
Instruments for Exploring Trauma-Informed Care

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Abstract

Trauma-informed care is rising in popularity as services are recognising that traditional models are not offering a capacity for healing once thought. Service providers are becoming aware of individuals facing significant re-traumatisation using their services, and so a practical need to explore and understand approaches that accounts for these occurrences has arisen. Trauma-informed care is observed to be represented as a culture and an understanding of what this means is necessary to begin to understand trauma-informed care and its implementation. At present, there are a wide array of instruments available to evaluate the implementation and facilitation of trauma-informed care in numerous organisational services. A review of existing qualitative and quantitative instruments for exploring trauma-informed care was conducted. Many of these instruments require further validation or are limited in their construction. Foundational and substantial research on instruments were identified and discussed. Future instrument development emerging from such comparison and understanding is proposed.

Key Words: Trauma-informed care; Instrument; Monitoring

Points for Practitioners:

- Any framework or instrument should consider the opinions and ideas of individuals in the organisation
- The framework or instrument must be dynamic, flexible, and bespoke to the individuals within the organisation
- The framework or instrument should be designed and redesigned, deployed and redeployed on a frequent basis to keep up with fluctuation in the organisation so that decision makers can make up-to-date decisions based on current circumstances

Introduction

Trauma-informed approaches to the delivery of services are quickly becoming popular in how organisations engage with their users and staff (Paterson, 2014; SAMHSA, 2014; Sweeney, Clement, Filson, & Kennedy, 2016; Yatchmenoff, Sundborg, & Davis, 2017). Not only is trauma-informed care inviting organisations to become more mindful of their interactions, but it is also raising the awareness of individuals that are using many of these services of their increased likelihood to be impacted by trauma or adversity. Being trauma-informed is a reminder of our basic humanity, our vulnerability, our creative capacity for adaptation, and

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our potential for growth within relationships that can heal and connect us. Trauma-informed approaches are relatively new in their development but have already generated a large amount of attention since their conception. There is a debate on the nature and scope of trauma-informed care, as trauma-informed care has been viewed as both an organisational structure and treatment framework (Fallot & Harris, 2001), and also as a culture (Bateman, Henderson, & Kezelman, 2013). Trauma-informed care is a system development model (Paterson, 2014) that moves away from the traditional diagnosis model of “*what is wrong with you*”, towards a story-based approach of “*what happened to you*” (Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018). Trauma-informed Care requires all agents to be operating within the environment to be engaging in trauma-informed practice. Aligned with the interpretation provided by Yatchmenoff et al. (2017), trauma-informed care can be objectified under three essential domains, of which, all other domains fall under; safety, empowerment, and self-worth. If culture is: “how we do things around here” then moving from one operational position to another, is a change associated with the changes in observable practices and structures.

Trauma-informed care is seen as a valuable system change to facilitate within the human service organisation (Muskett, 2014). As with all change programmes, there is considerable interest in being able to demonstrate that change has taken place. Researchers are attempting to develop instrumentation that can allow for the detection of change and to offer the opportunity for further learning and deploy interventions to take organisations towards their goals of being trauma-informed (Baker, Brown, Wilcox, Overstreet, & Arora, 2016; Bassuk, Unick, Paquette, & Richard, 2017; Goodman et al., 2016; Richardson, Coryn, Henry, Black-Pond, & Unrau, 2012). Definitions of trauma-informed care are many, and measuring the implementation and facilitation of trauma-informed care can be confusing (Fallot & Harris, 2001; Sweeney et al., 2016; von der Embse, Rutherford, Mankin, & Jenkins, 2019; Yatchmenoff et al., 2017). Whether or not trauma-informed care can be effectively measured is up for debate (Yatchmenoff et al., 2017). At present, there exists a wide array of instruments developed to evaluate the facilitation of trauma-informed care in numerous organisational services (Baker et al., 2016; Bassuk et al., 2017; Goodman et al., 2016; Richardson et al., 2012).

