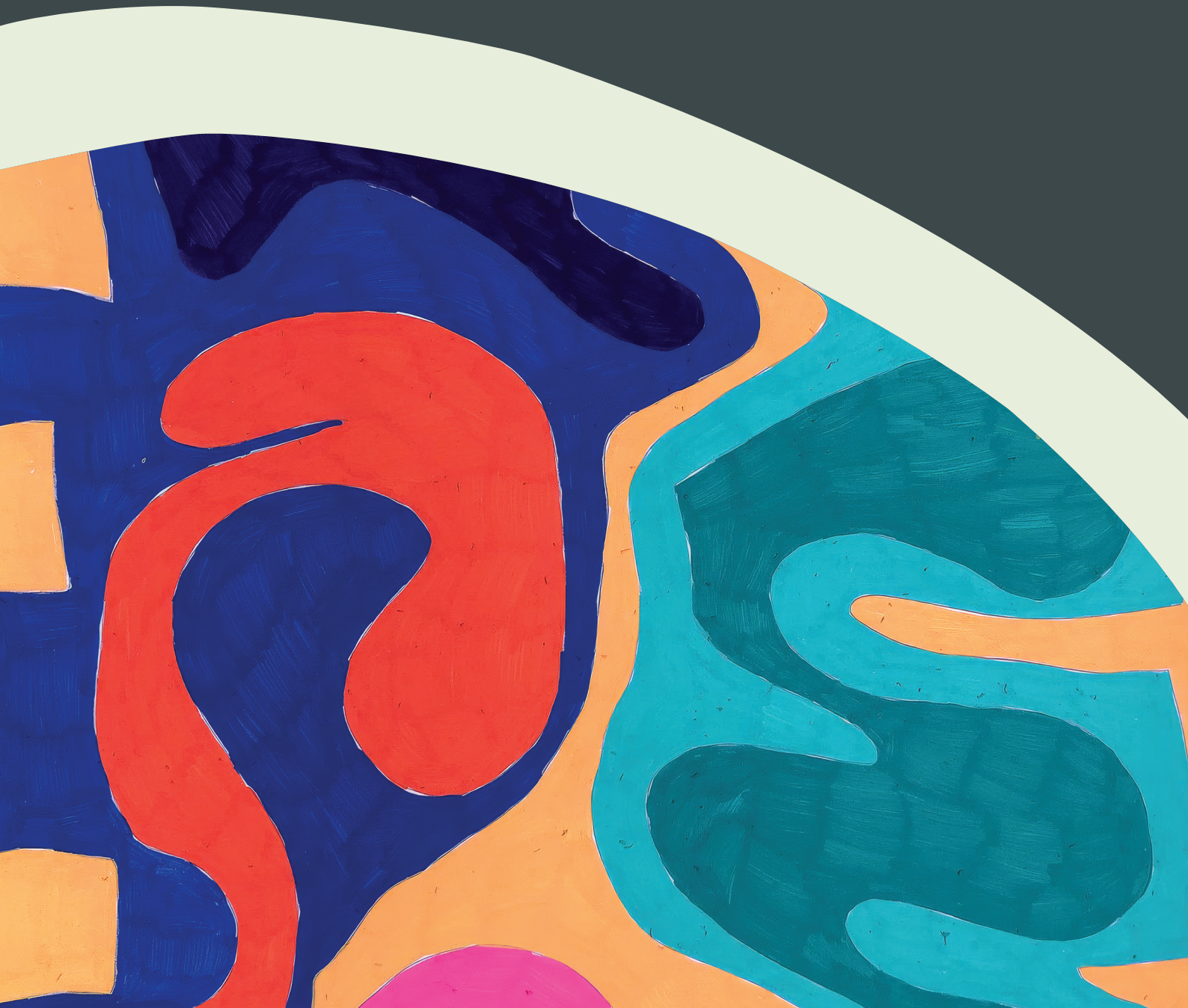


The Trust Guide

Trauma-transformative practice in health care
with people with intellectual disability

2026



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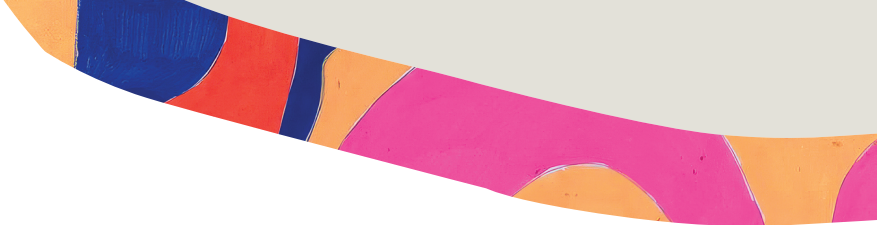
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Acknowledgement of Country

We acknowledge the Traditional Custodians of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present. We pay our respects to all First Nations people with intellectual disability and acknowledge the higher prevalence of intellectual disability among First Nations peoples and the distinct challenges they face, along with the contributions they make to society.

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Conflicts of interest

None declared

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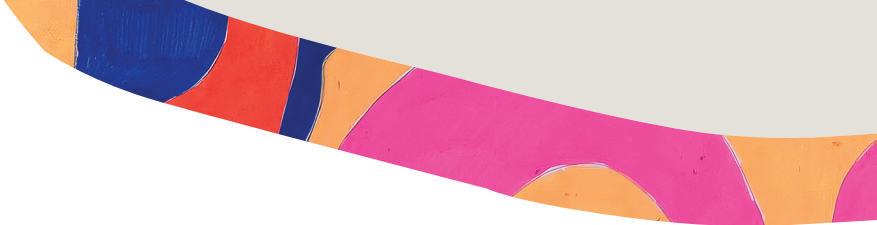
National Centre of Excellence in Intellectual Disability Health

The establishment of the National Centre of Excellence in Intellectual Disability Health was in response to the significant health disadvantage experienced by people with intellectual disability. The Centre supports the delivery of the Australian government's National Roadmap for Improving the Health of People with Intellectual Disability.

The Centre builds on the work of 3DN and the Centre's nine Consortium organisations – First Peoples Disability Network, Council for Intellectual Disability, Down Syndrome Australia, The Kids Research Institute Australia, Queensland Centre of Excellence in Intellectual Disability and Autism Health, Queenslanders with Disability Network, Centre for Disability Studies, University of Melbourne and UNSW.

Our vision is that every person with intellectual disability in Australia gets high quality health care.

Our mission is to work together with people with intellectual disability to make their health as good as it can be.



Our values

- We support the leadership of people with intellectual disability in their own lives and in the Centre.
- We are leaders in accessible communication and other inclusive practices.
- We respect family members and other advocates.
- We include people from diverse backgrounds.
- We listen to each other and value all perspectives.
- We are honest and open.
- We are accountable to people with intellectual disability and each other for what we do.

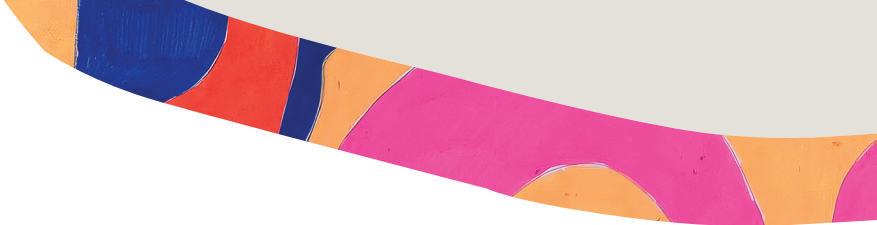
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Abbreviations

ACEs — Adverse Childhood Experiences

AGREE II — Appraisal of Guidelines for Research and Evaluation II

A2D — Admission2Discharge (resource/pathway)

BCBA — Board Certified Behaviour Analyst

BKF — Blue Knot Foundation

CB — Consensus-based (action/recommendation type)

CDS — Centre for Disability Studies

CRPD — United Nations Convention on the Rights of Persons with Disabilities

DisDAT — Disability Distress Assessment Tool

EAC — Expert Advisory Committee (comprising the Professionals-EAC and Living Experience-EAC)

EB — Evidence-based (action/recommendation type)

EtD — Evidence-to-Decision (framework)

FID/FMH — Forensic Intellectual Disability / Forensic Mental Health

GDG — Guideline Development Group

GPS — Good Practice Statement

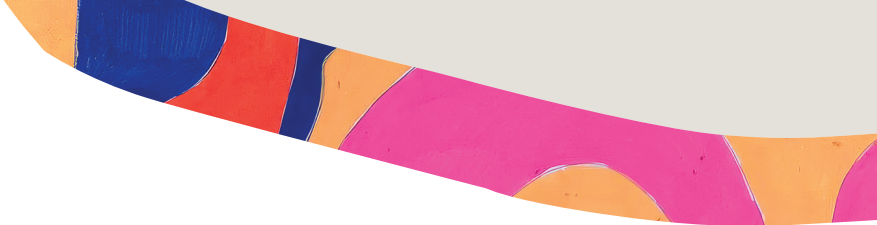
GRADE — Grading of Recommendations Assessment, Development and Evaluation

GRADE-ADOLOPMENT — GRADE Adopt/Adapt/De Novo framework for guideline adaptation

ID — Intellectual Disability

IDD — Intellectual and Developmental Disability

MMAT — Mixed Methods Appraisal Tool



NCEIDH — National Centre of Excellence in Intellectual Disability Health

NDIS — National Disability Insurance Scheme

NG11 / NG54 / NG93 — National Institute for Health and Care Excellence Guideline [number]

NICE — National Institute for Health and Care Excellence

NSQHS — National Safety and Quality Health Service (Standards)

PBS — Positive Behaviour Support

PHN — Primary Health Network

PICo — Population, Interest/phenomenon of Interest, Context

PRISMA — Preferred Reporting Items for Systematic Reviews and Meta-Analyses

ProQOL — Professional Quality of Life Scale

QCEIDAH — Queensland Centre of Excellence in Intellectual Disability and Autism Health

RDG — Research assistant/reference group member with intellectual disability

SAMHSA — Substance Abuse and Mental Health Services Administration

STS — Secondary Traumatic Stress

TIC — Trauma-Informed Care

TICPOT — Trauma-informed Care and Practice Organisational Toolkit

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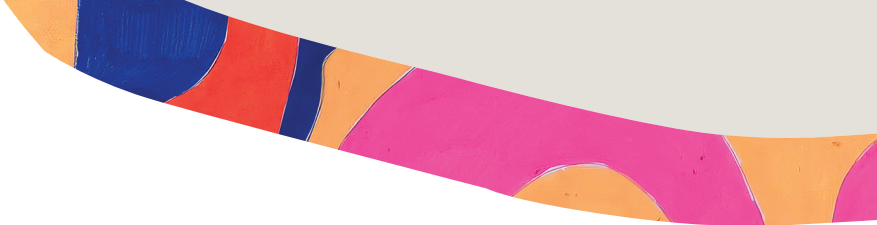
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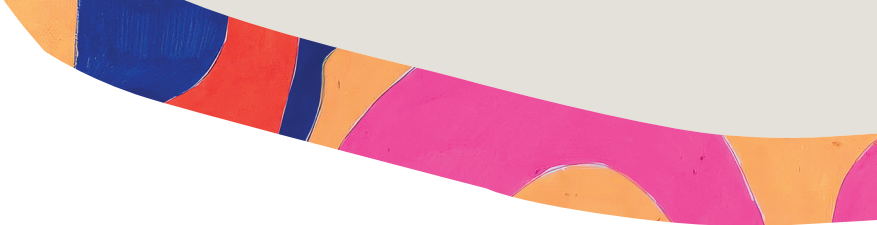
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Foreword

We are Jess, Mandy, Ruby and Ana, the *Living* Experience-Expert Advisory Committee. We have been working together to help co-design the Trust Guide. We are living with intellectual disability, so we know what will help. We say '*Living*' because our experiences are current, just like the other hundreds of thousands of Australians living with intellectual disability. We are interested in improving health care with people with intellectual disability. At the moment, it is clear that *"there's a big problem, nothing has been addressed and people are suffering."* We came together to make health care safer and give people with intellectual disability a voice through practical advice.

We have listened to each other and told stories about our experiences in healthcare, residential care, research, advocacy, and everyday life. For us, communication is the heart of everything. The Trust Guide is the platform for our stories and choices to be heard and respected.

Health care should feel safe, accessible, and inclusive. Unfortunately, that is not always our experience. *"We need to better communicate with people with severe and profound disability and those who are not verbal. And it's a big problem because they are excluded. Never included. They need better support."* We have been frustrated, excluded, silenced, and dismissed. Some of us have even lost people we love. It has left us wondering, *"How can we make [healthcare] better?"*

It takes, *"a lot of patience and empathy,"* and *"trust"* which is *"basically everything."* We know this because we have also experienced health care that felt safe, respectful, and compassionate. This is what we want for all and that is why we helped co-design the Trust Guide, because *"everyone deserves full access and the correct help."*

Our hope is that health workers, health services, and health systems will use the Trust Guide to make meaningful changes. Whether it be a smile, a check in, or changing the way they communicate, *“even small [changes] can make big differences”* to someone who is frightened, in pain, or unable to speak up for themselves.

We are not finished with this work. But we hope this is a step in the right direction. We are a *Living* Experience Committee who will continue advocating and helping everyone, no matter their communication style, background, or disability.

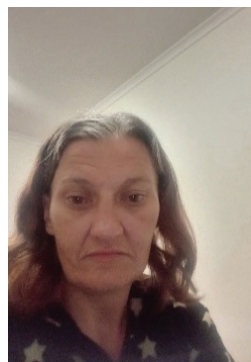
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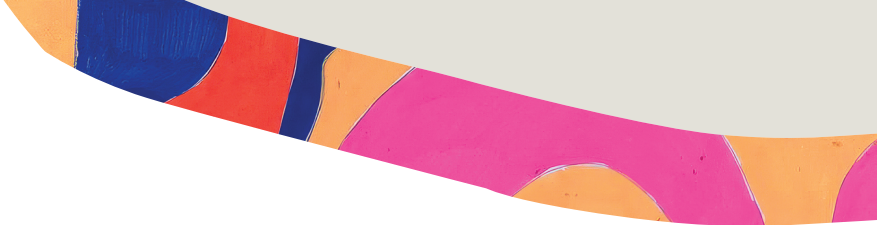
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Preamble

The Trust Guide has been developed to support health workers, health services, and health systems in providing trauma-transformative care with people with intellectual disability. Its development was prompted by the widespread experiences of trauma described by people with intellectual disability, often beginning in childhood. Of the 2 per cent of Australians with intellectual disability, nearly two-thirds of those aged 15 years and over have experienced at least one incident of violence (Bourke et al., 2024; Disability Royal Commission, 2023b). The Trust Guide is a direct response to these experiences, providing practical guidance to foster trust, safety and positive health care interactions.

The Trust Guide is grounded in a trauma-transformative rather than a trauma-informed approach. While trauma-informed care has made an important contribution to improving services, recent critiques suggest that its principles largely reflect broader notions of good practice and do not fully capture the complex ways trauma shapes a person's engagement with healthcare (Tucci et al., 2024). Trauma-transformative practice extends beyond awareness of trauma and its impacts. It recognises both acute and everyday experiences of trauma and shifts the focus from what has happened to an individual to how health workers, services and systems can actively address the enduring and cumulative effects of trauma. In doing so, it encourages changes to the structures, practices and cultures of healthcare systems to foster trust, safety and healing for people who have experienced trauma over time.

Executive Summary

The Trust Guide provides implementation-focused recommendations for delivering trauma-transformative practice in health services with people with intellectual disability. The recommendations are structured across three levels — health workers, health services, and health systems. This reflects the understanding that everyone has a role to play in trauma-transformative practice, which requires ongoing change at the interpersonal, organisational, and systemic levels. Underpinning the recommendations across the three levels is a single guiding principle that applies to all: *“treat everyone with respect, compassion, and kindness.”*

A summary of the three levels is as follows:

1. At the health worker level, recommendations call for awareness and person-centredness.
2. At the health service level, recommendations call for improved organisational capability, support, and culture.
3. At the health system level, recommendations call for connectivity and leadership.

Each recommendation is accompanied by a set of practical Actions to support its implementation. The Actions were co-designed with people with intellectual disability to ensure they are informed by, and responsive to, their lived experiences and support needs. There are also suggestions for monitoring and evaluation, along with links to additional resources and sources of further information. Together, these recommendations and accompanying supports embody the core values of the Trust Guide.

Below are the nine guiding recommendations of the Trust Guide (See Section 2 for Actions, Monitoring, and Resources).

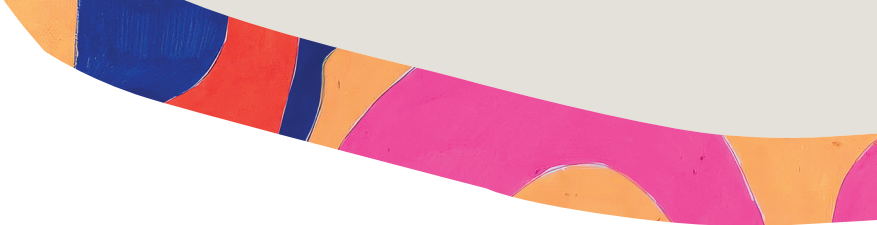
Level	#	Recommendation
Health workers	1	Know that people with intellectual disability often experience more trauma in their lives than other people.
	2	Centre the voice and choice of the person with intellectual disability in all health care interactions.
	3	Focus on the person with intellectual disability, working together with family or support people to balance everyone's needs.
Health services	4	Support health workers to deliver safer care through evidence-based training and resources.
	5	Build a culture where everyone feels safer and valued.
	6	Make the service environment more inclusive and accessible.
Health systems	7	Ensure different health workers, services, and systems stay connected and work together.
	8	Establish strong, positive leadership and a committed workforce.
All	9	Treat everyone with respect, compassion, and kindness.

Purpose and scope

The Trust Guide is intended for health workers, health services and managers, and health systems, as well as the broader community and social services sectors supporting people with intellectual disability. In addition, it prioritises inclusiveness and accessibility, to benefit a wider population than its primary audience alone.

The overall objective was to develop an evidence-based clinical practice guideline for trauma-transformative practice with people with intellectual disability. Specific objectives were to:

- Improve trauma-transformative practice regardless of trauma diagnosis or disclosure
- Improve health service outcomes with recommendations grounded in methodological rigour and the latest evidence
- Use co-design to ensure accessibility, inclusiveness and practicality
- Align with several national initiatives, including:
 - > The Disability Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023)
 - > The National Roadmap for Improving the Health of People with Intellectual Disability (2021)
 - > Australia's Intellectual Disability Health Capability Framework (2024)
 - > The National Centre of Excellence in Intellectual Disability Health's submission on the National Safety and Quality Health Service (NSQHS) Standards (third edition)
 - > Australia's Disability Strategy 2021-2031 (2024 update)



Conceptualisations of disability and trauma

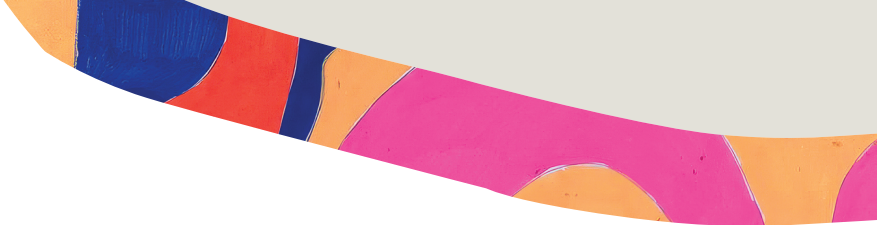
The Trust Guide's conceptualisation of intellectual disability is grounded in the social model of disability, which considers a person's physical, mental, intellectual, or sensory impairments together with their interactions with the environment, recognising that it is the environment, rather than impairment itself, that hinders equitable and active participation in society (Convention on the Rights of Persons with Disabilities, 2006). The Trust Guide aligns with the obligations set out in the United Nations Convention on the Rights of Persons with Disabilities 2006, which was ratified by Australia in 2008.

Trauma has been defined as:

An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (Substance Abuse and Mental Health Services Administrations, 2014).

This traditional, event-based conception of trauma does not fully capture the living reality of many people with intellectual disability, for whom harm is often cumulative, ongoing, and embedded in everyday interactions rather than confined to discrete events. The Trust Guide therefore also draws on the concept of insidious trauma — an indirect trauma that shapes a person's worldview and sense of self, fundamentally associated with the devaluation of their identity (Root, 1992) and arising from oppression and stigmatisation rather than isolated incidents of violence or abuse.

Because insidious trauma can be subtle, ambiguous, and easily overlooked, it closely aligns with the notion of 'everyday harm', defined as the accumulated effect of negative, everyday experiences occurring at the interpersonal level (Smyth et al., 2024). Recognising both forms of trauma is critical to health care practice, as the ongoing, less visible nature of insidious and everyday trauma means it can go unidentified and unaddressed within health systems, yet still profoundly shape how people with intellectual disability experience trust, and engage with care.



Development of the Trust Guide

The Trust Guide was developed with the GRADE-ADOLOPMENT framework, a structured, rigorous approach to adapting and adopting evidence-based recommendations (Klugar et al., 2024). Several source guidelines were identified with one standing out as a priority guideline: The Taking Time Framework (Jackson & Waters, 2015). Development was co-designed with two Expert Advisory Committees: one with people with living experience, and another with healthcare and research professionals. Broader consultation with key community stakeholders was also undertaken.

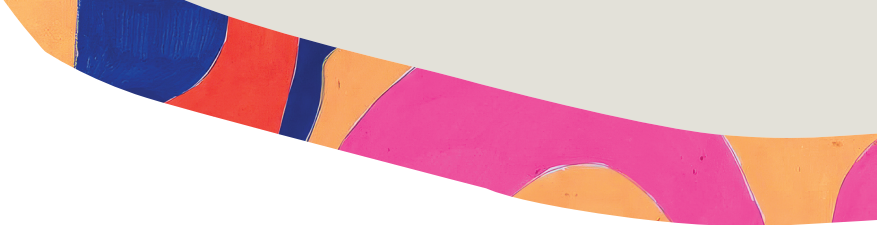
Living experience was embedded throughout the Trust Guide's development utilising co-production principles. The term 'Living' is favoured by the committee to represent the ongoing experiences that are faced daily. The Living Experience-Expert Advisory Committee was actively involved throughout the whole process, including in defining the Trust Guide's objectives, shaping research questions, and developing recommendations. The Trust Guide was further strengthened through a community consultation process and internal peer review.

Intended impact

The Trust Guide represents a significant step toward improving the health care experiences and quality of life of people with intellectual disability in Australia. At the practice level, its implementation is intended to improve health worker knowledge and confidence in delivering trauma-transformative care, reduce experiences of healthcare betrayal among people with intellectual disability, support the wellbeing of families and carers, and strengthen the uptake of healthcare services for this population.

