that really need it I think sometimes." (*Katie, p4, ln128*)*

Participants further expressed worry of being perceived as disingenuous, meaning they felt they had to try hard to convey their honesty and deservingness of PIP. This tied in with the complexity of needing to prove and evidence mental health struggles, as considered above.

Distrust of system

A marked distrust of the DWP and benefit system was expressed by all 12 participants. The system was described as malevolent, *"it wasn't there to help me, it was there to catch me out" (*Jack, p10, ln384*).* Some participants described the assessment process as being set up to *"trick"* them (Ross, p2, ln52), with the aim of *"saving as much money as they can for the government. They're not trying to help people" (*Tara, p3, ln103*).* The precariousness of receiving the benefit created a pervasive feeling of uncertainty, which maintained individuals' lack of trust in the system and their ongoing anxiety and distress. The frequency of appeals and re-assessments reinforced participants' lack of belief in the system.

"*I feel as if when you go, you'll either get nothing or less than what you've got. They're reducing the help they give you every time you go." (*Katie, p5, ln176*)*

Distrust of assessor

Ten participants expressed not trusting the person who assessed them. This seemed reflective of participants' underpinning distrust of the system and DWP. A number of participants described an incongruence between what they said and what was written in their report. One participant conveyed the perceived double standard in the honesty required from claimants versus assessors:

"You've got the date wrong and they'll say you lied. But they can blatantly lie, not mistakenly,

*blatantly lie, and get away with it.” (*Susan, p4, ln147*)*

Rigidity

The theme of rigidity is marked by the inaccessibility and inflexibility that seven participants described experiencing, as well as the *“tick box” (*Susan, p1, ln36*)* feel of the assessment itself. Additionally, three participants perceived the assessor to be rigid and *“robotic” (*Tom, p6, ln229*)* in their approach.

Inaccessibility

Participants who had comorbid physical health problems described finding the building the assessment took place in as not meeting their needs. Consequently, this created physical pain and emotional stress as they attempted to navigate an environment that was not suitable for their needs:

*“And I was asked to go upstairs as well. I said do I need to go upstairs really, she goes there’s a lift there. And I thought, even walking to the lift there, walking to where it was I was in agony and practically holding on to the wall.” (*Katie, p2, ln69*)*

Inflexibility

A marked lack of choice was reported by seven participants. Participants felt they had no choice as to the date, time and location of the assessment even if it was very inconvenient for them.

*“I feel like maybe we should be given the choice to these are the days I can do, these are the times I can do. You know, it may not be possible, but it's just something that I feel like would be better for quite a lot of people.” (*Tara, p2, ln66*)*

A couple of participants highlighted that due to their trauma history it would have been important for them to choose the gender of their assessor, but this was not an option.

Tick box exercise

The notion of the assessment being a tick box exercise further amplified the rigidity and impersonality of the assessment experienced by participants, where they did not feel they were being understood as a person or engaged with on a human level. Katie described: *"it feels like you'd be better… sitting there answering questions and pressing buttons" (*P1, ln23*).* There was a sense that the process as it stands could be facilitated by a computer system, due to the impersonal nature of the assessment and the requirement to answer set questions in a particular way.

"*You just feel like they are putting data into the system and you're just relaying it to them or something… it's not like an actual person you know" (*Jean, p8, ln255*).*

Robotic assessor

Linked to the assessment being perceived as a tick box by some participants, it was described how the assessors displayed a detached and robotic stance. Participants explained how the assessors' body language was experienced, particularly lack of eye contact:

*"The woman hadn't even looked at me, she was just sitting there typing you know… it did just feel very impersonal. When you're talking to someone and they're not even looking at you, it's not nice at all." (*Jean, p7, ln249*)*

Seven participants felt their assessor lacked empathy, with one participant noting that the assessor *"never asked once if you were okay or anything"* (Ross, p3, ln101*)* after he'd had a panic attack during the telephone assessment. Similarly, another participant described how they became overwhelmed and tearful during the assessment *“but she [the assessor] kept ploughing on with the interview, they had an end goal to get to” (*Lucy, p5, ln199*).* Participants’ responses indicated a marked lack of sensitivity to their feelings, with the focus being on completing the assessment regardless of the distress this may cause.

However, two participants described having experiences where the person who assessed them did show empathy and was attuned to their feelings, which helped their anxiety during the assessment.

Intimidation

The main theme of intimidation is marked by participants describing a stark power imbalance between themselves, their assessor and the DWP. Participants also expressed how the physical environment and processes of the system produced feelings of intimidation, threat and discomfort.

Threat

A pervasive sense of threat was described by several participants, for example waiting for a letter, phone call or re-assessment. Heightened threat responses are a key component to PTSD (Kimble *et al.,* 2014) which the assessment process exacerbated. There was a feeling that there is a threat lurking in the background of participants’ lives, even when the assessment outcome has been decided:

“I'm just waiting. I'm waiting for the next letter to turn up today… It's the sword of Damocles. Just hangs there and hangs there and you never know whether it's gonna fall on you.” (Jack, p8, ln309)

The sense of threat was identified by the researcher during the initial interviews when participants expressed concern that the lead researcher was linked to the DWP, and that this would get back to the DWP and they would face negative consequences.

Surveillance

Linked to the sense of threat described by participants, several participants recalled feeling like they were being watched and judged when they were in the building before their assessment:

*“They watch every single thing. Every single thing from the moment you walk in that building.” (*Emma, p9, ln337*)*

Participants further described feeling disconcerted during assessments, feeling *“under the microscope” (*Tara, p1, ln24*)* – like everything they said or did would be analysed and held against them.

The dreaded brown envelope

Participants’ fears and anxieties about engaging with the system could manifest in *“the dreaded brown envelope” (*Tom, p4, ln56*)* from the DWP. It was described how seeing any brown envelope could cause participants to *“freak out” (*Jon, p7, ln298*)* and experience strong physical and emotional reactions:

*“It’s just anxiety in my stomach constantly. Even, see when the letters come in the morning from the postman, my heart literally starts beating and I know if it’s a normal letter I’m fine, but if it’s a brown letter my anxiety keeps going.” (*Christine, p10, ln407*)*

One participant expressed the insidiousness of worrying about receiving a letter from the DWP, making it impossible for them to focus on their mental health: “*The cumulative effect of* *every day of the week worrying about the post tires you out for all other tasks" (*Jack, p6, ln233*).*

Austere environment

The physical environment where the assessment took place was described by some participants as "*anxiety provoking*" (Jon, p3, ln65) and *"absolutely awful and disgusting" (*Susan, p5, ln176 *)*. Participants conveyed how the waiting room could be very stressful, exacerbating their anxiety:

*"It is a powder keg of a situation. It really is, and the amount of time that you're left alone together in that one room, you can feel it. You know, and that makes yours even worse, it is just a room full of anxiety. Just feeding more anxiety." (*Tom, p8, ln321*)*

Being on trial

As noted above, the concept of proof came up in several interviews whereby participants felt they had to give 'evidence' for the validity of their claim. Parallels were drawn by four participants of being in court, highlighting how they felt they were treated like they had done something wrong and had to prove themselves. Participants described how anxiety inducing it was to be *"interrogated and accused" (*Emma, p2, ln60*)* and *"cross examined" (*Christine, p5, ln207*)* by their assessor*.* The austere physical environment and hostile interactions with staff further reinforced the feeling of being in a situation which felt inherently punitive.

Hostile relationship with assessor

Ten participants expressed feeling uncomfortable with the person who did their assessment. Participants described experiencing a lack of empathy, including non-verbal cues which signified irritation and feeling like they had not been heard. Emma described the marked power imbalance between themselves and their assessor:

“You're in this vulnerable spot sitting in this chair with… I’m making it terrible, but it is, it’s like Atilla the Hun sitting there, and again it’s a person in control… almost of your feelings as well.” (P6, ln223)

Another participant described the *“sternness there… just the intimidation of it… it just triggered me a bit”* (Christine, p5, ln158), highlighting the impact of this dynamic, which triggered memories of past traumatic experiences.

Powerlessness

Powerlessness was a theme derived from participants’ responses highlighting a lack of control, agency and autonomy. There was a sense that participants felt that they did not have a voice anyone would listen to, and a feeling of being “done to”.

Lack of control

Ten participants expressed feeling like they had little control in the assessment process and influence in the outcome. Due to the stressful nature of the assessment, some participants described feeling like they had less control than usual as they felt so anxious. One participant explained how daunting it was to have a stranger make a decision that would have a big impact on their life:

*“And then you’re let loose in front of a stranger who decides what happens in your life. I find that quite scary”. (*Tom, p8, ln322*)*

A rigged game

There was a marked lack of trust in the broader benefit system and DWP, with one participant describing it as a "*rigged game… this whole system is like playing a game of snakes and ladders where every single snake goes back to zero. And there are very few ladders" (*Jack, p10, ln364*).* Participants spoke about the unfairness and injustice of the system:

*"It's not a level playing field. I don't think it's meant to be a level playing field" (*Lucy, p9, ln346*).*

This could lead to a state of learned helplessness (Peterson & Seligman, 1983), where participants feel they cannot influence the outcome, and that their claim would be unsuccessful no matter what they did.

Dehumanisation

The assessment being dehumanising was poignantly expressed: from the environment, to the questions that were asked, to the manner of the assessor. The combination of this resulted in participants feeling de-valued and less than. One participant said that they *"didn't really feel like a person" (*Emma, p1, ln35*),* which conveys the impact the assessment process had on their sense of self.

The theme of dehumanisation was further constructed from participants' accounts where they described being treated *"like just another number" (*Katie, p2, ln43*).* Another participant highlighted that they were assigned a number upon arriving for their assessment and that they were called by that number, not their name: "*that made me feel a bit… funny… it made you feel so small… like you are just a number you know" (*Jean, p7, ln245*).*

Intrusive questions

A further manifestation of powerlessness came from the questions participants were asked, which could be perceived as intrusive. In particular, personal questions that were asked about self-care. Participants would struggle to find words when conveying these feelings, creating a tangible sense of shame as they recounted their experience. Participants also highlighted that being asked *"incredibly intrusive questions that you're answering to complete strangers" (*Jack, p1, ln31*)* made it more difficult, as there was no pre-existing relationship or trust established. Eight participants spoke about feeling like they had to disclose personal information, even though they were deeply uncomfortable. Mariah explained that *"I don't want to, but I feel I need to, so that they'll understand my struggles" (* P3, ln91*).*

Help from professionals

Three participants spoke about how it was helpful to get letters of support from their psychologist and that they found this empowering by proxy. One participant explained *"with him [psychologist] having the Dr before his name… it cuts so much ice with the DWP" (*Jack, p7, ln279*).* This could be interpreted as the DWP considering professionals' views as more valid than claimants'. Another participant described having to get support from someone who is perceived to have higher social influence as being disempowering:

"*It's the fact that I've got to get my psychologist to give proof, it's quite crap… like I've got to get evidence from a higher up person that you're speaking to" (*Mariah, p4, ln138*).*

Discussion

The primary aim of this research was to understand to what extent, based on participants' experiences, the process of PIP assessment fits the principles of TIC. The secondary aim was to identify what other experiences participants describe that were not captured by the TIC framework. It was found that participants' experiences powerfully contrasted the TIC principles. Therefore an alternative framework was created, which was driven by the themes in the data. These themes can be conceptualised as being on the opposite end of a spectrum to the TIC constructs: harm, distrust, rigidity, intimidation and powerlessness. This alternative framework could be conceptualised as being 'trauma blind' (Quadara & Hunter, 2016). The concept of 'trauma blindness' was recently highlighted in a research study which explored experiences of the UK social security system from the perspectives of veterans' with PTSD, which were found to contrast the TIC constructs (Scullion & Curchin, 2020). A trauma blind organisation means that the lack of identification and understanding about trauma results in practices which traumatise and re-traumatise those within it. Constructs such as "Trauma blind" and "Trauma informed" imply dichotomies that are unlikely to reflect implementation in the real world. One solution to this could be to outline more clearly how TIC can be understood from a continuum point of view where such a model could then enable organisations to map and externally accredit their progress towards becoming increasingly trauma informed.

The findings of the present study mirror prior research into benefits systems, with similar themes of claimants' fear of the brown envelope and disempowerment (Ploetner *et al*., 2019; Garthwaite, 2014). The results indicate that mental health difficulties, including trauma responses, are not being recognised in PIP assessments. This lack of recognition is experienced as invalidating, often bringing up individuals' past experiences of stigma, abuse and not being believed. Attending an interview for this study appeared to evoke feelings in participants that they experienced during their PIP assessment. The researcher became acutely aware of participants’ need to prove the validity of their experiences and to be believed.

Trust and safety are both fundamental concepts of TIC, yet participants described a pervasive lack of these in the PIP assessment process. Attending PIP assessments triggered and re-traumatised claimants, evoking feelings of shame and powerlessness, which are detrimental to mental health (Edmiston *et al.*, 2017). The complex interactions between claimants, DWP assessors and the broader benefit system can mirror one another through parallel processes (Bloom, 2010) whereby two-way interactions fuel and perpetuate negative dynamics. Working in retraumatising systems may also have an impact on staff, who may experience conflict between their job duties and personal values. This can result in othering and reduced empathy, as a way of coping with their role (Sweeney *et al*., 2016).

Most research into the implementation of TIC has been based in North America, but there are some examples of successful implementation within the UK (Wilton & Williams, 2019). For example, Tees, Esk and Wear Valleys NHS Foundation Trust implemented a programme to develop trauma-informed services throughout its adult services. Trauma champions, supervision and follow-up training plans were identified as key facilitators to implementation. Further studies have highlighted similar findings, emphasising the need for strong leadership, commitment to long-term training, recognition of vicarious trauma and the need for staff to receive supervision from experts in trauma such as applied psychologists, even outside of a health care setting (Chandler, 2008; Drabble *et al.,* 2013).

In 2016, NES was commissioned by the Scottish Government to develop and roll out the National Trauma Training Programme, with the aim that general services should be trauma aware. The findings of this study highlight an urgent need for this training to be implemented in the benefits system, so that PIP assessments do not retraumatise claimants. However, staff attending training alone would not be enough to create meaningful systemic change. To effect organisational change, there needs to be a commitment from leadership to ensure the principles of TIC are embedded in organisations, which includes prioritising the wellbeing of staff. Without this, TIC could be tokenistic and at risk of co-optation, in the same way the concept of recovery has been criticised (McWade, 2016). The significant changes to the benefits system in Scotland provides a unique opportunity for trauma-informed service design and delivery.

As it can take 10-15 years for policies to be incorporated into routine clinical practice (Proctor *et al*., 2009), immediate support for TIC implementation is crucial. Implementation science has an important role in organisations such as the DWP taking steps to becoming trauma-informed (Damschroder *et al.,* 2009). This could involve understanding the current organisational culture and what is needed to create change, identifying trauma champions and leaders in services, conducting service evaluations and implementing a rewards and recognition scheme for staff (Tansella & Thornicroft, 2009).

The final aim of this research was to establish the limitations of the TIC framework for understanding participants' experiences. Whilst the NES TIC framework highlights important principles which underpin trauma-informed approaches, per Harris and Fallot (2001), it does not capture the relational and dynamic nature of these. There is a complex interrelationship between the different aspects of the TIC framework, which are best understood together and not as their individual parts. The researcher's experience of using framework analysis was challenging, due to fitting complex and subjective experiences into distinct themes, the process of which did not reflect the interwoven relationships between constructs which were often inextricable. It was therefore important to hold the TIC principles in mind, but flexibly to develop the alternative framework to ensure that it captured the themes in the data and that participants' voices were not overshadowed by the a priori framework.

Strengths and limitations

This research provides valuable insights into the lived experiences of twelve individuals who attended a PIP assessment, through a trauma-informed lens. Although this was a small sample from a particular locations in the west of Scotland, it contributes to an under-researched area with participants whose voices are often not given platform to be heard. Whilst framework analysis provided a rigorous and transparent method of conducting qualitative research, a phenomenological approach may provide different perspectives and insights.

Due to time constraints, it was not possible to give participants the choice of reading through and commenting on their transcripts. Member checking has been used to promote trustworthiness; however, it has also been criticized for being time-consuming and potentially distressing for participants, particularly if their transcript is of an emotive nature (Birt *et al.,* 2016). The researcher used supervision successfully to draw out plausible alternative constructions and challenge assumptions. Supervisors also checked the researchers' coding of a transcript, to ensure reliability of the analysis.

