East Sussex
County Council

Understanding the effects of trauma on mental health and enablers for effective prevention

Contents

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Introduction

The prevention of mental health problems has been identified as a priority by both the East Sussex Mental Health Oversight Board and the East Sussex Health Outcomes Improvement Oversight Board. The latter has established a Mental Health Prevention Group to identify opportunities where activity to prevent mental health problems and promote good mental health can be strengthened. This group agreed to take a thematic approach to this work by exploring, in depth, some key factors contributing to poor mental health, starting with trauma.

The focus of this work is to prevent or attenuate trauma across the life course, understood as the negative psychological consequence of traumatising events.

The outcomes of the project were,

- To promote a greater awareness and understanding of the impact of both diagnosed and undiagnosed trauma on wider mental health throughout the life-course.
- To understand and explain the evidence base relating to the prevention interventions that act to prevent or attenuate trauma and its impacts for both diagnosed and undiagnosed individuals and communities.
- To understand the strengths and weaknesses of existing preventative approaches in East Sussex.
- Produce a set of recommendations for strengthening prevention across the system.

Process

Stage 1: Understanding the evidence base

- An evidence-based summary of trauma, prevalence and its relationship to mental health
- An evidence review of 'what works' at each level of prevention (primary, secondary and tertiary)

Stage 2: Mapping and understanding local needs and provision

- Stakeholder consultations to elicit local expert views and map current service provision

Stage 3: Articulating a plan for trauma-related mental health in East Sussex

- A multi-agency SWOT analysis workshop
  - Development of a set of recommendations for strengthening prevention activity and policy communicated by written report and presentations to key

stakeholders and oversight boards.
Due to the time and resource limitations and other mental health transformation programmes in progress, a detailed mapping of service provision was not undertaken. However, stakeholders were asked about the strengths and weaknesses of the current offer.

Executive Summary

Experience of a traumatic event is a near universal experience at some point in our lives. How we experience these events and the psychological impact is highly dependent on the nature of the event and our individual characteristics. Inequalities exist, such that some people are more likely to experience a traumatic event due to factors such as race, upbringing, occupation, socio-economic status and experiences of conflict and global displacement. Equally, the factors known to protect and reduce to the chances of psychological harm are not equally experienced, such as secure childhood attachments, high self-esteem, feelings of safety, companionship and sense of belonging.

Whilst diagnosis and evidence-based treatments for PTSD and CPTSD play a vital role in helping people recover, they cannot and should not be the only form of response. Early help in the form of psychological first aid and other emotional and practical support is very important. So too is creating a widespread understanding of trauma and how people can help themselves and others at an early stage.

The case for prevention is particularly strong in relation to Adverse Childhood Experiences (ACEs), which has a well-established evidence base. It is by its nature a multifactorial phenomenon requiring action across many areas. The first priority of protecting children from harm and providing family based early help is the core business of local authority and children's services and the wider safeguarding partnership. However, building resilience and bolstering the range of protective factors known to mitigate the impact of ACES should be considered the mission of our wider society.

Trauma informed approaches have the potential to be a unifying thread for mental health prevention in East Sussex. They provide the frameworks needed to create a universal understanding of the significance of trauma, help us recognise the signs and symptoms, respond in the right way and ensure that we don't retraumatise in our efforts to help. It is important to recognise however that trauma informed approaches are equally relevant at a service and community level, than at an individual practitioner level. There is a tendency to assume that the main focus for trauma informed approaches are 'frontline staff'. Another important aspect to emphasise is that the more we recognise the potential for trauma in our staff groups, the healthier the workforce will be and the better our ability to help others.

Finally, the greatest gains are likely to arise from the combined efforts of the system as a whole. Several areas in the country have explored how this can be approached and these could provide a blueprint for action across East Sussex and Sussex. It is notable that 'training' was identified in our stakeholder engagement as a strength, gap and opportunity. This reflects the great work and enthusiasm that already exists in East Sussex, as well as desire to expand the knowledge and application of trauma informed principles.

Recommendations

Recommendation 1

The opportunities to prevent trauma and take trauma informed approaches cannot be realised without the meaningful involvement of people with lived experience. For those with a history of long term serious mental illness or multiple compound needs, their 'history' of traumatic events very often includes interaction with mental health and other services.

How

- Ensure that the involvement of people with lived experience is a feature of service design activity and delivery from the outset, using the 6 principles of trauma informed care to guide this work.
- Ensure that where 'lived experience' involvement does take place, that the skills and experience of those people is harnessed to develop and improve trauma informed approaches.

Recommendation 2

There are significant opportunities to reduce the impact of trauma on the population as a whole by addressing risks and promoting the factors that are known to be protective.

How

- Ensuring that a 'trauma lens' is applied to those people and communities known to be at higher risk of being exposed to traumatic events. This means understanding how past trauma shapes their lives and how to support them in a trauma informed way.
- Bolstering resilience of children and their families through evidence-based programmes of intervention and support.

- Ensuring women's health, maternity, children services are aware of the impact of pregnancy, terminations, pregnancy loss and having babies removed may have on the women using these services.
- Understanding that resilience is the result of individuals being able to interact with their environments and the processes that either promote well-being or protect them against the influence of risk factors.
- Building community resilience by increasing opportunities for individuals to connect with each other and their communities and ensuring that communities have an active role in identifying and addressing their needs.

Recommendation 3

Awareness of the rationale and benefits of trauma informed approaches needs to be widened, so that it becomes a universal and unifying principle amongst local authorities, the NHS and VCSE sector.

How

- Support the continued work of the ICS Trauma Informed Network and other communities of practice
- Ensure training in trauma informed working is available and that it extends beyond frontline workers to those in managerial and senior leadership roles. This should include the impact of vicarious trauma and the benefits of early psychological first aid
- Create a central repository of resources that aid implementation at individual, service and community levels
- To review physical spaces where mental and physical health and social care is provided to ensure lighting, signage and ambience promote safety

Recommendation 4

The biggest impact for residents and those providing services for them, will happen through concerted and combined efforts of the system as a whole to prevent trauma.

How

- Providers of health and social care to work towards becoming trauma-informed organisations, meaning the organisation as a whole: understands what this means, understands their strengths and weaknesses and implements an action plan or strategy to develop and improve (using an agreed framework described below). This should be co-produced with people with lived experience
- Develop or adopt a framework for trauma-informed working which acts as a guide and benchmarking tool for local organisations and the ICS as a whole.

This should aim to establish some consistency in approach and equip organisations with the tools they need, such as developmental toolkits and strategy templates. Essential components should include,

- How to ensure meaningful involvement through coproduction from people with lived experience
- A shared vision for trauma prevention, by embedding trauma informed approaches
- Templates for organisations and services to self-assess their approach to trauma prevention and to implement a development plan
- Guidance on how to take a public health approach to reducing health inequalities by implementing both universal and more targeted approaches to trauma prevention
- Adopt consistent language, definitions and principles, including the 4'R's and 6 principles of trauma informed care, to aid a unified approach
- Understand that whilst trauma-informed approaches are important the opportunities for trauma prevention are far broader

Recommendation 5

Early support for those experiencing trauma and NICE recommend treatment should be made more widely available.

How

- Undertake mapping of existing services delivering care and treatment for the impact of trauma, including PTSD, or ensure it falls within scope of existing mental health development work
- The Sussex Resilience Forum undertake a training needs assessment to understand the availability of timely psychological first aid response to those experiencing a major incident

Recommendation 6

Major incidents can have a significant and lasting effect on the mental health of those experiencing and responding to the event. Partners should seek assurance that the psychological support required is available and sufficient.

How

- Test the new Psychosocial Care Plan through scheduled desk top exercises run by the Sussex Resilience Forum

Part 1 – Evidence review

This section provides a summary of the evidence relating to trauma and mental health. More specifically it aims to describe,

- what is meant by trauma, how it is defined, and what causes it
- the relationship between trauma and mental health problems
- how trauma can be prevented and treated

1. Defining Trauma

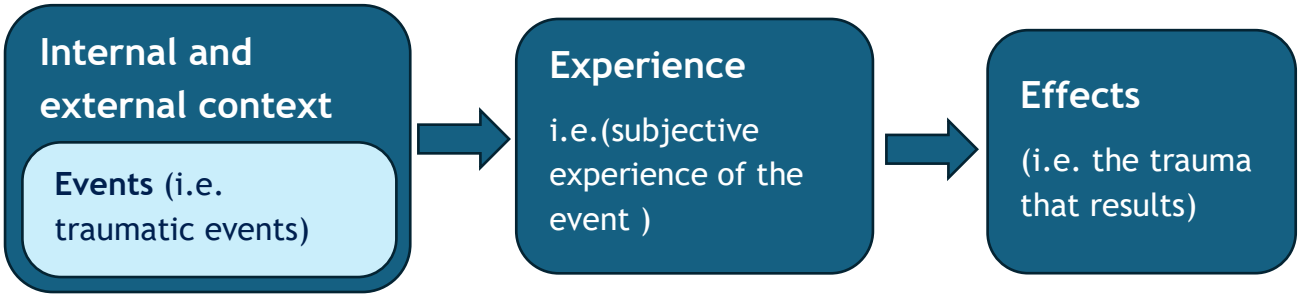
Trauma is defined differently by different experts and in wider society. Without a shared understanding it can be difficult to work together to prevent trauma and minimise its effects.