Realising this vision requires commitment at every level. Health workers are called to reflect on and transform their individual practice. Health services, including hospitals, primary care, and allied health, are called to build a culture, environment, and workforce capable of delivering safer, accessible, and inclusive care. Health systems are called to ensure connectivity, leadership, and accountability across the system. Lastly, further funding and systemic support are needed to make equitable, high-quality health care for people with intellectual disability not only possible, but sustainable.

People with intellectual disability deserve health care that recognises the full spectrum of their experiences — not only discrete traumatic events, but the cumulative, everyday harm that shapes how they approach, engage with, and trust the systems meant to support them. The Trust Guide offers a practical, evidence-based, and co-designed pathway toward that care.



Introduction

Who is the Trust Guide for?

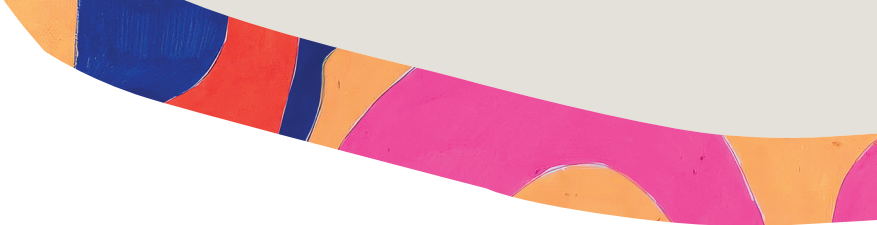
The Trust Guide provides implementation-focused recommendations of how to provide trauma-transformative practice in health services with people with intellectual disability. Trauma-transformative practice goes beyond recognising and responding to trauma by actively transforming the way individuals, organisations and services collaborate to promote healing from the ongoing effects of trauma. This approach recognises that for people with intellectual disability, trauma can be both acute and cumulative, arising from everyday interactions, systemic experiences, or isolated or recurring events (Tucci et al., 2024). Trauma-transformative practice calls for cultural and systemic transformation, rather than just changes in individual practice.

The target audience is health workers, health services and managers, and health system leaders involved in the health care of people with intellectual disability. The target audience also includes the broader community sector and social services organisations who are involved with the care of people with intellectual disability. This includes, but is not limited to, general practice, acute care, mental health services, allied health, community health, specialist services and disability support services. The Trust Guide is intended to be applicable across the spectrum of health care experiences, from first contact through to ongoing care and transition.

Approximately 2% of Australians have an intellectual disability, although the true prevalence is likely higher due to under-identification and undiagnosed cases (Bourke et al., 2024). While average adult literacy levels in Australia are generally consistent with upper secondary school attainment, an estimated 40–50% of Australians have literacy skills below this level (Australian Bureau of Statistics, 2014). Lower literacy can significantly affect healthcare access by limiting a person's ability to understand health information, navigate healthcare systems, complete forms, interpret medication instructions, understand consent processes, and engage effectively in discussions about their health and treatment options.

For people with intellectual disability, these challenges are often more pronounced. Literacy and communication differences can make it difficult to access, understand, evaluate, and use health information, reducing opportunities for informed decision-making and self-management of health conditions. These difficulties are often compounded by a health system that has not been consistently designed to meet their needs, resulting in barriers such as inaccessible information, communication mismatches, diagnostic overshadowing, fragmented care pathways, and the impact of previous negative healthcare experiences. Together, these factors can contribute to delayed care, poorer health outcomes, reduced participation in preventive health care, and ongoing health inequities.

Furthermore, exposure to trauma is common within the general Australian population, with many individuals experiencing one or more traumatic events across their lifetime (Australian Institute of Health and Welfare, 2025b). The pervasiveness of trauma has implications for public health and the healthcare system as it may deter people from seeking care, reduce engagement, and erode trust in the system. Therefore, The Trust Guide prioritises clarity, accessibility, and person-centred communication, and is likely to benefit a wider segment of the population.



The Trust Guide objectives

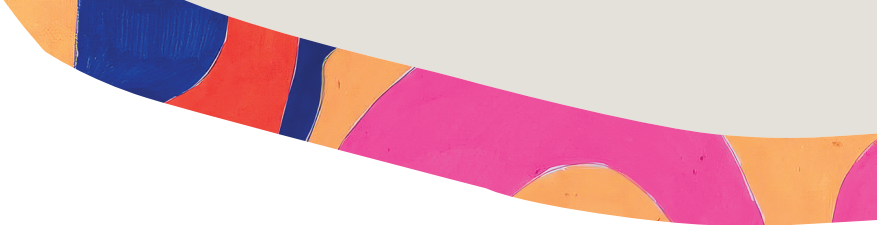
The overall objective was to develop an evidence-based clinical practice guideline for trauma-transformative practice with people with intellectual disability. The Trust Guide aims to address a recognised gap in the existing evidence base, where trauma-informed care principles have not been contextualised to reflect the specific needs, experiences, and contexts of people with intellectual disability accessing health services.

Specific objectives of the Trust Guide were to:

- Improve the provision of trauma-transformative practice with people with intellectual disability, regardless of any trauma diagnosis or disclosure. This includes recognition of insidious and everyday trauma, which may not be formally identified or disclosed but nonetheless shapes health care experiences and engagement.
- Improve health service outcomes for people with intellectual disability through the dissemination of evidence-based recommendations underpinned by methodological rigour.
- Utilise co-design with key stakeholders including people with intellectual disability, families, carers, and support people, and health workers and services to ensure recommendations are accessible, practical, and responsive to living experience and service needs.

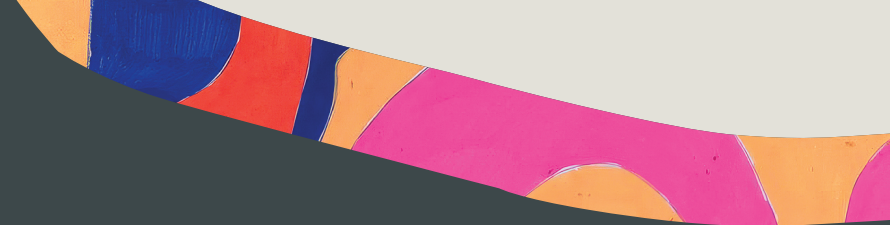
The content of The Trust Guide aligns with contemporary policy and reform agendas:

- The Disability Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission, 2023a)
 - > Aligns with several of the 222 recommendations, particularly those contained within:
 - Volume 6, Enabling autonomy and access.
 - Accessible information and communications, supported decision-making, cultural safety, health capability, training and development, navigating the health system and restrictive practice.
 - Volume 10, Disability services.
 - Embedding human rights in service design, choice and control over how services are delivered.
- National Roadmap for Improving the Health of People with Intellectual Disability (Department of Health, 2021)
 - > **Recommendation B1.M1.** *“Commonwealth Department of Health to work with state and territory governments, professional colleges, PHNs, researchers and other key partners to improve the evidence base on integrating trauma-informed practice into models of care.”*
- Australia’s Intellectual Disability Health Capability Framework (Department of Health, Disability and Ageing, 2024)
 - > **Capability 3.15.** *“Work in a way that sensitively considers and responds to the greater likelihood that a person with intellectual disability may have experience of trauma, including health care related trauma.”*
- National Centre of Excellence in Intellectual Disability Health submission on the National Safety and Quality Health Service (NSQHS) Standards (third edition)

- 
- > **Recommendation 1.e.vi.** *“There should be a specific standard focused on Diversity.”*
 - *This standard should; For people with intellectual disability, key actions should cover:*
 - *Trauma-informed practice*
 - Australia’s Disability Strategy 2021-2031 (2024 update).
 - > Aligns with several of the policy priorities located within Health and Wellbeing, and Safety, Rights and Justice (Department of Social Services, 2025).
 - Health and Wellbeing
 - **Policy Priority 1.** *“All health service providers have the capabilities to meet the needs of people with disability”*
 - > Safety, Rights and Justice
 - Policy Priority 1.** *“People with disability are safe and feel safe from violence, abuse, neglect and exploitation”*
 - Policy Priority 2.** *“Policies, processes and programs provide better responses to people with disability who have experienced trauma”*

Scope of the Trust Guide

The Trust Guide addresses aspects of interpersonal interactions, staff training and collaboration, and organisational standards. These are addressed through recommendations structured across three levels (health workers, health services, and health systems) reflecting the understanding that trauma-transformative practice cannot be achieved by any single practitioner or service alone but requires coordinated commitment across the system. The Trust Guide does not address the clinical management of specific trauma diagnoses, nor does it provide recommendations for non-health settings; however, it does recognise that community and social services play an important role in the broader care of people with intellectual disability.



Section One: Background

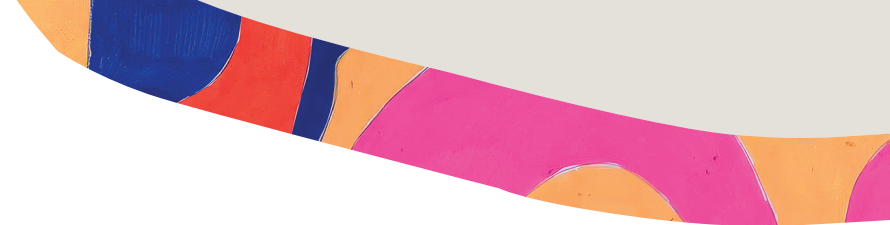
Disability in Australia

The social model of disability considers the person's physical, mental, intellectual, or sensory impairments together with interactions with the environment, and suggests that it is the environment rather than impairments that hinder a person's equitable and active participation in society (Convention on the Rights of Persons with Disabilities, 2006). For example, a lack of accessible education can be disabling, rather than a person's intellectual impairment. This approach to disability was adopted by the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and signed and ratified by Australia in 2008 and 2009 (Department of Health, Disability and Ageing, 2026).

Approximately 16 per cent of the population worldwide experience significant disability (World Health Organisation, 2023a). In Australia, that estimate is closer to 18 per cent (Australian Institute of Health and Welfare, 2024). An estimated 2 per cent of Australians live with an intellectual disability (Bourke et al., 2024) with almost half being below the age of 24 (Australian Institute of Health and Welfare, 2024). However, these figures are likely to underestimate the true prevalence of intellectual disability, reflecting ongoing inequities in identification, diagnosis, and access to health and disability supports among priority populations, including First Nations peoples, culturally and linguistically diverse communities, and those living in rural and remote areas (Brooker et al., 2024).

Intellectual disability

Intellectual disability has been defined as *“a neurodevelopmental disorder that begins in childhood and is ‘characterised by intellectual difficulties as well as difficulties in conceptual, social and practical areas of living’”* (American Psychiatric Association, 2022). Presentations of intellectual disability are highly individualised with diagnosis occurring across multiple dimensions such as communication, personal care, community participation, physical and mental health, adaptive functioning, and functional skills (Katz & Lazcano-Ponce, 2008). Culturally, varying attitudes, beliefs, knowledge, and awareness towards intellectual disability may further complicate presentation. For example, some cultures may associate intellectual disability with shame, leading to concealment, social isolation or marginalisation (Bunker & Upadhyay, 2024; Zeilinger et al., 2020). People with intellectual disability are also likely to have co-occurring physical and psychiatric conditions (Astilleros Martínez et al., 2025; Peña-Salazar et al., 2022), leading to multimorbidity and complex health care needs.



Health inequities in intellectual disability

People with intellectual disability tend to have less favourable health outcomes compared to the general population (Emerson et al., 2016). In Australia, the life expectancy of people with intellectual disability at birth was reported as 67 years, 16 years shorter than the average. Life expectancy for people with Down syndrome was significantly shorter again at 54 years (Srasuebkul et al., 2026). Reduced life expectancy may be due to a higher prevalence of physical health conditions such as epilepsy, obesity, osteoporosis, congenital heart defects, and thyroid disorders (Capone et al., 2018; Liao et al., 2021; Robertson et al., 2015; Srikanth et al., 2011), or severe mental health difficulties (Arnold et al., 2025; Emerson et al., 2016). Furthermore, the number of potentially avoidable deaths of people with intellectual disability is nearly double that of Australia's general population (Trollor et al., 2017)

Despite the substantial disparities in health outcomes experienced by people with intellectual disability, significant barriers to accessing essential health care remain. A systematic review identified minority background, socioeconomic disadvantage, and residence in rural and remote areas as key barriers to healthcare access. These barriers were associated with limited availability and quality of primary and specialist services, as well as insufficient health resources and training for health professionals (Kreps et al., 2026).

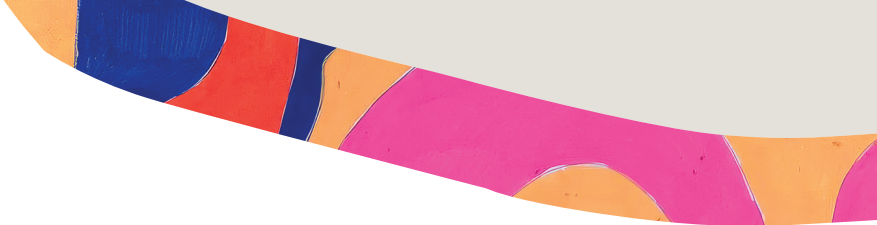
Further evidence suggests that inaccessible health information, limited health literacy, stigma, discrimination by health-care professionals, and inadequate organisational support present additional barriers to accessing health care for people with intellectual disability (Barrington et al., 2026). Conversely, when health services are inclusive, accessible, and responsive to individual needs, people with intellectual disability are more likely to engage with and utilise available healthcare services (Robinson & Graham, 2021; Ryan et al., 2024). However, these systemic barriers remain pervasive and persistent, contributing to ongoing health inequities and highlighting the complex sociocultural factors that shape the health experiences of people with intellectual disability.

Psychological trauma

Theories of psychological trauma

Psychological trauma (hereby referred to as trauma throughout), is the result of *“an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being”* (Substance Abuse and Mental Health Services Administration, 2014). Exposure to trauma can occur to different degrees in a variety of contexts, and any single experience or group of experiences has the potential to cause trauma (Magruder et al., 2017). For example, two different individuals who experience the same negative experience (e.g. loss of a family member) will have different degrees of trauma as a result. The differences in experience can be explained by Bronfenbrenner’s Ecological Systems Theory (2000) which posits that one’s ability to cope is not only shaped by their individuality, but by the complex interactions between their family and social environments, and their communities, institutions, and culture.

A closely related conceptualisation of trauma is insidious trauma defined as, *“an indirect trauma that shapes the subject’s worldview and sense of self, fundamentally associated with the devaluation of an individual’s identity,”* (Root, 1992). Insidious trauma may result from oppression and stigmatisation experienced by a person and is distinct from more isolated incidents of violence or abuse. However, occurrences can be subtle, occasionally ambiguous, and easily overlooked, making them hard to conceptualise, similar to the idea of ‘everyday harm’ which is the cumulative effect of negative, everyday experiences that occur at the interpersonal level (Smyth et al., 2024).



The cumulative effects of feeling unsafe, devalued, disrespected, threatened, and silenced lead to internalised shame, emotional and psychological suppression, and harms on the soul and spirit (Gur, 2026; Smyth et al., 2024), which can be further exacerbated by the intersections between gender, culture, and disability (Ford, 2024). The result may manifest as full traumatic stress responses following seemingly minor incidents. However, this can be understood when recognised as a response to ongoing oppression and stigmatisation. While not a traditional form of psychological trauma, vicarious trauma's on functioning and wellbeing due to a set of circumstances aligns with the traditional definition and likely has implications for individuals accessing healthcare.

Betrayal trauma theory posits that the psychological impact of trauma is influenced more by the significance of the victim's relationship with the perpetrator than by the specific nature of the traumatic event itself (Freyd, 1998; Tamaian et al., 2017). In the context of health care, the relationship between a person and their clinician is one that requires high levels of trust (Smith, 2017; Souvatzi et al., 2024; Taylor et al., 2023) and safeguarding (Duffy et al., 2025) due to the vulnerability that is experienced during a health crisis. If clinicians are not sensitive to these vulnerabilities, mistreat, or misdiagnose, then this could be considered by the individual as an institutional betrayal (Smith & Freyd, 2013; Tamaian et al., 2017) and cause high betrayal trauma (Freyd, 2008) or perpetuate existing trauma.

Quantitative evidence from Selwyn et al. (2021) found childhood trauma on its own, and in combination with experiences of institutional betrayal, to be associated with health care avoidance behaviours, further highlighting the implications of trauma on healthcare access and engagement.

Effects of trauma

Trauma can have major impacts on an individual's health and functioning. As previously mentioned, the associated symptoms are largely influenced by factors such as age, developmental phase, gender, socioeconomic status, and culture (Olf et al., 2025). Regardless, common experiences and responses to trauma can be arranged under the following categories: emotional, physical, cognitive, behavioural, social/interpersonal, and developmental (Center for Substance Abuse Treatment, 2014). Table 1 outlines these categories with the associated symptoms which can express trauma.

Table 1 Examples of Trauma Symptoms Across Domains (Center for Substance Abuse Treatment, 2014).

Symptom category	Key examples
Emotional	Fear, anger, sadness, shame, emotional numbness
Physical	Sleep disturbances, hyperarousal/hypervigilance, muscle tension, somatic complaints
Cognitive	Intrusive thoughts and memories, excessive guilt, feeling unsafe, hopelessness about the future
Behavioural	Avoidance, substance use, self-harm, high-risk behaviours
Social/ interpersonal	Withdrawal from others, difficulty trusting others, shame, disrupted attachment
Developmental	Fear and nightmares in children, aggression or regression in school-age children, social withdrawal and risk-taking in adolescents, hypervigilance and isolation in adults

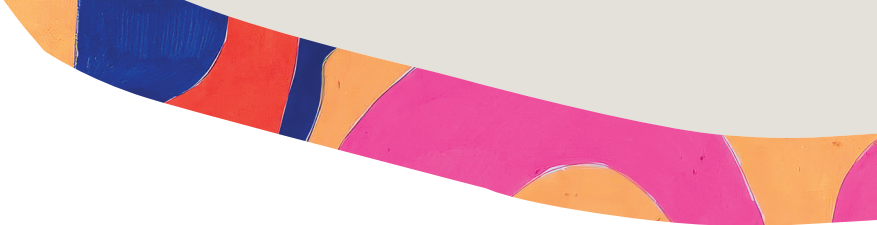
Understanding how exposure to trauma can impact multiple domains has implications for health care. For example, a person affected by trauma across any of the domains in Table 1 may have difficulties engaging with health services or being socially withdrawn (Bae et al., 2025; Ding & Zhang, 2022).

On a more granular level, someone who has developed behavioural issues such as substance use or eating disorders, may require more intensive healthcare support due to medical complications and comorbidities (Brewerton, 2022; Lawrence et al., 2023). Experiences of trauma and the associated symptoms require health services to provide tailored support that is sensitive to an individual’s personal experiences.

Experiences of trauma in people with intellectual disability

Compared to the general population, people with intellectual disability are more likely to experience interpersonal violence, abuse, and childhood adversity (Disability Royal Commission, 2023b; Kildahl & Helverschou, 2024; Santoro et al., 2018; Tomsa et al., 2021). For example, almost half of a sample of autistic adults with an intellectual disability were reported to have been exposed to violence and/or sexual abuse (Kildahl & Helverschou, 2024). Similarly, a sample of adults with intellectual and developmental disabilities living in residential settings in Pennsylvania estimated rates of childhood adversity to be at 84.1 per cent (Santoro et al., 2018). Evidence also indicates that victimisation continues into adulthood. A systematic review and meta-analysis found that approximately one in three adults with intellectual disability experience sexual abuse during adulthood (Tomsa et al., 2021). Comparable findings have been reported in Australia, with data suggesting that nearly two in three Australians with intellectual disability have experienced at least one incident of violence since the age of 15 (Disability Royal Commission, 2023b).

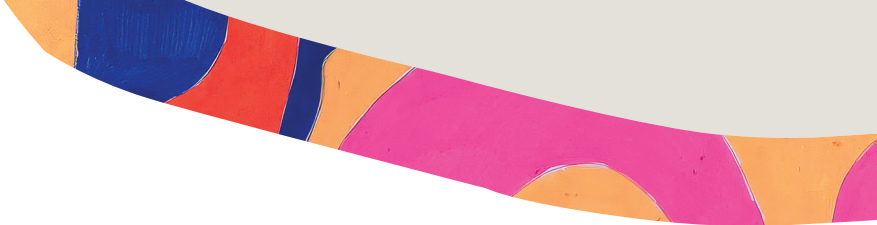
Furthermore, there may also be experiences of oppression and marginalisation that lead to insidious trauma (Gur, 2026). A person with intellectual disability who has experienced devaluation (Dorozenko et al., 2015; Logeswaran et al., 2019) and stigmatisation (Anis & Nordin, 2024; Pelleboer-Gunnink et al., 2019) may have negative impacts on their self-worth, independence, identity and relationships. If experienced from an early age, potentially through systemic healthcare neglect, then the cumulative experiences and subsequent effects may be consistent with insidious trauma.



The Royal Commission enquiry also uncovered evidence of systemic neglect of people with disability in the Australian healthcare system. It found people with intellectual disability experienced significant of trauma and distress from inadequate health care, which in the most extreme cases, led to several preventable deaths. This can be attributed to devaluing lives, unconscious biases, diagnostic overshadowing, failure to listen to parents and advocates, and failure to provide reasonable adjustments. Table 2 presents examples from the Royal Commission (2023) that demonstrate these experiences of exclusion. Such experiences have the potential to result in betrayal trauma and insidious trauma, underscoring the ways in which conventional health-care models often fail to adequately support people with intellectual disability.

Table 2 Key examples of inadequate health care with people with intellectual disability from the Royal Commission Enquiry (Disability Royal Commission, 2023b).

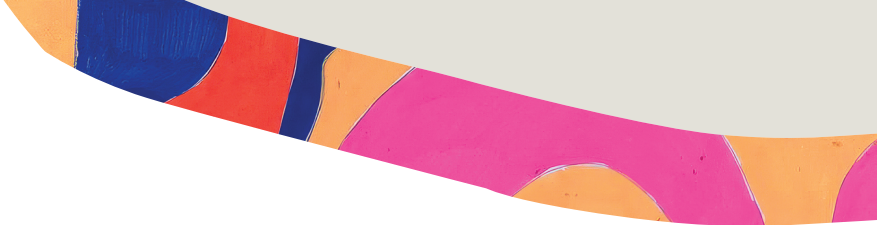
Experience	Example
Devaluing	A mother described how a doctor recommended against potentially life-prolonging treatment for her daughter in infancy to fix a heart defect. When her daughter was 25 and experienced a stroke, she was not offered standard treatment protocols with the treating doctor questioning the point of any effort due to her Down syndrome.
Unconscious bias	A mother believed her son's disability influenced the care he received in hospital. The final time mother and father attended hospital prior to their son's death, they were asked if they wanted to 'let him go,' causing them to question their assumptions about the value of his quality of his life.
Diagnostic overshadowing	A mother gave evidence that she believed her son had been 'in constant excruciating pain every single day'. She described that doctors repeatedly attributed his presentation to his "Down syndrome".
Failure to listen to parents and advocates	A proud Wiradjuri woman and enrolled nurse's son with intellectual disability had a blood test that indicated cancer. Due to his significant fear and anxiety in medical settings, he lashed out at the doctors who attempted to perform a biopsy. No adjustments were made to general protocols to improve his access to the required tests. It was not until two years of advocating for her son's medical care was he able to get the surgery he needed.
Failure to provide reasonable adjustments	The mother of a 12-year-old boy described being prevented from accompanying him into the operating room for an anaesthetic, despite a prior arrangement that she would be able to do so.