Clinical implications

This study highlights how distressing PIP assessments can be for those who have experienced trauma. It is important for mental health professionals to have an awareness of the potential impact of the benefits assessment process on their clients. The present research demonstrates how mental health professionals can use their position to support claimants who are navigating this process, for example by writing letters of support.

As outlined above, the results suggest that there is much to be gained from the application of TIC to the benefits system. This could reduce distress from re-traumatisation, which would be of benefit to claimants, families and the wider system. For example, less referrals to mental health services due to the distress induced by benefits assessments. Making the benefits system trauma-informed could also improve working conditions for DWP staff, by recognising staff wellbeing and providing them with the training needed to be able to assess mental health difficulties in a sensitive way.

Future research

Research into the timing of PIP assessments and subsequent physical and mental health outcomes in Scotland would be recommended, to further understand the potential impact of PIP assessments. Given the existing data science infrastructure in Scotland there is potential for larger scale data linkage studies. There is opportunity to link longitudinal administrative data from the DWP to other data sources in Public Health Scotland, including from mental health services.

Future research exploring DWP workers' perspectives would provide insights into the other side of the system. A lack of empathy and responsiveness from assessors was described by participants, which raises questions about the reasons for this. This is particularly important given the current context of Covid-19, which has put more pressure on systems and resulted in increased levels of staff burnout (Prasad, 2021).

Considering the high prevalence of people who access the benefits system who have experienced trauma, and how PIP assessments can be experienced as re-traumatising, it would be important that the National Trauma Training Programme is implemented in a benefits system context. Psychologists have a crucial role in delivering this training to staff, to promote a greater understanding of trauma and how this may present in the people they assess. Post-training, ongoing research is needed to evaluate how the principles of TIC are being meaningfully implemented into PIP assessments and the broader benefits system, and how this can be measured.

Conclusions

PIP assessments were found to be re-traumatising and having an adverse impact on claimants' mental health, which is in line with prior research into the benefits system. Participants' experiences contrasted the principles of TIC. Therefore, an alternative framework was created which had five key oppositional themes: harm, distrust, rigidity, intimidation and powerlessness. Rather than being trauma-informed, at present the PIP assessment process could be described as trauma blind and not recognising individual's experiences of trauma.

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Appendices for Systematic Review

Appendix 1.1: Coding Key

Master theme	Sub themes
Trust	T1 – Clients T2 - Clients and staff T3– Staff
Safety	ES1 – Emotional safety clients ES2 – Emotional safety staff PS1 – Physical safety clients PS2 – Physical safety staff
Choice	C1 – Clients C2 – Staff
Empowerment	E1 – Clients E2 – Staff
Collaboration	CO1 – Clients CO2 – Staff
Facilitators	F1 – Positive relationships F2 – TIC training F3 – Leadership F4 – Staff support F5 – Reflective practice F6 - Resources
Barriers	B1 – Lack of leadership B2 – Conflict of TIC constructs B3 – Community resources and stigma B4 – Prior training B5 – Lack of staff support B6 – Vicarious trauma

Appendix 1.2: Coding Sample

Chandler (2008) results

The experience of staff, and their working with patients to reduce symptoms in a traditional inpatient model and a trauma-informed treatment model, was described in terms of creating a culture of safety. Content analysis of narratives describing symptom management revealed an overarching theme of transferring control from staff to patient. Within this theme, the experiences of staff nurses were captured via four categories: changed perspectives, collaborative patient–staff relationships, the implementation of safety protocols (including staffing ratios), and the prescription of individualized evidence-based educational resources.

For each category, participants first described their experience in the traditional model, then that in the trauma-informed model.

At the beginning of every interview, participants emphasized that their experience in transitioning from traditional to trauma-informed treatment was not a simple case of going from a bad approach to patient care to a good approach but more of moving from a traditional inpatient program to a patient-centre approach with a milieu-based focus on safety.(ES1) As one participant said, "There was always a culture that supported the staff. Communicating with each other and the patients has always been really respected, but now we have shifted control from the staff to the patient."(C01 & C02) Participants suggested that control was historically maintained by different means—for example, through physical plant design, rigid protocols, information control, and physical/chemical interventions.(C01) One participant said, "Then people fit into the protocol rather than adjusting the protocol to meet patients' needs. There were clear lines drawn between who was ill and who was in control."(C01) Today, the philosophy of collaboration between the staff and patients is the basis for symptom management. Participants described their experience of changing perspectives,(F2) developing collaborative staff–patient relationships,(F1) implementing safety protocols,(ES1) and using educational resources.(F6)

Staff members who had worked on the inpatient unit for more than 12 years had been trained in managing patient symptoms by supervising the milieu, monitoring medications, and controlling information.(C01) The participants reported a gradual change of perspective regarding patient behaviour owing to consultation with a trauma expert and to required education on the effects of trauma on inpatient behaviours.(F2) The shift in perspective initiated by staff development was reinforced by role modelling of the nurse manager who deeply believed in trauma informed treatment. One participant said, "She was there to teach us about new approaches and on the unit demonstrating how to interact with patients when things were quiet and when there was a crisis. We could count on her."(F3) Creating a structure of active administrative involvement, staff development, skills training, and staffing ratios was critical so that staff had the tools to try new approaches to patient care.(F4)

Participants voiced that patient–staff relationships had always been central to the treatment milieu but that under the traditional model there was a pronounced hierarchy that went from the physician to the social worker to the nurse to the mental health counsellor and finally to the patient, with everyone on the staff understanding that the therapy was conducted by the psychiatrist, with the expectation that all symptoms would be resolved before discharge. The milieu had "insight-oriented groups, and patients were absolutely required to attend." Group attendance was a struggle for some patients, which had to potential to escalate into a staff–patient control issue. Minimal information was offered to patients; information flowed down the hierarchy, with the physician as primary source of information. A participant commented that the staff gave “much less information to patients; people weren’t even given their diagnosis. There was a stigma about diagnosis, it was too shameful.”(F1) Family, friends, or sponsors were not involved in therapy. Patients were warned against sharing information. A participant recalled, “The rule was [that] patients could not exchange any personal information related to their life outside of the hospital. Patients were also forbidden to contact each other after discharge.”(F4) Separating and silencing patients was another approach to keeping control in the hands of the staff, which in turn increased patient dependence. With trauma-informed care, the relationship hierarchy shifted. Participants described a trauma informed philosophy as one that recognizes that information is the key to empowering patients to have control over their lives. Thus, sharing information with patients begins on admission: Within 24 hours of admission, a specific, individualzed plan is developed with each patient to specify a written agreement of responsibility for the patient, physician, nurse, social worker, art therapist, and occupational therapist. The staff functions as a team, with each member contributing information that is respected and recognized as a critical piece of the patient’s life puzzle. One participant reported, “We tell patients that there’s a recipe for managing symptoms: ‘What ingredients work for you?’” During the treatment-planning meeting within the first day on the unit, patients are informed of educational resources, with specific tools being prescribed and implemented with their assigned staff nurse or counselor. The milieu is structured with art therapy groups, dialectical–behavioral therapy groups, recovery meetings, wellness exercises, and a community meeting.(E1) Every community meeting, which has “a human rights officer” to protect patient rights, begins with a mindfulness meditation exercise and ends with an inspirational quote. Patients can choose whether to attend group meetings, but the staff encourage them to actively participate in their treatment.(C1)

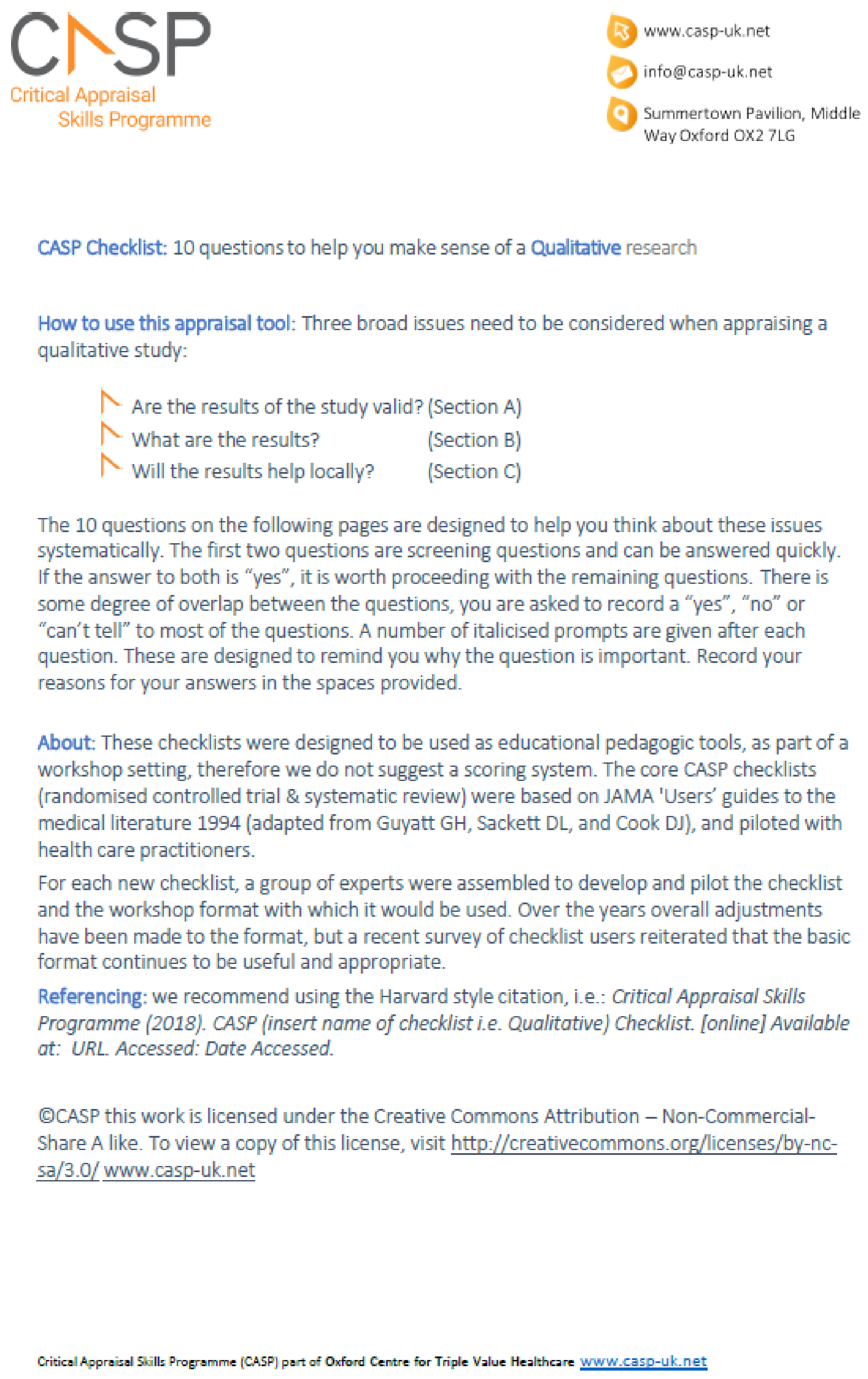
Patients are perceived by other patients as a resource, helping one another manage symptoms and develop coping skills. Patients share the community services that work well, and they refer others to successful outpatient programs. The policy of no contact between patients after discharge has evolved into one that recognizes that patient networks are a key component to recovery.(F1) Patients decide whether they will continue the relationships formed in the unit.(C1) One participant said, “It used to be patients just talking to their therapist. They were missing their whole support base. Now we have friends and sponsors come on the unit, to meetings, and they become part of the discharge plan.” A support network of friends and family is one component of creating a culture of safety. (ES1)

Appendix 1.3: Framework Analysis

	Trust	**Safety**	**Choice**	**Collaboration**	**Empowerment**	**Facilitators**	**Barriers**
Drabble *et al.* (2013)	***Clients*** ***Staff***	***Emotional: clients*** ***Emotional: staff*** ***Physical: clients*** ***Emotional: staff***	***Clients*** 23 – 28 – Flexibility of assessments ***Staff***	***Clients*** 83 – 86 – Collaborative approach ***Staff***	***Clients*** ***Staff*** 89 – 90 – Fostering hope and inspiration 91 – 101 – Greater job satisfaction; making a difference	***Relationships*** 71 – 89 – Greater empathy and relationships between clients and staff ***Training*** 1 – 14 – Heightens awareness of what clients go through 41 – 51 – Training supported systems change 59 – 70 – Think trauma first 193 – 195 – Formal commitment ***Leadership*** 15 – 22 – Trauma consultant helpful 187 – 252 – Need leadership and trauma champions ***Staff support*** 198 – 213 – Staff supported to make decisions	***Prior training*** 102 – 171 – Clash in values and philosophies. Prior training can contradict the principles of TIC ***Lack of staff support*** 172 – 181 – Lack of funding, high turnover of staff, inconsistent approach ***Vicarious trauma*** 182 – 186 – Social workers retraumatised too ***Lack of leadership***

						Reflective practice	***Clash of TIC constructs*** ***Community resources & stigma***
	Clients ***Staff***	***Emotional: clients*** ***Emotional: staff*** ***Physical: clients*** ***Emotional: staff***	***Clients*** ***Staff***	***Clients*** ***Staff***	***Clients*** ***Staff***	***Relationships*** ***Training*** 1 – 14 – Heightens awareness of what clients go through ***Leadership*** 15 – 22 – Trauma consultant helpful ***Staff support***	***Prior training*** ***Lack of staff support***

Appendix 1.4: CASP (2018) Qualitative Checklist (Completed by Researcher)



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CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Critical Appraisal Skills Programme (CASP) part of Oxford Centre for Triple Value Healthcare www.casp-uk.net

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Paper for appraisal and reference: WALL, 2020

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: Yes, clear aims identified. To explore the impact of trauma on student behaviour and learning at a local elementary school; to identify Trauma-Informed Approach (TIA) educator supports; and to ascertain the impact of a TIA on student functioning.

2. Is a qualitative methodology appropriate?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: Qualitative methodology fits the aims of the research.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: Yes, interviews and questionnaires.

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

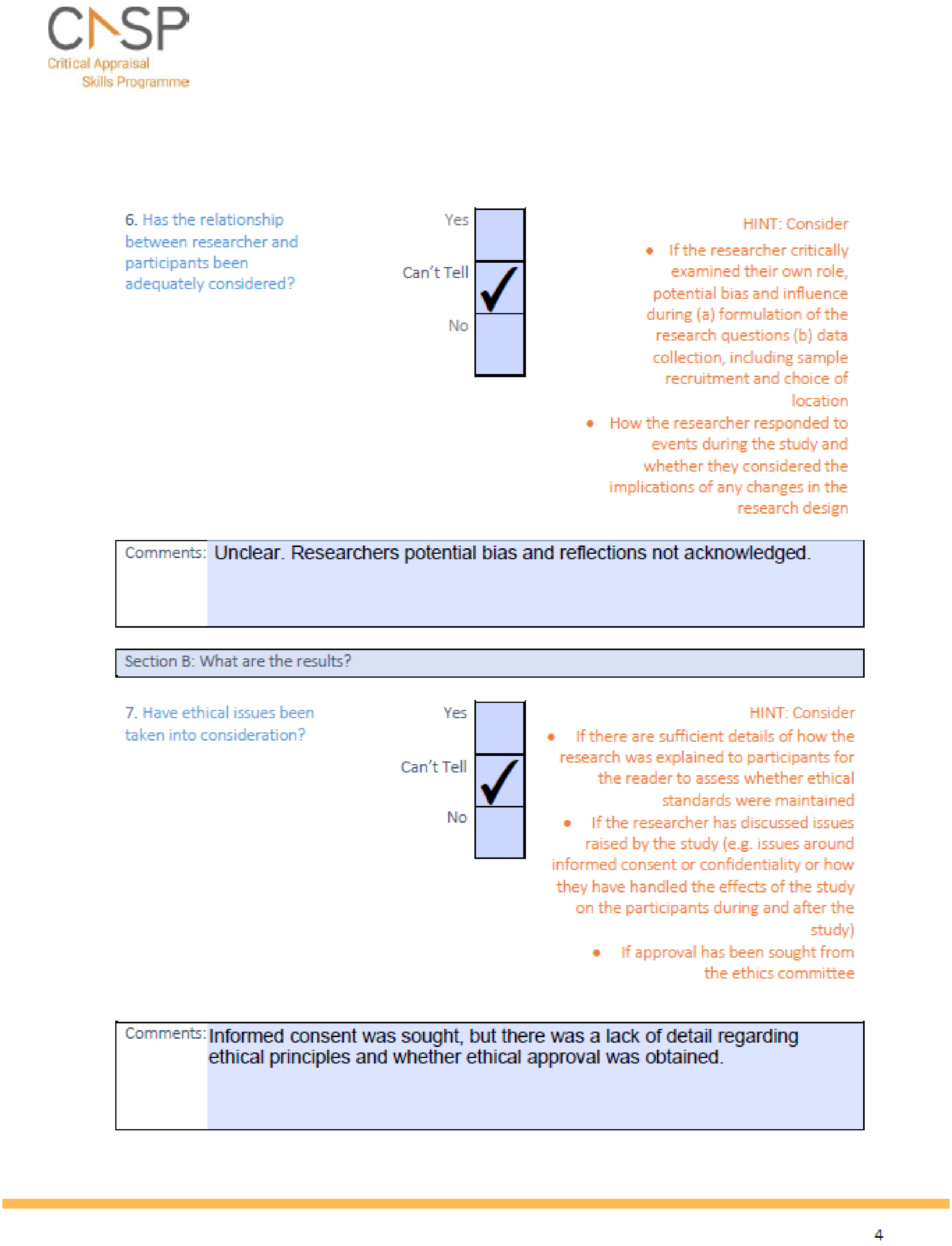
Comments: Seems appropriate but brief reporting of recruitment method - would have been helpful to have provided more detail here.