Trauma is sometimes **described** as a combination of the 'Three Es'– Event, Experience and Effects[1].

- An **Event** or series of events that are physically or emotionally harmful or life-threatening
- The individual's **Experience** of these events, which can vary based on personal factors
- The **Effects** of these events, which may have lasting adverse impacts on the individual's functioning and well-being.

This model recognises that Events together with the context of the person's life can create an Experience which causes Trauma (i.e. the Effects) will vary across individuals and populations due to other factors such as the amount of support people have around them, being neurodivergent (e.g. autistic or ADHD) or being from a sexual or ethnic minority group which reduces our sense of trust and safety in the world.

The '3 Es' of trauma and how they fit together are shown below.



Even though the event, the way it is experienced, and the effects are all different, it is common to hear people using the term 'trauma' to refer to any or all of these elements.

For the purposes of this report and recommendations, we define the goal of prevention being to avoid or diminish its ***Effects*** (see below). However, understanding the ***Events*** and ***Experiences*** are key to identifying those at risk and implementing prevention strategies.

2.1 The Prevention Aim – Effects of Traumatic Events

The Royal College of Psychiatrists define trauma as,

"the psychological and neurobiological effects of an event or series of events that cause overwhelming fear, stress, helplessness, or horror. Trauma can have lasting adverse effects on a person's mental, physical, social, emotional, and/or spiritual well-being".

Similarly, **Bessel van der Kolk defines trauma as:**

'Trauma is an event that **overwhelms** the central nervous system (CNS), and changes the way you remember and react…to things that remind you of it. It's something very bad that happens to your CNS, to your mind that you are incapable of assimilating…and integrating into your life'

'trauma is actually NOT the story of what happened a long time ago; trauma is residue that's living inside of you now….in horrible sensations, panic reactions, uptightness, explosions, and impulses'

Bessel van der Kolk, author of 'The body keeps the score'

2.2 Understanding 'Traumatic' Experience

In contrast with events, experiences are subjective. The American Psychiatric Association (APA) describes traumatic experiences as:

"Any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behaviour, and other aspects of functioning"

Understanding the role of experience in the development of trauma is helpful for a number of reasons. Firstly, it opens up secondary prevention opportunities, by thinking about how we might positively change the experience around the event in the aftermath (e.g. through interpersonal opportunities around meaning making and offering containment).

Secondly, it recognises that the types of events that result in trauma (effects) may differ greatly depending on personal experience and characteristics. For example,

an autistic person may be more sensitive to being traumatised by certain events compared to a neurotypical person due to heightened sensory experience. Equally, someone from a gender or ethnic minority may be more sensitive to being traumatised by certain events if they have already experienced as hostile and unsafe due to systematic prejudice and discrimination.

Table 1- Types of TRAUMA

Single event trauma - Single event trauma is related to a single, unexpected event

Complex trauma - Complex trauma is related to prolonged or ongoing traumatic events

Vicarious trauma - Vicarious trauma can arise after hearing first-hand about another person's traumatic experiences

Trans- or intergenerational trauma - Trans- or intergenerational trauma comes from cumulative traumatic experiences inflicted on a group of people, which remain unhealed, and affect the following generations.

Source: Orygen (the Australian National Centre for Excellence in Youth Mental Health[1])

The key risk factors for development and maintenance of PTSD are strongly associated with the experience of the event itself and post-event factors[2,3]. These include

- the severity of the event and perceived level of threat to life
- feeling isolated or unsupported after the event
- re-exposure to trauma
- dissociation during or immediately following the event(s)
- intensely negative emotional responses immediately following the event (e.g. extreme fear, helplessness, horror, shame)
- co-morbid mental health problems and on-going life stresses

The nature of the event and how it is experienced has implications for what prevention activities might look like, and so it is helpful to describe these in detail. Table 1 lists the main types of trauma and the kinds of events that precede them.

2.3 Understanding 'Traumatic' Events

Given the influence of 'Experience' and also Context (shown above in the diagram), not everyone will be traumatised by the same events. Therefore, it is helpful to describe them as '*potentially* traumatic events'. The range of potentially traumatic events is therefore limitless, but commonly recognised ones include.

Types of Single Event

One-off events such as an accident, violent attack or natural disaster

Seeing someone else get hurt

Large-scale traumatic events like natural disasters (e.g. earthquakes, hurricanes, floods), human disasters (e.g. chemical spills, living in an unstable or unsafe environment)

Being directly harmed or neglected

Being affected by trauma in a family or community, including trauma that has happened before you were born

Surgery

Sudden/unexpected bereavement

Living losses – incl. relationship breakdown

Humiliating or deeply disappointing experiences (especially if someone was deliberately cruel)

Ongoing or Repeated Events

Childhood abuse

Intimate partner abuse

Bullying

Long-term illness

Historical trauma – inflicted in the past on certain cultural groups, which have effects on current generation

Exposure to horrific images not personally experienced (e.g. terrorist attacks, plane crash, mass shooting)

Workplace events – such as 'blue light' responses

Mass societal events – (such as COVID-19)

Chronic adversity

What are ACEs?

Adverse Childhood Experiences (ACEs) refer to stressful or traumatic experiences occurring before the age of 18. There is a significant body of evidence linking ACEs

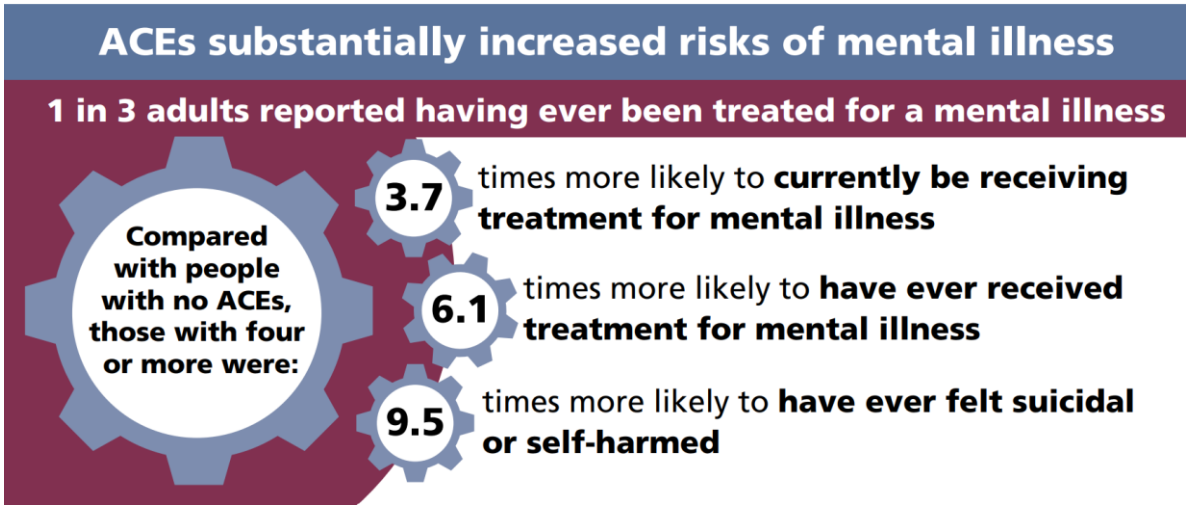
to a range of significant and lasting negative outcomes for mental health during childhood and later in life.

The evidence links ACES to an increased risk of,

- Suicidality
- Risky sexual experiences
- Sexual victimisation in adulthood
- Domestic violence and being both a perpetrator and/or a victim of interpersonal violence
- Self-harm
- Physical inactivity, obesity, heart disease, cancer, & liver disease
- Sexually transmitted diseases & teenage pregnancy
- Homelessness and unemployment

A review of 39 longitudinal cohort studies[4] was able to map those ACEs that were most likely to lead to adult depression, health anxiety, eating disorders and substance abuse. Their results revealed a significant association between the following childhood exposures and adult mental disorder: bullying (victimhood, and frequency), emotional abuse, neglect, physical abuse, parental loss, and general maltreatment.

The experience of multiple traumas among children has a cumulative effect, so that exposure to more than one trauma increases the likelihood of both the onset and persistence of mental health disorders. There is wealth of evidence demonstrating this 'dose effect', For example, a Welsh study[5] of 2,500 adults in 2017 demonstrated the extent to which experiencing four or more ACES increases the risk of poor mental health outcomes, compared to experiencing none.



In terms of understanding the relationship between ACEs and adult outcomes, some research has evidenced the impact on brain development in adolescence. Young people and children process trauma differently because their brains are still

developing. This means that the types of things that children experience as traumatic, and how they understand them, can be different to adults[6].