The substantial health inequities experienced by people with intellectual disability are likely to arise from complex and cumulative interactions between interpersonal and systemic forms of violence and abuse, resulting in heightened exposure to trauma. Exposure to trauma—irrespective of source, timing, or severity—can have profound and lasting implications for health and healthcare engagement. These effects are further compounded by disproportionate exposure to adverse social determinants of health, including poverty, insecure or inadequate housing, unemployment, and discrimination, all of which are more prevalent among people with intellectual disability (Allerton et al., 2011). Although it cannot be assumed that modification of any single factor will, in isolation, lead to improved health outcomes for this population, it is evident that health systems that lack the capacity to respond effectively to the needs of people with intellectual disability may inadvertently perpetuate traumatic stress. Consequently, it is imperative that health services operate with the explicit recognition that people with intellectual disability are more likely than the general population to have experienced trauma across the life course.

Protective factors for people with intellectual disability

Fortunately, research has suggested that there are protective factors against experiences of trauma and associated symptoms. Patience, empathy, and consistency with caregivers and educators act as a buffer against psychological harm for people with intellectual disability who have experienced trauma (Wilson et al., 2026). Positive relationships and strong social networks provide opportunities to learn coping skills and to feel safe and supported to talk about experiences (Scheffers et al., 2022; Schepens et al., 2019), which may improve internalised shame, and psychological and emotional suppression. Furthermore, participation in self-advocacy groups can provide opportunities for people with intellectual disability to process and reflect on traumatic experiences in a supportive environment, while also building self-advocacy skills, increasing awareness of personal rights, and strengthening their capacity to protect themselves from future harm. (Tilley et al., 2020). Despite disproportionate exposure to trauma experiences among people with intellectual disability, it is possible that the appropriate support can improve outcomes for people with intellectual disability.



Trauma-informed care

A commonly-held definition of trauma-informed care from The Substance Abuse and Mental Health Services Administration (SAMHSA) is,

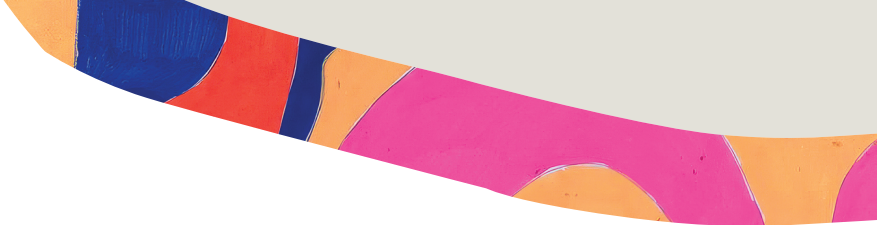
A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization (SAMHSA, 2014, p. 9).

It is worth distinguishing a trauma-informed approach from a trauma-specific approach, the latter of which has “a more focused task to directly address trauma and its impacts, and to facilitate trauma recovery” (Fallot & Harris, 2006). Trauma-informed care has a greater focus on the recognition that trauma experiences are a possibility for anyone (Kezelman & Stavropolous, 2012), compared to trauma-specific practice which is more aligned with explicit treatment of trauma or associated symptoms. Trauma-informed care emphasises that health services should be equipped to identify and respond to the neurological, biological, psychological, and social effects of trauma with sensitivity; and calls for physically and emotionally safe environments that promote healing (Jackson & Waters, 2015).

SAMHSA (2014) established six core principles that are well-recognised to underpin trauma-informed care. The principles are listed in Table 3, alongside a brief definition within the context of trauma-informed health services.

Table 3 Substance Abuse and Mental Health Services Administration's (2014) six core principles of trauma-informed care.

Principles	Definition
1 Safety	Ensuring the environment is physically safe, and interpersonal interactions promote a sense of psychological and emotional safety. The understanding of safety must be defined by those served.
2 Trustworthiness and transparency	Operations and decisions are conducted with transparency, with the aim to build and maintain trust among all.
3 Peer support	"Peers" or, individuals with lived/living experience, are key caregivers who establish safety, hope, trust and collaboration. Their stories of survival are often used as vehicles to promote recovery and healing.
4 Collaboration and mutuality	Working together in a respectful and equal way, where everyone's knowledge, roles, and contributions are valued. It recognises that healing and support happen through relationships, shared decisions, and teamwork, not just through one expert directing care.
5 Empowerment, voice, and choice	Making sure people are listened to, respected, and involved in decisions about their care. It supports people to have control, express what matters to them, and make meaningful choices wherever possible.
6 Cultural, historical, and gender issues	Recognising that people's experiences are shaped by their culture, identity, background, and past experiences of discrimination or harm. It involves providing care that is respectful, inclusive, and responsive to these experiences.

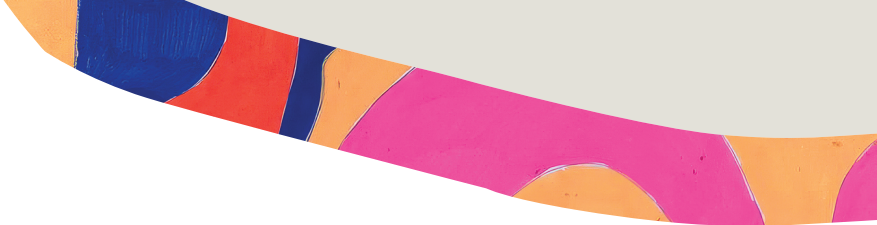


The six key principles of trauma-informed care are widely reported in the literature as being associated with better health outcomes when delivered in the context of trauma-informed care (Goldstein et al., 2024; Guo et al., 2025) as well as independently through patient experiences of safety (Doyle et al., 2013), trust (Birkhäuser et al., 2017), and shared decision making (that is, collaboration, empowerment and choice (Shay & Lafata, 2015). Peer and social support has also been associated with better coping abilities, health, quality of life in the face of stressful life events (Drageset, 2021), and health promotion (Fisher et al., 2017; Ramchand et al., 2017). Lastly, some evidence suggests that cultural competence training delivered to clinicians was significantly associated with increased patient satisfaction (Govere & Govere, 2016), however, this appears dependent on minority status (Castro & Ruiz, 2009; Coelho & Galan, 2012). Overall, the evidence suggests that the principles of trauma-informed care are associated with improved patient experiences and health outcomes, supporting their integration into routine healthcare practice.

Trauma-informed care in health services

There is an urgent need for action to improve health outcomes for people with intellectual disability, including addressing the significant and often cumulative impacts of trauma (Brooker et al., 2024; Department of Health, 2021; Department of Health, Disability and Ageing, 2024; Haverkamp et al., 2025). In Australia, the National Roadmap for Improving the Health of People with Intellectual Disability (2021) sets out a vision for the health care of people with intellectual disability to be person-centred, multi-disciplinary and trauma-informed, and the Intellectual Disability Health Capability Framework (2024) calls for quality, evidence-informed health care grounded in person-centred and social justice principles; highlighting '*Responding to trauma*' as a key capability (Capability 3.15).

The practicalities of trauma-informed care with people with intellectual disability are yet to be firmly grounded in evidence. Much of the evidence on trauma-informed care focuses on outcomes within different populations. The evidence relating to trauma-informed health care with people with intellectual disability usually focuses on the perspectives of the health professionals who work with the person with intellectual disability or their families or carers (Keesler & Isham, 2017a; Luiselli et al., 2025; McNally et al., 2023; O'Malley et al., 2020; Presnell et al., 2022; Rich et al., 2021; Schofield et al., 2021). Evidence focusing on the perspectives of those with intellectual disability are limited (McKenzie & Charlton, 2025; Strnadová et al., 2023) in forensic mental health settings (FMH).

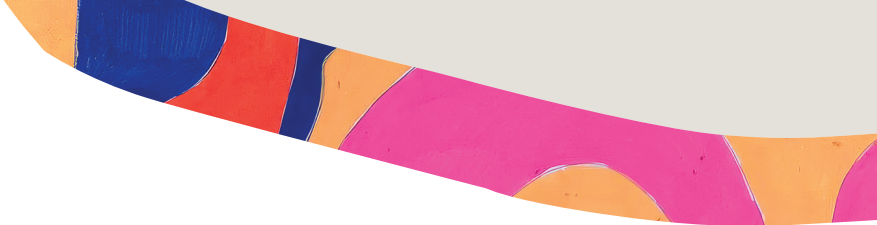


While health professionals consider trauma-informed care a worthwhile and useful approach when working with people with intellectual disability, the implementation of trauma-informed care tends to be limited by leadership (Keesler & Isham, 2017a; Presnell et al., 2022; Rich et al., 2021) fidelity towards trauma-informed care principles (Keesler & Isham, 2017a), and a lack of training or knowledge (Keesler & Isham, 2017b; O'Malley et al., 2020; Presnell et al., 2022; Rich et al., 2021). Although the evidence is limited, perspectives from people with intellectual disability suggest that trauma-informed care is an unfortunate necessity due to the pervasiveness of traumatic experiences (Strnadová et al., 2023). While it does promote feelings of safety, belonging, and identity (McKenzie & Charlton, 2025) it is further complicated by people with intellectual disability not always choosing to disclose trauma (Strnadová et al., 2023). Despite these barriers, trauma-informed care is still generally considered as important by health professionals (Keesler, 2016; Truesdale et al., 2019) potentially highlighting gaps between intent and implementation.

From informed to transformative: paradigm shift to trauma-transformative practice

Recent critiques of the conceptualisation of trauma-informed care have suggested that trauma-informed care principles are fundamentally ‘good practice’ principles that do not reflect the nuanced impact of trauma on healthcare engagement. Trauma-informed care often focuses on the experiences of individuals and lacks focus on the sociocultural context within which traumatic events can occur. This is particularly relevant for people with disability who are more likely to experience violence, abuse, or neglect at a systemic or institutional level. This is compounded by ableism and discriminatory attitudes, unconscious bias, lack of skills and knowledge, fragmented systems (e.g. gaps between, health, justice and disability), inaccessible communication, and environments and processes which prevent people from seeking help or reporting harm (NDIS Quality and Safeguards Commission, 2025; Woollard, 2021).

The experience of complex trauma is inextricably linked with systems of power and oppression. Violence, abuse, neglect, and exploitation of people with disability occurs as a result of a complex interplay between individual vulnerabilities, intersectionality, service level deficiencies, and systemic societal issues, therefore requiring an approach which is holistic, multi-level, and integrated in order to reshape structures and cultures that perpetuate harm (NDIS Quality and Safeguards Commission, 2025). In this context, Tucci et al. (2024) proposed a paradigm shift towards trauma-transformative practice which involves guiding *“principles and interpretive constructs that aim to transform the ways health professionals, organisations, and systems operate with collective therapeutic intent to make the continuing effects of trauma become less influential in the lives of victims and survivors and reduce the pain and suffering they experience over time.”*



The co-designed Trust Guide provides a trauma-transformative approach aimed at the individual, organisational and system levels.

A trauma-transformative approach builds on the principles of trauma-informed care but moves beyond awareness and accommodation towards systemic change (Tucci et al., 2024). Rather than focusing solely on how services can respond sensitively to trauma, it seeks to redesign systems so they do not reproduce harm. This involves shifting from trauma awareness to organisational accountability, from helping individuals adapt to harmful environments to addressing the structural conditions that create trauma, and from equality to equity by recognising that some groups, including people with intellectual disability, are disproportionately exposed to ongoing traumatic experiences. Trauma-transformative approaches also broaden the concept of safety beyond psychological wellbeing to include legal, relational, cultural, and rights-based protections, acknowledging that trauma is often institutional and relational in nature (Tucci et al., 2024). Finally, responsibility for trauma prevention is embedded across governance, policy, and service design, reducing the burden on individual practitioners and promoting shared systemic responsibility for change. The responsibility for implementing the cultural shift towards trauma-transformative practice should be shared by individuals (health workers), organisations (health services), and systems and leaders (health systems).

How to use the Trust Guide

There are nine guiding recommendations written in plain language to support clarity, accessibility, and uptake. Each recommendation is grounded in relevant research, aligns with trauma-transformative practice, and was co-developed with input from a Professional Expert Advisory Committee and a Living Experience Expert Advisory Committee. The descriptions within the recommendations offer context and living experience examples that lead into the Actions, Monitoring and Resources.

The Actions outline practical steps that health workers, services, and systems can take to support implementation of each guiding recommendation. Each Action contains a judgement on its strength (strong, conditional) and is further categorised as evidence-based, consensus-based, or good practice statement (good practice statements are judged conditional to indicate that there are considerations to implementing the Action) according to the criteria in Table 4. The Monitoring section provides examples of how the Actions can be evaluated or monitored. Resources provides useful links to further information that may support or enable implementation.

Table 4 Categories for the type of Action.

Type of Action	Evidence base
Evidence-based (EB)	Action formulated with evidence-informed source guideline recommendations and/or systematic review findings that clearly link to the Action.
Consensus-based (CB)	Action formulated in the absence of high-quality evidence, but with Expert Advisory Committee Consensus.
Good practice statement (GPS)	Action co-designed by the Expert Advisory Committees that was formulated outside the scope of the source guidelines and systematic review.

Each guiding recommendation has an accompanying justification table presenting a summary of the Evidence-to-Decision framework highlighting the Expert Advisory Committee's key considerations in the co-design and adaptation of the Actions. These are in Appendix 1. For further details on how the frameworks were applied, see Section 3; Phase 2 for further information.

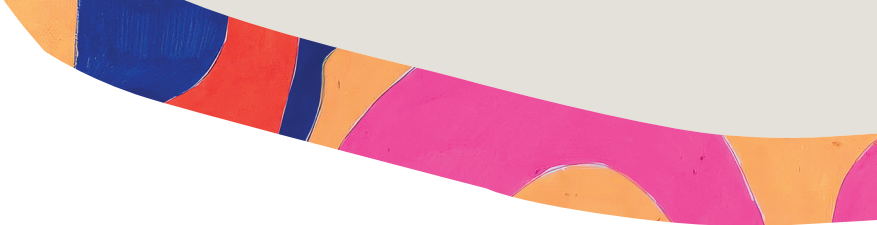
Notes on terminology

- The two Expert Advisory Committees (EAC) will be referred to as Professionals-EAC and Living Experience-EAC.
- The term “living experience” is used in favour of “lived experience” to represent the ongoing experiences of the Living Experience Expert Advisory Committee. This decision was made by the Living Experience-EAC. “Lived experience” is used only as a general descriptive term, not as a reference to the committee.
- This Guide is grounded in trauma-transformative practice, however trauma-informed care may be referred to throughout The Trust Guide where it is more closely aligned to the source of the information.
- The term ‘safer’ is used instead of safe throughout the Trust Guide to reflect the ongoing journey of providing safety in health care.
- ‘Health worker’ is used to refer to staff working in health services which was indicated by the Living Experience-EAC as their preferred term.

Recommendations

Level	#	Recommendation
Health workers	1	Know that people with intellectual disability often experience more trauma in their lives than other people.
	2	Centre the voice and choice of the person with intellectual disability in all health care interactions.
	3	Focus on the person with intellectual disability, working together with family or support people to balance everyone's needs.
Health services	4	Support health workers to deliver safer care through evidence-based training and resources.
	5	Build a culture where everyone feels safer and valued.
	6	Make the service environment more inclusive and accessible.
Health systems	7	Ensure different health workers, services, and systems stay connected and work together.
	8	Establish strong, positive leadership and a committed workforce.
All	9	Treat everyone with respect, compassion, and kindness.

Section Two: The Trust Guide - Actions, Monitoring and Resources



1. Know that people with intellectual disability often experience more trauma in their lives than other people

People with intellectual disability experience significantly higher rates of trauma and are more likely to experience violence, abuse, neglect, and exploitation, and to be victims of violent crimes (Australian Institute of Health and Welfare, 2025a). Article 16 of the CRPD (2006) states that all people with disability should be protected from exploitation, violence, and abuse, and that appropriate measures must be taken to promote *“the physical, cognitive and psychological recovery, rehabilitation and social reintegration”* in environments that *“foster the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.”* Trauma-transformative practice requires going beyond the individual level of ‘what has happened to you’ to a sociocultural perspective that considers the complexity of trauma’s impacts through an intersectional lens and across social ecological systems (Tucci et al., 2024).

Traumatic experiences can have lifelong consequences, as the effects of trauma may become embodied and manifest in emotional, psychological, and physical difficulties throughout a person’s life. These include mental illness (Byrne, 2022; Cummings et al., 2012); deficits in cognitive, social, and emotional competencies (Enoch, 2011; Gur, 2026); and an increased risk of chronic disease (Dong et al., 2003; Mann et al., 2023). The lifelong manifestations of trauma require more than an informed, personalised approach.

Trauma-transformative practice provides a framework for deep-rooted, interpersonal and systemic transformation. This starts with the knowledge and recognition that people with intellectual disability often experience more trauma in their lives than other people. A member of the Living Experience-EAC said, *“[Health workers need to be] willing to understand, listen, learn, [be] challenged, and open minded. That is crucial. They need to be willing to open their hearts.”*

Actions

Health workers to:		
1a.	Adopt a trauma-transformative practice for all people, regardless of whether trauma is known or disclosed, and tailor support to each person's needs. <i>(Strong)</i>	EB
1b.	Prepare for appointments in advance. i. Review relevant history. ii. Contact the person before the appointment to explain what to expect (e.g. waiting times, processes, triage) and check if they prefer to be introduced to unfamiliar health workers. iii. Liaise with family, support people, and the broader care team where appropriate. <i>(Strong)</i>	CB
1c.	Ask about, identify, and reduce restrictive practices and potential triggers before appointments occur. i. Understand the person's baseline functioning, health care anxiety, psychotropic medications, and comorbidities. ii. Review behaviour support plans, where available. iii. Provide reasonable adjustments (see 6a and 6b). iv. Potential triggers may involve unfamiliar health workers, diminishing or infantilising the person, speaking about the person as if they are not present, racism, touching without consent or dominating postures. <i>(Strong)</i>	EB

Health workers to:

1d.	Recognise common signs of trauma and distress. i. May include physical, emotional, psychological, and behavioural signs. ii. Do not minimise, dismiss, or deny experiences or signs of distress. (Strong)	CB
1e.	Consider integrating a trauma checklist, if useful in raising awareness or supporting care pathways (see resource 1.1). (Conditional)	GPS

Note. EB = evidence-based; CB = consensus-based; GPS = good practice statement

Monitoring

- Ensure continued access to professional development opportunities.
- Assess understanding of trauma-informed practice against the Quick Guide for Busy Clinicians - the Integrated Trauma-Informed Practice Guide (see resource 1.3).

Resources

- 1.1 Trauma Checklist for People With a Learning Disability Accessing Community Health and Support Services (Wigham et al., 2026)
- 1.2 Trauma-informed service provision fact sheet – Disability Services and Inclusion Act 2023 | Australian Government Department of Health, Disability and Ageing
- 1.3 Quick Guide for Busy Clinicians Trauma-Informed Care Framework | NSW Government

2. Centre the voice and choice of the person with intellectual disability in all health care interactions

Trauma-transformative practice maintains that meaning making is derived from personal experience (Tucci et al., 2024). Therefore, health workers should prioritise the perspectives and lived experiences of people with intellectual disability during health care encounters, adapting their communication approaches to support each person's preferred way of expressing themselves. The Living Experience-EAC said that *"It can be very frustrating when doctors are talking and you don't understand what they're talking about,"* and that it was important to *"make sure the person is always involved in decision making... and that the doctor is properly asking them questions instead of just their family members."* Centring the voice and choice of the person with intellectual disability may look different depending on their preferences, so health workers must ensure they uphold the principles of the CRPD (2006) which states, *"respect for inherent dignity, individual autonomy, including the freedom to make one's own choices..."*

The Professionals-EAC raised that there may be differences between a person with intellectual disability's 'legal capacity' to make decisions and their 'decision making ability.' In this case, exercise appropriate duty of care and work with family, support people, and carers to centre the voice and choice of the person with intellectual disability in a way that *"affirms the right to be supported to exercise their equal legal capacity in a way that respects their will, preferences, and human rights"* (Article 12, CRPD, 2006). Actions 2e and 2f address supported decision-making in more detail.

Actions

Health workers to:		
2a.	Offer choices in ways that are clear, manageable and responsive to the person's preferences and needs during all aspects of health care. i. Involve them in all decisions. ii. Direct communication to them first. iii. Provide information in accessible formats (e.g. Easy Read, visual supports, or with support from a trusted person where appropriate) and check for understanding using methods such as teach back. iv. Use resources 2.3 and 2.4 to centre the voice of the person with intellectual disability. <i>(Strong)</i>	EB
2b.	Seek informed consent at each stage of care and respect the person's boundaries. <i>(Strong)</i>	EB
2c.	Explain each step of the process clearly and transparently. i. Recognise and be responsive to diverse communication methods and functional abilities. ii. Demonstrate the skills, values, and attitudes needed to communicate effectively and respectfully. <i>(Strong)</i>	EB
2d.	Promote genuine autonomy and self-determination, to uphold the person's human rights and freedoms. <i>(Strong)</i>	CB

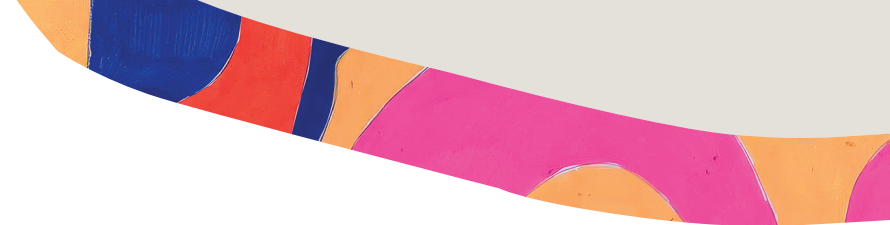
Health workers to:

Actions for supported or substitute decision-making:

2e.	When a supportive or substitute* decision-maker is involved, work with family, support people, and/or the supportive or substitute decision maker to ensure the person with intellectual disability is included in all discussions so their views are expressed and considered. i. Refer to your State's relevant 'Supported and Represented Decision-Making Act' (see resource 2.1 for further details). (Strong)	CB
2f.	When decisions are made for the person with intellectual disability by a substitute decision-maker (e.g. taking medications, preventive health care measures, lifestyle changes) that may or may not align with their preferences, acknowledge the potential for distress, and work with them and the substitute decision maker. i. Provide health information and check for understanding. ii. Exercise clinical judgement and investigate for further information if needed. iii. Maximise opportunities for the person to make informed decisions, when appropriate. (Conditional)	GPS

Note. EB = evidence-based; CB = consensus-based; GPS = good practice statement

*'Supportive' decision-maker refers to 'supported decision-making' which is when a person with disability is supported to make their own decisions about their lives. 'Substitute' decision-maker refers to 'substitute decision-making' which is when someone else is appointed to make decisions on behalf of the person with disability (Council for Intellectual Disability, 2026).