5. Was the data collected in a way that addressed the research issue?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: Questionnaire and interviews, interview guide and approach to analysis described.



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6. Has the relationship between researcher and participants been adequately considered?

☐ Yes
☑ Can't Tell
☐ No

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: Unclear. Researchers potential bias and reflections not acknowledged.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

☐ Yes
☑ Can't Tell
☐ No

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: Informed consent was sought, but there was a lack of detail regarding ethical principles and whether ethical approval was obtained.

8. Was the data analysis sufficiently rigorous?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

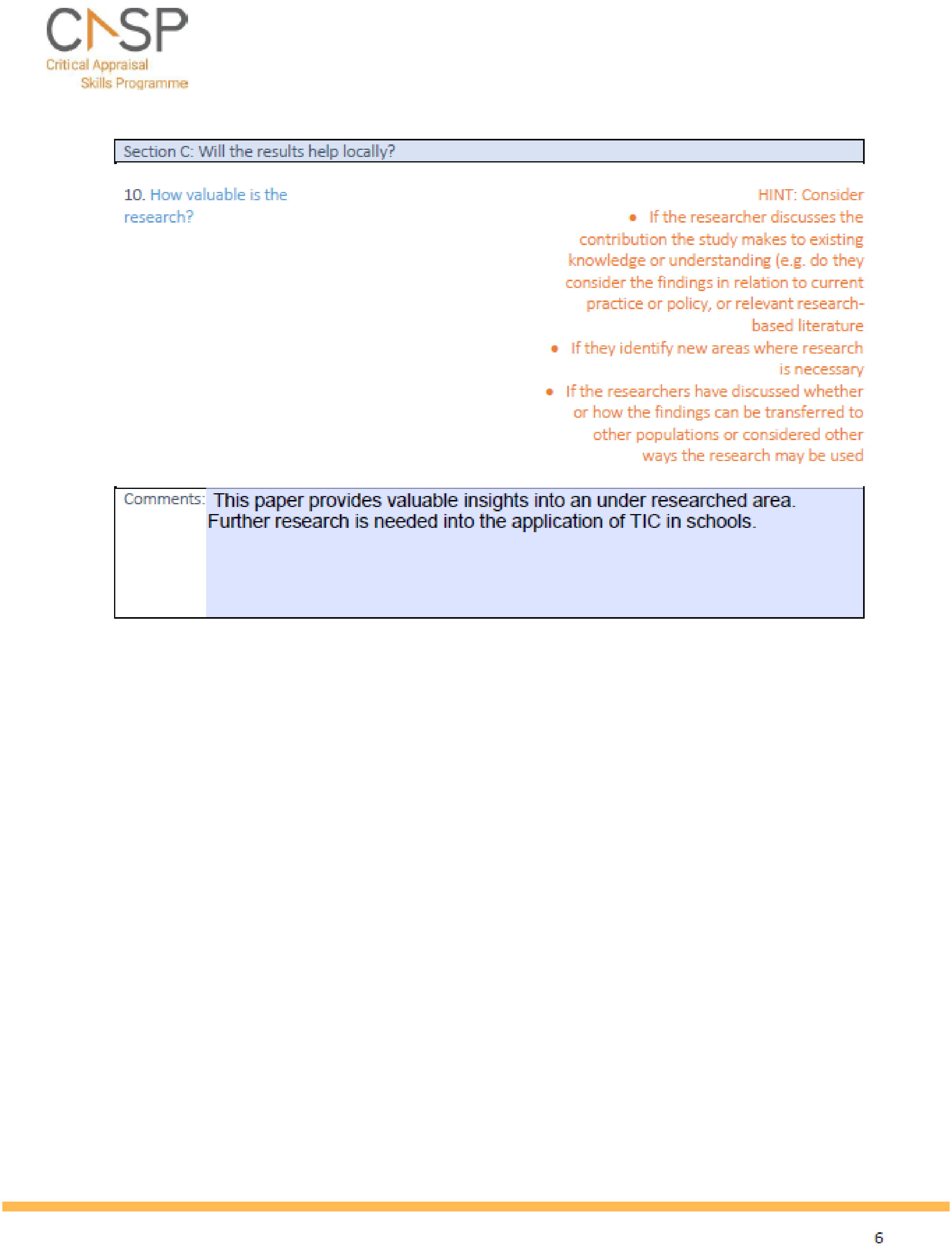
Comments: Content analysis used, coding explained. Rigour would have been strengthened if reliability/credibility of coding transcripts had been described e.g. was there more than one analyst?

9. Is there a clear statement of findings?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: Findings were well organised, included quotes from participants. The discussion was quite short.



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Section C: Will the results help locally?

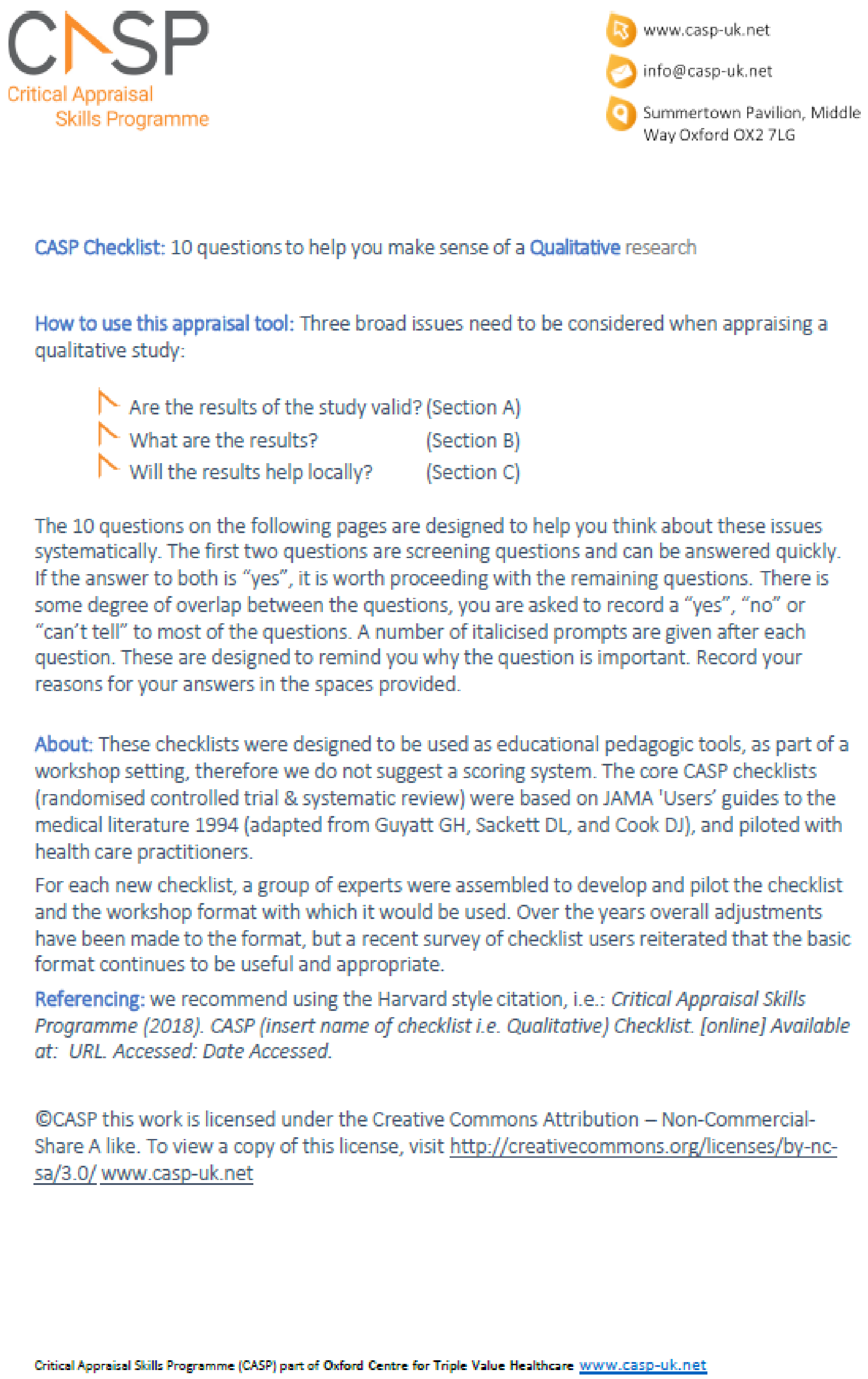
10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments: This paper provides valuable insights into an under researched area. Further research is needed into the application of TIC in schools.

6

Appendix 1.5: CASP (2018) Qualitative Checklist (Completed by Trainee Clinical Psychologist, D.R.)



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CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Paper for appraisal and reference: Wall 2020

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: - To conduct a literature review identifying the core compontents of the Trauma-Informed Approach in education
- To explore the impact of trauma on student classroom behaviour and learning from the perspective of the educator
- To identify trauma-informed teacher supports and pedagogical straetgies
- To ascertain the imapct of trauma-informed approach on student behaviour and learning.
- Overall the aims appear to be very clear and important!

2. Is a qualitative methodology appropriate?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: - Appears multi-layered and rigorous? Questionnaire with a follow up interview. I'm assuming with an interview guide this interview may have been semi-structured?

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☑
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: - It reads as if that teachers were recruited at a staff meeting, and I am not too sure if they were aware of this research prior to this (I assume so but I don't think it's explicit?). I imagine it would have been helpful for them to be aware to give consideration as to whether they would like to participate in an initial questionnaire prior to a follow-up interview.

5. Was the data collected in a way that addressed the research issue?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☑
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: - I'm not sure if you can see, but I am not sure if the interviewer was independent or also a teacher?

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☑
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: - In my opinion there does not seem to be a lot of detail on ethical considerations, just that informed consent was obtained?

8. Was the data analysis sufficiently rigorous?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

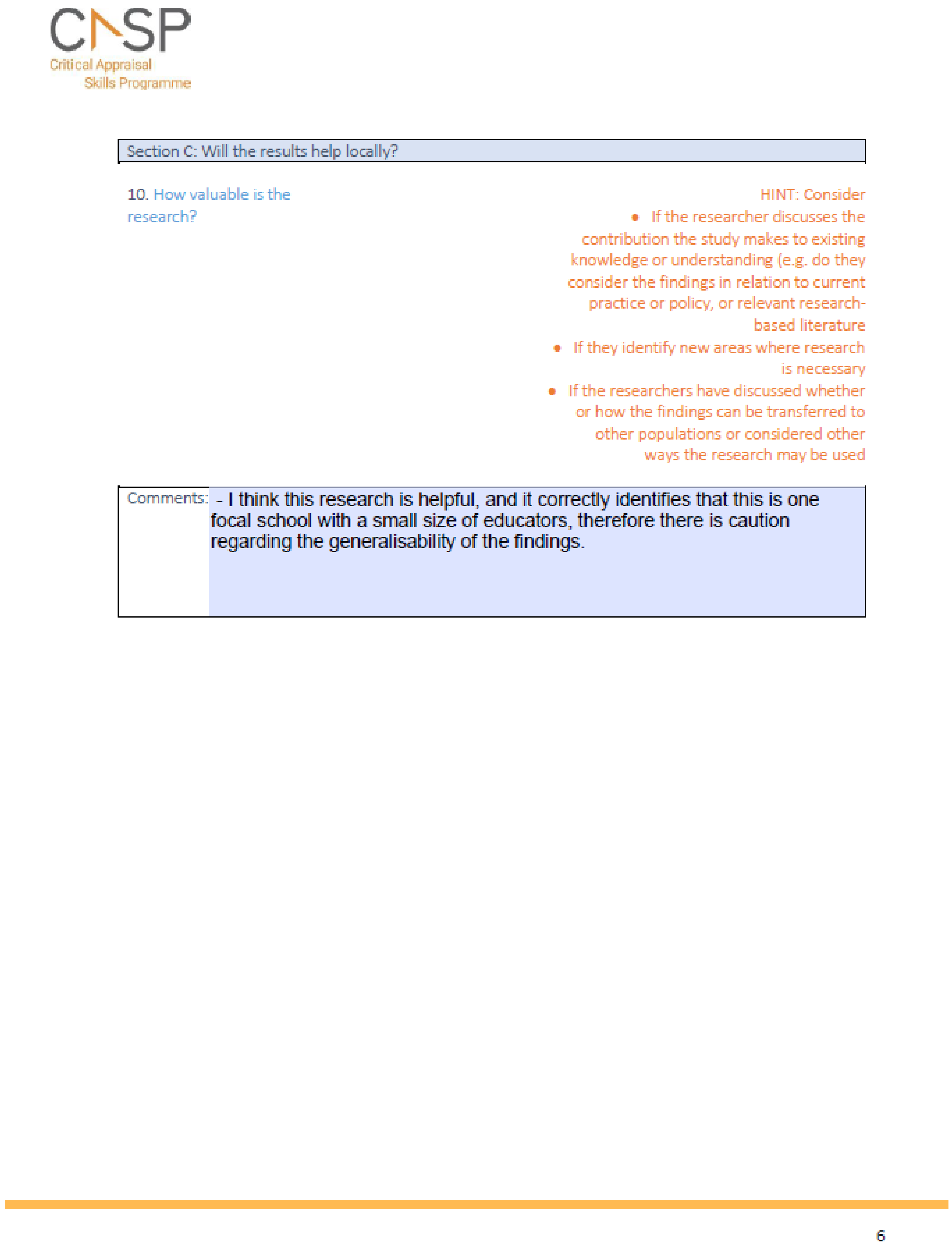
Comments: - Content analysis was used and there is detail regarding the coding of data.

9. Is there a clear statement of findings?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: - Clearly detailed with the use of sub-headings.