This review intends to assist in the future development of instruments to monitor trauma-informed care, and prefers to adopt the term “monitor” when approaching this topic; a monitoring process is one of the observations accompanying a narrative-based approach, to verify mental models are in congruence with the organisation's ideals. Monitoring enables organisations to detect shifts of momentum and offers the opportunity, in the moment, to deploy an intervention that can enable a nudge towards the preferred direction (Baweja et al., 2016; Petersen & Spencer, 2012).

Existing qualitative and quantitative instruments are reviewed for the exploration of trauma-informed care. Trauma-informed care is an optimistic approach to how interactions should occur in services, it is an acknowledgement of the trauma-imprint, which is to be sensitive to the unknown, to be conscious of the impact that history has had on an individual. The trauma-informed approach delivers results that are genuinely healing, by improving the relationships of staff and service users with a greater understanding, respect,

and trust between them (Sweeney et al., 2018). This document has three purposes: (1) to document existing instruments, (2) to offer guidance towards selecting an instrument, and (3) to introduce a bespoke instrument development method that factors in the processes behind the development of all previous instruments. The review is accompanied by a compilation of the identifiable features within these instruments which uses the framework put forward by Jung et al. (2009). This compilation of instruments is undergoing a frequent update and is available upon request.

This research provides a theoretical review of the instruments available in the field of trauma-informed care and offers practical guidance to those with a desire to evaluate the implementation of trauma-informed care in detail, and those who wish to move in the direction of trauma-informed service delivery. It also contributes to the ever-developing evidence base of choosing to adopt trauma-informed care over other approaches as trauma-informed care has priorities with healing. This approach to healing through relationships delivers results not seen before by other approaches. The conclusions will be of particular interest to practitioners and clinicians that wish to move forward in the adoption, implementation, and more specifically, the process of monitoring to ensure that trauma-informed care and the principles of it are being employed in practice.

Methods

This review has chosen to adopt the established guidelines for systematic reviews provided by the Centre for Reviews and Dissemination at the University of York (Reviews & Dissemination, 2009). Searching for these particular instruments proved difficult, as trauma-informed care is in its infancy and instruments to evaluate its implementation are few in the literature (Berger, 2019). Internet searching was undertaken because most of the trauma-informed care literature is considered grey literature and many of the studies are published informally. Therefore, internet searching using the Google search platform was undertaken to investigate results emerging from the keywords "*trauma-informed care instrument*". The keyword "*instrument*" was subject to various alterations such as "*measurement*", "*evaluation*", "*assessment*", while an addition of the keyword "*tools*" assisted in the identification process. The results proved effective in uncovering various instruments, some emerging from research articles such as the Attitudes Relating to Trauma-informed Care (ARTIC) (Baker et al., 2016), The TICOMETER (Bassuk et al., 2017), the Trauma-informed Practice Scales (TIP Scales) (Goodman et al., 2016), and the Trauma-Informed System Change Instrument (TISCI) (Richardson et al., 2012). Other instruments identified were developed by professional bodies in industries such as healthcare, education, and other human services. Many of these instruments were often difficult to access due to restrictions placed upon them (monetary, regional, etc.) Therefore, this review is restricted in its analysis. There also may be instruments that are not readily available in the literature.

The instrument and any body of work, article, and publication that might be attached to it were examined. Because of the scarcity of the instruments available, limited access did not eliminate an instrument from the study, rather, this review attempts to review what is readily accessible. The framework constructed by Jung et al. (2009) was used in attempting

to review all identifiable instruments. However, many fields in the compilation are left unpopulated due to limited access to the instrument. This framework was used as it allowed for a uniform comparison of all instruments as fields are identical. Basic information was identified such as country of origin, development date, available versions, definition or conceptual model, intended purpose, format, domains, items and scales, procedures for scaling and aggregation, level of measurement, methods used in item generation, and methods used in item reduction and modification. This review examines the landscape and examines many instruments available in the domain of trauma-informed care but scopes in on the ARTIC, the TICOMETER, the TIP scales and the TISCI. These instruments were selected to undergo critical review as they are substantially constructed, and journal articles are available to review which provide ample information.