Monitoring

- Use peer reflective practice or case study discussion in team meetings to reflect on communication methods and how to improve.
- Monitor non-verbal communication skills.
- If possible, use healthcare experience measures with people with intellectual disability (see resource 2.5).

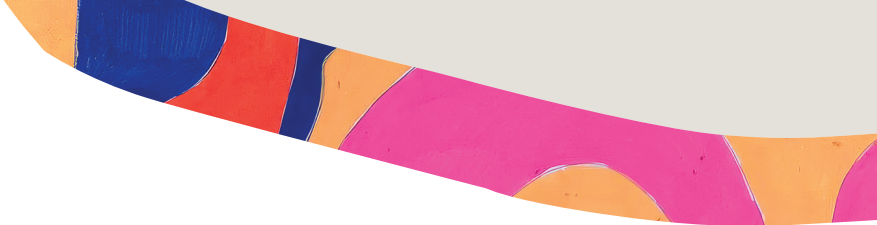
Resources

- 2.1. Recommendation 6.4 – Terms and definitions in guardianship and administration legislation | Australian Government Department of Health, Disability and Ageing
- 2.2 Supported Decision Making | Disability Gateway
- 2.3 Good communication and positive behaviour support - Easy read | Australian Commission on Safety and Quality in Health Care
- 2.4 Effective Communication in Health Care for People with Intellectual Disability | Excellence in Practice: Voices for Better Care (Podcast) - National Centre of Excellence in Intellectual Disability Health
- 2.5 Listen to me | CHSSR | AIHI | Macquarie University (ongoing co-design project of patient-reported experience measures with people with intellectual disability to improve health care quality and outcomes)
- 2.6 Article 12 - Equal recognition before the law | Division for Inclusive Social Development (DISD)
- 2.7 Say less show more | Agency for Clinical Innovation

3. Focus on the person with intellectual disability, working together with family or support people to balance everyone's needs

Person-centred care is not just ingrained in trauma-transformative practice but is the foundation of all high-quality health care. It allows people to be supported in ways that respect their needs, preferences, histories and backgrounds (Jackman-Galvin & Partridge, 2022; Ouellette-Kuntz et al., 2019; Pinals et al., 2022). This is especially important when the person with intellectual disability has diverse needs and preferences. *"It just depends on the person and that person's needs,"* said a family member from the Living Experience-EAC.

A key preference among the Living Experience-EAC during health care was having choice over how their family is involved. One member preferred to go to the GP with their carer and then *"ring mum and let her know, I've been to the GP..."* Another member said they hear stories of people with intellectual disability attending appointments with family members, only to be left out of conversations and spoken about behind their backs, *"the [people with intellectual disability] were happy to have their families and carers involved in their health care, but they themselves would also like to be directly involved in it as well."* Families and carers also highlighted the importance of working with the person with intellectual disability first, then including them, *"Just listen to her. Actually acknowledge what she's saying... Don't brush her off and look directly at me."*



Effective person-centred care should focus on the person first, but when involving family and support people, it is important to carefully balance everyone's needs. This may become complex if families or carers feel they have a better understanding of the person with intellectual disability's needs (Geuze et al., 2023; Lahaije et al., 2024; Nieuwenhuijse et al., 2023; Zaal-Schuller et al., 2016), or feel stress or vicarious trauma from their day-to-day care (Griffith & Hastings, 2014; Hoogstad et al., 2026; Xiong et al., 2022). Where possible, ensure advocacy and support services are available to them, and, if preferred by the person with intellectual disability, work together with family and support people throughout the provision of health care.

Actions

Health workers to:		
3a.	Take a holistic approach to understand all areas of a person's life that may be affecting their health. i. Understand support needs, strengths, and functioning to guide care planning and delivery. (Strong)	EB
3b.	Support the person to take an active and informed role in decisions and everyday aspects of their care. i. If supported or represented decision-making occurs, remain transparent and support the person with intellectual disability's involvement as much as possible (see 2e and 2f for further detail). (Strong)	EB
3c.	Gather relevant information about the person to inform care. i. Contact the person, their family, carers, support people, and other involved health workers, where appropriate and with consent. ii. Review available records, case notes, and personal health resources (see 7e for personal health resources). iii. See 1b when preparing for appointments in advance. (Strong)	EB
3d.	Recognise and respect the person's cultural, religious, gender, and sexual identities, and how these may shape their experiences and needs. (Strong)	EB
3e.	Use a preventive approach relevant to the person and their needs to support health and wellbeing, before challenges escalate (see resource 3.1 for preventive health care examples). (Conditional)	EB

Health workers to:		
3f.	Create regular opportunities for the person (and their family, carers, and support people, where possible) to raise concerns before, during, and after appointments. <i>(Strong)</i>	EB
3g.	Respect the person's preferences about how family, carers, and support people are involved in their care. i. Offer choice about the person attending appointments with or without support people, where possible. ii. Work collaboratively over time to support the person's preferred ways of accessing care. iii. Advocate for the support person to be present in any setting, including when in-person healthcare restrictions are in place (Recommendation 6.31b of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, p.230). <i>(Strong)</i>	EB
Actions when family, carers, or support people are involved:		
3h.	Understand and be responsive to the level of health knowledge of the person's family, carers, and support people. i. Work with the family, carer and support people on how they can be involved in the person's care. ii. Consider English literacy when working with people from communities where English is not their first or only language and offer accessible and inclusive resources. iii. Consider digital literacy when formulating plans and communication. <i>(Strong)</i>	CB
3i.	Utilise carer burden tools (see resource 3.2 for an example of a caregiver assessment) to understand support needs of family and carers. Where possible, refer them to support services. <i>(Conditional)</i>	GPS
Note. EB = evidence-based; CB = consensus-based; GPS = good practice statement		

Monitoring

- Self-reflection of person-centred skills (see resource 3.3).
- Assess cultural capabilities (see resource 3.4).
- Assess person centredness at the organisation level against the Australian Commission standards (see resources 3.5 and 3.6).

Resources

3.1 Types of preventive healthcare to stay healthy | UNSW

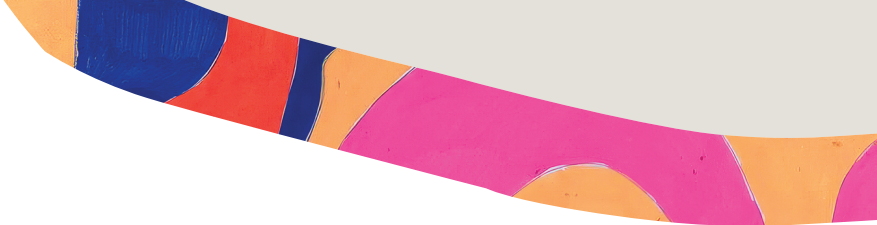
3.2 Caregiver Self Assessment Questionnaire | HealthInAging.org

3.3 Person-centred care | Australian Commission on Safety and Quality in Health Care

3.4 Cultural Capability Resource Checklist - The First Nations Training Strategy
- Cultural Capability Resource - Publications | Queensland Government

3.5 Person-centred organisations - Self assessment tool | Australian Commission on Safety and Quality in Health Care

3.6 Partnering with Consumers: A guide for consumers | Australian Commission on Safety and Quality in Health Care



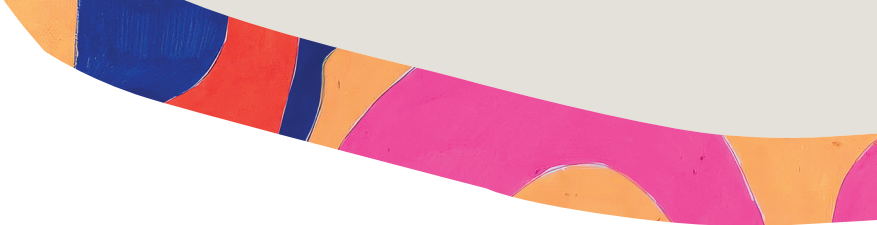
4. Support health workers to deliver safer care through evidence-based training and resources

Health services and systems need to ensure they are fostering an environment where health workers feel supported and have the knowledge, skills, and resources to provide safer care. The Professionals-EAC discussed that health workers have the right to be and feel safe; and acknowledged that exposure to trauma may affect their ability to provide trauma-transformative approaches to care. This is reflected in research where health workers involved in the care of people with intellectual disability felt secondary trauma and burnout in the absence of support (McNally et al., 2022; Mercer et al., 2023; Truesdale et al., 2019). Delivering trauma-transformative practice requires supporting the wellbeing of health workers.

Workforce capabilities are another key component of trauma-transformative practice. Starting with new recruits through to senior leadership, ongoing training, resources, and professional development should be provided for trauma-transformative practice, (Tucci et al., 2024) and for the human rights and needs of persons with disabilities as outlined in Article 25 of the CRPD (2006). This knowledge must then be integrated within the knowledge and practices that are specific to the health service, in line with Article 26 which promotes the *“development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services”*. This allows for a broader, transformative understanding of how trauma can impact people with intellectual disability, as well as health workers; and the role that health services play in supporting people after traumatic experiences.

Actions

Health Services to:		
4a.	Provide training that: i. Is role-appropriate in the delivery of trauma-transformative practice. ii. Equips health workers with knowledge, skills and confidence to support people with intellectual disability. iii. Assists health workers to engage in reflective (thinking back on your experience) and reflexive practice (examining your role, assumptions and influence) (see resource 4.1 for the Reflective Practice Workbook). iv. Builds the capacity of health workers to understand their own wellbeing needs so they know when they need to access wellbeing support. <i>(Strong)</i>	EB
4b.	Recognise that exposure to trauma and violence can affect health workers' wellbeing and capacity to provide safe, effective care. i. Wellbeing support should be prioritised, clear and accessible (e.g. Employee Assistance Programs). <i>(Conditional)</i>	CB
4c.	Promote a culture where wellbeing, safety, and help-seeking are supported. <i>(Strong)</i>	EB
Note. EB = evidence-based; CB = consensus-based		



Monitoring

- Regular supervision that considers the impact of individual, social and environmental factors.
- Consider the use of consensual recording of appointments to evaluate adherence to trauma-transformative practice.
- Establish formal methods to provide feedback on strategies and barriers of trauma-transformative practice.
- Use assessments to monitor health worker's levels of quality of life (e.g. Professional Quality of Life Scale; see resource 4.3).

Resources

- 4.1 Clinical Excellence Commission - Reflective Practice Workbook | NSW Government
- 4.2 Laying the Groundwork for Trauma-Informed Care | Center for Health Care Strategies
- 4.3 Professional Quality of Life (ProQoL)

5. Build a culture where everyone feels safer and valued

The Living Experience-EAC valued health services that felt *“safe and comfortable”* and described positive care experiences as those in which health workers *“made [them] feel safe.”* In trauma-transformative terms, this aligns with relationally integrative practice (Tucci et al., 2024). At a service level, this means establishing care processes and a culture that supports the person with intellectual disability to feel safer, welcomed, and valued during health care.

The Living Experience-EAC emphasised that a continuing, non-judgemental relationship should form the basis of therapeutic alliance, with one member stating that *“it’s just about [health workers] building relationships with you for you to feel safe.”* The Professionals-EAC also commented that feeling safer is relational and bidirectional, with one member noting, *“We cannot provide safety if we ourselves do not feel safe.”* This highlights the importance of fostering continuity, consistency, and relational approaches to care across the service, rather than limiting safety to isolated interactions during care. Relational safety depends on a workforce culture and service processes that enable health workers to provide safe and responsive care, while also feeling safe, and is a key component of trauma-transformative practice.

Actions

Health Services to:		
5a.	Foster a healthcare environment where everyone feels safer, welcomed, and respected. i. This includes the person with intellectual disability, their family, carers and support people, and other health workers in the care team. ii. The service culture should support authentic, consistent, and non-judgemental interactions. (Strong)	EB
5b.	Put processes in place to support clear, accessible explanations and the involvement of support people in communication where needed. (Strong)	EB
5c.	Maintain respectful and consistent relationships between everyone . i. Establish consent, roles, and boundaries within care relationships and between the care team. (Strong)	EB
5d.	Provide support after initial appointments or treatment (e.g. follow-up appointments, referrals, resources, check ins). i. Also offer psychological support or counselling to everyone . (Strong)	CB
Note. EB = evidence-based; CB = consensus-based		

Monitoring

- Establish systems that enable delivery of safer processes. For example, documentation systems and clinical alerts for required adjustments, behaviours, and relevant trauma history.
- Assess relational safety of the person (see resource 5.1).
 - > Where possible, assess in collaboration with the person with intellectual disability (e.g. I START Toolkit for social and sexual safety of people with intellectual disability; resource 5.2).

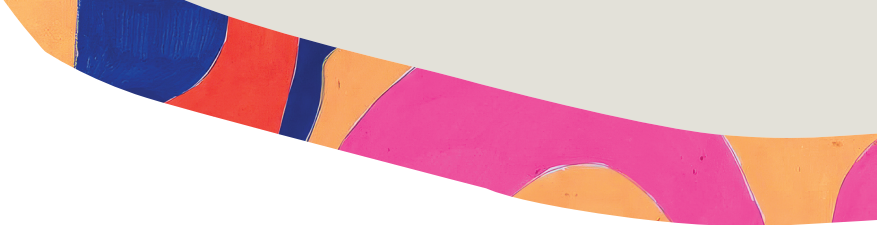
Resources

5.1 Measures of patient safety culture | Australian Commission on Safety and Quality in Health Care

5.2 National Guidelines for workers to create social and sexual safety for, and with, people with disability | Safer Me Safer You

5.2.1 I START Toolkit (link above)

5.3 Australian Open Disclosure Framework - Better communication, for better care | Australian Commission on Safety and Quality in Health Care



6. Make the service environment more inclusive and accessible

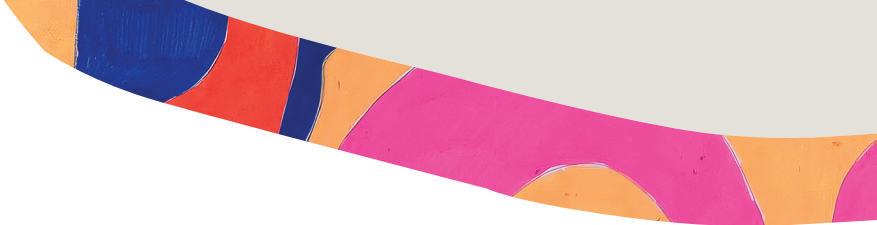
Accessible service environments enhance health care experiences for people with intellectual disability (Heslop et al., 2018; Lokman et al., 2025; Malapela, 2024; Marsden & Giles, 2015). This recommendation expands understanding of the concept of reasonable adjustments. It involves collaborating with the person with intellectual disability to understand their preferences and support needs. This was consistently raised by both Expert Advisory Committees. The Living Experience-EAC discussed a participant's MRI scan, *"I was allowed to keep my teddy with me... So, I thought because I've got anxiety issues and sensory issues as well, that really did help..."*

What specifically makes the service environment more accessible depends on the person with intellectual disability. For some it may be consideration of the sensory environment including light, sounds, texture and comfort of furniture. For others — visual aids, plain language resources, interpreters/support people, or holding appointments in homes or places where they regularly spend time. A family member reflected on a time when the environment had a negative impact on the health care interaction for their daughter *"She couldn't even see over the desk... Independence was really important to her."* Article 9 of the CRPD (2006) affirms this call for accessibility, *"...to enable persons with disabilities to live independently and participate fully in all aspects of life..."*

Trauma-transformative practice advocates for a collaborative and participatory driven approach (Tucci et al., 2024). This ensures the person with intellectual disability is responded to holistically through the shared lens of their preferences and living experience. Unfortunately, there may be barriers when implementing adjustments in some contexts (for example, hospitals) due to clinic constraints, or policy and compliance requirements. However, trauma-transformative practice calls for organisational change (Tucci et al., 2024), which means advocacy and lobbying for the resources required to make service environments more accessible is needed.

Actions

Health Services to:		
6a.	Provide logistical reasonable adjustments to reduce distress and support access to care (for examples see resource 6.1). ii. Offer longer appointments where needed. iii. Offer care in less restrictive settings where appropriate and feasible (e.g. the person's home or community, or via teleconferencing or phone). <i>(Strong)</i>	EB
6b.	Provide environmental reasonable adjustments to reduce distress and support access to care (for examples see resource 6.1). i. Sensory (e.g. comfort and sensory items, rooms with dimmed lighting). ii. Communication (e.g. respectful pacing, clear explanations, no pressuring, offering accessible communication formats). iii. Physical (e.g. mobility aids, assistive technology, comfortable seating). <i>(Strong)</i>	EB
6c.	Put clear escalation pathways in place so health workers know how to seek approval for reasonable adjustments when barriers arise. <i>(Conditional)</i>	GPS
Note. EB = evidence-based; GPS = good practice statement		



Monitoring

- Use the Australian Commission on Safety and Quality in Health Care's four steps to making reasonable adjustments (see resource 6.2).
 - > Plan — for reasonable adjustment
 - > Understand — the person and their disability
 - > Communicate — directly with the person
 - > Act — on a person's health needs
- Environmental auditing tools (see resource 6.3).

Resources

- 6.1 Reasonable adjustments | Australian Commission on Safety and Quality in Health Care
- 6.2 Four Steps to Making Reasonable Adjustments - Fact Sheet | Australian Commission on Safety and Quality in Health Care
 - 6.2.1 Infographic Poster
- 6.3 Neuro-affirming Environment Audit Tool: Health | National Autism Implementation Team 2025 (also designed for adults with intellectual disabilities)

7. Ensure different health workers, services, and systems stay connected and work together

Quality and equitable health care with those with intellectual disability depends on health workers, services, and systems staying connected and working collaboratively. A reflection from the Living Experience-EAC was about a new physiotherapist who became involved in the care team of one of the members, their support person said, *“it really helped you were supported by Mum and Dad, and they had some communication with the physiotherapist. We all worked together as a team and that helped a lot.”*

Care should be *“based on the multidisciplinary assessment of individual needs and strengths”* (CRPD, 2006). This means sharing information, using clear communication, and creating smooth pathways between services so no one falls through gaps. Members of the Professionals-EAC advocated for partnerships with consumer experts to protect these gaps and foster authentic and safe outcomes. A family member reflected on a time when she felt her daughter fell through the gaps, *“If there was that person that coordinated the safe transition home, then that could have potentially saved her life.”*

Trauma-transformative practice is inherently a multi-disciplinary collaboration and a congruence of language and shared meaning between organisations and practitioners. This is essential when working with the person with intellectual disability as they are often engaged with multiple services. When hospitals, GPs, allied health, disability services, and community support coordinate their work, care becomes safer, more consistent, and easier to navigate (Keesler, 2016; Rich et al., 2021; Truesdale et al., 2019). Strong relationships, shared planning, and a common understanding of the person's needs help everyone provide care that is respectful, timely, and truly person-centred. At a systems level, leadership must ensure that multi-disciplinary care pathways are accessible and integrated.

Actions

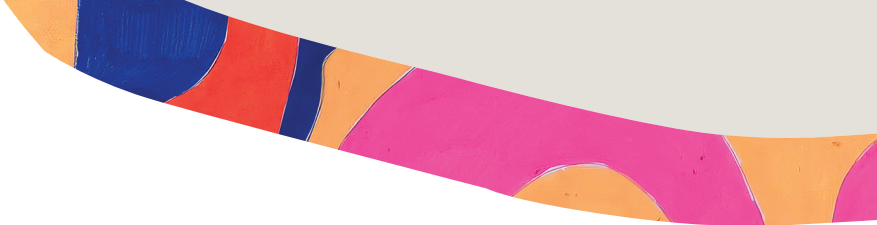
Health Systems to:		
7a.	Design care pathways (see resource 7.1) and transitions (see resource 7.2) in partnership with the person and, where appropriate, their family, carers, support people, and involved health workers. i. Ensure they are clear, accessible, and responsive. ii. Integrate them to reduce fragmentation and barriers between services. iii. Focus care coordination on outcomes that matter to the person (e.g. quality of life, care satisfaction). iv. Include health workers and advisors with living experience in the design and improvement of care pathways. (Strong)	EB
7b.	Establish clear leadership and accountability for coordinating care pathways across services and systems. (Conditional)	EB
7c.	Ensure collaboration and continuity between all stakeholders, including providers and settings. i. Identify and partner with/consult relevant specialist intellectual disability health teams, if available. (Conditional)	EB
7d.	Put clear processes in place for sharing information across stakeholders. (Strong)	CB
7e.	Utilise and promote health resources (see resource 7.3) to support continuity and consistency of care, e.g. i. My Health Matters folder. ii. Julian's Key Health Passport. (Strong)	GPS
Note. EB = evidence-based; CB = consensus-based; GPS = good practice statement		

Monitoring

- Ensure people with intellectual disability are involved in co-developing and planning models of care to ensure good cross-sectoral care (see resource 7.4).
- Partner with paid experts with living experience for consultation and guidance.

Resources

- 7.1 Australian models of healthcare for people with intellectual disability - A scoping review | National Centre of Excellence in Intellectual Disability Health
- 7.2 Transitions of care for people with intellectual disability - Easy read | Australian Commission on Safety and Quality in Health Care
- 7.3 Personal Health Resources for people with intellectual disability
 - 7.3.1 My Health Matters folder | Council for Intellectual Disability
 - 7.3.2 Assembling an Admission2Discharge (A2D) Together Folder | South Eastern Sydney Local Health District
 - 7.3.3 Julian's Key Health Passport | Queensland Health
- 7.4 Chapter 3: Partnering with Consumers | Australian Commission on Safety and Quality in Health Care



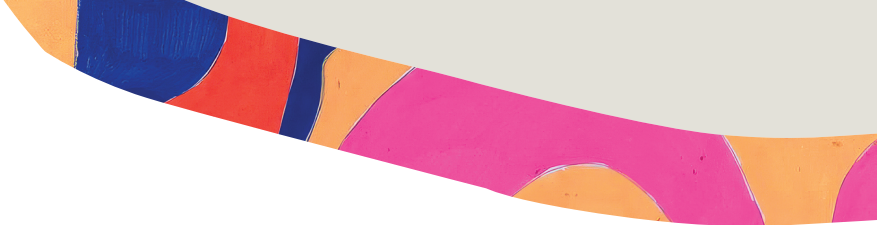
8. Establish strong, positive leadership and a committed workforce

Health services and systems need strong, positive leadership and committed health workers to provide trauma-transformative care (Tucci et al., 2024). When teams have clear guidance, ongoing learning, and a culture that encourages openness rather than blame, and curiosity instead of judgement; they are better equipped to provide care that is healing, consistent, and centred on the person with intellectual disability (Bryson et al., 2017; Fernández et al., 2023). This means leaders who model respect, safety, and compassion, and who create environments where health workers feel supported, valued, and encouraged to engage in reflective and reflexive practice.