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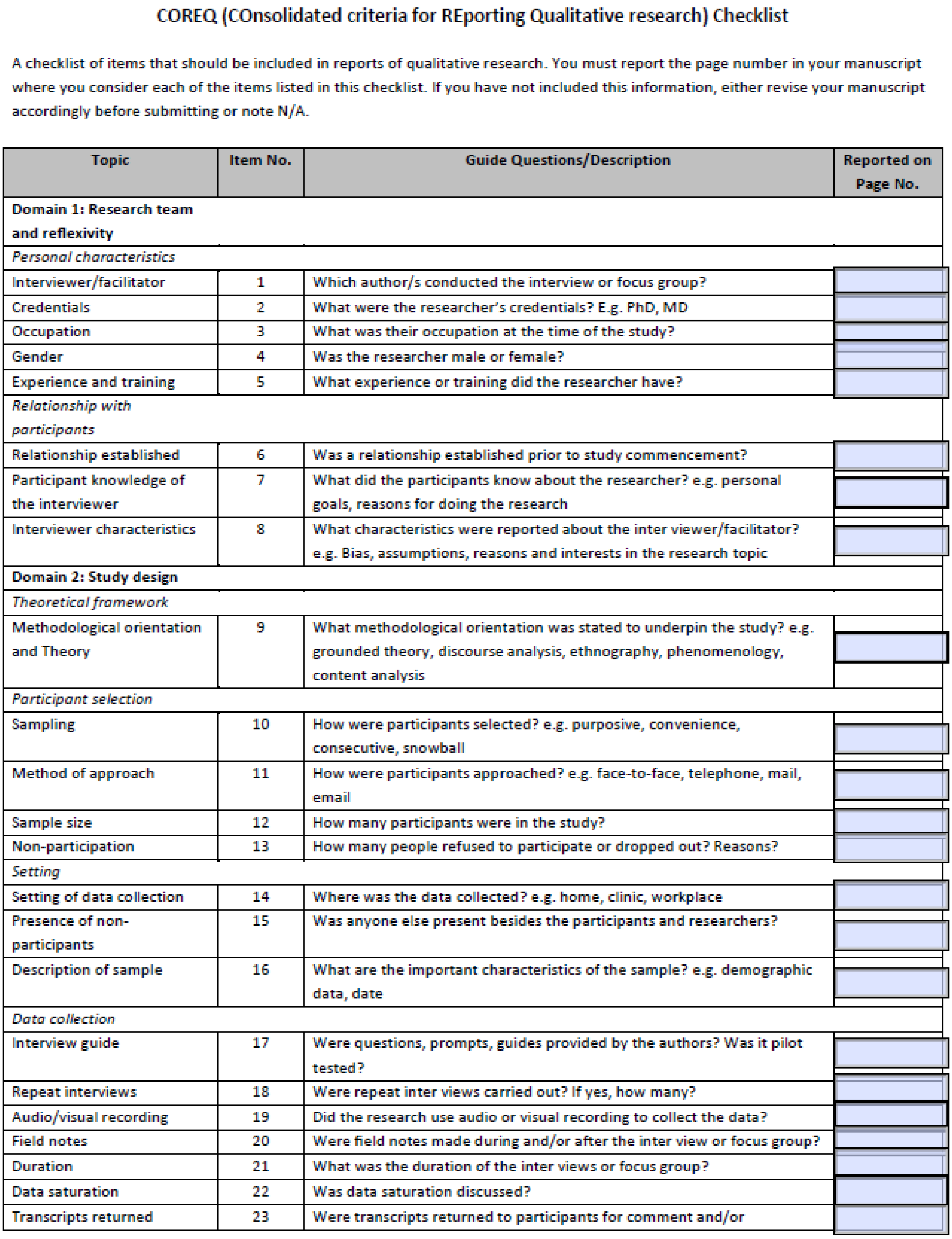
Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments: - I think this research is helpful, and it correctly identifies that this is one focal school with a small size of educators, therefore there is caution regarding the generalisability of the findings.

Appendix 1.6: CORE-Q Checklist



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the inter view or focus group?	
Duration	21	What was the duration of the inter views or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	**Item No.**	**Guide Questions/Description**	**Reported on Page No.**
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Appendices for Major Research Project

Appendix 2.1: Research Proposal

Experiences of Personal Independent Payment assessments from the perspective of individuals seeking therapy for trauma

Abstract

Objective: The primary aim of the study is to understand the extent to which participants' experiences of attending a PIP assessment can be made sense of in the context of the Trauma Informed Care (TIC) framework. There are two secondary aims: firstly, to identify what other experiences participants describe that are not captured by the TIC framework. Secondly, to establish the limitations of the framework for understanding participant's experiences.

Design: A qualitative Framework method will be used. Semi-structured individual interviews will be audio recorded and transcribed verbatim.

Methods: Between 10-16 participants will be recruited from NHS mental health services. Participants will be seeking therapy for trauma and will have also attended a PIP assessment. Framework Analysis will be utilised to map initial interview themes onto the TIC framework. Thematic Analysis will then be used to identify other experiences that are not captured by the framework but emerging from the data.

Applications: It is hoped this research will contribute to the emerging evidence base for the application of TIC in broader public services, as well as giving a voice to individuals' experiences of the benefit system.

Introduction

There is an increasing amount of research exploring the impact of austerity measures on mental health over recent years (Edmiston et al., 2017). Shame and humiliation may be experienced by individuals who are engaged in the benefits system and affected by the changes due to austerity policies (Garthwaite, 2014; Samuel et al., 2018). The experience of ongoing shame and humiliation has been found at the core of many forms of psychological distress and increases the risk of depression, particularly in individuals who are socially isolated (Kim et al., 2011).

Personal Independence Payment (PIP) replaced Disability Living Allowance (DLA) in 2013, with the qualifying criteria being narrower, making it more difficult to claim (Machin, 2017). PIP is conditional upon a medical assessment, conducted by a registered health care professional. There is a concern that these assessments are overly medicalised, focusing on a person's physical ability to carry out tasks, which may be unrelated to the issues for which they are seeking support (Baumberg et al., 2015). Therefore, their daily functioning and associated difficulties (psychologically, emotionally, cognitively) may not be truly captured. Claimants have reported the assessment process as being geared towards physical disability not mental health difficulties (Shefer et al., 2016). Considering nearly 50% of individuals claiming PIP have a mental health condition (Department of Work and Pensions (DWP), 2018), this is concerning.

Qualitative research findings suggest that attending PIP assessments can be distressing for claimants (De Wolfe, 2012). Significant fear of contact from the DWP has been described, with participants' "*fear of the brown envelope"* dominating their lives (Garthwaite, 2014). Additionally, the assessment process was described as being "*pretty depressing"* due to the focus on an illness model and limitations (Gillespie & Moore, 2016). Claimants reported feeling that they were not treated with respect or sensitivity, both in encounters with benefits officials and in the wider benefits system (Bauld et al., 2012).

The process was felt to be particularly insensitive to the needs of those with mental health difficulties (Hamilton et al., 2016). A participatory social welfare study found that claiming benefits for mental health-related difficulties is “*humiliating, isolating and frightening*” for claimants; creating a sense of powerlessness (Poetner et al., 2019). Prior studies have produced similar findings; claimants described the “*anxiety and dread*” of attending assessments (Barr et al., 2016) and reported the assessment process making them feel suicidal (Saffer et al., 2018). Assessments were described as being re-traumatising as claimants were asked to talk about intimate experiences without emotional support (Shefer et al., 2016). Personal experiences of those attending a PIP assessment who had a diagnosis of Post-Traumatic Stress Disorder (PTSD) have reported them as being highly distressing and panic-inducing (The Guardian, 2016), with assessors lacking empathy and not being trauma-informed (The British Psychological Society, 2018).

There is a growing research base which increasingly supports the hypothesis that experiencing trauma can significantly contribute to the causation and perpetuation of many forms of psychological and emotional distress (Bentall *et al.*, 2014). There is a call for the impact of trauma to be recognised and responded to more helpfully in society (Varese et al., 2012). The Adverse Childhood Experiences (ACE) study found that the greater number of adverse life events experienced in childhood, the greater the likelihood of psychological, psychosocial and health issues in later life (Anda *et al.*, 2010). The ACE research, along with similar studies, highlights the link between experiencing trauma in childhood and long-term negative health outcomes in later life (Talbot et al., 2011; Wheeler et al. 2005).

There has been growing recognition that systems (e.g. mental health care, health care, criminal justice) can serve to harm and re-traumatise individuals who have a history of trauma (O’Hagan et al., 2008). This has led to a call for organisations to acknowledge the social and psychological factors in the development and maintenance of distress (Johnstone et al., 2014) and to develop trauma-informed approaches which acknowledge the impact of trauma and resist re-traumatisation (Hodas, 2006). The Power Threat Meaning Framework (Johnstone et al., 2018) was established as an alternative way to conceptualise the medicalised model of distress; recognising the impact of traumatic experiences and changing the narrative from ‘what is wrong with you?’ to ‘what has happened to you?’.

Trauma Informed Care (TIC) was developed in recognition of the prevalence of trauma and need for services to become more trauma informed to support individuals (Harris & Fallot, 2001). It is applicable to all public services, including medical care, mental health, education, criminal justice and social care (Cole *et al.*, 2013). Therefore trauma-informed services are not just designed to treat the impact of trauma, they are services where the importance of creating a safe space and relationships with individuals is recognised (Jennings, 2004).

NHS Education for Scotland (NES) is an education and training body in Scotland, providing training to NHS workers and broader public services. NES was commissioned to develop ‘Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce', as part of the Scottish Government's commitment to developing a National Trauma Training Strategy. The Trauma Informed Practice level describes the baseline knowledge and skills required by everyone in the Scottish workforce, including the benefits system. The Framework is based on existing TIC literature and service user experiences, with the following five principles identified: choice, collaboration, trust, empowerment and safety (NHS Education for Scotland, 2017).

At present, and to the best of our knowledge, there is no research into TIC being implemented in the benefits system in the UK. This research therefore aims to explore of experiences of PIP assessments, from the perspectives of those who have experienced trauma. These experiences will be mapped onto the TIC framework, to gain an understanding of whether participants’ experiences can be captured by this.

Aims

The primary aim of the study is to understand the extent to which participants' experiences of attending a PIP assessment can be made sense of in the context of the TIC framework.

There are two secondary aims: to identify what other experiences participants describe that are not captured by the TIC framework, and to establish the limitations of the framework for understanding participants' experiences.

Research questions

1. To what extent does the TIC framework capture participants' experiences of attending a PIP assessment?

2. What experiences do participants describe that are not captured by the TIC framework?

3. What are the limitations of the TIC framework for understanding participants' experiences of PIP assessments?

Participants

Participants will be 18 years of age or over, have attended a PIP assessment in the last 3 years, be attending psychological therapy for trauma-based difficulties (in NHS Greater Glasgow and Clyde and Lanarkshire health boards) and be willing to talk about their experiences.

Justification of sample size

A sample size of 12–18 participants is in line with previous qualitative doctoral theses where Framework Analysis has been used (Artis, 2012; Purvis, 2017; Xanidis, 2018). Flexibility is needed to ensure there will be sufficient data, which will be assessed through the analytical process. It is recognised that recruitment may be more difficult as a result of COVID-19 and NHS services being stretched, therefore a slightly smaller sample size of 10-16 participants may be realistic.

Inclusion and exclusion criteria

People aged below 18 will be excluded from participation. English language proficiency below the level required to understand written information sheet and questionnaires. The decision to exclude those without sufficient understanding of written English is to ensure individuals have the capacity to understand the information about the study and take part independently. As this is a qualitative study, the ability to communicate in English is necessary for the analytic process. Individuals who are unable to complete the study due to experiencing significant cognitive impairment (e.g. diagnosis of Dementia, Learning Disability, those with anoxic brain injury). Individuals with the aforementioned conditions will be excluded as they may not be able to provide informed consent. Individuals who are acutely distressed will be excluded from the study, due to the risk of the interviews causing further destabilisation.

Participants will not need a formal diagnosis of PTSD to be eligible for the study but will have been receiving psychological therapy in an NHS mental health service for trauma-based difficulties.

Type I trauma is defined as a single incident which results in anxiety; flashbacks, nightmares and ‘re-living’ the traumatic event. Type II trauma is defined as repeat trauma, often experienced in childhood or early stages of development. Individuals experiencing Type II

PTSD will meet criteria for Type I, but with additional symptoms such as difficulties with interpersonal relationships and regulating emotions (Herman, 1992).

Individuals will not meet the criteria to take part in the study if they are not currently seeking psychological treatment for trauma, they are seeking psychological therapy for trauma in a non-NHS setting and if they have not attended a PIP assessment within the last 3 years.

Recruitment procedures

Participants will be recruited through psychological therapy services in NHS Greater Glasgow & Clyde and NHS Lanarkshire.

Information leaflets will be made available to clinicians to circulate in their teams, with further information about the study. Information leaflets for participants will also be provided, so that clinicians can give these to interested potential participants who meet the inclusion criteria.

After participants have given verbal consent, participant information sheets will be sent via post or email. The participant information sheet will contain the interview topics that will be asked about. The researcher will then explain, prior to interview, confidentiality, anonymity and the participants' right to withdraw at any stage. Participants will then be asked to complete consent forms online via, or will be sent these through the post if they do not have access to the internet. The online consent forms will be hosted by a secure UK-based online platform called Online Surveys, available from the University of Glasgow. All interviews will be carried out by the lead researcher and will take place at a mutually convenient location (NHS clinics, depending on availability) telephone or over Attend Anywhere. In total, the maximum amount of participants time taken including the consent process, will be 2.5 hours.

Method

Individual semi-structured interviews will be conducted. The interview will last around 60 minutes, with 9 broad topic areas. These will be open-ended questions, in order to prompt subject areas for discussion, without constraining participants' responses. In light of the

COVID-19 pandemic and restrictions in place, interviews may need to be completed digitally instead by use of NHS-approved web-based platform Attend Anywhere. Participants may be given the option of having a face to face interview (in line with Scottish Government social distancing guidelines) at a mutually convenient location, or an interview over telephone or Attend Anywhere.

An interview topic guide has been developed to reflect the research aims and questions. The TIC framework has been used to highlight key areas used to develop the questions in the topic guide, to allow participants to reflect on the key TIC constructs.

Framework

The TIC framework as defined by this study is based on the NES policy document 'The Scottish Psychological Trauma Training Plan' (2019) which draws upon the current literature and evidence-base for trauma-informed organisations. There are 5 further underpinning values: choice, collaboration, trust, safety and empowerment. These 5 principles will be the framework which informs the interview topics and subsequent analysis for this study.

Design

This study will utilise a qualitative design to explore individuals' perspectives of attending a PIP assessment through the lens of TIC, using semi-structured interviews. The epistemological position of this study will be critical realism, in recognition that the experience of participants, and the researcher, is influenced by the social, structural and political context in which the study is conducted (Danermark et al., 2002).

Data management plan

As an NHS employee the researcher must comply with the NHS Confidentiality Code of Practice on Protecting Patient Confidentiality (2002) and updated General Data Protection Regulation (GDPR) guidance.

No data processing has been identified as high risk for this project. Potential participants will be identified from clinicians in NHS Psychology services who meet the criteria to take part in the study. If participants express an interest in taking part, they will be asked by their clinician to provide contact details (e.g. email address, home address or telephone number) so that the researcher can make contact. The clinician will document this on the NHS electronic computer system. If participants express an interest in participating and then later decline, no personal details will be retained.

Participants will also be asked if they would like to receive a copy of the results. Participants' contact details will be stored electronically on a password protected NHS computer system. It is anticipated that personal information will be stored until the end of the study and then destroyed. All other data will be archived for 10 years.

The study will involve participants completing consent forms and demographic information using an online survey, whereby the data will be kept digitally. If participants do not have access to the internet or if they are meeting the researcher in person, paper consent forms and demographic information forms will be provided instead. This will then be scanned and saved in a secure file on an NHS computer system. Only the lead researcher will have access to this information, which will be password protected. Those participants who are unable to access the internet will be sent paper copies of the consent form and demographic data sheet, alongside a stamped addressed envelope, to return to the lead researcher at the University of Glasgow. Any paper consent forms will be stored at the University of Glasgow in a secure/locked filing cabinet, the scanned copies will be retained in the NHS server.

Interviews will be audio recorded using an encrypted digital recorder. This will then be transcribed by researcher, whereby all data will be saved in a password-protected file on an encrypted NHS drive. During transcription the names of individuals, relationships, locations and places will be replaced using the following anonymisation <Name1><Relationship1><Location1><Place1> etc. These anonymised data will be only be accessed by members of the research team. In addition, the study sponsor, NHS Greater

Glasgow & Clyde, may also access relevant files and data for audit purposes. The data will be stored securely for ten years and then deleted from the computer system.

The researcher may make electronic notes following the interviews, which will be used as part of the data analysis process. These notes will be stored alongside the transcriptions. Participants will be informed of how long their data will be processed and stored.

The lawful basis for processing will come under Legitimate interests. Specifically, there is a legitimate interest in processing research participants/NHS patients' data to:

- Contribute to the growing literature seeking to understand the lived experiences of the benefit system from those who have experienced trauma.
- Contribute to the emerging evidence-base for the implementation of Trauma Informed Care in broader public services in the United Kingdom.

The processing is necessary to achieve the purpose and the research's specific aims. There are no known other/less intrusive ways to achieve the same outcome. The research and data collection methods have been designed in a in a way to meet the data minimisation principle. No unnecessary data will be collected or processed.

Data analysis

Framework analysis will be used to analyse the data captured in the interviews, to find themes in the data and to evaluate whether the TIC framework captures participants' experiences.

Framework analysis will be carried out in line with the seven stages as outlined by Gale (2013): transcription; familiarisation; coding; developing a working analytical framework; applying the analytical framework; charting data into the framework matrix, and interpretation. The researchers' field notes and reflective notes will also be considered at familiarisation stage.