More specifically, being exposed to trauma when very young can change how the brain grows, negatively affecting the ability to learn[7,8,9]. There is a complex relationship between adverse experiences and brain development, and brain connectivity may provide the neurodevelopmental pathway between adversity in adolescence and mental health outcomes[10].

Trauma Informed Lancashire have produced a '7 minute Briefing' on the impact of trauma on brain development and functioning in children[11].

Types of ACE

The Early Intervention Foundation[12] list 10 ACEs as follows:

- Physical abuse
- Sexual abuse
- Psychological abuse
- Physical neglect
- Psychological neglect
- Witnessing domestic abuse
- Having a close family member with problematic drug and/or alcohol use
- Having a close family member with mental health problems
- Having a close family member who served time in prison
- Parental separation or divorce on account of relationship breakdown

Prevalence of ACES

The extent of ACEs shows variation with somewhere between one-half and two-thirds of children having experienced at least one ACE[13,14,15,16] . Particularly high numbers of ACEs are found among children in care[17].

As a point of context, it is recognised that traumatic events and a young person's reaction to them vary between people (e.g. different people will be affected to different degrees by different events), and within the same person over time, or depending on the type of traumatic event they have experienced. There are many factors that influence whether or not a young person develops mental ill-health after experiencing a traumatic event or events. These include the severity and type of trauma, the support available, how easily they can access this support, past traumatic experiences, family history, and physical health[18,3].

As with adults, the presence of mental ill-health in childhood does not necessarily mean that they have experienced trauma. There are many additional risk factors that contribute to the beginning of mental ill-health. These can include environmental, genetic, social, and cultural risk factors[19].

3. Prevalence of Trauma

It has been estimated that 70% of the general population have been exposed, either directly or indirectly to a traumatic event at some point in their lifetimes. Previously associated with particular people such as war veterans, it is now considered to be far more widespread and affecting a much larger proportion of our society[20], with some estimates suggesting this is up to 90% of the general population[21].

Although difficult to make accurate estimates locally, data shows,

- 37% of secondary school aged pupils, and 25% of primary school aged pupils feel anxious or stressed almost every day/most days[22] (not necessarily related to trauma)
- 6,500 children are exposed to domestic abuse each year in East Sussex[23]
- the most common crimes in East Sussex are the traumatic events of violence and sexual offences[24]

4. Relationship Between Trauma and Mental Health

The link between trauma and poor mental health (including PTSD) is well evidenced. Traumatic stress-related diagnostic categories being Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (CPTSD).

However, there are a few important things to note about the diagnosis of trauma related conditions:

- traumatic events do not always lead to PTSD or other mental health problems. Following a single traumatic event the most common outcome is natural recovery, in which there is a temporary experience of traumatic stress symptoms, followed by reduction.
- not everyone experiencing the symptoms of PTSD or CPTSD will receive or seek a diagnosis
- It is possible for the presence of PTSD or CPTSD to be misdiagnosed for example, as personality disorders and /or chronic depression and anxiety. These difficulties can also be present concurrently with PTSD.
- Adverse childhood experiences and traumatic events in both childhood and adulthood are a feature of many other mental health, drug and alcohol problems

Worldwide point prevalence of PTSD (i.e. the number of people with PTSD in the population at any one moment in time) has been estimated at between 6% and

9%[25], but UK estimates are lower (around 3%)[26]. It is estimated that the prevalence of PTSD in the adult U.S. population is 8%[27].

5. Common Features of Trauma

People who experience trauma may describe a range of responses during or afterwards[28],

- Frightened
- Under threat
- Humiliated
- Rejected
- Abandoned
- Invalidated (for example your feelings or views have been dismissed or denied)
- Unsafe
- Unsupported
- Trapped
- Ashamed
- Powerless
- Self-blame and guilt
- Physical symptoms (such as fatigue, muscle tension, racing heartbeat & memory problems)

These are common and normal after traumatic events. The feelings of self-blame and guilt can stem from wishing they could have done something differently at the time, or not done something that they did do.. Somone else may be blaming them or acting like it was their fault. Some people are made to feel responsible for someone else's actions, even when they had power over them.

Experiencing traumatic events may also lead to a number of related problems[28] including,

Flashbacks – re-living aspects of a traumatic event or feeling as if it's happening now. It could involve seeing images of what happened, or experiencing it through other senses like taste, sound, or physical sensations in your body.

Panic attacks – a type of fear response. They're an exaggeration of the body's response to danger, stress or excitement.

Dissociation – one way the mind copes with overwhelming stress. The person might feel numb, spaced out, detached from their body or as though the world around them is unreal.

Sleep problems – finding it hard to fall or stay asleep, feel unsafe at night, or have nightmares.

Self-neglect – being unable to look after yourself and meet basic needs like eating, keeping clean or keeping your home safe. This may be related to low self-esteem, or because they're having trouble adjusting to life following trauma. Trauma might disrupt regular routines making it harder than usual to look after oneself. Some trauma might put people in situations where they have limited resources to meet these basic needs.

Self-harm – hurting oneself as a way of dealing with very difficult feelings, painful memories or overwhelming situations and experiences.

Suicidal feelings – including being preoccupied by thoughts of suicide, thinking about methods of suicide or making plans to complete suicide.

Problematic drug and/or alcohol use – as a way to try and cope with difficult emotions or memories.

6. Diagnosable Conditions

6.1 Post-traumatic Stress Disorder (PTSD)

PTSD might be an individual's primary presenting difficulty, or it may be in the context of other

problems, such as psychosis or a long-term physical health condition.

To formally meet criteria for PTSD the following three sets of symptoms must be present:

- Re-experiencing: unwanted memories, flashbacks and nightmares of the trauma, or reacting as though it is still happening
- Avoidance: of feelings and reminders relating to the trauma
- Hyperarousal: sensitivity to threat, anxiety
- Negative alterations in mood and thinking[29]

The UK-based National Institute for Health and Care Excellence or NICE (2024) estimate that around 25–30% of people experiencing a traumatic event go on to develop PTSD. PTSD is more common in women compared to men.

While traumatic stress symptoms are common and normal after traumatic events, those symptoms that continue for more than one month, are distressing, and interfere with daily functioning can lead to formal diagnosis of PTSD.

6.2 Complex Post-traumatic Stress Disorder (CPTSD)

CPTSD is a relatively new addition to the ICD-11 diagnostic manual. It was introduced following years of debate amongst the clinical, academic and service user communities to reflect that some individuals exposed to chronic, repeated or prolonged and often inescapable trauma —such as childhood abuse, domestic violence exhibited symptoms beyond those of PTSD. To meet criteria for Complex PTSD a person must also meet criteria for PTSD. As such people who meet criteria for Complex PTSD are a subset of the people who meet criteria for PTSD.

In addition to the core symptoms of PTSD those who meet criteria for CPTSD also report the following three sets of symptoms:

- Difficulties in forming and maintaining relationships
- Persistent feelings of worthlessness
- Difficulties in managing emotions, including dissociation

Misdiagnosis might be particularly common in those with CPTSD, as discussed above, due to the wide range of presenting symptoms. People with lived experience of CPTSD often report that experience of the mental health system itself can be traumatising (e.g. misdiagnosis, long waiting times, repeated assessment, lack of continuity of care, access to evidence-based treatment).

6.3 Acute Stress Reaction/ Disorder

Acute Stress Disorder (ASD) is a mental health condition that occurs within a month after a traumatic event, according to DSM5 diagnostic manual (American Psychiatric Association). ASD following trauma exposure is associated with increased risk for developing PTSD.

The ICD-11 diagnostic manual, more commonly used in the UK doesn't have a directly equivalent diagnostic category, however it does include Acute Stress Reaction (ASR). Both describe similar symptoms that occur within 1 month of a traumatic event and are considered at this stage 'sub-threshold' symptoms of PTSD.

NICE guidelines recommend trauma-focused CBT intervention for adults and children with a formal diagnosis of ASD. However, the same is not recommended for ASR. Given the clinical challenges of distinguishing between ASD, ASR and other subclinical symptoms, the favoured approach locally would be to consider active monitoring within a month of the event, with a 1 month follow up. This is also approved by NICE[101].

7. High Risk Groups

Being able to identify who may be more likely to experience trauma could be a critical first step in shaping where prevention resources should be allocated.