The Professionals-EAC reflected that often the *“culture of inclusivity is missing at the top-down level”* and made calls for more senior staff to get involved in all aspects of training and discussion, rather than just leaving the responsibility to the health workers directly involved in health care. This notion is set in the General Obligations of the CRPD (2006) which calls on organisations to, *“take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities”* and *“take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes”*. A strong leadership team sets the foundation for trauma-transformative practice to grow and remain sustainable among services and staff over the long term.

Actions

Health Systems to:		
8a.	Train directors, senior leaders, and managers in trauma-transformative practice. i. Involve senior staff in training, reflection, and ongoing discussion about trauma-transformative practice. <i>(Strong)</i>	CB
8b.	Embed trauma-transformative values and approaches across organisational policy, systems, and governance. <i>(Strong)</i>	CB
8c.	Establish a dedicated disability liaison officer to ensure responsive care and identify gaps in care quality and safety (see resource 8.1). <i>(Strong)</i>	GPS
8d.	Invest in a workforce culture that supports safe, skilled, and trauma-transformative practice. i. Recruit, train, and retain health workers (particularly front facing health workers and social workers) with the knowledge, skills, and support needed to provide high-quality care. <i>(Conditional)</i>	CB
8e.	Include the voice of living experience. i. Share power and governance in genuinely inclusive ways across planning and decision making. ii. Improve and develop resources, procedures, and service improvements through co-production (see resource 8.1). <i>(Conditional)</i>	CB



Health Systems to:		
8f.	Integrate data systems to monitor key safety and quality indicators, including restrictive practices and chemical restraint. <i>(Conditional)</i>	GPS
8g.	Ensure organisational policy addresses health workers' burnout, moral injury, and wellbeing through clear and accessible system supports. <i>(Conditional)</i>	GPS
Note. CB = consensus-based; GPS = good practice statement		

Monitoring

- Monitor high-impact safety indicators (e.g. restrictive practices, chemical restraints; see resource 8.2).
- Use the Trauma-Informed Care and Practice Organisational Toolkit (see resource 8.3) to audit policies and procedures.
- Ongoing review of trauma-transformative culture against the Handbook of Trauma-Transformative Practice (see resource 8.4).
- Build a shared understanding of trauma-transformative practice.
- Leadership should seek health workers' feedback on trauma-transformative processes.
- Team case studies with evaluation of cases involving trauma.

Resources

8.1 Partnering with Consumers Standard | Australian Commission on Safety and Quality in Health Care

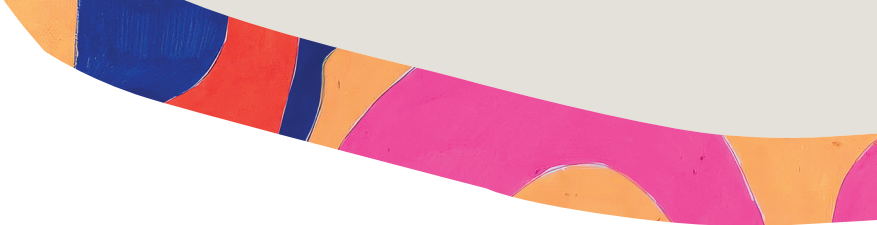
8.1.1 Effectiveness of a Disability Liaison Officer service in a metropolitan emergency department (O'Shannessy 2025)

8.2 Indicators, measurement and reporting | Australian Commission on Safety and Quality in Health Care

8.2.1 Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard | Australian Commission on Safety and Quality in Health Care

8.3 Trauma-informed Care and Practice Organisational Toolkit (TICPOT) | Mental Health Coordinating Council

8.4 The Handbook of Trauma-Transformative Practice (Tucci et al .2024)



9. Treat everyone with respect, compassion, and kindness

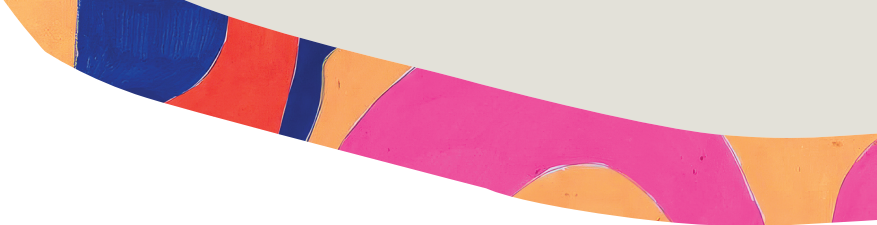
Everyone deserves to be treated with respect, compassion, and kindness. This includes health workers and other staff, people with intellectual disability, and their families and supporters. A member of the Living Experience-EAC described the importance of something as simple as a smile, *“It all just goes back to if the doctor or the nurse has got a smile on their face as well... Make your patient think it’s gonna be OK, I know what I’m doing, I know what I’m talking about, here to help...their body language is really important.”*

Being treated with respect, compassion and kindness is the basis of trust. The Living Experience-EAC said, *“trust is basically everything.”* They also reflected that *“patience and compassion is important to let [the person with intellectual disability] know they’re safe”*. Trauma-transformative practice has a strong focus on compassion, which, alongside trust, cultivates empathy and understanding towards everyone’s unique experiences (Tucci et al., 2024).

To build trust, it is imperative that health workers are responsive and sensitive to the needs of the person with intellectual disability, including experiences of shame and loss. It is important that health workers clearly explain each step of the process and reassure them throughout. This was highlighted by a member of the Living Experience-EAC who said, *“If they don’t reassure you, things are going to be fine, things will be OK... If they don’t say that, you’re not going to want to trust them again.”* If a mistake occurs, be open and transparent by immediately acknowledging what happened and take accountability when appropriate. A member of the Living Experience-EAC shared a story of a healthcare incident where they fell off their bed, *“they should have like, as soon as it happened... they should have at least told my mum, ‘Hey, this is what’s happened. She’s OK, but we’ve addressed it, I’m sorry that that happened.’”* Trust is more likely to be damaged by a perceived lack of openness and communication after an incident, rather than by the incident itself.

Actions

All to:		
9a.	Build trust through clear and honest communication, teamwork, and genuine rapport, including family, carers, and support people where appropriate. <i>(Strong)</i>	EB
9b.	Always respect the person's privacy. <i>(Strong)</i>	CB
9c.	Clearly explain why assessments, procedures, and other aspects of care are needed, particularly during supported decision-making. i. See 2e and 2f for further details on supported decision-making. ii. Be open and transparent during disclosures (see resource 9.1). <i>(Conditional)</i>	EB
9d.	Show genuine care, compassion, and kindness in all interactions. <i>(Strong)</i>	EB
9e.	Consider using clear indicators of accessibility and experience in working with people with intellectual disability (e.g. sunflower lanyard). <i>(Strong)</i>	GPS
9f.	Use open, respectful body language that helps the person with intellectual disability feel at ease. <i>(Strong)</i>	CB



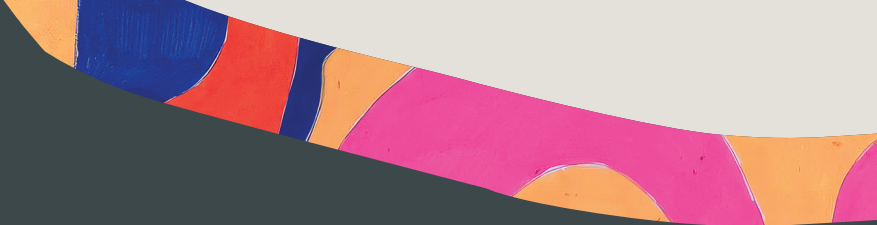
All to:		
9g.	Establish informed consent and boundaries in collaboration with the person with intellectual disability, their families, carers, and support people, and representative decision-makers. See 2e and 2f for working with substitute decision-makers. (Strong)	CB
9h.	Offer calm, reassuring verbal and non-verbal communication. (Strong)	CB
9i.	Consider unconscious biases and examine them with reflexive practice when working with the person, to remain open-minded, responsive and compassionate. (Strong)	GPS
Note. EB = evidence-based; CB = consensus-based; GPS = good practice statement		

Monitoring

- Reporting pathways for incidents and complaints (see resource 9.1).
- Monitor practice to ensure it is compassionate (see resource 9.3 for possible tools).
 - > If the person with intellectual disability has capacity, ask them to evaluate compassionate care. If necessary, involve families, carers and support people
- Monitor the person with intellectual disability's level of distress throughout care (see resource 9.4).

Resources

- 9.1 Australian Open Disclosure Framework - Better communication, for better care | Australian Commission on Safety and Quality in Health Care
- 9.2 Fact Sheet: Preparing and participating in open disclosure discussions | Australian Commission on Safety and Quality in Health Care
- 9.3 See Me. Hear Me. Respect Me. campaign resources for adults | Queensland Health
- 9.4 Understand and respect my rights and care preferences" Working with people with intellectual disability | Queensland Health
- 9.5 An Interactive Tool for Selecting the Best Measure to Assess Compassion Across the Healthcare System | Compassion Measure
- 9.6 Disability Distress Assessment Tool (DisDAT) | CONNECT Children's Services and Adult Learning Disability Services



Section Three: Development of the Trust Guide

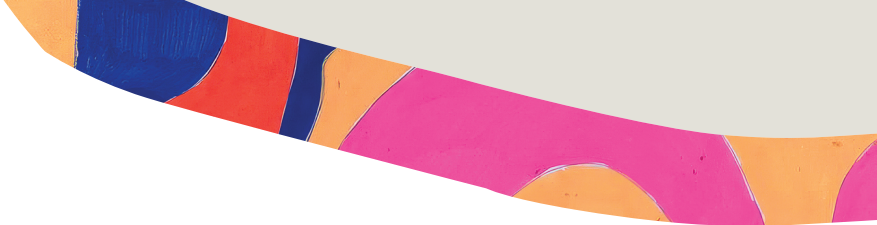
Phase 1: Team Establishment and Co-Design Process

Establishment of the Guideline Development Group

This project was a collaboration between consortium members of the National Centre of Excellence in Intellectual Disability Health (NCEIDH). Organisation and planning were executed by a Guideline Development Group (GDG) made up of researchers from the Queensland Centre of Excellence in Intellectual Disability and Autism Health (QCEIDAH) and the Centre for Disability Studies (CDS). The GDG consisted of a project lead (chair) and seven researchers. One of the GDG members was a research assistant with intellectual disability (RDG) who would facilitate the co-design process and provide oversight through a living experience lens. The GDG scoped the feasibility of the Trust Guide and developed governance and conflict of interest management processes for the Expert Advisory Committee who would be involved in the co-design of the Guide.

Expert Advisory Committees

The Expert Advisory Committee included representatives from key stakeholder groups. Representation around Australia was sought with a variety of professional (healthcare and research) and living experience backgrounds (people with intellectual disability and support people). Initially, it was planned to have all members serve on a single committee. However, advice from RDG was that having a separate Expert Advisory Committee of people with living experience would provide better opportunities to gather deeper and more meaningful perspectives. Thus, two Expert Advisory Committees were formed: those with professional experience working with people with intellectual disability (Professionals-EAC) and those with living experience (Living Experience-EAC).



Professionals-EAC members were invited to participate through the professional networks of NCEIDH, QCEIDAH, and CDS. Eight professionals were invited to take part and seven accepted. Living Experience-EAC members were recruited through community networks and NCEIDH's Learn and Lead Group. Learn and Lead is a group of people with intellectual disability who develop their leadership and advocacy skills through participation in the work of NCEIDH. Four members were initially invited to participate who all accepted. However, one dropped out prior to the first meeting. A fourth member was invited to participate later in the project and agreed to be involved. Living Experience-EAC members were given the opportunity to participate with or without a support person. Only one decided to attend with a support person. Expert Advisory Committees were briefed on their role which was to provide expert guidance, contextual information, and living experience discussions throughout the development of the Trust Guide. All members of the Expert Advisory Committees were offered equal remuneration for their time.

Co-design process

The co-design process underpinning the Trust Guide was informed by the National Mental Health Consumer and Carer Forum definition of co-design, which emphasises the collaborative development of health services with the people they are intended to serve (National Mental Health Consumer & Carer Forum, 2021). Co-design is a key component of co-production, which extends beyond service design by enabling people to participate in the delivery of the services they help create (National Mental Health Consumer & Carer Forum, 2021). Both committees contributed to the co-design process through knowledge generation, collaborative decision-making, and inclusive participation (Strnadová et al., 2022a). This approach aligns closely with the 'Doing' and 'Sense Making' phases of the *Doing Research Inclusively: Co-Production in Action framework*, which emphasises shared reflection, meaning-making, and collective action throughout the research process (Strnadová et al., 2022a).

Phase 2: Guideline Adaptation Methodology — GRADE-ADOLOPMENT

Step 1: Planning of methodology

A key objective of the Trust Guide was to develop evidence-based recommendations through co-design and methodological rigour. Therefore, the GRADE-ADOLOPMENT approach was chosen due to its utility in updating available evidence while also engaging local stakeholders (Darzi et al., 2017). The approach uses Evidence-to-Decision criteria that considers evidence quality, stakeholder values and preferences, resources, feasibility and acceptability issues, and health equity impacts (Klugar et al., 2024; Schünemann et al., 2017). This was justified as useful criteria in the context of the project, which was to co-design an evidence-based guideline that improves health care and equity for people with intellectuality disability.

GRADE-ADOLOPMENT

The GRADE-ADOLOPMENT approach comprises fifteen main steps that start with one or more source guidelines subject to question prioritisation, evidence update, stakeholder evaluation, and Evidence-to-Decision framework justification. Each step is addressed systematically by guideline developers to inform contextual recommendations which are either adopted (that is, none or minimal changes), adapted (that is, further contextualised to context), or developed de novo (that is, create new). ‘Adolopment’ is a coinage of these terms. The 15 steps of the approach summarised by the World Health Organisation (2023b) are in Figure 1. A guidance paper from the GRADE-ADOLOPMENT creators identified 21 applications of the approach worldwide, showcasing its applicability and efficiency in a range of contexts (Klugar et al., 2024).

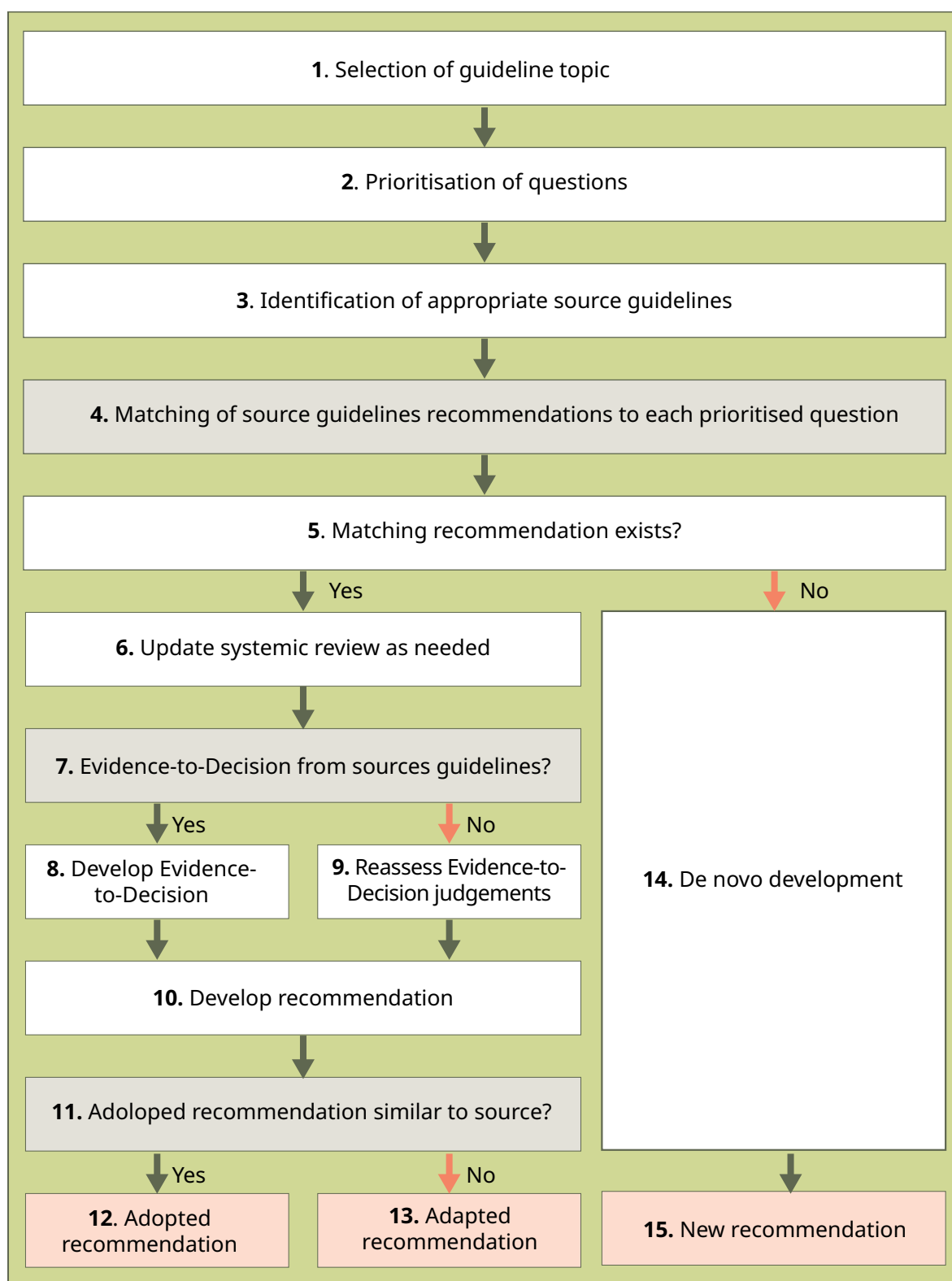
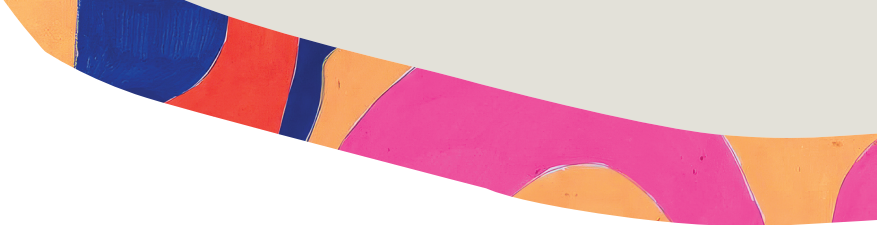


Figure 1. The 15 steps of the GRADE-ADOLOPMENT approach taken from the World Health Organisation (2023b)

Application of GRADE-ADOLOPMENT

The current state of the literature made it difficult to apply standard GRADE-ADOLOPMENT methodology. Following preliminary scoping of the topic of the guidelines, it became apparent that existing guidelines were either not developed using the GRADE approach or lacked high-quality empirical research. While the approach does not necessarily require source guidelines to strictly adhere to GRADE methodology or utilise Evidence-to-Decision frameworks, its exclusion may impact the efficacy of its application (Darzi et al., 2017; World Health Organisation, 2023b).

Modifications to the approach were necessary given the lack of quantitative data and standardised measures of the experiences of people with intellectual disability accessing health services. For consistency, available quantitative evidence was generally synthesised narratively. Qualitative evidence and stakeholder input were analysed through thematic analysis and co-sense making to uncover the recurring ideas, concerns, and living experiences of people with intellectual disability, their families, carers, and support people, and health workers (Braun & Clarke, 2006; Strnadová et al., 2022a). The elicitation of living experience is a key element of co-production, particularly in the co-design of health services (Morley et al., 2024), making the approach well suited to informing guideline recommendations and Evidence-to-Decision criteria.



Evidence-to-Decision frameworks were developed with the Professionals-EAC. Criteria were slightly modified, as Evidence-to-Decision frameworks are intended to be flexible, based on the context and requirements (Brennan & National Health and Medical Research Council, n.d.). Due to the project's emphasis on co-design, values and preferences, and acceptability and feasibility were primarily informed by input from the Expert Advisory Committees. This was justified by the Australian Commission on Safety and Quality in Health Care (2025), who highlight the understanding of values, equal partnership, and transparency of processes as key principles of co-design. Furthermore, input from the Expert Advisory Committee was considered in each criterion to emphasise the Australian Commission on Safety and Quality in Health Care's (2025) principles of accessibility and inclusiveness. Definitions of the Evidence-to-Decision criteria and how they were applied in the Trust Guide are summarised in Table 5.

The other criteria considered were the balance of effects (benefits and harms), evidence certainty, resources, and health equity. Due to methodological heterogeneity across evidence (for example, variation in populations, interventions, outcomes, and measurement), statistical pooling was not appropriate. Therefore, qualitative evidence was considered in parallel to quantitative evidence, with findings being converged (Hong et al., 2017) in the development of the Trust Guide. For resources, cost-effectiveness data were considered where available, as well as practical and educational resources as suggested by the Professionals-EAC. Health equity additionally considered alignment with the United Nations Convention on the Rights of Persons with Disabilities (2006) as it was agreed by the Professionals-EAC as a fundamental standard of human rights.

In standard GRADE approaches, Evidence-to-Decision criteria are generally assigned a rating of the strength of the evidence by the guideline's development committee. An overall assessment can then be made to inform the strength of the recommendation (for example, weak, conditional, strong; Alonso-Coello et al., 2016). The Autism CRC guidelines informed the Trust Guide's approach (Goodall et al., 2023) whereby recommendations were judged on the quality of the available evidence from the source guidelines, evidence updates, Expert Advisory Committee input, and community consultation. A summary of the Trust Guide's proposed methodology adapted from GRADE-ADOLOPMENT is summarised in Figure 2.

Table 5 Definitions of Evidence-to-Decision criteria and how they were applied in the Trust Guide.

Criteria	Definition	Use in the Trust Guide
Balance of benefits and harms	"Judgement of whether the benefit outweighs the harms."	Judgement on the likely benefits and/or risks for people with intellectual disability and whether the benefits outweigh risks. Based on available evidence and stakeholder input.
Certainty rating	"Overall judgement of the certainty of the evidence."	Judgement on the overall certainty of the available evidence. Based on methodology and application of GRADE, where applicable.

Criteria	Definition	Use in the Trust Guide
Values and preferences	"Judgement of whether people receiving the intervention value the outcomes."	Judgement on the consistency with the values and preferences of people with intellectual disability. Based on input from people with intellectual disability.
Resources required	"Judgement of the resource requirements to implement the intervention."	Judgement on whether additional funding by health services or resources for health workers is required. Based on available evidence and stakeholder input.
Equity	"Judgement on whether the recommendation would improve health equity."	Judgement on the impact on health equity for people with intellectual disability. Based on available evidence and alignment with the United Nations Convention on the Rights of Persons with Disabilities (2006).
Acceptability and feasibility	"Judgement on whether the intervention is acceptable and feasible to stakeholders."	Judgement on acceptability by people with intellectual disability, and acceptability and feasibility by health workers, health services, and health systems. Based on available evidence and stakeholder input.