Although the TIC framework will be used to identify interview topics, it is important to be open minded and flexible at both interview and data analysis stages. Inductive thematic analysis will also be carried out to ensure that all participants' data is captured, even if it does not fit within the TIC framework.

The results of the study will be formally written up as a submission according to requirements for the degree of Doctor of Clinical Psychology (DClinPsy) at the University of Glasgow. Participants will be given the option to receive a copy of the study results, as documented in the consent form. It is anticipated that the results will be disseminated via publication in a peer-reviewed journal, conference presentation and shared by colleagues and professional groups who have expressed an interest in this topic area.

Ethics

This research will be conducted in line with the principles of TIC. Careful consideration will be given to possible re-traumatisation and distress caused by recounting difficult experiences of PIP assessments. Care will be taken to ensure there is a trauma informed approach to this project, including any changes made due to COVID-19 restrictions such as interviewing over video call. Consideration will be given to participants' feeling safe to speak in their home environment. The participant information sheet contains the topics that the interview will cover, it is hoped this will make the interview process more transparent. The researcher will explain that there may be topics that arise organically that do not fall within the planned topics, due to the flexible nature of the interviews. It will be made clear to participants that they can choose not to answer questions.

To minimise risk of distress, participants will be made aware of what the study involves by the Participant Information Sheet and by speaking with the researcher. The researcher will check in with participants during the interviews and prioritise attending to any distress experienced. Participants will be supported to contact support available in their health board if needed. All participants will be currently receiving psychological support in the NHS.

To prevent risk of coercion, it will be explained to clinical staff that participation is voluntary, and no pressure should be exerted upon anyone to take part. If an individual expresses an interest in taking part in the study, the researcher will then be in contact to provide further details. It will be made clear to potential participants that they could withdraw from the process at any time without giving a reason, including mid-interview. Information collected will be used for analysis.

Confidentiality will be explained to participants, both written and verbally. This includes explaining that data quotations will be used but anonymised to ensure confidentiality.

Data will be anonymised and stored in a password protected computer in line with Greater Glasgow and Clyde NHS guidelines on handling confidential data. It is anticipated that there will be minimal manual files, if there are paper copies of consent forms these will be scanned onto an NHS database. The paper copies will be kept in a secure locked filing cabinet at the University of Glasgow by the researcher.

The Research Proposal and proposal amendments for this study will be approved by NHS Ethics.

Financial issues

See Appendix 2.

Proposed Timetable

Autumn 2020 – Submit Ethics application.

Winter 2020–Spring 2021 – Recruitment and interviews.

Summer 2021 – Analysis and write up.

Practical applications

This project will add to the growing research base of the impact of austerity measures on mental health (Barr, 2015; Cummins, 2018). There is also a lack of research into the TIC framework being implemented in the UK, and none involving the benefits system.

Responsibility for all devolved benefits, including PIP, will sit with the Scottish Government from 1 April 2021. The assessment process is being re-designed and it is hoped that this research can provide insight into creating a trauma-informed approach. Due to COVID-19, many people are accessing the benefits system for the first time so further research into individuals' experiences of this is currently very relevant.

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Appendices

Appendix 1. Health and Safety Form

University of Glasgow
College of Medical, Veterinary & Life Sciences

HEALTH & SAFETY FORM

HEALTH AND SAFETY FOR RESEARCHERS

1. Title of Project	Experiences of Personal Independent Payment assessments from the perspective of individuals seeking therapy for trauma; a Trauma-Informed Care Framework analysis
2. Trainee	Helen Roberts
3. University Supervisor	Dr Andrew Gumley
4. Other Supervisor(s)	Dr Simon Stuart and Dr Stephanie Allan
5. Local Lead Clinician	Three Psychologists; in Glasgow, Lanarkshire and Edinburgh

6. Participants: (age, group or sub- group, pre- or post-treatment, etc)	Individuals who are 18 + years of age, English speaking, receiving psychological therapy for trauma-based difficulties, have attended a Personal Independent Payment benefit assessment and be willing to talk about their experiences
7. Procedures to be applied (eg, questionnaire, interview, etc)	In-depth interviews
8. Setting (where will procedures be carried out?) i) General	NHS clinics in Glasgow, Lanarkshire and Edinburgh or over Attend Anywhere/telephone, in light of COVID-19 restrictions
ii) Are home visits involved	No
8. Potential Risk Factors Identified see chart	Risk to participants, research procedures, settings.
10.Actions to minimise risk (refer to 9)	Careful consideration will be made to ensure the research process is trauma-informed to prevent distress and re-traumatisation. Participant information sheets will be available and participants will be currently in treatment in Clinical Psychology services. If a participant became distressed during the interview process, the researcher will check in with the participant and attend to this. The interviews may take place in an NHS clinical setting that participants routinely attend. They have procedures in place to minimise risk to staff and these are thought to be adequate in the context of the proposed study. Alternatively, interviews will take place over the web-based platform Attend Anywhere and care will be taken to ensure participants feel they are in a safe, confidential space to speak.

Appendix 2. Equipment costs form

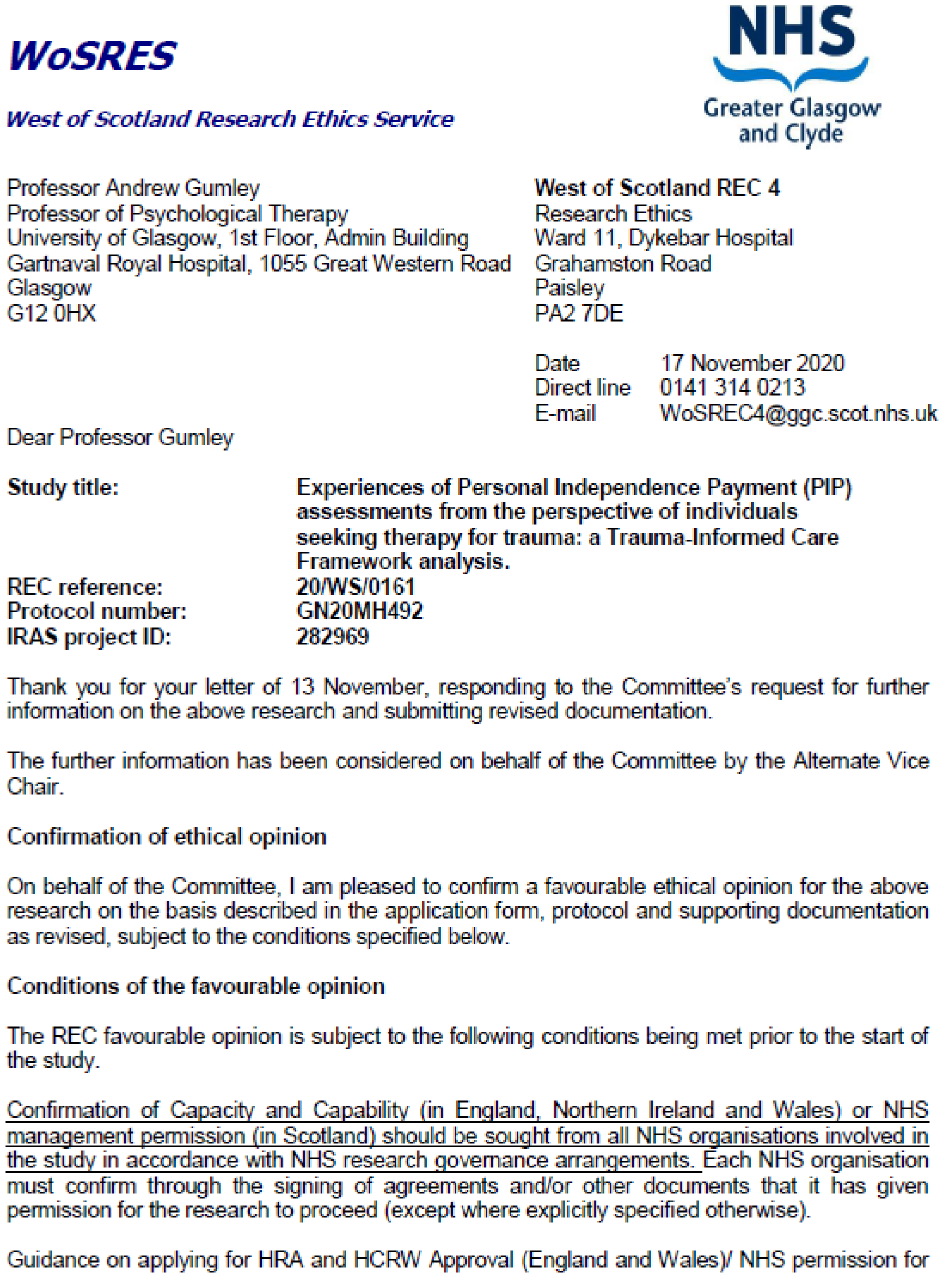
University of Glasgow | College of Medical, Veterinary & Life Sciences

RESEARCH EQUIPMENT, CONSUMABLES AND EXPENSES

Item	Details and Amount Required	Cost or Specify if to Request to Borrow from Department
Stationary	- Envelopes A4 – 1 box of 250 to send interview topic guides for consultation, to send transcripts to participants for member reflections, and to send plain language summaries of findings to participants and stakeholders - Ream of white paper x 3 for transcription and data analysis.	-Box of 250 A4 envelopes = £10.73 -3 reams of 500 sheets white paper at £2.57 each = £7.71
Postage	-Postage to send transcripts to participants for member reflections (20), and to send plain language summaries of findings to participants (20) and stakeholders (10) – 2nd class x 50 -Freepost x 20 for any written member reflections to be returned to researcher	-50 large letters at £0.83 per 100g = £41.50 -20 freepost envelopes at £0.61 each = £12.20

Photocopying and Laser Printing	-Participant information sheets - estimated 2 pages x 50 -Consent form -estimated 2 pages x 20 -Interview topic guides - estimated 2 pages x 40 - Field notes record form – estimated 2 pages x 20 - Transcripts – estimated 40 pages (large print) x 20	1100 pages of B&W print at £0.05 per page = £55
Equipment and Software	-Audio recording equipment -Laptop -Encrypted USB stick -Foot pedal for transcription	Request to borrow from Department
Measures		.
Miscellaneous	Public transport costs for participants	£10 per person X 20 = £200
Total		£327.14 (*These costs may be amended if interviews are carried out over video call – no public transport costs necessary)*

Appendix 2.2: Ethical Approval – NHS West of Scotland Research Ethics Committee REF: 20/WS/0161



WoSRES

West of Scotland Research Ethics Service

NHS
Greater Glasgow
and Clyde

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West of Scotland REC 4
Research Ethics
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Grahamston Road
Paisley
PA2 7DE

Date 17 November 2020
Direct line 0141 314 0213
E-mail WoSREC4@ggc.scot.nhs.uk

Dear Professor Gumley

Study title:	**Experiences of Personal Independence Payment (PIP) assessments from the perspective of individuals seeking therapy for trauma: a Trauma-Informed Care Framework analysis.**
REC reference:	**20/WS/0161**
Protocol number:	**GN20MH492**
IRAS project ID:	**282969**

Thank you for your letter of 13 November, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Alternate Vice Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Registration is a legal requirement for clinical trials of investigational medicinal products (CTIMPs), except for phase I trials in healthy volunteers (these must still register as a condition of the REC favourable opinion).

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral:
https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

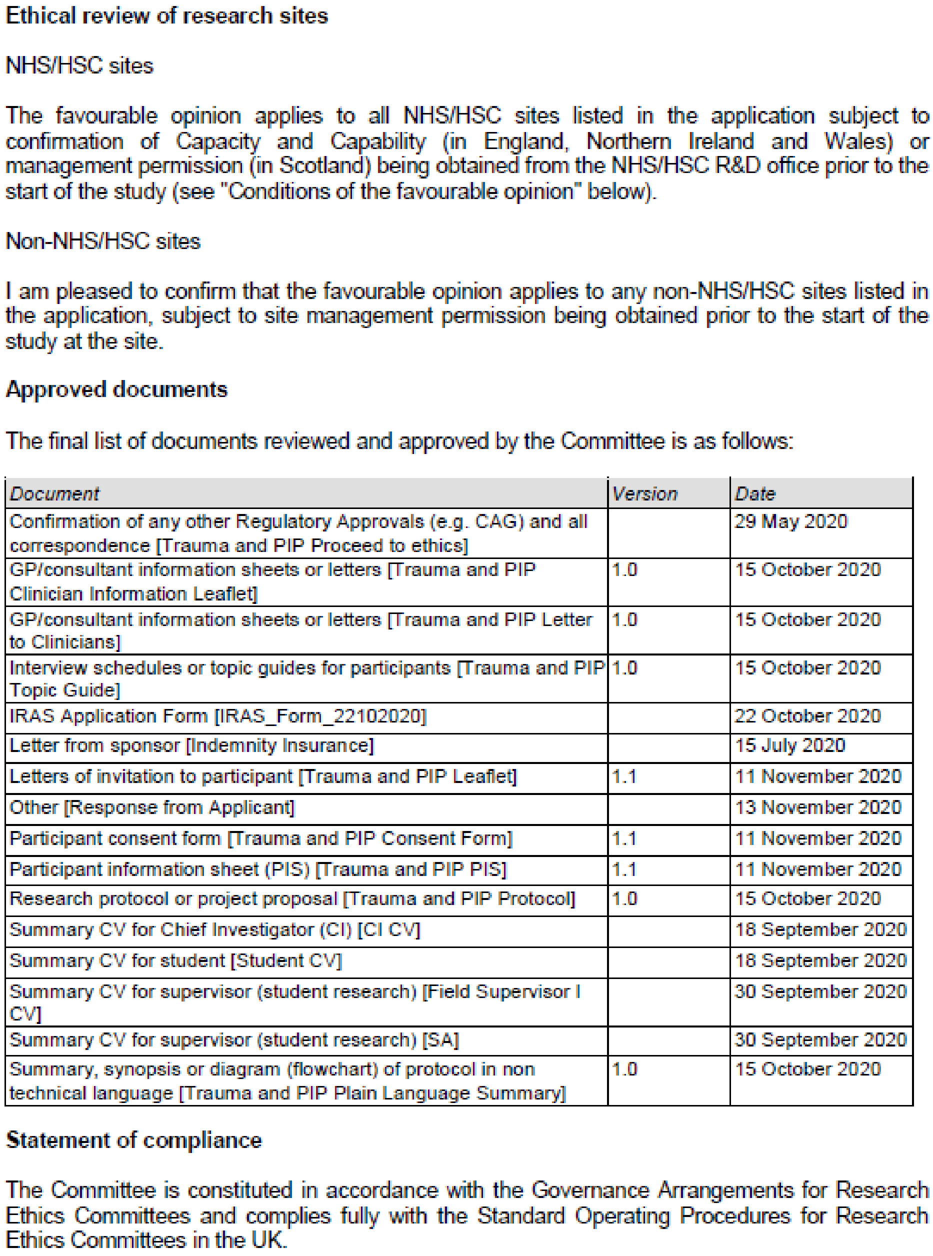
It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at
https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.



Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites listed in the application subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

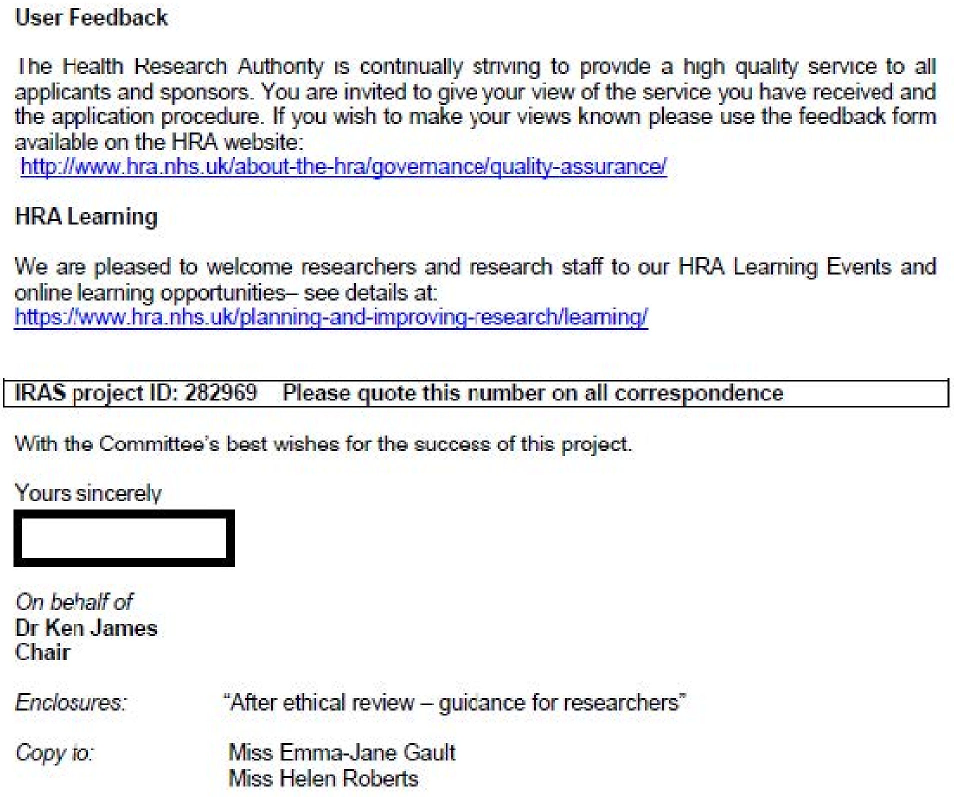
Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Trauma and PIP Proceed to ethics]		29 May 2020
GP/consultant information sheets or letters [Trauma and PIP Clinician Information Leaflet]	1.0	15 October 2020
GP/consultant information sheets or letters [Trauma and PIP Letter to Clinicians]	1.0	15 October 2020
Interview schedules or topic guides for participants [Trauma and PIP Topic Guide]	1.0	15 October 2020
IRAS Application Form [IRAS_Form_22102020]		22 October 2020
Letter from sponsor [Indemnity Insurance]		15 July 2020
Letters of invitation to participant [Trauma and PIP Leaflet]	1.1	11 November 2020
Other [Response from Applicant]		13 November 2020
Participant consent form [Trauma and PIP Consent Form]	1.1	11 November 2020
Participant information sheet (PIS) [Trauma and PIP PIS]	1.1	11 November 2020
Research protocol or project proposal [Trauma and PIP Protocol]	1.0	15 October 2020
Summary CV for Chief Investigator (CI) [CI CV]		18 September 2020
Summary CV for student [Student CV]		18 September 2020
Summary CV for supervisor (student research) [Field Supervisor I CV]		30 September 2020
Summary CV for supervisor (student research) [SA]		30 September 2020
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Trauma and PIP Plain Language Summary]	1.0	15 October 2020

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.



User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 282969 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

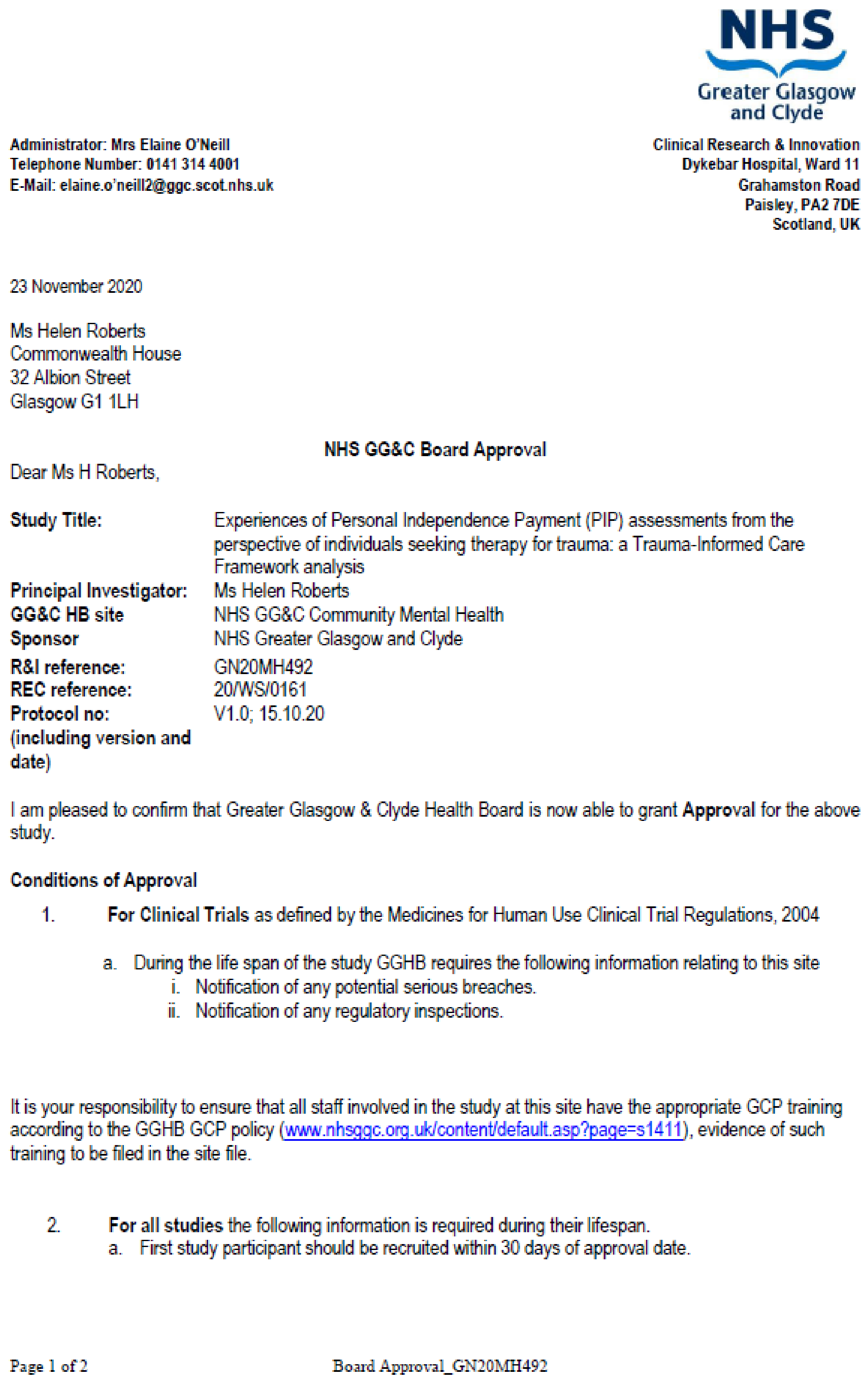
[redacted]

On behalf of
Dr Ken James
Chair

Enclosures: "After ethical review – guidance for researchers"

Copy to: Miss Emma-Jane Gault
Miss Helen Roberts

Appendix 2.3: Ethical Approval – NHS GREATER GLASGOW AND CLYDE (GG&C) REF: GN20MH492



NHS
Greater Glasgow
and Clyde

Administrator: Mrs Elaine O'Neill
Telephone Number: 0141 314 4001
E-Mail: elaine.o'neill2@ggc.scot.nhs.uk

Clinical Research & Innovation
Dykebar Hospital, Ward 11
Grahamston Road
Paisley, PA2 7DE
Scotland, UK

23 November 2020

Ms Helen Roberts
Commonwealth House
32 Albion Street
Glasgow G1 1LH

NHS GG&C Board Approval

Dear Ms H Roberts,

Study Title:	Experiences of Personal Independence Payment (PIP) assessments from the perspective of individuals seeking therapy for trauma: a Trauma-Informed Care Framework analysis
Principal Investigator:	Ms Helen Roberts
GG&C HB site	NHS GG&C Community Mental Health
Sponsor	NHS Greater Glasgow and Clyde
R&I reference:	GN20MH492
REC reference:	20/WS/0161
Protocol no: (including version and date)	V1.0; 15.10.20

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

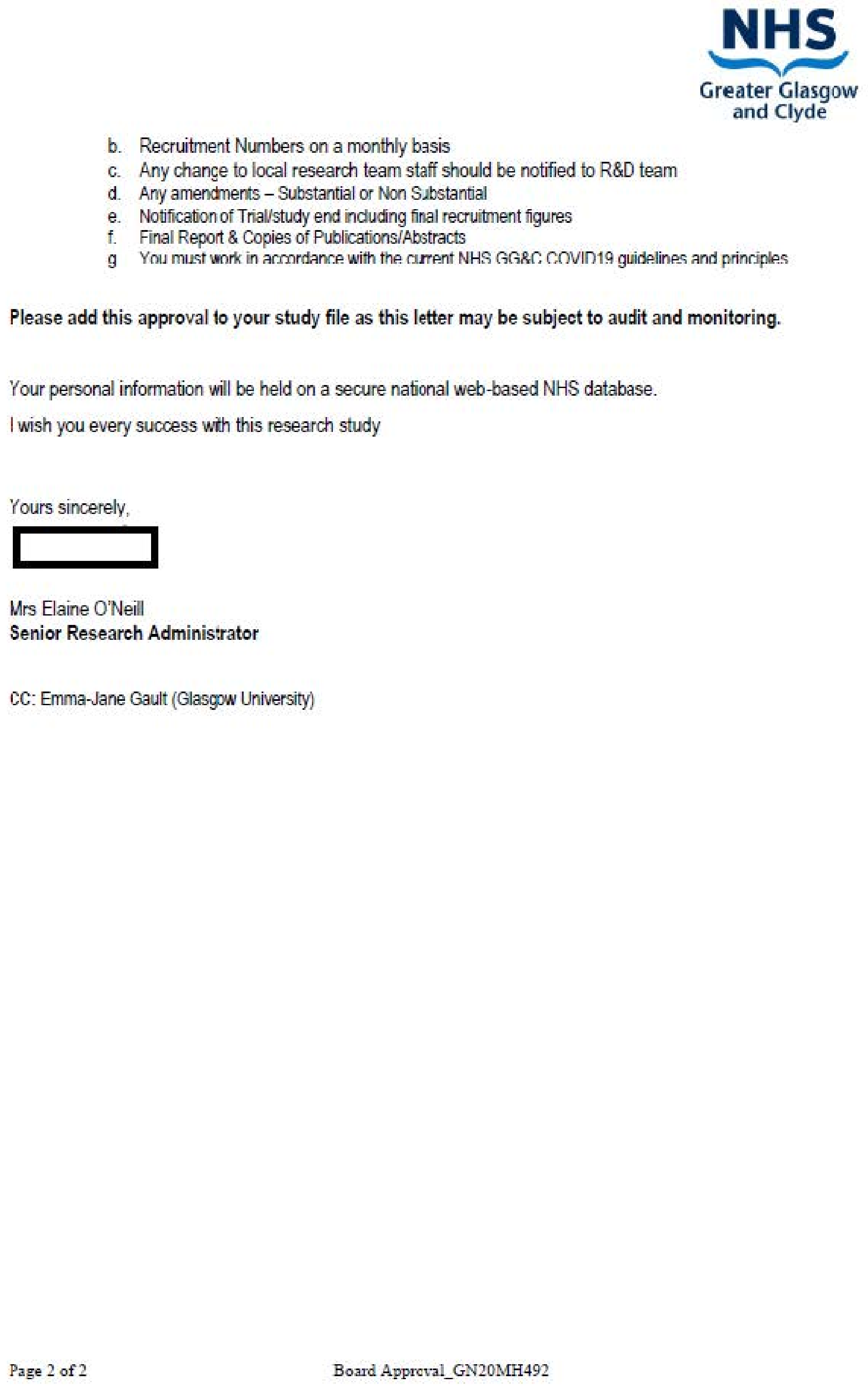
Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004

   a. During the life span of the study GGHB requires the following information relating to this site
      i. Notification of any potential serious breaches.
      ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
   a. First study participant should be recruited within 30 days of approval date.



NHS
Greater Glasgow
and Clyde

b. Recruitment Numbers on a monthly basis
c. Any change to local research team staff should be notified to R&D team
d. Any amendments – Substantial or Non Substantial
e. Notification of Trial/study end including final recruitment figures
f. Final Report & Copies of Publications/Abstracts
g You must work in accordance with the current NHS GG&C COVID19 guidelines and principles

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

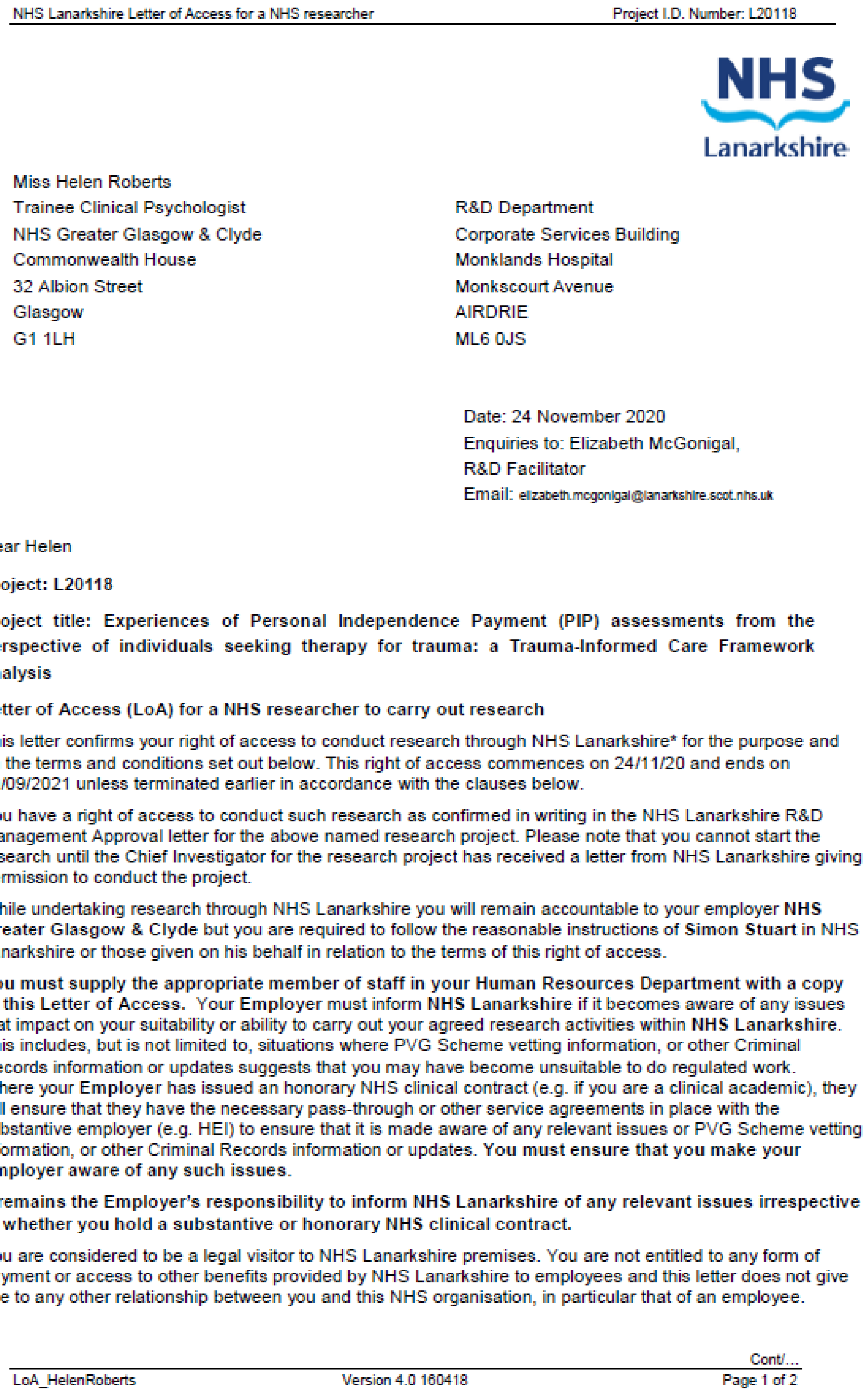
Yours sincerely,

[redacted]

Mrs Elaine O'Neill
Senior Research Administrator

CC: Emma-Jane Gault (Glasgow University)

Appendix 2.4: Ethical Approval – NHS Lanarkshire REF: L20118



Miss Helen Roberts
Trainee Clinical Psychologist
NHS Greater Glasgow & Clyde
Commonwealth House
32 Albion Street
Glasgow
G1 1LH

R&D Department
Corporate Services Building
Monklands Hospital
Monkscourt Avenue
AIRDRIE
ML6 0JS

Date: 24 November 2020
Enquiries to: Elizabeth McGonigal,
R&D Facilitator
Email: elizabeth.mcgonigal@lanarkshire.scot.nhs.uk

Dear Helen

Project: L20118

Project title: Experiences of Personal Independence Payment (PIP) assessments from the perspective of individuals seeking therapy for trauma: a Trauma-Informed Care Framework analysis

Letter of Access (LoA) for a NHS researcher to carry out research

This letter confirms your right of access to conduct research through NHS Lanarkshire* for the purpose and on the terms and conditions set out below. This right of access commences on 24/11/20 and ends on 30/09/2021 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the NHS Lanarkshire R&D Management Approval letter for the above named research project. Please note that you cannot start the research until the Chief Investigator for the research project has received a letter from NHS Lanarkshire giving permission to conduct the project.