All instruments were also assessed on the appropriateness (face validity, acceptability, feasibility, susceptibility to systematic bias), reliability (internal consistency, test-retest, and inter-observer), validity (content, criterion, and predictive/concurrent, convergent, discriminative, cross-cultural, dimensional, structure) responsiveness, and interpretability (norms, calibration). Many of these instruments lack accompanying background information and so data remains insufficient in many sections of the compilation. Although, as is customary to the framework, this lack of data would eliminate an instrument from the review, in this case, as there are so few instruments currently available in the field of trauma-informed care, the instrument remained in the study. As instruments to monitor the implementation of trauma-informed care are scarce, this review prioritised producing a comprehensive assessment of select instruments. The framework provided by Jung et al. (2009) was useful in allowing for a birds-eye view of the instruments available in trauma-informed care. They were cross-examined and compared; a sample of this compilation can be seen in Table 1.

Survey of the Landscape

All the instruments under review were developed in the United States. The instruments vary in age, however; it would seem that the earliest was developed in 2001 (Fallot & Harris, 2001; Harris & Fallot, 2001). The first instrument, Creating Cultures of Trauma-informed Care (CCTIC), is foundational as almost all other instruments have recognised their contributions in their development. Although many instruments did not specify a development date, certainly, they have all emerged within the last 20 years in alignment with the introduction of trauma-informed care. Relatively new instruments, such as the TICOMETER and the Trauma-informed Agency Assessment (TIAA), acknowledge that predecessor tools were examined in their development process. The TICOMETER compared the domains identified in the literature and those found in other tools to contrast with input given by panel members and service users to review and to prioritise a core set of domains that reflected the most pertinent organising concepts (Bassuk et al., 2017). The TIAA established a workgroup, which reviewed the literature and current existing tools to draft questions for different perspectives (Thrive, 2011).

Table 1 – Instrument Comparison

Instrument Name	Main Features	Timeline	Scope of use
Agency Self-Assessment	Self-report questionnaire. Can be implemented online	NR	Used to assess the organisation's readiness to implement a trauma-informed approach
Attitudes related to Trauma-informed Care	A psychometrically valid measure of trauma-informed care. In-depth development process	2012	Assess service providers' attitudes relevant to Trauma-informed care
Creating Cultures of Trauma-informed Care	Acts as a set of guidelines or framework for adopting trauma-informed care	2001	To be used in the development, implementation, evaluation, and ongoing monitoring of trauma-informed care
TICOMETER	A psychometrically valid measure of trauma-informed care. In-depth development process	NR	To measure staff's perceptions of trauma-informed care adoption. Does not directly measure the perceptions of service users
TIP Scales	In-depth development process. Free to access TIP guide	NR	An exploration into whether and to what degree programs are succeeding in their efforts to adopt a trauma-informed approach
National Council for Behavioural Health: TIC organisational Self-Assessment	Self-report questionnaire	NR	Designed to increase awareness and readiness to adopt the key components of a trauma-informed care organisation and to identify what is required to keep doing and reinforcing, stop doing, or start doing the right thing
PRoQOL	Not a measure of trauma-informed care adoption, but a measure of the aspects of caring	2009	To measure the positive and negative aspects of caring
TIC-OSAT	Strengths-based organisational tool	NR	Provides organisations with a point in time snapshot
TIAA	Validated tool. Self-report questionnaire	2012	Pinpoint areas where organisations are doing well and pinpoint areas for improvement
Trauma Informed Organisational Self-Assessment	Built with feedback from trauma and research experts, consumers and community providers	NR	Organisations can use this assessment to examine their current practices and take steps to become trauma-informed
TISCI	Uses a systems perspective. Wording has universal meanings. In-depth development process	2010	Provides a snapshot of the extent to which the current community child welfare system is trauma-informed.
TreSIA	Self-report questionnaire using score mapping	NR	Assess readiness for implementation of trauma-informed care
Trauma System Readiness Tool	Self-report measure designed for child welfare systems to use	2012	Part of a larger practice toolkit that includes a number of resources to be used by child welfare systems in their goals to become trauma-informed
TIC in Youth Service Settings: OSA	Self-report questionnaire	NR	Implementation of elements inclusive in the instrument, representing an ideal to strive for