Some groups of people are more likely to experience trauma than others, typically minoritised groups and those who face health inequalities. These include,

- Black and Racially Minoritised (BRM) people (e.g. related to ACEs, poverty, racism)[30,31,32]
- people who have served or who are serving in the military, including peace keeping roles[33,34,35]
- people with learning difficulties (higher risk of ACEs[36,37]and being victim of violence, abuse & neglect) [38]
- people who are in prison or have been in prison in the past (often stemming from childhood, not prison itself)[39,40]
- refugees and asylum seekers[41,42,43,44]
- LGBTQIA+ people[45,46,47]. People who are transmen are particularly likely to have experienced ACEs[48]
- those working in stressful workplaces (e.g. intensive care, ambulance personnel, paramedics, police, firefighters)[49,50, 51,52]
- those who have unemployed fathers (due to increased risk of sexual abuse, neglect, physical abuse and child maltreatment)[53]
- people experiencing poverty[54]
- people who are homeless[55]

Women are more likely than men to experience domestic abuse. Around one in four women (27%) have experienced domestic abuse since the age of 16. For men, the figure is around one in seven (13.9%). For partner abuse only, the figures are 22.7% for women and 10.2% for men[56].

There is some evidence that while women were more likely to report childhood sexual abuse, men are more likely to report childhood physical abuse[57].

The Covid pandemic may have led to increased rates of PTSD[58,59,] A study of nearly 35,000 NHS health care workers found that over a fifth met the threshold for diagnosable mental disorders during the Covid period from March to August 2021[60].

Some have argued that how an individual responds to or recovers from trauma exposure is also affected by a genetic predisposition[61, 62].

There is evidence that the experience of pregnancy, terminations, pregnancy loss and having a baby removed by children's social care can exacerbate existing trauma and in some cases cause trauma in themselves[63,64]. Exposure to ACEs increases the risk of pregnancy complications and adverse pregnancy outcomes, suggesting preventive strategies, screening and trauma-informed care need to be a feature of maternal and child health services.[65]

In addition to specific population groups most at risk from trauma-based mental health, prevention efforts can be shaped through knowing the risk factors for trauma. These include a history of prior trauma, depression or anxiety, lack of social support and family history of trauma.

8. Prevention

The avoidance of traumatic events and experiences will clearly have an impact on the prevalence of trauma and mental health problems. The extent to which this is possible and realistic varies considerably on the experience in question. Natural disasters and some causes of sudden and unexpected death may be very hard to prevent. However, these are likely to account for a minority or traumatic events experienced in the UK and there are many opportunities to intervene to reduce the psychological impact of a traumatic event or events, and to avoid making matters worse for those seeking help.

8.1 Protective Factors

Certain 'internal' and 'external' characteristics have been linked to promoting resilience to PTSD, offering opportunities for prevention: [66]

Internal	External
• Self-esteem • Trust • Resourcefulness • Self-efficacy • Internal locus of control • Secure attachments • Sense of humour • Self-sufficiency • Sense of mastery • Optimism • Interpersonal abilities • (e.g. social skills, problem-solving skills, impulse control)	• Sense of safety • Religious affiliation • Strong role models • Emotional sustenance (i.e. receiving from others understanding, companionship, a sense of belonging, positive regard)

The importance of coping and resilience is supported by research. Strengthening the individual's capacities for resilient coping can alleviate the negative effects of early trauma on psychological functioning and health in later life[47,67,68,69].

However, being resilient involves being able to identify resources, whether psychological, social, cultural and physical, that may sustain health and wellbeing[70]. It is up to families, communities and governments to provide these resources in the way individuals' value. Unfortunately, those who are at most likely to face adversity and need greater resilience are least likely to have the resources to build it. This 'double burden' contributes to health inequalities[71].

8.2 Understanding Mediating Relationships

In research terms, a mediator is something that helps explain the relationship between two other linked variables, such as trauma and poor mental health. For example, in a study about socioeconomic status and reading ability in children, might find that parental education level (the mediator) explains why low socioeconomic levels impacts on low reading ability.

The following examples help explain the effects of trauma on mental health and offers routes towards prevention.

Variables	**Mediator**
Childhood maltreatment leads to depression, PTSD, and anxiety symptoms,	***through* self-stigma (**the internalisation of negative stereotypes about one's experiences)[72]
The impact of ACEs on mental health can be reduced,	***through* positive neighbourhood environment** (crime rates, poverty, green space, and food access)[73]
The impact of ACEs on mental health can be exacerbated,	*through* neighbourhood disconnection[74]
The impact of ACEs on depression can be reduced,	*through* improving self-esteem of adolescents[75,76]
The impact of ACEs on mental health can be reduced,	***through* improving self-efficacy** - an individual's belief in his or her capacity to execute behaviours necessary to produce specific goals[77]

This type of research can also reveal where certain factors do not mediate the relationship between ACEs and poor mental health. One study found that while ACEs increase the risk of subsequent depression and cognitive impairment, this is

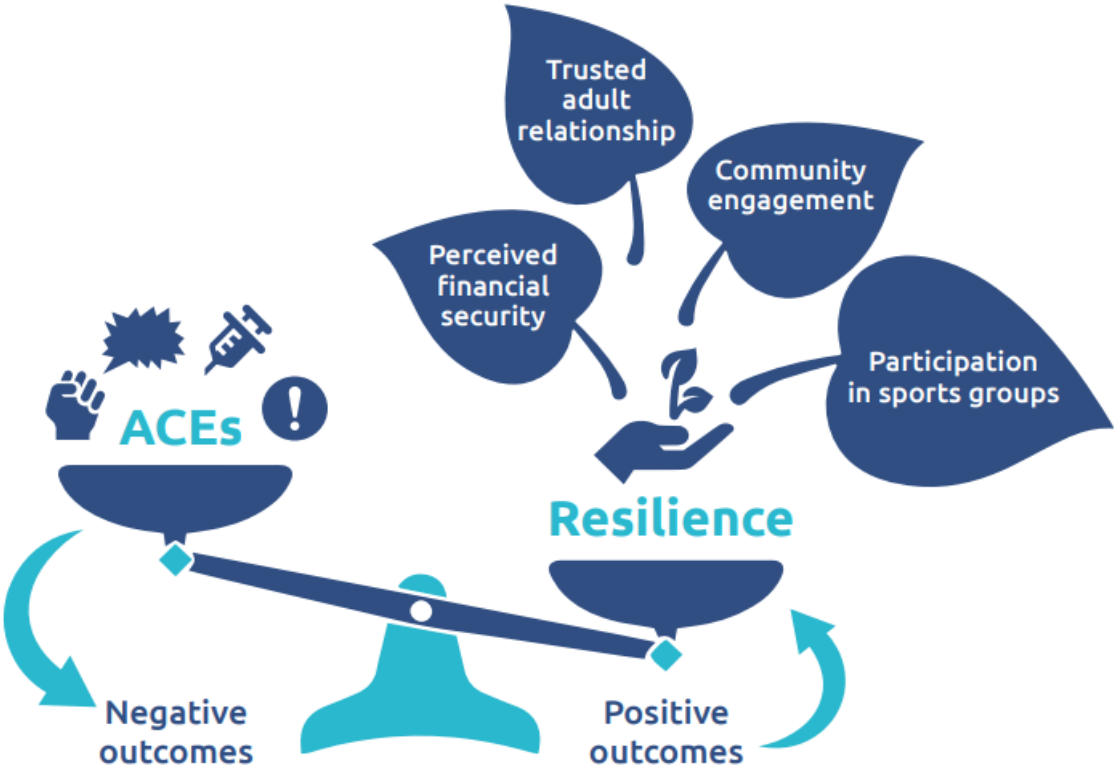
regardless of their sociodemographic characteristics – in this case, including age, sex, educational level, or family's financial status. This means that varied sociodemographic characteristics cannot explain why ACEs affect people differently[Error! Bookmark not defined.].

8.3 Preventing the Impact of ACEs on Children's Mental Health

Efforts aimed at reducing ACEs offer an early intervention opportunity and there is much evidence to support this approach.

Building resilience can help mitigate the negative impacts of ACEs. Fig 1 shows an illustration of the balance between **ACEs and resilience** and how building the latter can 'outweigh' the effects of ACEs, creating more positive outcomes for children.

Fig 1- ACES and Resilience



Source: Di Lemma (2019)[16]

In terms of building resilience and bolstering protective factors, the evidence supports both inter-personal and intra-personal factors:

- School-based anti-bullying interventions

- Parenting programmes (including, breaking the intergenerational cycle of ACEs and building childhood attachment)
- Building supportive social networks and peer support
- Social skills development
- Coping strategies and mindfulness
- Addressing attachment problems
- Increasing self-esteem, emotional regulation
- Promoting better sleep and reducing insomnia
- Physical exercise.

Children may be more vulnerable from the impacts of PTSD when moving from child to adult services. Children with ACEs value stability and continuity in the support they receive, allowing them to build up trust[78]. There is a need to provide additional support to children and young people with PTSD who are within the care system when they are transitioning between services or settings[79]. For example, the referring team should not discharge the person before a care plan has been agreed in the new service. The latest NICE guidelines talk about having a key professional to oversee the whole period of care transition[80].

Additional protective factors against the impact of trauma include spiritual and religious beliefs. A study among 254 adult 'survivors'81 report that those exposed to ACEs with more supportive social networks as adults had diminished odds of reporting poor mental health. Conversely, an increasing number of stressful social relationships contributed to continued mental health challenges.