While undertaking research through NHS Lanarkshire you will remain accountable to your employer **NHS Greater Glasgow & Clyde** but you are required to follow the reasonable instructions of **Simon Stuart** in NHS Lanarkshire or those given on his behalf in relation to the terms of this right of access.

You must supply the appropriate member of staff in your Human Resources Department with a copy of this Letter of Access. Your **Employer** must inform **NHS Lanarkshire** if it becomes aware of any issues that impact on your suitability or ability to carry out your agreed research activities within **NHS Lanarkshire**. This includes, but is not limited to, situations where PVG Scheme vetting information, or other Criminal Records information or updates suggests that you may have become unsuitable to do regulated work. Where your **Employer** has issued an honorary NHS clinical contract (e.g. if you are a clinical academic), they will ensure that they have the necessary pass-through or other service agreements in place with the substantive employer (e.g. HEI) to ensure that it is made aware of any relevant issues or PVG Scheme vetting information, or other Criminal Records information or updates. **You must ensure that you make your Employer aware of any such issues.**

It remains the Employer's responsibility to inform NHS Lanarkshire of any relevant issues irrespective of whether you hold a substantive or honorary NHS clinical contract.

You are considered to be a legal visitor to NHS Lanarkshire premises. You are not entitled to any form of payment or access to other benefits provided by NHS Lanarkshire to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

Cont/...

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by NHS Lanarkshire in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with NHS Lanarkshire policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with NHS Lanarkshire in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on NHS Lanarkshire premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.elib.scot.nhs.uk/SharedSpace/ig/Uploads/2008/Oct/20081002150659_6074NHSCode.pdf) and relevant UK and EU Data Protection legislation. Furthermore you should be aware that unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that NHS Lanarkshire accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

NHS Lanarkshire will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of UK and EU Data Protection legislation. Any breach of the UK and EU Data Protection legislation may result in legal action against you and/or your substantive employer.

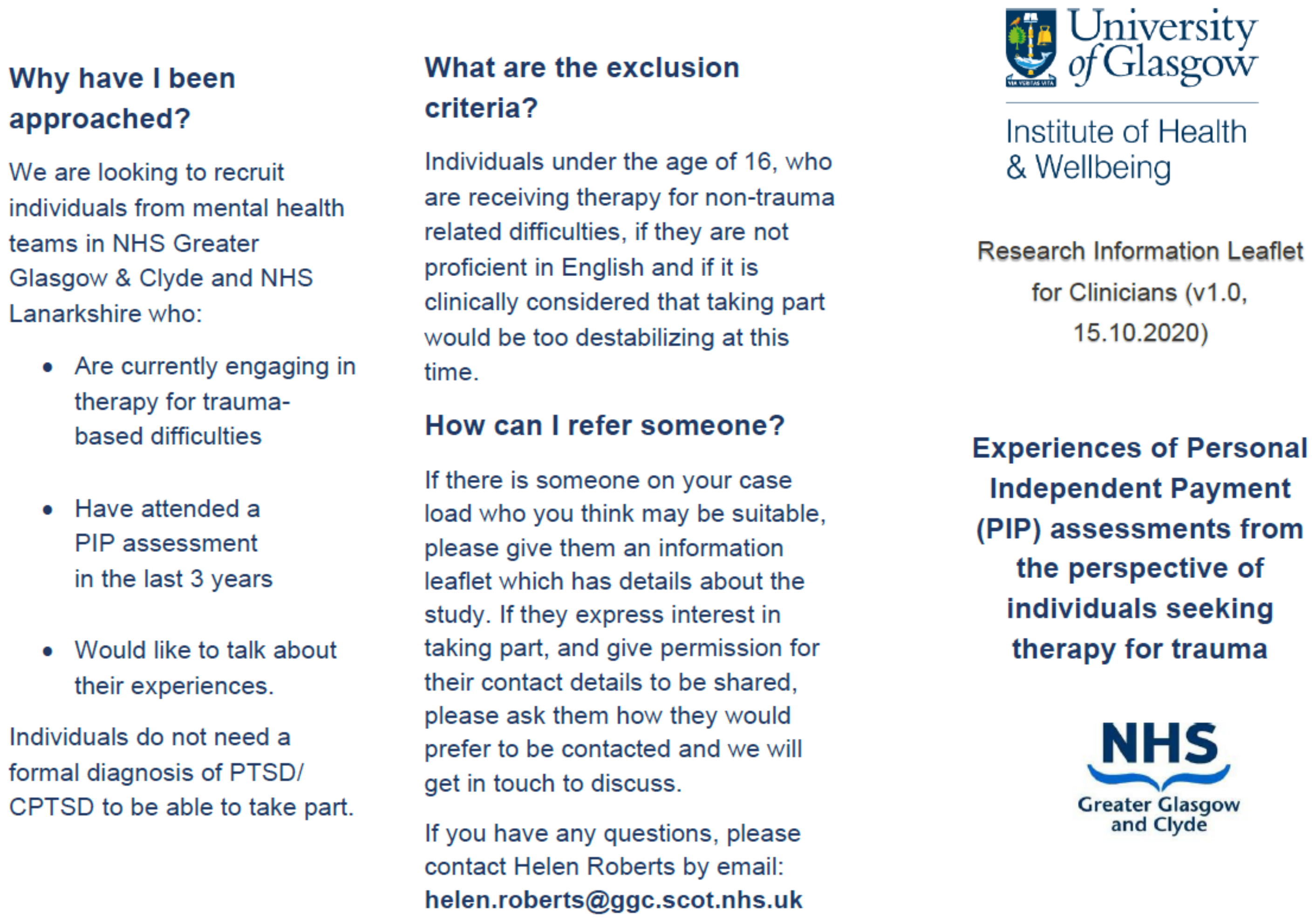
If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in NHS Lanarkshire.

Yours sincerely

Raymond Hamill,
Senior Research & Development Manager

NAME	TITLE	SITE	ROLE
Simon Stuart	Clinical Psychologist	Simon.Stuart@lanarkshire.scot.nhs.uk	Principal Investigator
Professor Andrew Gumley		andrew.gumley@glasgow.ac.uk	Chief Investigator
Emma-Jane Gault		emmajane.gault@glasgow.ac.uk	Sponsor Contact
Ruth Stocks	Professional Lead Psychology	ruth.stocks@ggc.scot.nhs.uk	Other

Appendix 2.5: Clinician Information Leaflet



Why have I been approached?

We are looking to recruit individuals from mental health teams in NHS Greater Glasgow & Clyde and NHS Lanarkshire who:

- Are currently engaging in therapy for trauma-based difficulties
- Have attended a PIP assessment in the last 3 years
- Would like to talk about their experiences.

Individuals do not need a formal diagnosis of PTSD/ CPTSD to be able to take part.

What are the exclusion criteria?

Individuals under the age of 16, who are receiving therapy for non-trauma related difficulties, if they are not proficient in English and if it is clinically considered that taking part would be too destabilizing at this time.

How can I refer someone?

If there is someone on your case load who you think may be suitable, please give them an information leaflet which has details about the study. If they express interest in taking part, and give permission for their contact details to be shared, please ask them how they would prefer to be contacted and we will get in touch to discuss.

If you have any questions, please contact Helen Roberts by email: **helen.roberts@ggc.scot.nhs.uk**

University of Glasgow

Institute of Health & Wellbeing

Research Information Leaflet for Clinicians (v1.0, 15.10.2020)

Experiences of Personal Independent Payment (PIP) assessments from the perspective of individuals seeking therapy for trauma

NHS
Greater Glasgow and Clyde

What is the study about?

This study aims to understand people's experiences of attending PIP assessments, specifically those who have experienced trauma.

Who is conducting the study?

The lead researcher is Helen Roberts, a Trainee on the Doctorate in Clinical Psychology programme at the University of Glasgow. The study is being supervised by psychologists from the University of Glasgow, NHS Greater Glasgow & Clyde and Lanarkshire.

What will participation involve for my client?

If your client is interested in taking part, we will make contact with them via their preferred way of being contacted (telephone, email, post). We will then arrange to either meet with them in person or speak over telephone or Attend Anywhere, to go through the Participant Information Sheet before providing informed consent.

The study will involve participating in an interview. The interview will around 60 minutes and the participant will be offered as much choice as possible as to how the interview takes place. This may be face to face, in a mutually convenient location. If this is not possible due to COVID-19 restrictions, interviews can be carried out over the telephone or Attend Anywhere (an online video messaging service).

What are the advantages and disadvantages in taking part for my client?

Participants may find it upsetting to talk about difficult experiences. They will be informed of the interview topics beforehand and can choose to stop at any time.

It will be made clear to participants declining to take part will not impact on their ongoing NHS care. Participation is entirely voluntary, so it is hoped that individuals will find it helpful to share their lived experiences, and that this may contribute to changes in the future.

Appendix 2.6: Participant Information Leaflet

Why have I been asked to take part?

We are interested in hearing from people who:

- Attend mental health services in Greater Glasgow & Clyde or Lanarkshire for trauma- based difficulties
- Have attended a PIP assessment in the last 3 years
- Would like to talk about their experiences.

You have been identified by your clinician as someone who may be eligible to take part in this study.

Do I have to take part?

No. The study is completely voluntary, and you are under no obligation to take part.

If you do choose to take part, you can withdraw from the study at any time. If you choose to withdraw, the NHS care you currently receive will not be affected.

How can I take part?

If you are interested in taking part in the study, and/or if you have any questions, please let your clinician know your preferred way for us to get in touch with you (email, telephone or post) to give you further details.

NHS
Greater Glasgow
and Clyde

University of Glasgow

Institute of Health
& Wellbeing

Participant Information Leaflet V1.1
(11.11.20)

Experiences of Personal Independent Payment (PIP) assessments from the perspective of individuals seeking therapy for trauma

As a survivor of trauma who has attended a PIP assessment, you are invited to take part in a research study.

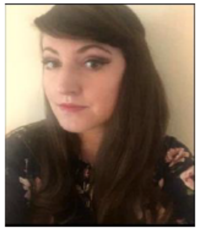
What is the study about?

Many people who attend mental health services for trauma-based experiences have also attended a PIP assessment.

We will be conducting interviews to find out about people's experiences of attending a PIP assessment. You will also be asked some questions based around these broad topics: safety, trust, choice, empowerment and collaboration.

These principles are considered to be good practice when working with survivors of trauma. For example, you may be asked how safe you felt during the assessment and whether you felt you had any control.

Who is conducting the study?



Helen Roberts is conducting this research as a Trainee on the Doctorate in Clinical Psychology programme at the University of Glasgow. The study is being supervised by psychologists from the University of Glasgow, NHS Greater Glasgow & Clyde and Lanarkshire.

What's involved?

If you are interested in taking part, Helen will provide you with a Participant Information Sheet which details further information about the study. She will meet with you to discuss the study and answer any questions you may have. Once you feel satisfied that you understand the study and what participation involves you can then decide whether you would like to participate or not. You will then be asked to complete a consent form.

The study will involve participating in an interview with Helen, so we can hear about your experiences. The interview will last around 60 minutes and the interview topics will be given to you beforehand in the Participant Information Sheet.

You will be given as much choice as possible as to how the interview takes place. This may be at a mutually convenient location, over the telephone or using Attend Anywhere (an online video service).

Appendix 2.7: Coding Key

Master theme	Sub themes
Trust	Distrust of the system (T1) Distrust of assessment: Lack of transparency (T2) Uncertainty – anxiety of not knowing outcome (T3) Of assessor: Distrust – lack of transparency - not giving anything away (T4) Sense of not being believed (T5) Distrust – of other claimants (T6)
Safety	Harm – anxiety – pre assessment (S1) Harm – distress – during assessment (S2) Harm – emotional impact of assessment (S3) Threat – fear of the brown envelope (S4) Threat – anxiety (S5) Threat – sense of surveillance (S6) Threat – sense of being punished (S7) Unsafe relationship with assessor – stranger (S8) Distressing environment (S9) Inaccessibility of environment (S11) Humiliation (S10) Need for emotional safety (S12)
Choice	Lack of choice (C1) Lack of flexibility (C2)
Empowerment	Feeling belittled (E1) Lack of control (E2) Having help from a professional (E3)
Collaboration	Relationship with assessor: Lack of collaboration (CO2) Power imbalance – intimidating (CO3)
Realisation [of trauma]	Assessor: Lack of understanding of MH (R1) System: Distress caused by repeat assessments (R8)
Recognise impact [of trauma]	System: Not sensitive to MH/trauma (R2)

	System: Not asking for input from MH professionals (R7)
Responding	**Assessor: Not responding to distress (R3)** **Lack of empathy (R4)**
Resisting re-traumatisation	**Assessment triggering prior trauma experiences (R5)** **Re-traumatisation – uncomfortable disclosures (R6)**
Other: **Personal context around assessment (O1)** **Personal MH experience (O2)**	

Appendix 2.8: Coded Transcript

Transcript #7 Christine

(Went through consent process verbally, re-capped study and confidentiality)

So in terms of getting started, do you have as a particular PIP assessment that you'd prefer to focus on today, to tell me about?

I've only ever had one I remember, which was the one couple years ago. Obviously I'm going through it the now but haven't had like a date or anything, where it'll be happening or how they'll be assessing, obviously because of Covid. (O1)

Yeah.

It just the one, it was was like, I think four years, three or three years ago, and it was in 2017 or so. Yeah, I can't even remember the exact date. It was last reviewed but obviously it was quite bad…experience. (O1)

What do you remember from that experience? Do you remember how you were feeling beforehand?

Yeah, I was really really nervous because I'd never been to anything like this before. (S1) And then I think it was the fact that you're having to discuss all your issues… there's something in my medical history that I don't talk to my family about, that I don't talk to anyone about. I'm quite a private person I would say. So I feel like it was this stranger and you're having to divulge so much information that… even like if you see someone, because I've been involved in CAMHS when I was younger as well and see the move over to like adult mental health, I've done that so…how to explain this sorry. (R6) It was done very… when it happened like I built up relationships, I didn't just start divulging. It takes me a while to… warm up. I don't know if that makes sense, to talk about things and obviously you don't get the opportunity to really warm up you just need to tell them everything (S8), and they probe and they ask things that you're currently going through. I did find that because obviously I was going through quite a traumatic experience… just having come out of…how do I explain this, I'd been abused…(R6) I'm trying to explain this sorry.

You're doing really well. You're explaining it really well.

It was just that was the worst possible time and I know that they're not aware of what you how you're feeling at that specific time. But I just don't think they're helpful. Like I just don't think they do.. I mean, what is me divulging my mental health issues or you know, to someone who is only medically equipped to deal with physical issues, e.g. a physio. That's like me divulging to complete strangers on the street with no knowledge because basically she has no knowledge of any of my issues. You know, as you've heard of, I've got Aspergers syndrome, and she hadn't even heard of Aspergers syndrome… So, like, if you haven't heard of my condition, it's like you're going in blind she doesn't know anything about it and how it effects me. I just think its very, I just think it needs…I think it's not the best way to assess people, whether they meet the criteria or not. Like there's better ways of doing things. I have a few suggestions but I don't think going into an assessment with someone who doesn't have a clue about any of your conditions is helpful and how are they best equipped to say whether you merit an award or not? (R1)

It feels geared towards the medical side of things, and not so much your emotional experiences?

That's been... I've heard now, they were being discriminatory against people with mental health issues and not allowing them to get the highest award for mobility, and obviously it was won at the high court and all of that. I mean that's disgraceful. That's, that's just like, I don't think they're well equipped at all when it comes to mental health. there's one thing that will accept at all, when it comes to mental health. And…I just… I think mental health is such a hard, difficult thing to assess whether they meet criteria on mental health, because how would you know? I mean, you would, I would say if I was doing it I'd base it on their notes, or their history…but they take it on this one assessment with all your details, I just don't get it. (R1)

And when you say that the assessor didn't really seem to understand mental health and doesn't understand Aspergers either… do you remember what things that happened or didn't happen, that left you feeling like that?

She literally said to me that she doesn't know what it was. She was like, what is that? It was myself, a social worker and my mum in the room and she literally asked us, what is that?