Younger instruments adopted the approaches of older instrument development and furthered the development by adding in additional steps. The typical process, which is often referred to as "being in alignment with trauma-informed care principles and practices" has

different interpretations for different instruments, though all seem to follow a similar approach.

- Firstly, a literature review is undertaken to investigate trauma-informed care
- Secondly, discussions are held with a combination of complementary expert consultations and survivor and advocate focus groups on the development of the instrument
- Thirdly, the data generated via these means are used to develop domains, descriptions, and items for the instrument. This preliminary instrument then undergoes pilot testing to conclude with a final draft of the instrument

Generally, a team is formulated, known as a workgroup, which then administers this process. For the ARTIC, such a team included experts in trauma-informed care, trauma and stress, school-based mental health, community mental health, and study design and methodology (Baker et al., 2016). The ARTIC began its current development building on from a previous instrument, incorporating trauma-informed care foundations, alongside utilising synthesised quantitative data from an ongoing risking connection program evaluation, and qualitative data from participant observations conducted within sites implementing trauma-informed care and findings from a cognitive interviewing process with service providers (Baker et al., 2016). This was produced together with a literature review of the theoretical, empirical, and measurement literature relevant to trauma-informed care, with an emphasis on what works and what is considered foundational to the field. This is extensive work in contrast to the explanation provided by the Agency Self-Assessment (Thrive, 2011), in which the authors reported that the instrument was developed using the National Centre on Family Homelessness Trauma-informed Organisational Self-assessment and the CCTIC.

Eight of the instruments are specific in their application to human services, though three are non-specific. The TICOMETER is specific in its application to health and human services, whilst the TIP Scales are non-specific. It is important to address the application of these instruments as trauma-informed care is not only a system model for health and human services, but it offers viability to be administered throughout any organisation. However, success for instruments is often found in bespoke development and application (Baker et al., 2016; Bassuk et al., 2017; Goodman et al., 2016; Richardson et al., 2012). A non-specific instrument is not designed to target a particular organisation and so is unable to extract meaningful data (Thrive, 2011). Instruments that are easily modifiable to accommodate different contexts are seen to be favourable. The instruments themselves are all located within the United States; this is likely due to trauma-informed care originating within the United States and has taken time for its spread to reach other areas of the world.

Sharing similar purpose, the instruments in question all aspire to report on the current standings of trauma-informed care implementation, they all desire to understand changes, and assess the trauma-informed nature of an organisation. Aside from the CCTIC, which is more likened to a guidance framework and the Professional Quality of Life Scale (PROQOL), which is a specific measure on the positive and negative aspects of caring. All the instruments adopt a *“self-report questionnaire”* approach to assessment. The Agency Self-

assessment is used to “*assess an organisation’s readiness to implement a trauma-informed approach*” (Thrive, 2011). The National Council for Behavioural Health’s Center for Substance Abuse (2014) self-assessment wishes to “increase your awareness and readiness to adopt the key components of a trauma-informed care organization and to identify what you need to keep doing and reinforcing, stop doing, or start doing the right thing”. The TICOMETER determines the nature and strength of trauma-informed care and practice across dimensions of service delivery. The general aim is to provide organisations with a point in time “*snapshot*” (Bassuk et al., 2017).