Note. Definitions summarised from National Health and Medical Research Council, Table 1 (Brennan & National Health and Medical Research Council, n.d.)

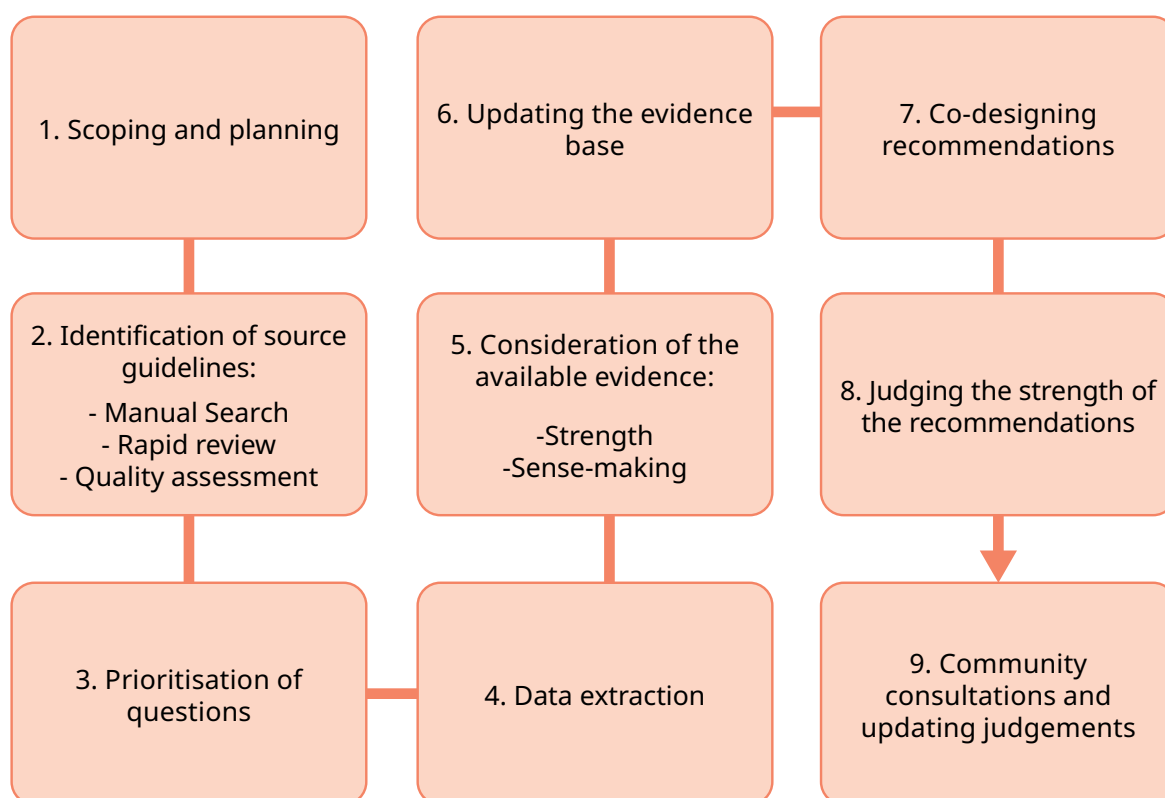
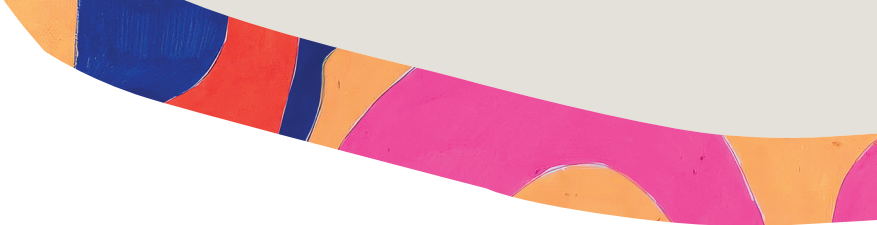


Figure 2. Proposed methodology modified from GRADE-ADOLOPMENT.

Expert Advisory Committee Meeting Structure

A series of one-hour online meetings were held with each Expert Advisory Committee (Professionals-EAC = 3, Living Experience-EAC = 4). At the beginning of each meeting, members were reminded to disclose conflicts of interest. No conflicts of interest were declared. Meetings were organised and facilitated by a member of the GDG and held between November 2025 and June 2026.

The main task of the Expert Advisory Committees was to lead the co-design process. Given the target audience of the Trust Guide were health workers and services working with people with intellectual disability, the representation of clinicians in the Professionals-EAC, as well as the people with intellectual disability in the Living Experience-EAC, were equally considered key stakeholders in co-designing the Trust Guide (Strnadová et al., 2022a). The Professionals-EAC also contributed to the GRADE-ADOLOPMENT process.



Step 2: Search for existing guidelines

Step 2.1: Manual search

In October 2025, an online database search was conducted for national and international guidelines relevant to trauma-informed care with people with intellectual disability. The guideline inclusion criteria and search strategy were discussed and agreed upon by the GDG with consideration to the objectives of the Trust Guide (Table 6).

A manual search was undertaken to search for grey literature guidelines using the terms in Table 7. During the search, the lack of existing, high-quality guidelines on trauma-informed care for intellectual disability health services became apparent. Therefore, the GDG decided that guidelines based in other support settings would be considered for adaptation, provided they were similar in population and scope. The number of manually identified guidelines subject to screening was 38. Seven were identified to have potential for GRADE-ADOLOPMENT.

Table 6 Inclusion criteria of search for source guidelines.

Criteria	Inclusions
Publication type	• Guidelines • Frameworks • Toolkits • Methodology publications outlining the development of a guideline
Scope	• Trauma-informed care with people with intellectual disability
Setting	• Developed countries with similar models of healthcare to Australia
Relevance	• Published from 2006 (to align with Australia's ratification of the UN Convention on the Rights of Persons with Disability) • Research questions and/or guideline objectives aligned to the scope of this guideline • English only
Databases searched	• World Health Organisation • National Institute for Health and Care Excellence • Guidelines International Network • Overton • INFORMIT • Australian Policy Online • Google Scholar • PubMed

Table 7 Manual search strategy for grey literature source guidelines.

Query	Search terms
1	"trauma-informed" OR "abuse" OR "neglect" OR "violence"
2	"guideline*" OR "framework*" OR "toolkit" OR "model of care"
3	"disability" OR "intellectual disab*" OR "learning disab*" OR "intellectual impairment" OR "developmental disability" OR "mental retardation" OR "IDD"

Identification of priority guideline

One guideline, the Taking Time Framework (Jackson & Waters, 2015) was identified as a priority guideline for adolopment with permission sought from the primary author. This was determined by its relevance in scope (trauma-informed care for people with intellectual disability) and context (support settings, including healthcare), and publication in 2015 which warranted a recency update. Recency relates to the concept of what is new in the evidence base since the creation of the guideline (Klugar et al., 2024). Furthermore, the Taking Time Framework was identified as a key example in NCEIDH’s submission on the National Safety and Quality Health Service (NSQHS) Standards (third edition), further highlighting its relevance and importance (see Step 3 for further details).

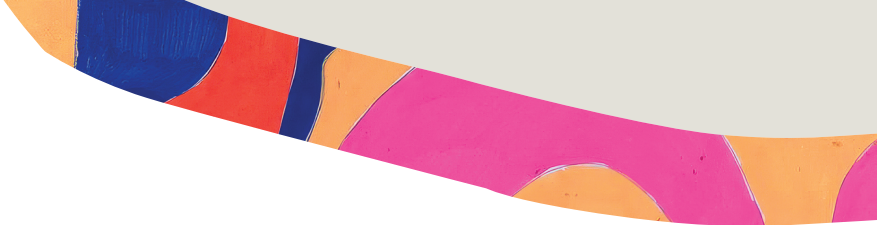
Step 2.2: Rapid review

In October 2025, an additional systematic search for guidelines was conducted. The following databases were searched; PubMed, Embase, CINAHL, Web of Science Core Collection and PsycINFO. Search terms were based on the manual search terms and developed with a librarian to include a combination of relevant MeSH and index terms relevant to each database. In addition to grey literature sources, peer-reviewed publications were searched in case methodology papers could be linked to guidelines. Guidelines were subject to the same criteria as the manual search, except limited to 2015 onwards, in line with the publication year of the Taking Time Framework. The search identified 4,084 citations. See Appendix 2 for the full search strategy and PRISMA flowchart. Citations were imported into Endnote for removal of duplicates and 3,298 were uploaded to Covidence for screening.

Due to resource constraints, the dearth of relevant guidelines, and the number of potential guidelines identified in the manual search, the GDG followed rapid review methods. While rapid review methods tend to be inconsistent, the Trust Guide rapid review followed an approach summarised by Tricco et al. (2016) that was congruent with the most frequently identified rapid review methodologies as voted by international organisations. A summary of the method is in Table 8.

Table 8 Rapid review methodology for the Trust Guide search for existing guidelines (Tricco et al., 2016).

Literature Search	Search limit	Screening	Data abstraction	Risk of bias appraisal
>1 database, published only	Both date and language	Two reviewers	One reviewer	One reviewer



While common in rapid review methodologies, grey literature databases were left out as they were already manually searched. When a publication was a guideline methodology paper, the original guidelines were sought and uploaded to the Covidence citation. Three relevant guidelines were identified from the rapid review; however, these were already identified in the manual search, keeping the number of potential source guidelines at seven.

Step 2.3: Quality assessment of source guidelines

A screen was conducted by one member of the GDG to assess the quality of identified guidelines using the AGREE II tool (Brouwers et al., 2010). The AGREE II is intended to evaluate methodological rigour and transparency, rather than quality or suitability of the recommendations (Tavender et al., 2021). Therefore, relevance (domain 1), stakeholder involvement (domain 2; for co-design considerations), and methodological rigour (domain 3) were chosen to evaluate overall quality. AGREE II is not designed with a standardised cut off point and thresholds are flexible to fulfil the needs of guideline developers (Brouwers et al., 2010). Therefore, no guidelines were excluded based on AGREE II scores. A second member of the GDG cross-checked AGREE II scores. A full second screening was not completed due to time constraints.

The scores of domain 1, domain 2, and domain 3 from the appraisal are in Table 9 as a percentage (see Appendix 2.3 for the individual item scores for each domain). Generally, scores greater than 70% are deemed high quality (Brouwers et al., 2010). For the Trust Guide, domain 3 determined overall guideline quality with thresholds set at: high (75%–100%), moderate (50%–75%), low (25%–50%), very low (0%–25%). The scores from the other AGREE II domains may be provided upon request. Additionally, data were extracted for scope, population, and target audience to confirm suitability (Table 9). The seven source guidelines identified from the search were all deemed suitable for GRADE-ADOLOPMENT.

Table 9 Summary of source guidelines and AGREE II scores on domain 1, domain 2 and domain 3.

Scope / objectives	Population	Target Audience	AGREE II domain overall score (%)			Quality
			1	2	3	
Taking Time Framework (Jackson & Waters, 2015)						
Establish a clear vision grounded in research, practice realities, and core values, providing practitioners and managers with a theory-informed framework and practical prompts to support best practice and link philosophy, interventions, and outcomes.	People with intellectual disability.	Disability services supporting people with intellectual disability.	95.24	100	53.57	Moderate
NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NICE, 2015)						
Provide recommendations to improve assessment, access to services, and evidence-based support for people with learning disability and behaviours that challenge, including psychological, environmental, psychosocial, and pharmacological interventions.	Children, young people and adults with a learning disability and behaviour that challenges.	Primary, community, secondary, tertiary and other health care professionals.	100	100	100	High
NG54: Mental health problems in people with learning disabilities: prevention, assessment and management (NICE, 2016)						
Provide recommendations to improve prevention, identification, assessment, and management of mental health problems in people with learning disabilities, including evidence-based physical, psychological, psychosocial, and pharmacological interventions.	Adults, children and young people with learning disabilities.	Primary, community, secondary, tertiary and other health care professionals.	100	100	100	High
NG93: Learning disabilities and behaviour that challenges: service design and delivery (NICE, 2018)						
Provide evidence-based recommendations to support people with learning disability, autism, and behaviours that challenge to live in the community, with a focus on effective, coordinated, person- and family-informed support services.	Children, young people and adults with learning disabilities and behaviour that challenges.	Commissioners, providers, and practitioners of health and social care services.	100	100	100	High

Scope / objectives	Population	Target Audience	AGREE II domain overall score (%)			Quality
			1	2	3	
GeneEQUAL Toolkit						
Provide an accessible, co-produced resource to improve workforce knowledge and capability to support safe, equitable, cost-effective, and high-quality genomic health care.	People with intellectual disability accessing genomic health care.	Health professionals	76.19	100	85.71	High
Blue Knot Foundation: Disability Guidelines for Trauma Informed Practice (Kezelman & Dombrowski, 2021)						
Provide practical guidance to help organisations and workers support trauma recovery for people with disability, while recognising that implementation requires ongoing training, funding, resources, and sector-wide support.	People with disability and trauma.	Organisations and workers supporting people with disability recover from trauma.	85.71	85.71	44.64	Low
A Framework for the Implementation of TRAUMA INFORMED CARE in Residential and Supported Living Services for Adults with a Learning Disability (McNally & Health and Social Care Northern Ireland, 2022)						
Provides a framework for understanding trauma and implementing trauma-informed care in learning disability services, with the aim of improving quality of life for adults with learning disability and supporting staff wellbeing and organisational culture.	People with a learning disability who may have been impacted by trauma history.	Organisations providing residential or supported living accommodation.	71.43	100	78.57	High

Step 3: Prioritisation of questions

The process to prioritise research questions was based on GRADE-ADOLOPMENT guidance from Klugar et al. (2024) where an existing guideline is selected first and used to prioritise questions to underpin the new guidelines (Figure 3). In this method, other appropriate source guidelines can additionally be utilised for adaptation.

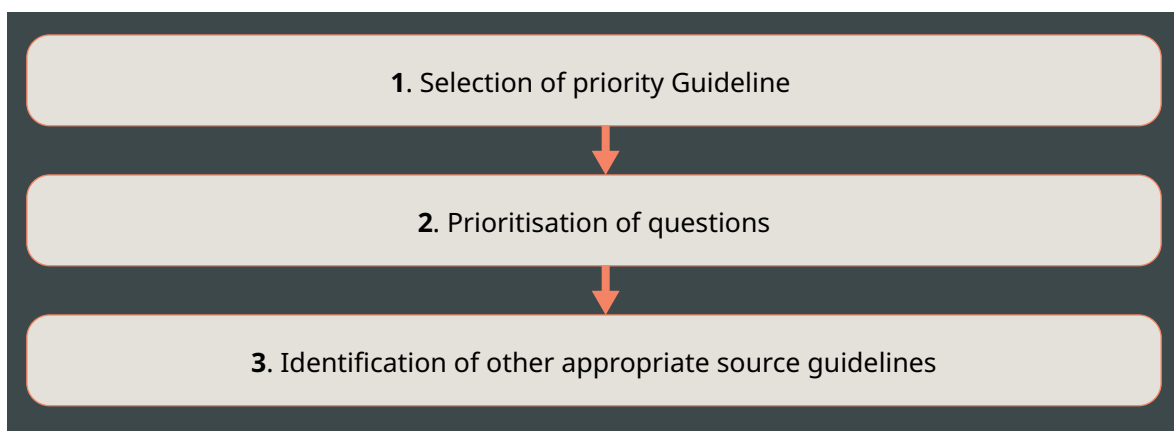
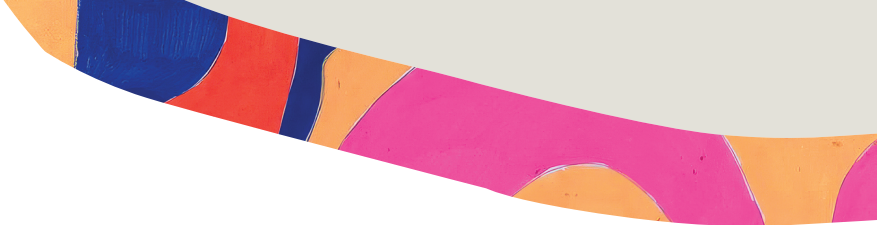


Figure 3. Approach to question prioritisation in the Trust Guide (Klugar et al., 2024)

In November 2025, the GDG met with the primary author of the Taking Time Framework to discuss its potential to be the priority guideline. It was agreed by the primary author of the Taking Time Framework, that its publication in 2015 warranted a recency and methodology update. The GDG and primary author of the Taking Time Framework agreed that the GRADE-ADOLOPMENT would provide enhanced methodological rigour through its systematic search methods, stakeholder collaboration, and Evidence-to-Decision frameworks.



Step 3.1: Formulating the initial questions

With the original author's permission, the priority guideline was used to formulate research questions that would underpin the Trust Guide. Using the aims, objectives, and recommendations of the Taking Time Framework, a set of 27 research questions were formulated. The questions were uploaded into a Qualtrics survey in three blocks (9 questions per block) where the Professionals-EAC (n = 7) ranked them in order of importance using a 7-point Likert scale (1 = not at all important, 3 = moderately important, 7 = extremely essential). The Professionals-EAC were invited to provide further feedback after each block of 9 questions via a free text box. The scores of each question were averaged and ranked to determine importance. The top 50% of questions (n = 14) were reviewed in detail by the GDG. When questions were conceptually similar, the lower rated question was removed. The 14 questions were collapsed into eight standalone themes. See Appendix 3.1 for the 14 questions organised by score and theme.

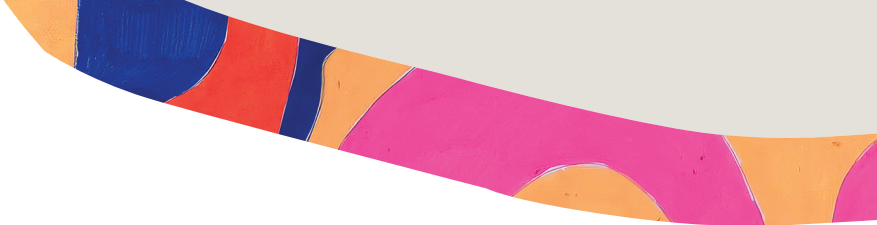
The eight themes were formatted into a draft set of PICO (population, interest/intervention, context) questions to guide the aims and objectives of the Trust Guide. Specific outcomes were not specified in the questions as they were primarily concerned with understanding the experiences of health care with people with intellectual disability and health service staff. See Appendix 3.2 for the initial eight research questions drafted by the GDG.

Step 3.2: Co-designing the questions with the Expert Advisory Committees

Following the formation of the draft questions was a key step of the co-design phase. The GDG presented the draft set of questions to the Professionals-EAC via email where they were invited to provide initial feedback. In November 2025, the GDG held the first of four virtual meetings with each Expert Advisory Committee to confirm the scope and questions that would underpin the guideline.

Professionals-EAC (Meeting 1)

The first Professionals-EAC meeting was facilitated by two members of the GDG. Six committee members attended via Microsoft Teams and participated in a semi-structured discussion on the draft research questions. Initially, the project scope and plan were introduced, then the eight questions were examined one by one. Expert Advisory Committee members were given the opportunity to provide their feedback and considerations. The semi-structured discussion took on a deductive approach where the Professionals-EAC discussed considerations relevant to each question, such as language, inclusiveness, and validity.



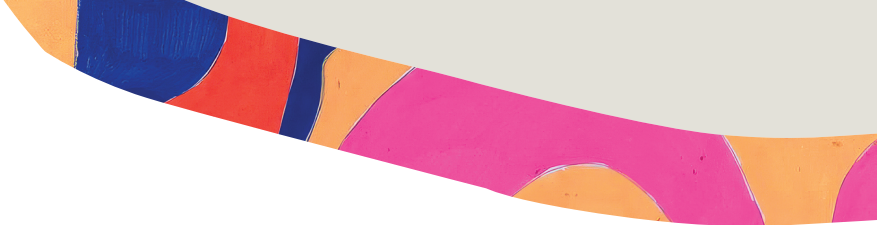
Living Experience-EAC (Meeting 1)

With the assistance of RDG, the research questions were collapsed into three broader questions and produced in Easy Read format. The Easy Read document was provided to the Living Experience-EAC three weeks prior to the scheduled meeting. This was to promote accessibility and participation in the meeting, as per advice from RDG who co-facilitated the meeting. Three Living Experience-EAC members (including RDG) attended the meeting and were queried on their living experience of health care to understand what makes it as safe as possible.

It was not explicitly revealed to the Living Experience-EAC that the project was related to trauma to avoid distress, a decision that was supported by RDG. Prior to the meeting, the Living Experience-EAC were provided with a resource offering options for mental health support. The online meeting was recorded, and the transcript was coded into key themes with supporting quotes (Table 10).

Table 10 Questions and key themes during the Living Experience-EAC Meeting #1.

Question	Theme and example quote
What helps people with intellectual disability feel safer and heard at the doctor or hospital?	1. Having a trusted person i. <i>"You may need like a parent with you or your cousin, for instance. Someone that can understand what the doctor's saying. You know who then can relay it back to you in words you actually understand."</i> 2. Clear communication and explanations i. <i>"For people with a disability or a hidden disability... make sure you have an understanding of what the doctor or the hospital is saying."</i> ii. <i>"It can be very frustrating if doctors talking and you don't understand what they're talking about."</i> 3. Comfort items and sensory supports i. <i>"if you're going for an MRI scan, let you keep your teddy with you like I was allowed to keep my teddy with me."</i>
What helps people get good care at the doctor or hospital?	1. Being included in decisions about own care i. <i>"most importantly, being involved in decision making... making sure the client's questions is being properly asked by the doctor instead of the doctor dodging questions or asking the family member instead of the person that needs to be asked [sic]"</i> 2. Everyone working together i. <i>"Had some communication with the physiotherapist and we all worked together as a team that helped a lot."</i> 3. Respect for privacy and boundaries i. <i>"...sometimes if they ask questions that are a bit out of nowhere, you want to know why maybe."</i>



Question	Theme and example quote
What helps people trust health workers?	1. Being friendly and building genuine rapport i. <i>"...having open body language as well because you don't want to talk to a GP or a doctor at the hospital when they've got that close body language."</i> 2. Honesty and reassurance i. <i>"If they don't reassure you, things are going to be fine. Things will be OK. If they don't say that, you're not going to want to trust them again."</i> 3. If health workers had better training about intellectual disability i. <i>"...they couldn't give a crap that I almost fell so they need like more training as well for people with an intellectual and hidden disability as well."</i> 4. Check ins following appointments i. <i>"I can understand that they're busy. But take like 5-, 10-, 20- minutes out of your day. Just to take someone for a walk so they're not developing blood clots..."</i>

Several themes emerged on what good and safe health care means to people with intellectual disability. These themes, representative of their living experience, further informed the co-design of the research questions underpinning the Trust Guide. A set of nine research questions was then finalised by the GDG (Table 11).