And then when you explained, do you remember -

(Interrupting) I think it was my mum that explained. And she went oh. (R1)

What was that like for you?

I think it was like a waste of, not being rude, it was a waste of my time being there because I felt like I'd stress myself out to the max.(S2) That didn't stop her continuing to ask questions about stuff that I was going through currently (R3), and stressing me out and having me in tears a few times and suffered in that…(S2) even though she doesn't have, she was a physio, she didn't have a clue anything about mental health, it seemed to me, obviously everyone has a basic knowledge of what your mental health is. But that doesn't mean that they're best equipped to… deal with you.(R1) If they ask you certain questions when you're going through… I literally was just out of being abused in supported accommodation. I think it was like, it wasn't even a full month.(R6)

Do you remember if you were given sort of any choice at all about this assessment taking place?

No. I was moving over from DLA. I think it was my age. So it was moving over from DLA to PIP, because I think I was on child PIP until DLA. And so it was moving over, when I was moving over in this assessment so we'd done the form, and it was, I mean, I had to do the form and all that… all that was completed when I had literally just come out of that situation, it was all within… I think that the actual changeover.. and the actual form being completed I think was within a week, I was on sleeping tablets and stuff.(O1) I wasn't sleeping and all that. And I had this stress on top, it was just an added stressor I didn't need at the time.(S1)

Yeah. Yeah. Did you feel was there any flexibility in changing the date at all?

No. Well you can get like..an extension, but an extension is like a couple of weeks to a month. Like it's not to complete the form.(C2) But because it was like a new application, I wouldn't have been receiving any money. And I was trying, I was trying to get my own house at that point. So I was trying to make sure that I had money away to get my own house, so that when I got my own house, I could actually furnish it. Um.. So it wasn't really an option not to, obviously I still had to live and stuff at that point. So I needed that money plus at that point… I couldn't do like any public.. still now, can't do any public transport and all that. So I really need that money for getting, if I was to get anywhere. If I was to go out or anything. My mum and dad and like family would take me but when they can't, it was like a taxi.(O1)

Yes, that makes sense. And what about the the person assessing you, were you given any sort of options about who that could be or any information about them?

Nope. I don't even remember… the start, like the start of it's a blur, but I just know that was just that person and they were assessing me. The social worker was there, my mum was there, went into a separate room because I couldn't handle the waiting room that was giving me too much anxiety. I was nervous. (S9) And I was embarrassed because it's like humiliating, I found it humiliating sitting in a waiting room with everyone to get assessed. It's like everyone knew in that waiting room, you've got issues, and that's why you're there. And you're there because you're trying to get a benefit award.(S10)

Can you tell me a bit more about that, in terms of what the physical environment was like?

It was in town. Um, I don't remember… All I remember is I wouldn't get out the car because I was like, shaking. I was nervous. Because I've never… at that point, I actually wouldn't go into any buildings. Like, see places that I've never been before. I just wouldn't. Like I just had bad anxiety about it. So because I've never been in this building before, I didn't know it, I was getting anxiety about going in.(S1)And obviously my dad had drove, and he like put his hazards on because it's at an awkward bit. I mean, I don't know… it wasn't very accessible for anybody who doesn't like public transport.(S9) So my dad had done that…and when I eventually got in, my mum had to arrange a separate waiting area, so we went into a wee room and then we changed rooms, it was just across the hall. (S9) And then we went in there and I just remember it being very, very long and how drained I was afterwards. 2 days in my bed.(S3)

Appendix 2.9: Initial Framework Development

	Safety ----- unsafe?	**Trust -------- distrust?**	**Choice ---- no choice?**	**Collaboration ---- no control?**	**Empowerment ---- disempowered?**
Jack	100-101 169 - 173 Negative impact on mental health 50 - 69 Distress 308 - 311 Threat 34 – 39, 231-237 Fear of brown envelope 29 - 31 Intrusive questions 155 Lack of dignity	139 – 140, 384 Distrust of the process 284 - 285 Distrust of DWP 47, 344 - 354 Unfair system	190 Lack of control 240 Draconian system	72 Being a passenger 210 – 224, 378 - 380 Lack of understanding of mental health	44- 45, 91-92, 195-198 Help from professionals 363 - 366 Unfair game
Katie	11 – 24, 263 – 266, 396 – 398, 466 - 476 Negative impact on mental health 38 – 58, 361 - 372 Lack of dignity 256 – 261 Threat	121 – 133, 322 - 334 Distrust of other claimants 174 – 179 Distrust of DWP 316 – 319 Not being believed	68 – 77, 346 - 360 Inaccessible environment 199 – 213 Lack of flexibility	34 – 37, 92 – 97, 181 - 192 Robotic 61 – 68, 267 – 277, 374 - 386 Distress not recognised 80 - 85 Lack of control	86 - 87 Feeling like a number

	303 – 307 Distress	459 – 460 Unfair system		107 – 113, 243 – 248, 292 - 297 Lack of empathy	
Lucy	175 – 183 Anxiety	38 – 54, 238 – 244, 311 - 341 Lack of transparency 66 – 70, 258 - 262 Distrust of the process 346 – 351 Unfair system	111 – 115 Tick box exercise 190 – 201, 380 - 386 Lack of flexibility 228 – 233 Lack of control	11 – 21, 114 – 145 , 359 - 367 Not being listened to 20 – 29, 205 – 223, 275 – 289 Distressed not recognised 81 – 111, 150 – 185 Lack of understanding of mental health	72 – 75 Unfair game
Tara	28 – 33, 113 – 114, 207 – 208, 303 Overwhelming 76 – 78, 291 - 292 Feeling judged 221 – 223, 284, 305 - 307 Anxiety	24 – 27, 295 Feeling under a microscope 82 – 84 Being undeserving 101 – 105, 108 - 110 Distrust of DWP 124 – 129, 132 – 160, 218 - 223 Lack of transparency	11 – 22, 165 - 166 Lack of control 56 – 58, 63 – 67, 169 - 183 Lack of flexibility	44 – 45, 200 - 203 Recognised distress	71 – 73 Difficult speaking up 234 – 256 Help from professionals

Appendix 2.10: Developing Alternative Framework

Original TIC framework (main themes)	Alternative TIC framework (main themes)	Alternative TIC framework (sub themes)
Safety	**Harm / unsafe?**	***Anxiety*** (before assessment, waiting for outcome, waiting for re-assessment) ***Distress*** (upset during assessment, FFFF response) ***Humiliation*** (embarrassment, feeling belittled) ***Negative impact on mental health*** (re-traumatisation, increase of threat responses)
Trust	**Distrust**	***Lack of transparency*** (of the assessment process, of the paperwork needed, of the outcome) ***Not feeling believed*** (‘at it’, MH not real) ***Distrust of assessor*** (writing report accurately) ***Distrust of other claimants*** (they are ‘at it’, the deserving vs undeserving) ***Distrust of system*** (unfair, broken, cutting costs)
Choice	**Rigidity / inflexibility?**	***Inaccessibility*** (of building/environment) ***Lack of flexibility*** (date/time/location/format of assessment) ***Tick box exercise*** (assessment questions) ***Robotic assessor*** (repeat questions, lack of empathy)
Collaboration	**Intimidation**	***Threat*** (triggered threat response, fear)

		Surveillance (watched, judged, under a microscope) ***The dreaded brown envelope*** (written contact from DWP causing fear and anxiety) ***Austere environment*** (stern, formal, unfriendly) ***Feeling on trial*** (interrogated, cross examined, proof) ***Hostile dynamic with assessor*** (lack of compassion and understanding, intimidating)
Empowerment	**Powerlessness**	***Lack of control*** (learned helplessness, no power) ***A rigged game*** (unfair, hidden agenda) ***Dehumanisation*** (treated like a number, impersonality) ***Intrusive questions*** (too personal, threat to dignity) ***Getting help from professionals*** (psychologist writing letter of support for claim)

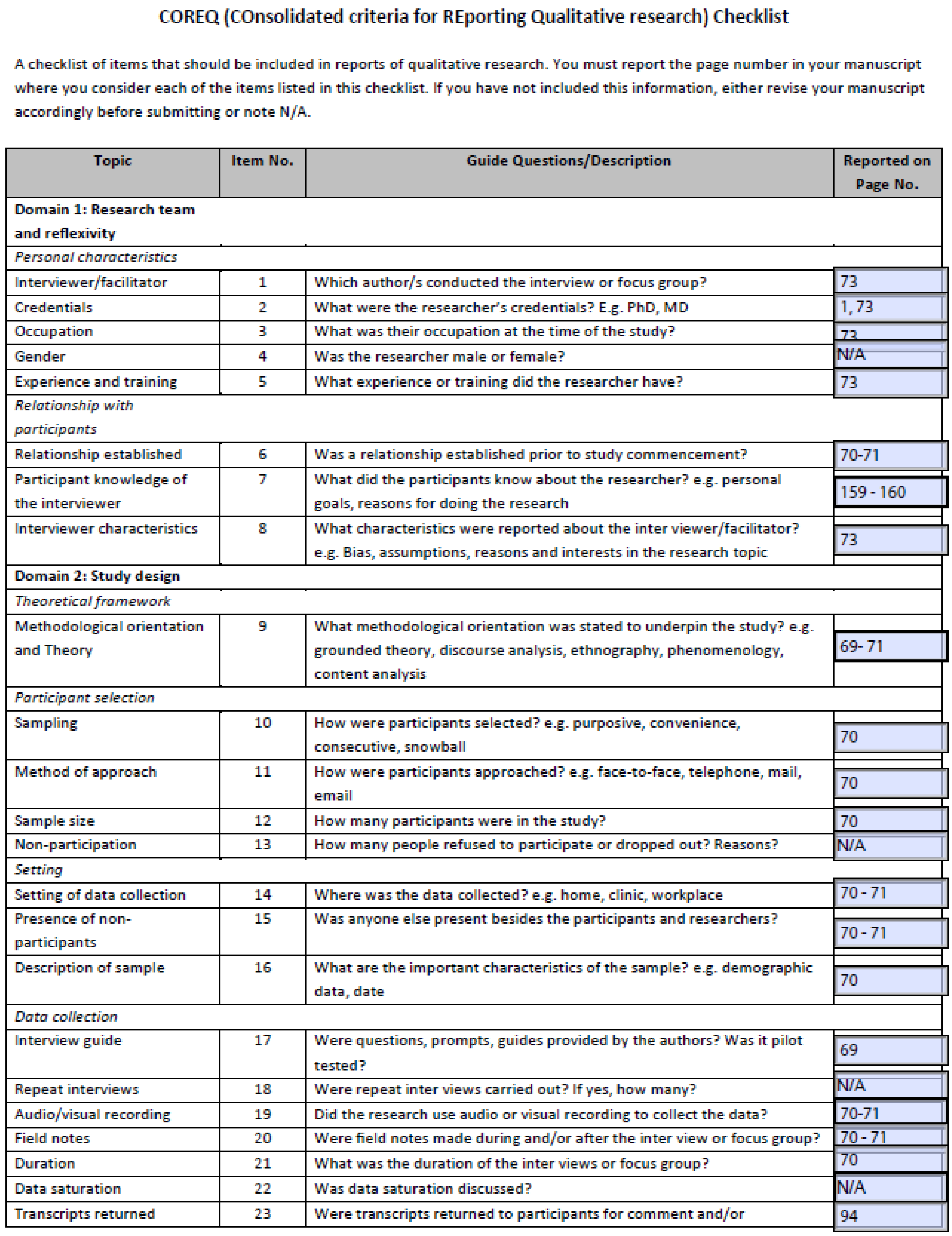
Appendix 2.11: Alternative Framework Matrix

	Harm	**Distrust**	**Rigidity**	**Intimidation**	**Powerlessness**
Emma	**Anxiety** 15 – 26 In waiting room 82 – 87 Bag of nerves 128 – 130 – Anxious wait **Distress** 137 - In tears **Humiliation** 4-10 In waiting room **Adverse impact on mental health** 41 – 42 In a stupor after 124 – Traumatised 133 – 135 – Anxiety and trauma	**Lack of transparency** 186 – 189 – No sense **Not feeling believed** 62 – Kidding on 84 – Believed or not 226 – 227 – At it 351 – Not being believed **Distrust of assessor** 199 – 200 – They’ll write you off **Distrust of other claimants**	**Inaccessibility** **Lack of flexibility** 150 – 153 – No choice **Tick box exercise** 364 – 369 – Not person centred **Robotic assessor** 159 – 168 - Unresponsive	**Threat** 222 – 224 Atilla the Hun sitting there 244 – 246 - Terror **Surveillance** 337 – 347 They watch everything **The dreaded brown envelope** 125 – Dreaded letter **Austere environment** 304 – 323 – Waiting room 330 – 335 – No privacy	**Lack of control** 119 – 121 They had the power 214 – 218 – No control **Rigged game** **Dehumanisation** 29 – 31 Treated like a number 35 – 37 Not treated like a person 40 – 41 Just another number 95 – 103 Another number to them 278 – I’m a person not a number

	362 – 372 – Lasting impact 195 – 196 – Traumatised 272 – Back to square one	**Distrust of the system** 192 – Never trusted it		**Feeling on trial** 59 – 60 Interrogated 64 – 67 Done something wrong 198 - Interrogated **Hostile dynamic with assessor** 281 – 285 - Belittling	351 – Treated like a number **Intrusive questions** 28 – 29 Stranger asking questions **Getting help from professionals**
Jean	**Anxiety** 11 – 15 - Nerve wracking 147 – Overwhelming 216 – 219 – Anxious wait 274 – 277 – Anxious thinking about going through it again **Distress** 24 – 29 - In tears 105 – Upset 125 – 126 - Crying **Humiliation** 72 – 76 – Looked down on, belittled 113 – Feeling small	**Lack of transparency** 59 – 63 – Didn’t know what to expect 100-101 – Strange 141 – 143 – No idea when would hear back 170 – 172 – Vague questions 184 – 186 – Confusing and chaotic 270 – 271 – Confusing 284 – 289 - Unexpected **Not feeling believed** **Distrust of assessor**	**Inaccessibility** **Lack of flexibility** 65 – 70 – Couldn’t change the date **Tick box exercise** 18 – 22 Repetitive questions 171 – 177 – Same questions again and again **Robotic assessor** 31 – 35 – Unresponsive 38 – 45 – Typing away	**Threat** 227 - Uncertainty **Surveillance** **The dreaded brown envelope** **Austere environment** 79 – 82 – Chaotic 150 – 156 – Anxiety provoking 164 – 165 – Claustrophobic 321 – 235 - Horrible	**Lack of control** 119 – 121 – No control **Rigged game** **Dehumanisation** 114 – No compassion 190 – 193 – Data input – I didn’t need to be in the room 339 – 245 – Assigned a number 253 – 256 – It’s not like an actual person 303 – 205 – Like I wasn’t a human

	Adverse impact on mental health 208 – 225 – Makes anxiety worse	179 – 181 – Not documented properly **Distrust of other claimants** **Distrust of the system**	131 – 136 – Same questions, no response to distress 249 – 250 – Rhyming off questions, no eye contact	**Feeling on trial** **Hostile dynamic with assessor** 93 – 97 – No understanding, rushed through 196 – Lack of empathy	**Intrusive questions** 259 – 262 – Personal questions repeated **Getting help from professionals**

Appendix 2.12: Completed CORE-Q Checklist



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	73
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	1, 73
Occupation	3	What was their occupation at the time of the study?	73
Gender	4	Was the researcher male or female?	N/A
Experience and training	5	What experience or training did the researcher have?	73
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	70-71
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	159 - 160
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	73
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	69- 71
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	70
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	70
Sample size	12	How many participants were in the study?	70
Non-participation	13	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	70 - 71
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	70 - 71
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	70
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	69
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	70-71
Field notes	20	Were field notes made during and/or after the inter view or focus group?	70 - 71
Duration	21	What was the duration of the inter views or focus group?	70
Data saturation	22	Was data saturation discussed?	N/A
Transcripts returned	23	Were transcripts returned to participants for comment and/or	94

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	71
Description of the coding tree	25	Did authors provide a description of the coding tree?	161
Derivation of themes	26	Were themes identified in advance or derived from the data?	71 - 77
Software	27	What software, if applicable, was used to manage the data?	71
Participant checking	28	Did participants provide feedback on the findings?	94
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	77 - 90
Data and findings consistent	30	Was there consistency between the data presented and the findings?	77 - 93
Clarity of major themes	31	Were major themes clearly presented in the findings?	74 - 77
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	85

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.