Domains of the instruments all share similarities in that they are all derived from trauma-informed care. They all resemble the domains offered by the CCTIC, which are: 1. Safety, 2. Trustworthiness, 3. Choice, 4. Collaboration, 5. Empowerment, and 6. Trauma Screening Process. However, they are context-dependent. The ARTIC includes a subscale titled: “*underlying causes of problem behaviour and symptoms*”, likely due to its focus on measuring attitudes. Whereas the TICOMETER includes a domain titled “*establishing trusting relationships*”, which is broader in its reach. The domains are typically how the instrument will present its questions or items, as with the CCTIC, Fallot and Harris (2001) state that “*an organisation must adhere to the six principles seen above; otherwise, it is not able to say that it is trauma-informed*”.

The standard methodology applied is usually a self-report questionnaire comprising a Likert Scale, delivered either in person or online. However, the TIAA, during its development process, which occurred over two years, began its assessment as a face-to-face interview. Shortly thereafter, during testing, stakeholders determined face-to-face interviews to be overly labour-intensive and modified the tool to a self-assessment (Thrive, 2011). Many instruments are free to use, they exist in the form of PDFs, available for download. Others come at a price, such as the ARTIC and the TICOMETER. Both of these instruments use pricing calculators, the ARTIC has three package options: advanced, advanced plus, and custom (Baker et al., 2016). The calculator is priced by these three package options and by the number of respondents. Using the calculator, the ARTIC would cost \$14,000 for 1000 respondents. The TICOMETER ranges from \$250 to \$1000+ depending on the number of employees in the organisation (Bassuk et al., 2017). It has been some time since the development of many of these instruments, and seemingly, updates have halted. Full access to instruments is limited; instruments like the TICOMETER and the ARTIC would require administrative requirements for analysis.

Comparative Assessment of the Four Main Instruments

The following section examines four instruments in detail using Jung’s framework as they used a reproducible participatory approach to generating domains: consulting experts, service users and staff. These four instruments, namely, the ARTIC, the TIP scales, the TICOMETER and the TISCI. These instruments were selected to undergo substantial comparative assessment for several reasons. Firstly, information is abundant for all four of these instruments, they each are associated with a journal article which makes understanding the instrument’s development, intent, and application straightforward. The articles make

these instruments ideal for comparison as the information contained is similar (Baker et al., 2016; Bassuk et al., 2017; Goodman et al., 2016; Richardson et al., 2012). Secondly, while there are other instruments available to use, many of these are difficult to access, these four are not. Thirdly, most other instruments are out of date and are no longer updated. And finally, these four instruments have substantial documented research into their development. These four instruments evidenced themselves as being substantial during Jung's analysis (Jung et al., 2009).

The ARTIC is constructed under the criteria that a trauma-informed organisation depends on the moment-to-moment, day-to-day behaviour of its personnel (Baker et al., 2016), the TIP scales require an understanding of the effect of trauma into every aspect of an agency's work (Bassuk et al., 2017), the TICOMETER is similar in its description and insists all services are provided through the lens of trauma (Goodman et al., 2016) and the TISCI is founded upon the need for a systems perspective (Richardson et al., 2012), asserting a trauma-informed system is essential when viewing the service user from the systems perspective.

The ARTIC exists in three versions, the ARTIC-45, the ARTIC-35, and the ARTIC-10 (Baker et al., 2016). The number relates to the number of items included in the form, if time is identified as an issue, then shorter forms are available to be issued. The measure was developed by using an extensive mixed-methods process utilising a community-based participatory research approach; this involved using synthesised quantitative data from an ongoing risking connection program evaluation, qualitative data from participant observations conducted within sites implementing trauma-informed care, findings from a cognitive interviewing process with service providers and an extensive literature review of the theoretical, empirical, and measurement literature relevant to trauma-informed care.