The academic literature relating to ACEs is extensive. Appendix 1 provides a summary of those identified through our literature search. Also, the Early Intervention Foundation (12)[12], list 33 interventions (available in the UK) which demonstrate the effectiveness of preventing at least one type of ACE. They argue that these evidence-based interventions, if integrated into a comprehensive public health strategy, could prevent or substantially reduce many ACEs, minimising the health-harming behaviours and experiences associated with ACEs, and specifically reducing ACE-related trauma.

The interventions are listed below. They have all been assessed as 'level 3' evidence, meaning the threshold at which causality can be attributed to the intervention model through robust evaluation methods has been reached. (See here for the full detail of the interventions with supporting evidence, some of which refer to treatments covered in the next section).

Table 2. EIF Evidence Summary – Prevention of ACEs

Intervention Point	**Programmes to address interventions with robust evidence**
Universal screening.	• Perinatal mental health screening. • Domestic violence screening.
Co-parenting interventions.	• Family Foundations. • Schoolchildren and Their Families. • Strengthening Families 10 to 14.
School-based interventions aimed at supporting children's social and emotional development and preventing health-harming behaviours and experiences.	• ASSIST (A Stop Smoking in Schools Trial). • Advanced Life-Skills Training. • Friends for Life (health led). • Friends for Youth. • Good behaviour Game. • Incredible Years Dinosaur Club. • Lion's Quest Skills for Adolescent Behaviours. • PATHs Preschool. • PATHS Elementary. • Positive Action. • Olweus Bullying Program.
Selective interventions made available to families on the basis of selected demographic risks.	• Family Nurse Partnership.
Targeted interventions made available to children and parents on the basis of a pre-identified need.	• Empowering Parents/Empowering Communities (EPEC). • Level 4 Triple P Group & Standard. • Family Check-up for Children. • Helping the Non-Compliant Child. • Hitkashrut. • The Incredible Years, Preschool Basic. • The Incredible Years School Age Basic.
Interventions for families where the parents are separating.	• Family Transitions Triple P. • New Beginnings.
Therapeutic interventions.	• Trauma focussed CBT.

	• Multidimensional Family Therapy. • Child-Parent Psychotherapy. • Child First.
Specialist interventions offered as alternatives to families with a child at the edge of going into care.	• Functional Family Therapy. • Multisystemic Therapy. • Multisystemic Therapy for Child Abuse and Neglect.

Lancashire University have produced a short guide, "The Little Book of ACEs" which provides an example of how to take a population approach to ACES using its PREVENT – DETECT – PROTECT – MANAGE - RECOVER model. These actions do not come in a defined order, rather, they should be thought of as happening simultaneously and should be on-going[82].

8.4 Trauma-informed Approaches

A 'trauma-informed approach' (TIA) is an umbrella term for ways in which providers and services can adopt practices to help prevent the trauma affecting a person's mental health to the extent it becomes a clinical need. This includes the

interchangeable terms of ‘trauma-informed care’ (TIC) and ‘trauma-informed practice’ (TIP).

For the purposes of this report, we focus on three levels of implementation,

There are some underlying frameworks that can help guide those working at each of these three levels, namely the 4 ‘Rs’ and the 6 Principles of TIA. The 4 ‘Rs’ describe **what** a TIA is trying to achieve, and 6 principles explain ***how*** this can be achieved.

The 4 Rs of Trauma Informed Care

Realize	• understand that trauma is widespread and impacts famlies, individuals, organisations and communities in unique ways.
Recognise	• know the signs and symptoms of trauma and recognise these may present differently among individuals and groups.
Respond	• respond to traumatic experiences with the knowledge that the event may impact on all involved. The effects of trauma can be hard to spot, so the propose response is crucial.
Resist	• resist retraumatising people, be aware of how your language and the environment you create can act as potential triggers

The 6 Principles of Trauma Informed Care

The Office for Health Improvement & Disparities (OHID)[83], advocate the following principles of trauma informed practice, based on the international recognised SAMHSA definition[1]. They are safety, trust, choice, collaboration, empowerment and cultural consideration. See Fig 2.

Fig 2. The 6 Principles of Trauma Informed Care

Individuals

Adopting the '4 Rs' and 6 principles framework above enables practitioners to respond positively to people who have experienced trauma.

When practice is ***not*** trauma informed it might demonstrate some of the following,

1) **Lack of emotional safety** – staff who are dismissive, judgemental, or lack empathy. Service users may feel unheard or invalidated. Focus on rules and procedures over emotional well-being.
2) **Authoritarian approach** - strict, inflexible policies (e.g. sudden discharges, punitive measures) can mirror past abuse or neglect. Power imbalances (e.g. staff exerting control over users) can trigger feelings of helplessness.
3) **Lack of choice and control** - services that do not offer choices or flexibility can replicate past experiences of coercion.
4) **Triggering environments -** loud noises, harsh lighting, crowded spaces, or an impersonal setting can increase anxiety. Being in a space that resembles a past traumatic environment (e.g., a hospital, police station, or institution).
5) **Invasive or insensitive assessments -** requiring users to repeatedly retell their trauma history without sensitivity can be overwhelming. Asking intrusive questions without building trust can make users feel exposed or violated.
6) **Failure to recognize trauma responses -** misinterpreting trauma-related presentations (e.g., withdrawal, anger, dissociation) as defiance or non-compliance. Punishing or dismissing users for behaviours linked to their trauma history.
7) **Stigma and discrimination** - bias against marginalized groups (e.g., survivors of abuse, people with mental health conditions, LGBTQ+ individuals). Labelling users as "difficult" or "manipulative" rather than understanding their trauma responses.

Central to adopting a trauma informed practice is thinking carefully about the language we use. Inclusive language can help people to connect and make sense of the world and their experiences. Conversely, language can also make people feel judged and blamed, excluded, mis-understood and not listened to, especially when the immediate focus is on ***what is wrong with***, rather than ***what has happened to*** someone[84]. Adopting this mindset helps to promote empathy, understanding, and healing.

Services

From a service perspective, TIC is focused on creating conditions within services and organisations that reduce harm and promote healing, especially for individuals who have already experienced trauma[85].

For example, a trauma-informed approach in schools might include professional development training for staff, ensuring the policies and procedures promote a safe and supportive learning environment, using evidence-based resources and prevention strategies, promoting resilience and protective factors, and encouraging the involvement of families[86].

The Mental Health Foundation proposes that, *"an understanding of trauma should underpin all interactions between the public sector and people across the UK."* TIC requires continuous persistence, determination and reflection on the part of each service or organisation. It means establishing a system-wide culture which supports the development of the right understanding, skills, values, attitudes and policies[87].

A study of English social work teams published in 2022[88], found TIC is widely used and perceived to add value to children's social care practice. Whilst some elements of TIC, such as taking a 'strengths-based approach' was almost universal practice, other elements such as routinely recording a child's history of trauma in their case files was far less common. The study concludes greater consistency is needed in defining this approach, as well as more research as to the benefits.

Communities & systems

Trauma disproportionately affects certain groups of people, some of whom are marginalised by society as a whole and may experience stigma, injustice and abuse. The Mental Health Foundation argue that if organisations and institutions are seen to perpetuate trauma for some individuals, this kind of 'systemic trauma' can also exist in wider structures such as societies, cultures and families[87]. For example, responding to the needs of communities experiencing the COVID pandemic, terrorist and other violent events, or taking a trauma informed approach to the needs of asylum seekers.

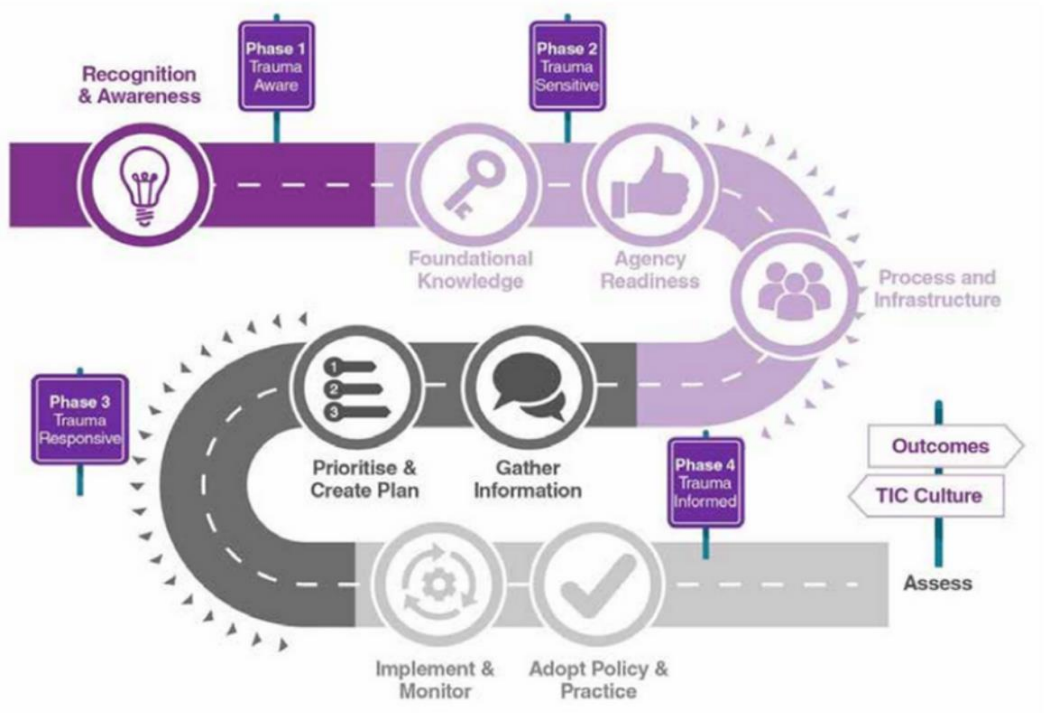
A 'systems' perspective to preventing trauma, might be considered to involve exploring the underlying mindsets, culture, relationships and infrastructure required to integrate trauma-informed approaches across policy and practice in East Sussex. Some areas are attempting to take this broader approach, such as the Scottish Government's 'Roadmap for Creating Trauma-Informed and Responsive Change'[89].