Step 4: Data extraction from source guidelines

Data extraction of the source guidelines was completed by one member of the GDG. The recommendations of each source guideline were collated and mapped onto the most relevant research questions of the Trust Guide. The mapping of the source recommendations was based on overall relevance, as well as the considerations that were proposed by the Expert Advisory Committees in Meeting 1. When available, evidence tables, and Evidence-to-Decision frameworks were extracted. Due to the breadth and heterogeneity of the evidence base, full GRADE Summary of Findings tables could not be developed for every source recommendation. Instead, evidence was summarised within the research question it was mapped to. Certainty ratings were extracted where feasible and limitations were documented. The methodology and findings of the source guidelines were discussed in detail among the GDG.

Table 11 The nine themes and research questions underpinning the Trust Guide.

Theme	Research Questions
Reduce traumatisation and re- traumatisation	How does health care that is trauma-informed improve experience and health outcomes for people with intellectual disability?
Prioritising voice, choice, and control	How should health services and staff prioritise and centre the voice, choice, and control of people with intellectual disability?
Facilitating compassion, responsiveness, and dignity	How should health services and staff facilitate compassion, responsiveness, and dignity with people with intellectual disability?
Capacity building and staff support	What training, support, and resources for trauma-informed care should be provided to health services and staff?
Emotional and psychological safety	How should health services and staff promote emotional and psychological safety with people with intellectual disability?
Person and/or family-centred approach	How should health services and staff provide health care that is person- and/or family-centred with people with intellectual disability?
Physical and environmental safety	How should physical and environmental safety be promoted by health services and staff during health care with people with intellectual disability?
Organisational and multidisciplinary collaboration	How should health organisations and multidisciplinary teams collaborate to improve the provision of trauma-informed care with people with intellectual disability?
System level policies and procedures	How should system level policies and procedures be developed to improve the provision of trauma-informed care with people with intellectual disability?

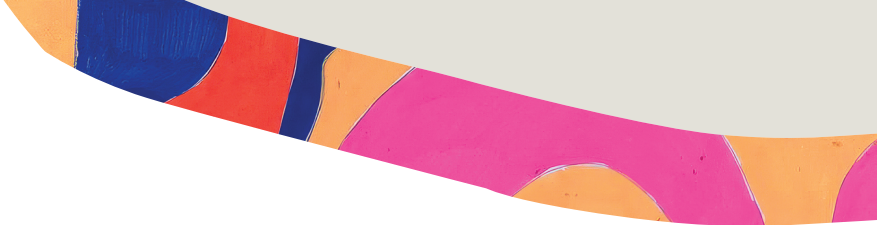
Step 5: Consideration of evidence supporting the source recommendations

Step 5.1: Evaluating the strength of the evidence

The next step considered the certainty and quality of the evidence supporting the source guidelines. The GDG further assessed which source recommendations could be appropriate in addressing the nine research questions of the Trust Guide. Since GRADE methods and Evidence-to-Decision frameworks were not consistently applied, the GDG additionally considered overall relevance, the type of evidence, and how it was summarised, synthesised and appraised, methods and transparency of guideline development, and additional requirements for contextualisation. A similar approach was used in the PREDICT Head Injury Guideline (Tavender et al., 2021) when source guidelines were not adequately based on GRADE-ADOLOPMENT.

It was decided that source guidelines using transparent and systematic methods would be considered higher quality and more suitable for adoption. Due to certainty ratings not being consistently available, source recommendations were categorised based on the quality of the available evidence (Hight & the Expert Working Group and Expert Subcommittees, 2023; Tavender et al., 2021). The categories were as follows:

- **Evidence-informed:** formulated from high-quality systematic review.
- **Consensus-based:** formulated in the absence of high-quality evidence, with or without expert consensus; or
- **Good practice statement:** unclear evidence and/or consensus only



Step 5.2: Co-sense making of the questions and evidence with the Expert Advisory Committees

Professionals-EAC (Meeting 2)

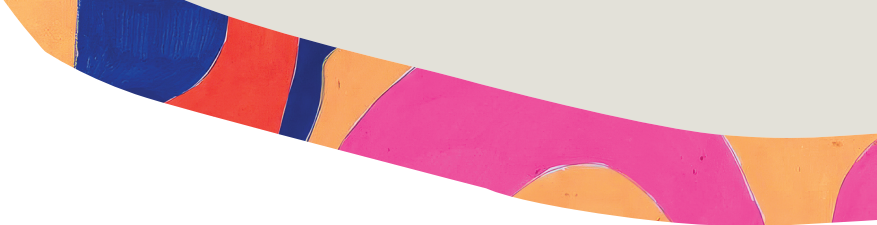
Prior to the second Professionals-EAC meeting, the source recommendations mapped to each Trust Guide theme were uploaded to a Qualtrics survey. The Professionals-EAC ranked them by importance from most important to least important. The meeting was facilitated by two members of the GDG and held on Microsoft Teams. Five members attended the meeting. The source recommendations were presented in order of ranking and reviewed for relevance and specificity. Recommendations that were deemed not relevant enough, or superseded by stronger, evidence-based recommendations were removed. The committee also considered how to best operationalise the recommendations and identified key areas that required further validation and/or contextualisation through evidence and/or living experience.

Living Experience-EAC (Meeting 2)

Rather than systematically discussing the available evidence already considered by the Professionals-EAC, the GDG considered advice from RDG which was to build upon the rich, living experiences that were elicited in the first meeting to further inform the recommendations of the Trust Guide. The GDG developed a set of four questions in Easy Read designed to build on the Trust Guide themes through deeper contextual meaning and living experience. These questions were designed to address some of the key considerations raised by the Professionals-EAC and co-developed in collaboration with RDG. The questions explored Trust Guide themes such as person-centred care, communication, reasonable adjustments, and choice and control. The questions were provided to the committee two weeks in advance, and the meeting was held online via Microsoft Teams. The meeting was recorded and the transcript was coded into key themes with supporting quotes (Table 12) to provide a deeper contextualisation of the recommendations and to start informing the implementation of the recommendations. Input from the committee was integrated into the relevant Evidence-to-Decision framework.

Table 12 Questions and key themes during the Living Experience-EAC Meeting #2.

Question	Theme and example quote
If someone with intellectual disability came to the hospital and they were very upset, what should health workers do?	1. Communication adjustments i. <i>"they could use a 'My Health Matters' folder ['a health folder about the patient themselves'] ... If the person doesn't feel comfortable talking to the doctor and they were really upset. They could hand over their My Health matters folder, so they don't have to speak directly."</i> ii. <i>"Having someone there explaining... the doctor will explain to the [support person] they're with and they will explain it better to their child or [person with intellectual disability] they're with."</i> 2. Physical and sensory adjustments to the environment i. <i>"If they're like real, like really little, they should take them into a room with like pictures on the wall, like, you know, Disney characters on the wall, a bucket full of toys under the bed..."</i> 3. Provide emotional support i. <i>"if you got a long stay they might be able to offer counselling or someone to talk to"</i>
How do you like your family and carers to be involved in your health care?	1. Choice around the involvement of family and carers i. <i>"I feel safer when mum's included, whether she's there or whether she just gets a phone call."</i> ii. <i>"I go with mum or carer. [If I go with carer] then mum gets notified."</i> 2. Do not let the involvement of family and carers be at the expense of the person with intellectual disability i. <i>"...they were happy to have their family and carriers to be involved in the health care. But they themselves would also like to be directly involved in, as well."</i> ii. <i>"there's been doctors that have been talking to family and friends that have left the client out themselves"</i>



Question	Theme and example quote
What can doctors and health workers do to make you feel like you have choice and control over your health care?	1. Health workers being transparent and establishing informed consent i. <i>"Just ask first. Like hey this is what I want to do, is this okay with you?... so at least then they have the chance to say, well, no, I don't agree with that or yeah, you can do it, but I want my mum in the room with me."</i> ii. <i>"...because of the anxiety, I like to be told like every step of the way, even when I go to the dentist."</i> 2. Not being overloaded with information i. <i>"Being asked so many questions all at once can get frustrating, especially someone who is verbal but they can get frustrated because they can't understand what the GP is trying to tell them...[Instead of lots of questions] I like being told what's going to happen"</i> 3. Being provided with accessible choices sensitive to needs i. <i>"someone's who's hearing impaired, they need to get one of the doctors or nurses that's on the same sort of level... even if the person can actually hear, but can [the health worker] sign as well?"</i>
How do health workers show respect to you?	1. Not being forced to do things i. <i>"Like, if you ask him to put a gown on... but they don't want to, you can then try and explain to them, but if they don't want to, don't force them."</i> 2. Having things directly and clearly explained i. <i>"Use simple language and be clear and concise"</i> ii. <i>"They need to be talking more to the patient."</i>

Step 6: Updating the evidence base

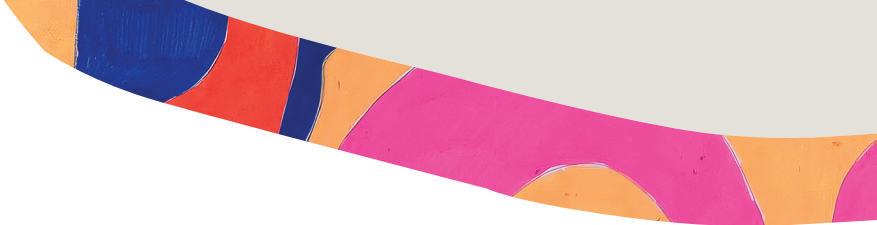
Step 6.1: Systematic review

Design and objectives

Due to the dearth of high-quality empirical data underpinning the source guidelines, an updated literature search and systematic review were undertaken in January 2026. There were two main objectives of the review:

1. To systematically summarise and synthesise the available literature on trauma-informed health care with people with intellectual disability,
2. Provide supporting evidence for the development of the Trust Guide's co-design approach to trauma-transformative practice.

To fulfil these objectives, it was decided that a framework-informed systematic review design would be utilised, alongside GRADE methods to ensure consistency with GRADE-ADOLOPMENT. Firstly, systematic review methods were used to identify, screen, appraise, and extract relevant literature. The nine Trust Guide themes were then used as a framework to structure the synthesis of data (Fife & Gossner, 2024). GRADE methods were then used to summarise and judge the certainty of the evidence for integration into the Evidence-to-Decision frameworks.



Search strategy

The search strategy was deliberately kept broad to capture all relevant literature on trauma-informed care with people with intellectual disability. The search was conducted in the following databases: PubMed, Embase, PsycINFO, and CINAHL. Searches were limited to 2015–2026, in line with the publication year of the priority guideline which warranted a recency update.

Search terms were developed in collaboration with a librarian. A combination of subject terms and key words were utilised. The first set of terms specified trauma-informed care and related terms with the use of proximity queries. The second set of terms included a more general set of trauma related terms, combined with care related terms. The two sets were combined and searched with intellectual disability and related subject headings and keywords.

Searches were kept at the title and abstract level. The setting was not strictly limited to health service settings, so long as the study involved the delivery of trauma-informed care by a medical or allied health practitioner (e.g. a social worker or positive behaviour support practitioner in a residential setting).

Only articles published in English were considered. See Appendix 4.1 for the full search strategy and Appendix 4.2 for the inclusion and exclusion criteria.

Screening and selection

The search identified 4,912 citations. After removal of duplicates, 3,831 articles were uploaded to Covidence for screening. A further five duplicates were removed by Covidence. See Figure 4 for the PRISMA strategy. Systematic review methodology was followed whereby two researchers independently screened by title and abstract and full text. Conflicts were resolved between the two researchers with input from a third when required. Following full-text assessment, 19 studies were included in the review (qualitative = 10, quantitative = 4, mixed methods = 5).

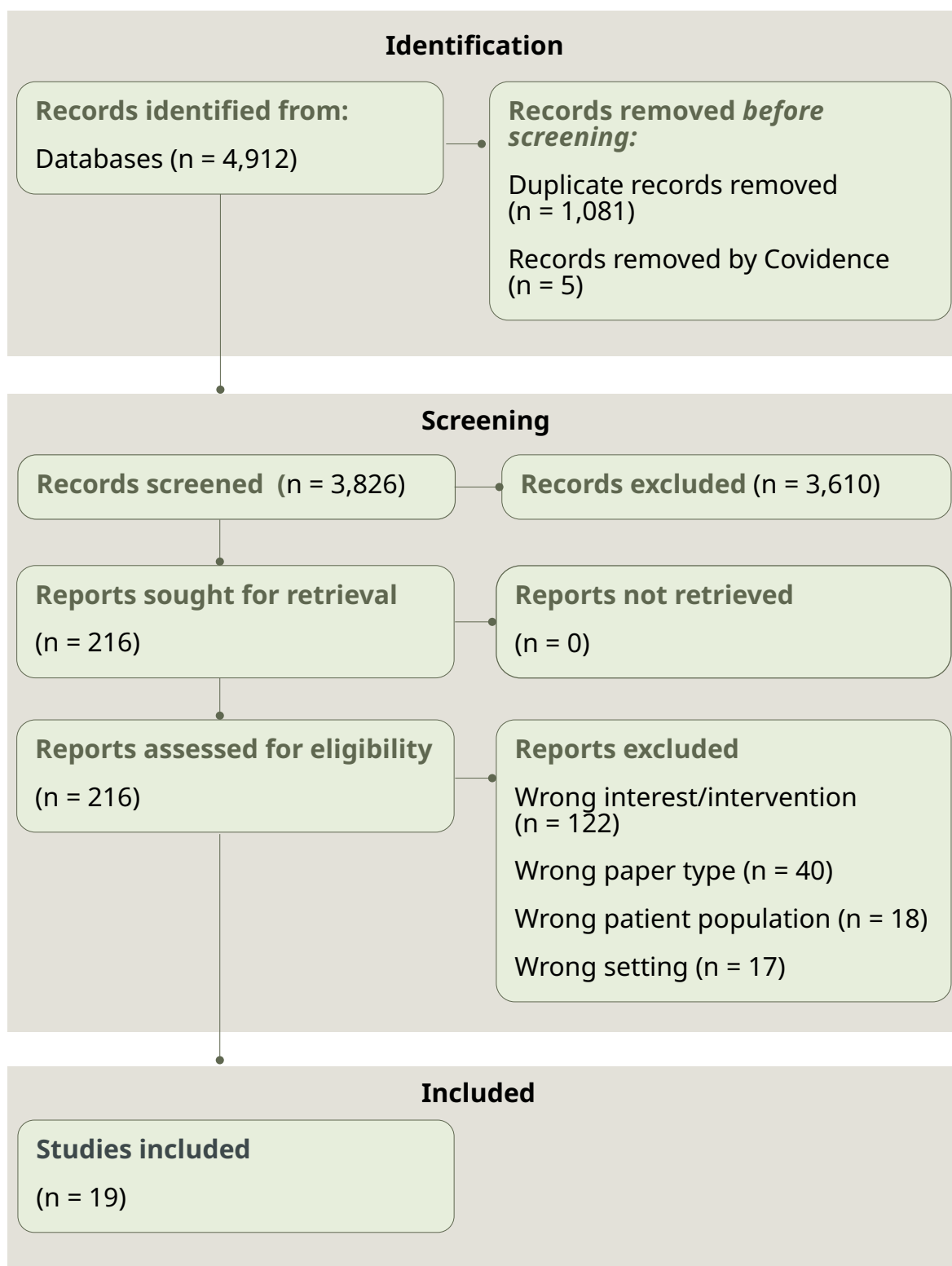
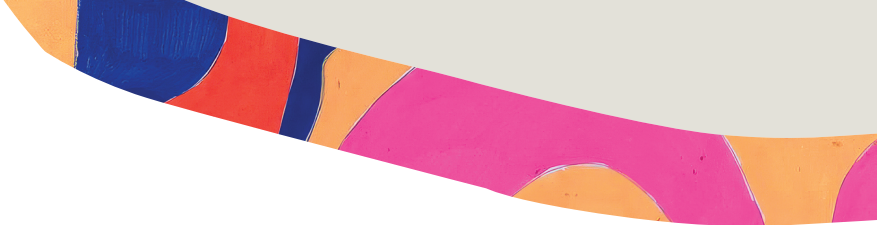


Figure 4. PRISMA flow diagram for the selection of studies.



Quality appraisal

The Mixed Methods Appraisal Tool (MMAT) was used to assess the methodological quality of the included studies. The MMAT was selected because it allows for the appraisal of qualitative, quantitative, and mixed-methods studies within a single review. This was appropriate for the current review because the evidence base included diverse study designs.

Appraisal was completed independently by two researchers. Following completion, conflicts were resolved through discussion, with input from a third reviewer where required. Overall scores were not calculated as suggested by the MMAT authors who discourage it in favour of transparency (Hong et al., 2018). Furthermore, the appraisal process was intended to support transparent interpretation of the individual studies mapped against the Trust Guide themes, rather than to exclude studies solely on the basis of quality. Appraisal findings could then be utilised to inform the interpretation of GRADE assessments. The quality assessment can be found below in Table 12.

Table 13 Quality assessment of included studies (MMAT).

Qualitative Studies	S.1	S.2	1.1	1.2	1.3	1.4	1.5
Keesler (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
McConnell & Phelan (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
McKenzie & Charlton (2025)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
McNally et al. (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
McNally et al. (2023)	Yes	Yes	Yes	Yes	No	Yes	Yes
Mokoena-de Beer et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
O'Malley et al. (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
O'Malley et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Punzi et al. (2026)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Truesdale et al. (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

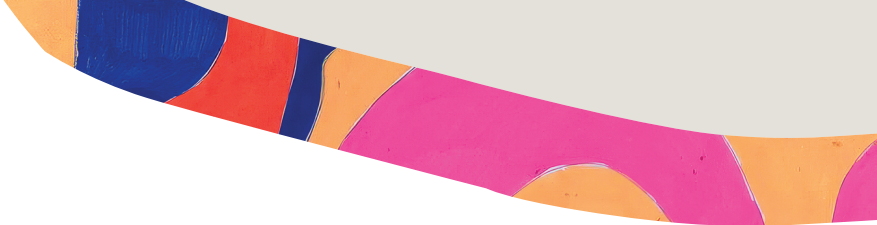
Quantitative non-randomized studies	S.1	S.2	3.1	3.2	3.3	3.4	3.5
Mercer et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Webb et al. (2021)	Yes	Yes	Yes	Can't tell	Yes	No	Can't tell
Quantitative descriptive studies	S.1	S.2	4.1	4.2	4.3	4.4	4.5
Presnell et al. (2022)	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes
Sullivan et al. (2025)	Yes	Yes	Yes	No	Yes	No	Yes
Mixed Methods Studies	S.1	S.2	5.1	5.2	5.3	5.4	5.5
Keesler et al. (2025)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Keesler & Isham (2017)	Yes	Yes	Yes	Yes	Yes	Yes	No
Luiselli et al. (2025)	Yes	Yes	Can't tell	Yes	Yes	Yes	No
Rich et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Strnadová et al. (2025)	Yes	Yes	Yes	Yes	Yes	Yes	No

Data extraction

Data were extracted from the included studies by three researchers using a structured form. Extracted information included author, year, country, setting, population, study design, aims, methods, sample characteristics, key findings, implementation implications, and relevance to the Trust Guide themes. Each study was mapped to one or more of the nine Trust Guide themes based on the study aim and reported findings. The characteristics of the included studies can be found in Table 15. Following extraction, the data for each study were discussed in detail between two of the researchers who completed the extraction.

Data analysis and synthesis

Qualitative data were analysed with a deductive approach (Fife & Gossner, 2024). Qualitative themes, findings, and supporting quotes were iteratively coded within their Trust Guide theme to establish evidence supporting or not supporting the Trust Guide theme. Quantitative data were summarised narratively due to heterogeneity in study design. A narrative synthesis of the findings within each Trust Guide theme was then completed (Popay et al., 2006). The synthesised findings along with a description are in Table 16.



GRADE assessment

Once synthesised qualitative and quantitative findings were established for the Trust Guide themes, GRADE methods were used to judge the certainty of the evidence. For qualitative findings, GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative Research) was used (Lewin et al., 2018). Evidence was judged on methodological limitations, relevance, coherence, and adequacy of the data with any concerns rated: no/very minor, minor, moderate or serious. Overall confidence was judged either high, moderate, low, or very low. Findings started as 'high confidence' and were judged down by one or more levels by the GDG based on concern. The full CERQual tables can be found in Appendix 4.3.

For the narratively synthesised quantitative findings, the approach took guidance from Murad et al. (2017) due to the absence of a single estimate of effect. The criteria and its implementation are outlined in Table 14. The overall judgement on the certainty of evidence for the quantitative findings started as "low", due to the observational nature of the included studies (Schünemann et al., 2019). Studies were rated down based on concerns with the criteria in Table 14. The full GRADE tables can be found in Appendix 4.4.

Table 14 Guidance for judging certainty of evidence with narratively synthesised findings (Murad et al., 2017).

GRADE criteria	How it was applied
Methodological limitations of the studies	Judged risk of bias across studies for each outcome, considering study size, risk of bias, and its likely impact on the summarised effect.
Indirectness	Made an overall judgement on how well the available evidence matched the review objectives, considering differences in population, intervention, and outcomes across studies.
Imprecision	Considered sample size relative to Murad et al.'s (2017) supposed threshold of ~400 participants/events, confidence intervals, and effect sizes.
Inconsistency	Judged inconsistency by comparing the direction and magnitude of effects across studies, treating widely differing estimates as evidence of inconsistency. The majority of studies did not include comparable effect sizes; therefore, inconsistency could not always be judged.

Table 15 Study characteristics of included studies.

Author (year)	Aim	Setting	Participants	Intervention / Exposure / Interest	Data collection and analysis
Qualitative					
Keesler (2016)	Explored staff perceptions, understanding and experiences of trauma-informed care (TIC) within a trauma-informed day programme.	Trauma-informed day program in the United States.	20 staff members (17 currently employed).	TIC delivered as whole-system organisational change via an 18-month online learning collaborative.	Semi-structured interviews (conducted ~19 months into programme). Inductive, iterative constant comparative analysis with systematic and open coding.
McConnell & Phelan (2022)	To generate guiding principles/ domains of support for social services workers assisting women with intellectual disability after leaving abusive relationships.	Social services (including social work) in Canada.	5 social workers.	Women with intellectual disability exposed to intimate partner violence and abuse.	Responsive interviews. Qualitative descriptive analysis with open coding and iterative category development.
McKenzie & Charlton (2025)	To explore how adults admitted to forensic intellectual disability/ mental health services experience TIC principles in the absence of specific TIC training.	Forensic intellectual disability (FID) and forensic mental health (FMH) inpatient service in the United Kingdom	10 adults (aged 37–58, mean = 44.7) 2 in acute FMH unit, 3 in acute FID unit, 5 in rehabilitation FID unit (6 of 8 FID unit participants had an intellectual disability diagnosis).	The experience of TIC and its guiding principles.	Focus groups. Reflexive thematic analysis.
McNally et al. (2022)	To explore direct care workers', managers' and specialist practitioners' understanding of trauma, trauma interventions and TIC for adults with ID in residential services.	Community residential services (direct care and specialist allied health support) for adults with intellectual disability in the United Kingdom	32 participants (13 specialist practitioners, 8 direct care workers, 11 managers).	The experience of TIC principles within the service.	Remote semi-structured 1:1 interview. Framework analysis.