Similarly, the TICOMETER used an expert panel comprising researchers, clinicians, trauma experts, and people with lived experience to guide the development of the TICOMETER measure (Bassuk et al., 2017). However, the TIP scales differ slightly as this measure focused more specifically on trauma-informed practices and indirect interactions between staff and service users. A qualitative content analysis of available publications describing trauma-informed approaches for domestic violence programs was undertaken, resulting in six broad principles (Goodman et al., 2016). The TISCI stemmed from an applied social work initiative, the development took place within the process of designing the initiative. All four instruments used an iterative approach to select the psychometrically strongest set of items. The TICOMETER resulted in a final set of 35 items across five domains; the ARTIC resulted in a final set of 45 items across eight domains, the TIP scales ended with 48 items over six domains and the TISCI resulted in 19 items which were fit into four domains.

Regarding face validity, Items in the ARTIC indicate that all items are written at a sixth-grade reading level as indicated by the Flesch-Kincaid Grade Level test (Baker et al., 2016) and instruments were developed with the assistance of trauma-informed content experts alongside in-depth literature reviews. The authors of the TICOMETER claim that the final 35 items represent the strongest indicators of trauma-informed care, as reflected in their analyses (Bassuk et al., 2017). The TIP scales correspond well with prior conceptualisations

of trauma-informed practice in the domestic violence context (Goodman et al., 2016). The authors of the TISCI imply that establishing the validity of measurement for tracking change in a complex system relies on the ability to define the system and to define how that system functions (Richardson et al., 2012). On acceptability, the ARTIC can be delivered to either school or human service settings with word modifications (Baker et al., 2016). The TICOMETER continuously assesses the relevance of the items to the domains and requests feedback from the expert panel about the relevance of the items to the construct of trauma-informed care (Bassuk et al., 2017). The TIP scales also exist in two separate versions, an English and a Spanish version (Goodman et al., 2016). The TISCI is context dependent and heavily influenced by child welfare systems (Richardson et al., 2012). The ARTIC-45 requires 10-12 minutes to complete (Baker et al., 2016), the TICOMETER requires 15 minutes (Bassuk et al., 2017), and the TIP scales last approximately 30 minutes (Goodman et al., 2016). The participants of the TISCI are given 10 minutes to complete the instrument (Richardson et al., 2012). However, the ARTIC-10 short form requires the least time with 2-3 minutes to complete (Baker et al., 2016).

All three forms of the ARTIC produce reliable measures of individual differences in attitudes relevant to trauma-informed care. Cronbach's alpha is a measure of the internal consistency of a test or a scale (Tavakol & Dennick, 2011), Cronbach's alpha for the ARTIC-45 ($\alpha=.93$) and ARTIC-35 ($\alpha=.91$) are excellent, whereas the ARTIC-10 is good ($\alpha=.82$) (Baker et al., 2016). The TICOMETER reportedly has high levels of internal consistency across items and the scores on the five domains had excellent internal consistency when taken as a unit (Bassuk et al., 2017). The Cronbach's alpha for the TIP scales in the sample was .96, indicating excellent internal consistency (Goodman et al., 2016). The TISCI demonstrated good reliability for the items "*Policy and Agency Practice*" on the first part of the instrument. The integration factor also showed good internal consistency. However, the alpha value is adequate for the item "*Openness*" and is very poor for the item "*Tradition*" (Richardson et al., 2012).

The ARTIC was developed using multiple sources; literature and in-house knowledge (Baker et al., 2016). The TIP scales used four data sources to contribute to the development of items. The TIP scales issued the Client Satisfaction Questionnaire-8, which reported a .96 Cronbach's alpha on the sample, identifying excellent for predictive and convergent validity (Bassuk et al., 2017). It is reported that the TICOMETER allows progress to be monitored over time (Goodman et al., 2016). Future editions of the TISCI are to learn using qualitative data to encourage an inductive approach to understanding other areas of system change (Richardson et al., 2012).