It attempts to define what 'good' looks like within organisations, systems and workforces across a number of domains,

Organisational Culture	Staff knowledge, skills and confidence
Leadership	Policies and processes
Staff care, support and wellbeing	Budgets
Feedback loops and continuous improvement	How we design and deliver services
Power sharing with people with lived experience of trauma	

Another good example of systems approach is 'Trauma Informed Lancashire', led by Lancashire Violence Reduction Network. It is described as a 'culture change initiative' with the aim of realising their shared vision of a trauma informed county[90]. It provides guidance for leaders and practitioners. Within the former, workshops and training is provided along with organisational development toolkits and strategy templates[91].

Fig X below shows a suggested roadmap to becoming a trauma informed organisation, within the Lancashire 'Trauma Informed Organisational Toolkit'[92].



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8.5 Prevention and Immediate Help

8.5.1 Psychoeducation

Psychoeducation is the process of providing individuals with knowledge and understanding about psychological conditions, mental health, and coping strategies. It can be used at different levels of intensity of psychological intervention. For example, self-help resources and early forms of mental health talking therapies.

It also forms part of NICE-recommended trauma focused therapies for PTS. CBT can offer strategies for managing arousal and flashbacks and EMDR (e.g. explaining impact of traumatic experiences and introducing strategies for dealing with regulating emotion, stress management, mindfulness, and relational skills building)[29].

There is little evidence to support the use of certain types of immediate post-event approaches, such as Critical Incident Stress Debriefing[93], or standalone brief psychoeducation[94] , in order to prevent PTSD. However these approaches may have wider individual and service benefits.

8.5.2 Self-help

Several organisations publish self-help guides for managing trauma, either preventing it from getting worse or being potentially useful while waiting for, or when receiving clinical treatment. For example, advice includes,[95]

- Continue to maintain valued activities and life roles – e.g. as a family member, and / or at work.
- Get moving (exercise) and mindfulness (focus on your body and how it feels as you move).
- Do not isolate, volunteer and make new friends.
- Self-regulate your nervous system e.g. mindful breathing.
- Take care of your health (having a healthy body can increase your ability to cope with the stress of trauma).

MIND[96] also provide some useful advice for coping with trauma and how to overcome barriers to seeking help What is trauma? | Types of mental health problems | Mind - Mind.

At the first signs of traumatic stress symptoms, NICE recommend a person should consider visiting a GP within primary care[79] . A GP may recommend careful monitoring of the symptoms to see if they improve. If they do not, then they may refer for more specialist help. However, given the symptoms of trauma may be felt but not understood to be related to trauma by the sufferer, other sources of early

mental health support are also available, such as NHS Talking Therapies[97], which do not require a GP visit first[98].

8.5.3 Immediate Response to a Traumatic Event

The available evidence suggests that emotional and practical support, along with active monitoring is the best way to support someone following a traumatic event, including Psychological First Aid (PFA)[101].

Psychological First Aid (PFA) aims to reduce the likelihood of PTSD through early intervention[27]. It is appropriate when an individual has an acute stress reaction in response to trauma (e.g. dissociative symptoms, extreme anxiety, a high level of cognitive impairment) or is at high risk for a traumatic stress reaction. The key features of PFA are, "contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping, and linkage with collaborative services."[99]

For children, young people and adults, the NICE guidelines recommend 'active monitoring' for people with subthreshold symptoms of PTSD within 1 month of a traumatic event and then to arrange follow-up contact to take place within 1 month. 'Active monitoring' is the regular assessment of circumstances and symptoms by a professional with the aim of promptly accessing evidence based treatment if the symptoms are not reducing.

In some circumstances where there has been an exposure to a 'large-scale shared trauma' within the last month, trauma-focused group CBT interventions can be considered for children and young people[101].

The British Safety Council recommend the use of TRiM (Trauma Risk Management), which originated in the UK military more than 20 years ago but has wider application such as within emergency services. It is a peer support intervention carried out following potentially traumatic events. TRiM practitioners are peer supporters embedded throughout an organisation who are trained to spot the signs of psychological distress in their colleagues that might otherwise go unnoticed, through a structured risk assessment process which supports an individual during the period of 'active monitoring' following a trauma, as recommended by NICE[100].

Psychologically-focused debriefing is NOT recommended following traumatic events as it is not supported by the evidence and may do harm by denying people access to more effective forms of help. This kind of psychological debriefing, delivered individually or in groups can involve encouraging participants to recount the traumatic experience very soon after the event [101].

8.4 Major Incidents

The potential for major events, such as natural disasters, terrorism and other violent acts to create trauma for those involved is very high. Everyone directly or indirectly involved may be affected and need psychological support. The UK's current threat level (as of June 2025) is rated as 'substantial'[102], meaning a terrorist attack is likely and the London and Manchester attacks in recent years, and the responses, are well documented. However, the National Risk Register[103] also includes many other 'non-malicious' risks, such as accidents and natural hazards, all with the potential to cause psychological harm.

As a consequence the Sussex Resilience Forum[104] has developed a 'Psychosocial Care Plan' which describes the management structures and procedures used by Sussex, as part of an incident response, to provide coordinated, accessible information and psychological support to all of those who may be affected by disasters, terrorism and traumatic events.

Another well documented source of potential psychological harm comes as a consequence of suicide. Those affected can include witnesses, the bereaved, blue light services and those who have found the body. Providing effective bereavement response in these circumstances is essential, particularly for children and young people where the potential for 'contagion' and further suicide amongst those affected is higher[105]. In Sussex, a multi-agency response is instigated following a suspected suicide of a child or young person to share information and ensure that those involved in the response have access to psychological support and supervision where necessary[106].

9. Treatment of PTSD

9. 1 NICE Recommended Treatments

There are two talking therapies recommend by NICE[107] for treating PTSD, namely Trauma-focused Cognitive Behaviour Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).

- **Trauma-focussed Cognitive Behavioural Therapy (tf-CBT)** helps process traumatic memories and address thoughts and feelings about a trauma. The NICE guidelines refer to four specific types of tf-CBT: Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Cognitive Therapy for PTSD (CT-PTSD), and Narrative Exposure Therapy (NET).
- **EMDR (Eye Movement Desensitisation and Reprocessing)** uses eye movements or other forms of rhythmic, left-right stimulation that can 'unfreeze' traumatic

memories. It aims to help the brain to process the memory properly, so it is no longer so intense.

The NICE guidelines[80] report that there is evidence for both supported and unsupported self-help, and computerised trauma-focused CBT, in terms of self-rated PTSD symptoms and other important outcomes. Group therapy is also advocated as this reduces isolation[107].

Some forms of drug treatment are recommended by NICE for adults, depending on presentation, preference and co-occuring symptoms such as psychosis. This includes venlafaxine, selective serotonin reuptake inhibitor (SSRI) and ant-psychotics. Drug treatments, including benzodiazepines, to prevent PTSD is are not recommended.

9.2 PTSD Co-morbidity

Many of the conditions associated with PTSD do not operate in isolation, so prevention efforts need to address comorbidities such as drug use and depression.

The co-existence with other mental disorders can make PTSD difficult to diagnose. For example,

assessment, diagnosis, and treatment of PTSD in older adults presents challenges resulting from a range of issues including potential cognitive or sensory decline, comorbid mental and physical disorders and differing conceptualisations of mental health in this age group order to ensure that this is accessible to older adults adaptations may need to be made[29].

National and local guidance recommends that the role of drugs and alcohol in causing or maintaining PTSD should be considered in primary and secondary care, and that individuals should not be excluded from treatment on this basis [29,101].

9.3 Alternative Therapies with Potential

- Music[108], visual arts therapy[109] and yoga[110,111] show some support for reducing PTSD, especially in children, although more research is needed to assess their effectiveness[112,113]
- None of these therapies are currently recommended by treatment guidelines in the UK or internationally.
- Internet-based/remote consultations (individual or in groups)[114,115,116] and virtual reality[117] are potentially useful in making treatments more accessible and using less therapist time.
- Schools, care homes[118] , workplaces[119] primary care settings[120] and Emergency Departments[121] are potential places from which to deliver interventions to promote mental health and administer brief trauma-focussed interventions.

10. Summary - Evidence for Prevention

Many of the causes of trauma are either difficult to prevent in the short-term (e.g. violence between parents, child maltreatment) or are unavoidable (e.g. natural disasters, pandemics). For this reason, most of the prevention efforts focus on bolstering the protective factors that mitigate the link between trauma and poor mental health. The key enablers for prevention are summarised below:

Support trauma-informed approaches

The 4 R's and 6 Principles of Trauma Informed Care provide the foundation for considering how trauma informed practice can be established at an individual, organisation and systems level.

Trauma informed approaches are relevant to all services serving the public including schools, workplaces, 'blue-light' emergency services, local authorities, NHS teams, infant and child nurseries, prisons, residential homes, fostering services and the criminal justice system.

Immediate response is key

Psychological debriefing *should not* be undertaken following exposure to a trauma, but self-help strategies and 'Psychological First Aid' are recommended and can evoke safety, comfort, and calmness.

In the weeks following a traumatic event, when waiting for treatment, regularly monitoring a person who has some symptoms but who is not currently having clinical intervention may reduce the extent of future mental health outcomes by promptly accessing help if symptoms do not reduce

Build on the factors known to mitigate the negative effects of ACEs

- Promote social development, cohesion, and positive relationships across the life course
- Promote cognitive behavioural and emotional development in childhood
- Promote self-identity and confidence in both children and adults
- Build knowledge and awareness about the causes and consequences of ACEs amongst the public and professionals
- Develop new skills and strategies for those affected to cope with diversity
- Early identification of the adversities by therapeutic and interfacing services
- Foster a collaborative approach across sectors and organisations
- Children with multiple ACEs should be a priority as these are known to have a cumulative effect which increases the likelihood of ongoing adult mental health problems.

- Ensuring transition from child to adult services is not detrimental to children experiencing ACES, supporting their recovery

Note: Early Intervention Foundation[12] list of 33 interventions that mitigate the risk from ACEs on mental health

Build protective factors for ACEs

- School-based anti-bullying interventions
- Parenting programmes (including, breaking the intergenerational cycle of ACEs and building childhood attachment)
- Building supportive social networks and peer support
- Social skills development
- Coping strategies and mindfulness
- Addressing attachment problems
- Increasing self-esteem, emotional regulation
- Promoting better sleep and reducing insomnia
- Physical exercise

Early identification and treatment of PTSD and CPTSD

- through raising awareness of the signs and symptoms of trauma and PTSD/CPTSD
- ensuring pathways are in place to support those in need of help, acknowledging the role of services providing help for emerging and mild to moderate mental health problems
- recognising the role alcohol and drug use plays in the lives of those seeking help for the impact of trauma

Identifying who may be more likely to experience trauma enables effective allocation of resources

- People from BRM (Black and Racially Minoritised) backgrounds,
- People who have served or who are serving in the military,
- People with learning difficulties
- People who are in prison or have been in prison in the past
- Refugees and asylum seekers
- LGBTQIA+ people,
- Those working in stressful workplaces (like hospitals)
- Those who have unemployed fathers, and people experiencing poverty.
- Women experiencing sexual abuse and partner violence

Treatment for PTSD/CPTSD

- Trauma-focused CBT and EMDR are the recommended interventions by NICE guidelines in England and in other guidelines worldwide.
- The emergence of internet-based/remote consultations and virtual reality solutions may be more accessible for some.
- People may also choose to access non-clinical interventions that fit with their past experience and values such as Taichi, creative pursuits, exercise, dance, breathing techniques

Part 2 – Stakeholder Engagement

This section describes the process and results of stakeholder interviews and a multi-agency workshop held early 2025.

1. 1 Interviews - Methodology

Eight semi-structured interviews were conducted between January to March 2025 amongst professionals with a remit or special interest in trauma prevention and attenuation in East Sussex. An additional written submission was also obtained. The participant cohort included a variety of roles from both the voluntary and statutory sector; these included:

- Training and Development Consultant (ESCC)
- Creative director of a community arts-based charity
- Senior practitioner adult social worker
- Principal Social Worker – Adult (ESCC)
- Principal Social Worker – Children (ESCC)
- Systems change coordinator for the Changing Futures Programme & ICS trauma informed lead
- Practice Manager – Changing Futures Programme
- Consultant Clinical Psychologist (SPFT)
- CAMHS Service Manager (Access and Early steps), SPFT

The following interview questions were also used with all participants:

- What are the key strengths and areas of good practice relating to prevention or attenuation of trauma in East Sussex?
- Are you aware of any groups that are particularly underserved in relation to identification/assessment/diagnosis/treatment of trauma?
- What are the key gaps in the systems response to people experiencing trauma?
- What key initiatives or changes to delivery would improve prevention or attenuation of trauma?

- What are the key opportunities for improving our system response to those experiencing traumatic events/ trauma?

All interviews were conducted on 'Microsoft Teams'. The transcripts were reviewed of accuracy and then processed to produce a thematic analysis, which involved a mixed methods approach between the interviewer and the 'Microsoft 365 Copilot' artificial Intelligence (AI) tool. The AI combed through 134 pages of transcript to identify a series of recurrent themes & subthemes. These findings were then supplemented and refined by the interviewer's knowledge of the data set to provide an accurate set of key findings.

1.2 Interviews – Results

Question 1 (key strengths)

- **Multi-disciplinary approaches** – e.g. partnerships between NHS, local authorities, VSCE and community groups - MDTs – mental health and GPs
- **Trauma informed training** – more widely available and has led to developments in practice – e.g. within hospital environments, recognition of trauma histories and greater focus on staff well-being
- **Communities of practice** - share knowledge, discuss challenges, and collaborate (ICS and ESCC)
- **Specialised support services** – sexual violence, domestic abuse and childhood trauma – focussing on immediate and long-term needs

Question 2 (under-served groups)

- Neurodivergent individuals
  - particularly child-adult transitions
  - potential for misdiagnosis
  - lack of reasonable adjustments – e.g. may need longer for therapeutic interventions
- **People who are homeless** – self-medication, undiagnosed SMI and traumatic life events perpetuated by living circumstances
- **People with problematic drug and/or alcohol use** – cyclical nature of problematic substance use as a coping mechanism for trauma
- **Domestic abuse victims** – huge number of referrals & services under pressure, yet many more are not identified and supported
- **Men** – less likely to seek help and have needs met
- **Minority ethnic communities** -these groups may face language barriers, cultural stigma, and lack of culturally relevant services, hindering trauma identification and access to treatment
- **Children and young people** - while some services exist, more tailored trauma-specific interventions for children and adolescents, especially those affected

by abuse or neglect, are needed. Children and young people requiring trauma focused therapy have long waits for intervention

Question 3 (gaps in system response)

Communication and co-ordination - lack of data sharing means duplicating assessments and disclosures of traumatic histories and fragmented care for those with multiple compound needs

Resource limitations - services that are overwhelmed & overstretched with long waiting times

developing trust and rapport takes time

Training and awareness

- better but more to do – e.g. in non-trauma services- clinical settings, schools, community services.
- can't assume health and care staff are sufficiently/consistently well informed or providing best practice

Child and family support - more family-centred interventions are needed, especially services that focus on supporting children and their families during trauma recovery

Question 4 & 5 (initiatives and opportunities for improvement)

Additional training

- broader and multi-disciplinary if possible
- trauma informed 'Practice Certificate'?
- addressing language that perpetuates stigma
- training shouldn't be sporadic in terms of availability

Continuity of care

- prioritising ability to work with people over extended periods of time when rapport is there
- managing transitions that support stability, familiarity and safety

Integrated care - models that bring together various services to provide holistic support to individuals experiencing trauma

- increased cross-sector collaboration
- enhanced info sharing, shared records
- reduce duplication of assessments

Investment in early intervention - focusing on prevention programs, particularly mental health support for children and outreach to at-risk populations

Community-based and peer support - developing peer support networks and community-driven initiatives can create accessible and trusted spaces for individuals to discuss their trauma and receive support

2.1 Workshop – Methodology

A multi-agency workshop was convened in April 2025, to bring together the findings of the evidence review and stakeholder interviews, as well undertake some group work with the participants. Speakers were invited from Public Health, Sussex Partnership Foundation Trust, Changing Futures and Compass Arts.

The workshop was open to anyone with an interest in the prevention of trauma. 40 participants attended from a range of statutory and VSCE services, as well people with lived experience.

2.2 Workshop – Results

What would you like to see more of, that's working well?"