All four instruments have been tested in health care settings. The ARTIC was developed to be used in many settings where trauma-informed care can be implemented such as primary care, corrections, whole communities, youth development, or law enforcement (Baker et al., 2016). The TICOMETER is non-specific and is developed to be used in health and human services (Bassuk et al., 2017), whereas the TIP scales are very specific and focused on being used in domestic violence programs (Goodman et al., 2016). The TISCI was administered to participants in the initiative in which child welfare professionals and caregivers took part (Richardson et al., 2012).

These instruments are comparable and seek to fulfil the same purpose; to monitor the implementation of trauma-informed care. However, they all have individual approaches, and these approaches are distinct in their contexts. The ideal instrument development approach would be developed using co-production, acknowledging all those involved and appreciating the value of their ideas and input. This is particularly important under context. Such a tool should be valid, reliable, consistent, brief, and most importantly, relevant. The tools foundation's should be developed by utilising multiple sources; literature, in-house knowledge, other instruments, etc. (Baker et al., 2016; Bassuk et al., 2017; Goodman et al., 2016; Richardson et al., 2012). Importantly, the tool should be tested and updated frequently, to acknowledge, understand, and appreciate fluctuations of the organisation's users (Bassuk et al., 2017).

Discussion

Culture is complex, consequently, as is the facilitation and evaluation of trauma-informed care (Zakszeski, Ventresco, & Jaffe, 2017), therefore, to evaluate and monitor the implementation of trauma-informed care, these complexities must be acknowledged. A pragmatic toolkit is necessary to effectively monitor change. One such instrument acknowledges the complexities of trauma-informed care, the Trauma-informed System Change Instrument, which defined a model that allowed system change to be monitored comprising policy, agency practice, and connections (between individuals and between agencies). The process that the authors advocate is to firstly define trauma-informed practice for those involved, from this definition to operationalise practice, and then to develop instrumentation to monitor the change (Richardson et al., 2012).

The most prominent types of approaching the exploration of trauma-informed care would seem to exist in the form of a self-report questionnaire. However, in their formulation, many different types of qualitative and quantitative methods are employed such as focus groups and interviews. It would seem that the more favourable approaches employ a mixed-methods approach in generating domains and items (Baker et al., 2016; Bassuk et al., 2017; Goodman et al., 2016). However, it is suggested that trauma-informed care and factors of organisational culture are too complex to be approached by any single instrument (Jung et al., 2009).

Monitoring the implementation of trauma-informed care is critical to ensuring that change is taking place. Understanding and mapping staff changes and then ensuring if they are trauma-informed or not is important for an organisation to become more trauma-informed. As Fallot and Harris (2001) declare, for an organisation to be trauma-informed it must adhere to a specific set of principles. Alongside identifying strengths and weaknesses within an organisation, instruments can be used to examine organisational capacity, receptiveness, and readiness for cultural change.

It would seem appropriate for an instrument to be directly transferable across contexts; however, evidence suggests it would be unwise to practise such an approach to trauma-informed care (Baker et al., 2016; Chafouleas, Johnson, Overstreet, & Santos, 2016). The application requires customisation, as words carry deep meaning and the instrument will

not retain its potential across context if it is created to be non-specific (Bassuk et al., 2017). An instrument should possess the ability to be modifiable so that it can be applied cross-context and a one-size-fits-all approach should be avoided by any means. If an accurate snapshot is desired, instrument fit should be inspected (Richardson et al., 2012).

Recommendations for Use

Each of these instruments present value and opportunity and much can be learnt from their study. However, the authors of this study are unable to recommend any of these instruments for use as they are. This is not to suggest that any of these instruments may not prove valuable when being used. These conclusions were arrived at after the analysis of these various instruments. Trauma-informed care focuses on the individual, their opinions, their ideas, and their choices, these are paramount to being a trauma-informed organisation. Therefore, using an instrument that has been developed outside of a country's own culture, and not reviewed by local service-users is not in alignment with trauma-informed care or the principles of it (Harris & Fallot, 2001). Many of these instruments acknowledge these conclusions but fail to implement or acknowledge them. Choice and empowerment are among the two most popular principles associated with trauma-informed care. Listening to both staff and service users is essential in developing an effective instrument. Yet, each of these instruments is developed using a different set of staff and service users to ones that may eventually be using and implementing these instruments. Therefore, it would be reasonable to suggest that all organisations must recognise this as people are different and even their perspectives of trauma-informed care differ. It can only be reasonable then to monitor trauma-informed care that is co-produced with those involved. This suggests that a bespoke development process must take place in all applications and participating members must be involved in the development process. This is in alignment with the principles of trauma-informed care. However, the authors would still recommend that these instruments be studied as much can be learned from them.

Targeted Process for Development of an Instrument

Recently, there has been considerable work undertaken in the field of trauma-informed care. The adoption, implementation and facilitation process has seen considerable development in the past 10 years. There is much to be learned from these developments. The authors do assume that readers of this manuscript have some existing knowledge of trauma-informed care. Although, it is always good practice to conduct an extensive literature review even if familiar with the work. The authors are the following approach to the development of a new UK based tool:

1. Conduct a thorough analysis of the literature and information available on trauma-informed care, specifically on monitoring and measurement. This literature expands and develops quickly.
2. The formulation of the instrument must consider the voices of staff and service users. They should be involved at every stage, beginning development with a combination of

complementary expert consultations and survivor and advocate focus groups to gather preliminary data on how the instrument should look (domains, descriptions, and items).

3. The data should be examined by the implementation group and a draft instrument should be created. This can then be put out to staff and service users to gain consensus. Multiple rounds of this stage should be taken until a consensus is reached.
4. The instrument should be pilot tested and assessed psychometrically.

It is of vital importance to remember that while an instrument may fit the people of one time, people do change. Therefore, while an instrument might seem appropriate to measure trauma-informed care at one stage, the perspectives of trauma-informed care might have changed and are measuring older opinions of trauma-informed care. This evolution of beliefs must be considered otherwise trauma-informed care remains stagnant and this is not the case for people. There is constant flux in opinions, ideas, motives, and behaviours. Being trauma-informed then means not only being sensitive to our interactions with others, but also means keeping up to date with change and recognising that nothing is ever the same. Not even the measurements of belief.

Conclusion

Many of the instruments reviewed prefer to adopt an emergent approach, relying on staff, service user, or expert involvement in the development of domains, which can assist by developing a range of ideas that encompass the notion of trauma-informed care within their context. The ideas that are generated through these focus groups can then be clustered by either the researchers or the group members into salient themes and rated for their relative importance before being used for further analysis. Some instruments adopt a dimensional approach with the intent to explore the nature of and extent to which trauma-informed care is present in an organisation (Harris & Fallot, 2001).

Even with the existence of instruments to monitor trauma-informed care, literature is scarce in their reported application. Such reporting is necessary for further development as the instruments can develop and learn with every application. As the instruments have value in their utility, this review failed to identify any significant cases of reported use in context. Different instruments offer different insights; therefore, all future development of instruments to be serviced in a context desiring a trauma-informed approach should acknowledge existing instruments on the evaluation of trauma-informed care before the construction of an evaluation instrument. The application of an instrument to monitor changes gradually should be subject to change. Such instruments prove ineffective if only applied once, and therefore must be scheduled frequently. The frequency will not only serve decision-makers in making up-to-date decisions based on current circumstances but also update the instrument alongside the dynamics of the organisation. The assessment and the information gathered by analysing instruments and their corresponding documents will be used by the authors to develop a framework, and thereafter an instrument to monitor culture change, or specifically, to engage in trauma-informed care implementation.

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