- More widespread training to understand the impact of trauma on staff in everyday service areas. The circulation of information, evidence, and case studies to bring issues to life is appreciated.
- Many responses stress the need for a trauma-informed approach across all levels of staff, from security and receptionists to heads of service. This includes changing language to be trauma-informed and ensuring that staff know how to support people experiencing trauma.
- Integrated services to reduce the need for individuals to revisit their histories and traumas when moving between services. One record held through integrated services, including charities, would be beneficial.
- Art therapy for children experiencing trauma is working well but more is needed.
- Schools promoting mental health and encouraging children to use mindfulness and other coping mechanisms are seen as positive and having a lifelong impact.
- More staff who can really listen and support people to fully explain what is going on without being misunderstood or misdiagnosed.

What are the key gaps in terms of prevention?

Reasonable Adjustments. There is a need for a more flexible approach to improve attendance, and easier access to venues. There was consensus that people with traumatic histories may take longer to establish a rapport and trust with a practitioner, and so longer contact/more sessions may be required. Teams often do not have the luxury of time to address issues effectively.

There was also a view expressed that many people may not seek help due to fear of burdening practitioners with their problems and traumatic histories.

Co-occurring Issues (incl. criminality, violence, alcohol and drug use) More efforts are required to address issues related to criminality, violence, and sexual

experiences associated with traumas. It's important to see individuals as humans rather than just their behaviours.

Community and Peer Support Opportunities. There is a need for more opportunities for informal community-level support and peer support opportunities, which was felt unlikely to improve given the current financial climate.

Integrated Services There is a need for better integration between VCSE and statutory services. There can be a lack of collaboration between services, leading to repeated sharing of details.

Access to Services. Difficulty accessing services, especially mental health services, is a significant gap, particularly when problematic drug and/or alcohol use is also an issue. Also, significant delays in accessing trauma interventions due to limited availability. Also, lack of active support while people are waiting for services.

Trauma Informed Organisations: More efforts are needed to make organisations trauma-informed.

Early Interventions: Early interventions such as art therapy, yoga, and tools for self-regulation could help prevent trauma from developing into more acute mental health issues.

Measuring Prevention: There is a need to measure prevention effectively and understand system pressures through dynamic metrics.

Part 3 – Recommendations

Recommendation 1

The opportunities to prevent trauma and take trauma informed approaches cannot be realised without the meaningful involvement of people with lived experience. For those with a history of long term serious mental illness or multiple compound needs, their 'history' of traumatic events very often includes interaction with mental health and other services.

How

- Ensure that the involvement of people with lived experience is a feature of service design activity and delivery from the outset, using the 6 principles of trauma informed care to guide this work.
- Ensure that where 'lived experience' involvement does take place, that the skills and experience of those people is harnessed to develop and improve trauma informed approaches.

Recommendation 2

There are significant opportunities to reduce the impact of trauma on the population as a whole by addressing risks and promoting the factors that are known to be protective.

How

- Ensuring that a 'trauma lens' is applied to those people and communities known to be at higher risk of being exposed to traumatic events. This means understanding how past trauma shapes their lives and how to support them in a trauma informed way.
- Bolstering resilience of children and their families through evidence-based programmes of intervention and support.
- Ensuring that a trauma lens is applied to women health, maternity, children and young people's services in general, and increasing awareness of the impact of pregnancy, terminations and having babies removed may have on the women using these services.
- Understanding that resilience is the result of individuals being able to interact with their environments and the processes that either promote well-being or protect them against the influence of risk factors.
- Building community resilience by increasing opportunities for individuals to connect with each other and their communities and ensuring that communities have an active role in identifying and addressing their needs.

Recommendation 3

Awareness of the rationale and benefits of trauma informed approaches needs to be widened, so that it becomes a universal and unifying principle amongst local authorities, the NHS and VCSE sector.

How

- Support the continued work of the ICS Trauma Informed Network and other communities of practice
- Ensure training in trauma informed working is available and that it extends beyond frontline workers to those in managerial and senior leadership roles. This should include the impact of vicarious trauma and the benefits of early psychological first aid
- Create a central repository of resources that aid implementation at individual, service and community levels
- To review physical spaces where mental and physical health and social care is provided to ensure lighting, signage and ambience promote safety

Recommendation 4

The biggest impact for residents and those providing services for them, will happen through concerted and combined efforts of the system as a whole to prevent trauma.

How

- Providers of health and social care to work towards becoming trauma-informed organisations, meaning the organisation as a whole: understands what this means, understands their strengths and weaknesses and implements an action plan or strategy to develop and improve (using an agreed framework described below). This should be co-produced with people with lived experience
- Develop or adopt a framework for trauma-informed working which acts as a guide and benchmarking tool for local organisations and the ICS as a whole. This should aim to establish some consistency in approach and equip organisations with the tools they need, such as developmental toolkits and strategy templates. Essential components should include,
  - How to ensure meaningful involvement through coproduction from people with lived experience
  - A shared vision for trauma prevention, by embedding trauma informed approaches
  - Templates for organisations and services to self-assess their approach to trauma prevention and to implement a development plan
  - Guidance on how to take a public health approach to reducing health inequalities by implementing both universal and more targeted approaches to trauma prevention
  - Adopt consistent language, definitions and principles, including the 4'R's and 6 principles of trauma informed care, to aid a unified approach
  - Understand that whilst trauma-informed approaches are important the opportunities for trauma prevention are far broader

Recommendation 5

Early support for those experiencing trauma and NICE recommend treatment should be made more widely available.

How

- Undertake mapping of existing services delivering care and treatment for the impact of trauma, including PTSD, or ensure it falls within scope of existing mental health development work
- The Sussex Resilience Forum undertake a training needs assessment to understand the availability of timely psychological first aid response to those experiencing a major incident

Recommendation 6

Major incidents can have a significant and lasting effect on the mental health of those experiencing and responding to the event. Partners should seek assurance that the psychological support required is available and sufficient.

How

- Test the new Psychosocial Care Plan through scheduled desk top exercises run by the Sussex Resilience Forum

Appendix 1 – Evidence Summary – Prevention of ACEs

Racine et al (2020)
Among children experiencing adversity, protective factors include individual coping strategies, peer support and individual social skills.
NICE 2024d
Among children experiencing adversity, protective factors include individual coping strategies, peer support and individual social skills.
Al Jowf et al (2022)
The provision of **emotional care** for children is a significant means of preventing trauma-induced mental health issues and may lead to better mental resilience when facing traumatic stress. This is in contrast to the poorer mental health for those experiencing emotional neglect and emotional abuse.
Elrefaay et al (2024)
A review of ACEs and depression showed that childhood trauma was associated with a higher risk of depressive symptoms among participants with lower resilience. The paper concludes by saying that those who experienced childhood trauma may benefit from evidence-based interventions focused on strengthening resilience and improving coping strategies.
Sahle et al (2022)
Reviewed a number of interventions and found four categories of effective ways to reduce the impact of ACEs: Community-wide interventions, parenting programmes, home-visiting programmes and psychological interventions. School-based anti-bullying interventions and psychological therapies for children exposed to trauma were recommended. The evidence was generated through consultation with health practitioners, researchers, and policy experts.
Wood-Jaeger et al (2018)
describing the potential to break the intergenerational cycle of ACEs through a family-centred approach - as parent aspirations to make children's lives better

and to provide nurturance and support Protective factors have also been classified as, with
Isabel et al (2019)
In reviewing 77 articles, found that resolving parental trauma and promoting parent-infant attachment were ways to break the intergenerational transmission of trauma within the family. They conclude that 'Systematic trauma-informed attachment-focused interventions in health and social service settings are recommended.' These findings show that family focussed interventions can help to promote resilience among parents and children exposed to early adversity.
(Ribaudo et al, 2002)
Interventions working with parents may offer an indirect route to preventing trauma (before it happens) among infants and children
Bethell et al (2016), Jovanovic and Garfin (2024), Kangaslampi and Peltonen (2002) Somohano et al (2022), Schramm et al (2022)
Suggests that **mindfulness-based**, mind-body approaches may strengthen families and promote child resilience to ACEs, as a mechanism of change in alleviating PTSD, and effective in preventing relapses in depression.
Shin et al (2024)
The effects of **spiritual and religious beliefs** have also been shown to protect against the mental health impacts of ACEs
(Jung and Lee (2023)
Attendance at religious events was also seen to reduce the impacts of ACEs on mental health, using data from the US 2016 Health and Retirement Study
Cloitre et al (2019)
Interventions that focus on improving emotion regulation skills might provide an efficient transdiagnostic treatment strategy for both psychological and physical health problems.
Panagou et al (2022)
Similar observations were found from) review of 31 papers and showed that perceived social support and emotional regulation were effective in reducing mental health problems.

Royer and Wharton (2022), Kinsman et al (2024)
The benefits of **physical exercise** on mitigating the link between ACEs and depression, with the latter study specifically mentioning PTSD

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