Author (year)	Aim	Setting	Participants	Intervention / Exposure / Interest	Data collection and analysis
McNally et al. (2023)	To co-produce a TIC framework for staff in residential services for adults with intellectual disability by exploring lived experience of TIC principles.	Residential and supported living services in Northern Ireland, United Kingdom	7 adults with intellectual disability (residents 8–26 years); 7 stakeholders (4 practitioners, 3 managers).	The experience of TIC principles within the service.	Two-stage design: focus groups/ interviews with residents (converted to individual interviews) plus 6 monthly co-production workshops with staff. Thematic analysis, iteratively refined with stakeholders.
Mokoena-de Beer et al. (2024)	To explore nurses' experiences of interpersonal violence when caring for people with intellectual disability and identify training/ support needs.	Psychiatric hospital, long-term intellectual disability units in South Africa.	16 nurses (10 female, 6 male; 2–16+ years of experience).	Nurses' exposed to interpersonal violence when caring for persons with intellectual disability.	Hermeneutic phenomenological interviews. Thematic analysis with independent coder and member checking.
O'Malley et al. (2019)	To establish what (particularly psychology) supports were available to adults with intellectual disability who experienced sexual abuse, and how these were experienced.	One voluntary community intellectual disability service (day/residential) in Ireland.	6 adults with mild-moderate ID (4 female, 2 male; aged 30–65).	Approach to violence-informed care to support individuals with intellectual disability who have been sexually abused.	Retrospective collective case study with a file review and interview. Factual descriptive analysis followed by conceptual analysis.
O'Malley et al. (2020)	To explore how clinical psychologists support adults with ID who experienced sexual/ other abuse, including service responses, therapy approaches/ processes, and barriers/ facilitators.	Four community-based adult intellectual disability services in Ireland.	6 clinical psychologists (<1–15 years of experience with intellectual disability).	Approach to violence-informed care to support individuals with intellectual disability who have been sexually abused.	Semi-structured telephone interviews from a transcendental, phenomenological perspective. Semantic and latent thematic analysis.
Punzi et al. (2026)	To examine how professionals/ agency representatives identify violence toward people with intellectual disability and provide care, and what is needed to improve identification, support, treatment and inter-agency cooperation.	Agencies in social service, school education, health care, police and prosecution authorities, government authorities., and NGOs in Sweden.	34 participants from 26 agencies.	Violence-informed approaches with people with intellectual disability exposed to violence.	Semi-structured interviews (in-person/Zoom, 40–120 min). Qualitative content analysis.

Author (year)	Aim	Setting	Participants	Intervention / Exposure / Interest	Data collection and analysis
Truesdale et al. (2019)	To explore intellectual disability health care professionals' views on service provision for people with intellectual disability and traumatic stress.	Specialist intellectual disability services in the United Kingdom	25 health practitioners (psychiatrists, nurses, allied health professionals, social workers; ~11 years of experience in intellectual disability).	Traumatic stress in people with intellectual disability.	Individual interviews (phone/face-to-face, 10–40 min). Thematic analysis.
Quantitative					
Mercer et al. (2023)	To investigate the prevalence of adverse childhood experiences (ACEs) in staff working with people with intellectual disabilities, and to examine the predictive role of ACEs, resilience and trauma-informed organisational climate (TIC) on staff burnout and secondary traumatic stress (STS).	Independent care agencies for people with intellectual disabilities in the United Kingdom	110 staff (73.4% female, 25.7% male; mean age 41.55 years, SD 12.36); mean 7.59 years in current role).	Perceived trauma-informed organisational climate, alongside ACEs and resilience, examined as predictors of burnout and STS.	Single-timepoint cross-sectional online survey (Qualtrics); no follow-up. Measures: ACE Checklist, Response to Stressful Experiences Scale (RSES-4), ProQOL (burnout, STS), Trauma-Informed Climate Scale (TICS-10). Descriptive statistics; Kendall's Tau-b correlations; bootstrapped hierarchical multiple regression; moderation/mediation analyses.
Presnell et al. (2022)	To understand alignment between current intellectual and developmental service practice and TIC, in order to inform implementation strategies.	Disability support organisations (non-healthcare setting), in one state of the United States.	288 participants from 53 service providers.	TIC as experienced within the organisation.	Cross-sectional online questionnaire Descriptive percentage analysis.
Sullivan et al. (2025)	To survey functional analysis (FA) researchers/presenters on use of FA strategies aligned with trauma-informed care commitments.	Functional behaviour analysis clinicians and researchers in the United States.	42 respondents: 26 FA corresponding authors, 16 TIC conference presenters.	FA modification strategies aligned with 4 TIC commitments (acknowledge trauma, ensure safety/trust, promote choice/governance, emphasise skill-building).	Cross-sectional online REDCap survey. Descriptive percentage analysis.

Author (year)	Aim	Setting	Participants	Intervention / Exposure / Interest	Data collection and analysis
Webb et al. (2021)	To examine the trauma-related needs of staff working in developmental disorder services within a secure psychiatric inpatient setting.	Secure mental health organisation (medium/low secure, specialist rehabilitation) in the United Kingdom.	278 clinical staff accessing an internal Trauma Support Service (102 in developmental disorder (DD) pathways, 176 in non-DD services).	Experiences of aggression and trauma, and use of an internal Trauma Support Service.	Retrospective extraction of routinely collected Trauma Support Service data (2018–2020). Non-parametric tests (Mann-Whitney U, Kruskal-Wallis H, Fisher's Exact, Chi-square).
Mixed Methods					
Keesler et al. (2025)	To describe and evaluate an 18-month national learning collaborative designed to support system-wide TIC change across intellectual/developmental disability organisations.	Four nonprofit intellectual and developmental disability organisations (residential, day, behavioural, vocational, foster care, psychiatric residential, nursing, group home settings) in the United States.	Baseline staff survey n=374 (follow-up survey n=172). Organisation liaisons also completed a post-intervention survey.	TIC delivered via whole-system 18-month learning collaborative (leadership engagement, TIC task forces, staff training, train-the-trainer, coaching).	Multi-method: pre/post staff surveys, liaison survey, process notes. Linear mixed models (R) with organisation random intercepts; qualitative thematic analysis mapped to TIC domains.
Keesler & Isham (2017)	To explore staff understanding/experience of TIC within a trauma-informed day program and examine integration of TIC principles.	Trauma-informed day program (Mon–Fri, ~1:1 staff-to-client ratio) in the United States.	20 staff (nurses/care staff) and 16 adults with intellectual and developmental disabilities.	TIC delivered through program design and daily operation (staff training, transition period, relationship-building, shared decision-making, daily reflective meetings).	Pre/post comparisons (TIC principles at 4 vs 16 months; behaviour at first vs last 3 months) using between-groups/paired t-tests. Semi-structured staff interviews analysed via constant comparative method.

Author (year)	Aim	Setting	Participants	Intervention / Exposure / Interest	Data collection and analysis
Luiselli et al. (2025)	To survey Board Certified Behaviour Analysts' (BCBAs) attitudes/opinions on TIC for people with intellectual and developmental disability, including training, supervision, implementation experience, and compatibility with behaviour-analytic practice.	One human services organisation (day/residential programs) operating across several states of the United States.	67 BCBAs invited; 65 completed the survey.	Staff's education and experience with TIC.	Online anonymous cross-sectional survey (SurveyMonkey). Descriptive quantitative analysis plus consensus coding of open-ended responses into 4 thematic categories.
Rich et al. (2021)	To explore the perspectives of intellectual and developmental disability service system staff on whether/how TIC philosophy is impacting their organisation, and barriers to improving trauma responses.	Intellectual and developmental disability organisations across 40 U.S. states and 2 Canadian provinces.	130 participants from over 100 organisations.	Integration of TIC within disability service systems.	Cross-sectional survey with descriptive and percentage analysis. Qualitative open coding mapped to Bronfenbrenner's ecological layers.
Strnadová et al. (2025)	To co-produce and evaluate the GeneEQUAL Toolkit, an educational toolkit supporting safe, high-quality and inclusive genetic health care for people with intellectual disability.	Genetic health care services in Australia.	74 clinicians (from 120 consented) 21 clinicians (interviews). 15 people with intellectual disability + 1 support person (focus group).	Experiences implementing and engaging with the GeneEQUAL Toolkit (includes TIC as one key learning principle).	Post-pre clinician survey plus interviews and focus group. Descriptive statistics, paired t-tests, Cronbach's alpha, inductive content analysis; mixed-methods integration via COM-B framework.

Qualitative Findings	Studies contributing to the theme	Overall confidence rating	Explanation of judgement
Recommendation 1: Know that people with intellectual disability often experience more trauma in their lives than other people.			
<i>Recognising trauma's pervasiveness requires staff understanding of its causes - and that understanding also protects staff.</i> Trauma is pervasive among people with intellectual disability and often inherent to standard healthcare/institutional experiences. Access to TIC should not depend on a confirmed history. This requires staff to understand trauma's causes and recognise its presentations, which both enables TIC delivery and protects staff themselves when impacted by workplace violence.	Keesler (2016); Keesler & Isham (2017); McNally et al. (2023); Mokoena-de Beer et al. (2024); Punzi et al. (2026); Strnadová et al. (2025)	Moderate	Rated down one level due to minor concerns about methodological limitations, relevance, and adequacy of data.
<i>Trauma is easy to miss, and standard practice itself is not yet consistently equipped to catch it.</i> Trauma presentations are often subtle and easily missed or misattributed appearing as self-harm, anxiety, agitation, avoidance, mood changes, or behaviour simply labelled "challenging." TIC itself remains inconsistently defined and under-researched in some practice areas, limiting the ability of healthcare staff to reliably identify and respond to trauma.	Keesler (2016); Luiselli et al. (2025); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026); Truesdale et al. (2019)	Moderate	Rated down one level due to minor concerns about methodological limitations, adequacy of data and moderate concerns about relevance.
Recommendation 2: Centre the voice and choice of the person with intellectual disability in all health care interactions.			
<i>Choice and autonomy support empowerment and inclusive practice.</i> TIC approaches that emphasised choice, refusal, autonomy and self-exploration (rather than compliance) were linked to feelings of empowerment, staff inspiring hope, and more communicative, inclusive practice.	Keesler (2016); Keesler & Isham (2017); McKenzie & Charlton (2025); McNally et al. (2023); Rich et al. (2021); Strnadová et al. (2025)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Genuine choice depends on relational trust and communication.</i> Autonomy was only meaningful when grounded in relational safety such as, safety planning, supportive relationships, basic needs being met, and being kept informed of things in advance built the trustworthiness needed for real choice.	Keesler (2016); McConnell & Phelan (2022); McKenzie & Charlton (2025); McNally et al. (2023)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Restricting or invalidating autonomy causes harm and conflict.</i> Choice was sometimes constrained despite its importance; external restrictions, infantilising treatment, discrimination and invalidating identities removed autonomy and were linked to conflict.	McKenzie & Charlton (2025); McNally et al. (2023)	Moderate	Rated down one level due to minor concerns about methodological limitations, relevance, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Overall confidence rating	Explanation of judgement
<i>Genuine voice requires active effort against disbelief and opportunities for disclosure.</i> People with intellectual disability are often disbelieved, invalidated or treated as unreliable, and are prone to acquiescence/suggestibility. Clinicians and services must actively listen, validate, check consent and understanding, and build accessible ways for people to disclose distress, violence, and preferences.	O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
Recommendation 3: Focus on the person with intellectual disability, working together with family or support people to balance everyone's needs.			
<i>Person-centred care is recognised by health professionals as a defining feature of trauma support through the way it can be adapted to support each person's individual identity and context.</i> Health professionals identified person-centred care as key to supporting trauma. It involved tailoring support to disability level, communication, gender, culture, migration background, socioeconomic context and support networks, underpinned by supportive relationships and safety planning that fostered relational autonomy.	McConnell & Phelan (2022); Punzi et al. (2026); Truesdale et al. (2019)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Non-judgemental, empathic, connection-focused approaches reduce vulnerability and isolation.</i> Reduced vulnerability was supported by nonjudgemental attitudes and empathic approaches, respected privacy, and connection and belonging fostered through social activity. Staff could further inspire hope and support the formation of new skills and coping strategies.	McKenzie & Charlton (2025)	Low	Rated down two levels due to only one study contributing to the finding, and moderate concerns about relevance and adequacy of data
Recommendation 4: Support health workers to deliver safer care through evidence-based training and resources.			
<i>Effective training must be specialised, dual-focused, and embedded from the tertiary through to leadership level.</i> Training needed to be embedded from graduate education through fieldwork, continuing education and ongoing professional development, covering both trauma and intellectual disability rather than one or the other, and supported by clear evidence, guidance and reflective practice.	Keesler (2016); Luiselli et al. (2025); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026); Truesdale et al. (2019)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Overall confidence rating	Explanation of judgement
<i>Training alone is insufficient without ongoing organisational support and attention to staff wellbeing.</i> TIC change relied on more than training alone. Increased trauma-informed language, staff interpreting behaviour differently, and genuine trauma knowledge among staff were needed to support training. Sustaining safe practice also required ongoing staff wellbeing support (including psychological help) and practical organisational backing (management support, increased staffing, shorter rotations in high-intensity settings).	Keesler (2016); McNally et al. (2023); McNally et al. (2022); Mokoena-de Beer et al. (2024); Rich et al. (2021)	Moderate	Rated down one level due to minor concerns about methodological limitations, and moderate concerns about relevance.
Recommendation 5: Build a culture where everyone feels safer and valued.			
<i>Trust, consistency, and emotional safety are central to a trauma-informed culture and to recovery.</i> Creating a safe environment was seen as integral to TIC, with safety linked to helpful staff as well as physical surroundings, and staff themselves needing more attention to their own wellbeing. Trust, consistency, predictability, validation, safe endings, and explicit protection from retraumatisation were identified as central, with trust, confidence, emotional safety and stable relationships also seen as central to recovery specifically.	Keesler (2016); McNally et al. (2023); McNally et al. (2022); O'Malley et al. (2020); O'Malley et al. (2019)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Relational factors can build or remove a sense of safety.</i> A sense of physical and emotional safety was promoted by reduced vulnerability, nonjudgemental attitudes, empathic approaches, respect for privacy, and clear, transparent, consistent boundaries, alongside advocacy and supportive relationships. Where privacy was breached, this directly undermined safety, producing uncertainty, confusion and mistrust.	Keesler (2016); McConnell & Phelan (2022); McKenzie & Charlton (2025)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Overall confidence rating	Explanation of judgement
<i>A trauma-informed culture must extend safety to staff as well as service users, and is shaped by structural and cultural barriers.</i> Safety was more than just a service-user concern. Violence between patients, self-injury and violence toward nurses all affected the wider care environment, meaning safety needed to include staff as well as people with intellectual disability, reinforced by the need for staff self-care and burnout prevention. Culture and stigma were identified as macro-level barriers to embedding a trauma-informed culture.	Keesler et al. (2025); Keesler (2016); Mokoena-de Beer et al. (2024); Rich et al. (2021)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
Recommendation 6: Make the service environment more inclusive and accessible.			
<i>Create more accessible environments (imagery, visual techniques, flexible pacing, and non-verbal approaches) that support sensory and communication needs.</i> Participants felt safer when staff knew their needs and the physical environment was safe and sensory-friendly. Accessible, flexible approaches, for example, imagery, visual techniques, flexible pacing, non-verbal methods, made support more accessible and adapted to communication needs.	Keesler (2016); McNally et al. (2023); O'Malley et al. (2019); Punzi et al. (2026)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Reasonable adjustments are a necessary, practical component of trauma-informed care, and staff benefit from structured support to deliver them.</i> Reasonable adjustments were identified as necessary when caring for people with trauma. Structured guidance helped staff put adjustments into practice.	Keesler (2016); Strnadová et al. (2025); Truesdale et al. (2019)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
Recommendation 7: Ensure different health workers, services, and systems stay connected and work together.			
<i>Coordinated pathways across services, professions and sectors are needed to prevent people falling through gaps.</i> TIC could not be left to isolated services. It needed coordinated pathways across psychology, psychiatry, social work, safeguarding, legal systems, residential/day services, families, health, police, schools and NGOs so no one falls through the gaps. TIC was reported as requiring collaboration at the organisational level, with multidisciplinary clinicians and organisations working together.	Keesler (2016); McNally et al. (2023); McNally et al. (2022); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026); Truesdale et al. (2019) High	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Overall confidence rating	Explanation of judgement
<i>Collaborative model encouraged cross-organisation learning and integration of TIC across clinical, residential, behavioural, and leadership systems.</i> Inconsistency between different settings created implementation problems for TIC. Within settings, staff relied heavily on teamwork, communication, handover knowledge and shared planning to manage risk day to day.	Keesler (2016); Keesler & Isham (2017); Mokoena-de Beer et al. (2024)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
Sustaining collaboration requires dedicated organisational structures and addressing community-level barriers. Key changes supporting whole-system TIC included establishing task forces and champions to drive collaboration. At a broader level, community-level barriers were identified as a main obstacle to TIC, pointing to a need for better collaboration between organisations and the wider community, not just between services.	Keesler (2016); Keesler et al. (2025); Rich et al. (2021)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
Recommendation 8: Establish strong, positive leadership and a committed workforce.			
<i>Leadership engagement, buy-in and style were either facilitators or barriers to TIC.</i> Stronger leadership engagement was a key driver of TIC, with broad buy-in being required. Success depended on leadership style, whether it fostered staff empowerment, shared decision-making, communication and training. Absence of leadership was identified as a macro-level barrier.	Keesler (2016); Keesler et al. (2025); Keesler & Isham (2017); McNally et al. (2023); Rich et al. (2021)	Moderate	Rated down one level due to minor concerns about methodological limitations, relevance, and adequacy of data.
<i>Sustaining TIC requires adequate workforce structures, staffing, and governance, not leadership commitment alone.</i> Nurses called for more staff, better staffing ratios, committed staff, management support, and appropriate rotation arrangements. More broadly, services needed clearer role definitions, policies, governance, specialist pathways, and workforce structures that prevented a “catch all” overload on individual staff or services.	Keesler (2016); Mokoena-de Beer et al. (2024); O'Malley et al. (2020)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Overall confidence rating	Explanation of judgement
Recommendation 9: Treat everyone with respect, compassion, and kindness.			
<i>Respect and compassion are enacted through relational practices that build the trust needed to manage distress and foster belonging.</i> Respect meant believing people, protecting privacy, validating experience, explaining care clearly, and avoiding dismissive or coercive engagement and was underpinned by mutual trust, patience and repeated opportunities for disclosure. This translated into advocacy, safety planning, relational autonomy and belonging, with relationships central to managing distress and helping people co-regulate.	Keesler (2016); McConnell & Phelan (2022); McKenzie & Charlton (2025); McNally et al. (2023); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Compassion needs organisational support. A lack of either was experienced by people with intellectual disability.</i> A nurse's "duty to care" reflects the importance of compassion, but compassion cannot rely on individual staff endurance alone; it needs organisational support to be sustainable. Reflecting the gap between this ideal and reality, people with intellectual disability often reported not feeling respected.	Mokoena-de Beer et al. (2024); Strnadová et al. (2025)	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

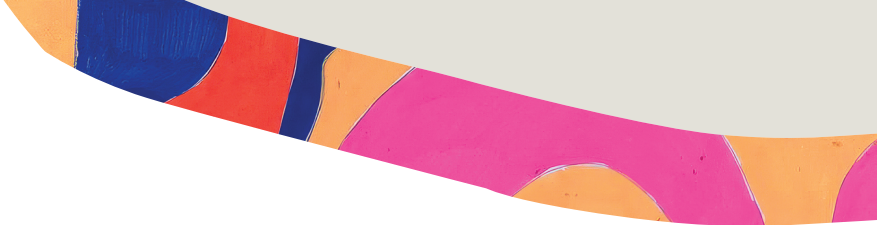
Quantitative Outcomes	Studies contributing to finding	Certainty in the evidence	Explanation of judgement
Recommendation 1: Know that people with intellectual disability often experience more trauma in their lives than other people.			
<i>Trauma is widely recognised as relevant and impactful, but is not consistently translated into consistent understanding or implementation.</i> Nearly all participants (92.2%) in Luiselli et al. (2025) agreed TIC is relevant to intellectual and developmental disability practice. This was supported by Presnell et al. (2022) where 93% of their sample agreed trauma can have lasting impact. However, 72.2% of the sample from Presnell et al. (2022) agreed it was not consistently defined or practiced. Findings from Rich et al. (2021) and Sullivan et al. (2025) supported this finding that most organisations did not fully understand trauma, and relatively low trauma-informed modifications rates among behaviour analysts, respectively.	Luiselli et al. (2025); Presnell et al. (2022); Rich et al. (2021); Sullivan et al. (2025); Webb et al. (2021)	Very low 	The finding started as low due to being observational. It was rated down due to risk of bias and concerns around indirectness and imprecision. The finding was therefore rated down. Inconsistency could not be measured.
<i>Awareness was unevenly distributed by role. Frontline staff were less aware than clinical/managerial staff.</i> Presnell et al. (2022, n=288) found formally trained clinical staff, directors and managers to be significantly more aware than non-practitioners (e.g. direct support professionals) of clients' trauma exposure risk. Direct support professionals were also less likely to recognise that staff can be triggered by challenging behaviour.	Presnell et al. (2022)	Very low 	The finding started as low due to being observational. It was judged as having only small concerns regarding indirectness and imprecision. Inconsistency could not be measured. Due to only one study being included, the risk of bias was high and the finding was rated down.
Recommendation 2: Centre the voice and choice of the person with intellectual disability in all health care interactions.			
<i>Choice/shared governance is broadly endorsed in principle, but implementation is partial and dependent on procedural burden.</i> One third of Luiselli et al.'s (2024) sample agreed TIC allows choice. When looking at the operationalisation of choice, however, Sullivan et al. (2025) found overall modification rates of 47.54% (client-facing) and 40.50% (therapist-facing). On a more granular level, 65.87% considered client/caregiver preference, but fewer implemented higher-burden practices such as client assent (43.03%), therapist preference in design (41.11%) and social validity data collection (39.9%).	Luiselli et al. (2025); Sullivan et al. (2025)	Very low 	The finding started as low due to being observational. It was rated down due to risk of bias and concerns around indirectness and not being able to measure inconsistency. Inconsistency could not be measured.
<i>Measured change in TIC principles pre/post TIC implementation trended downwards, except collaboration.</i> Keesler & Isham (2017) found no significant pre/post difference in relevant scores of TIC principles among staff. All measures trended downwards, except collaboration.	Keesler & Isham (2017)	Very low 	The finding started as low due to being observational. It was judged as mostly having concerns regarding risk of bias due to being the only study, and imprecision. Inconsistency could not be measured. The finding was therefore rated down.

Quantitative Outcomes	Studies contributing to finding	Certainty in the evidence	Explanation of judgement
Recommendation 3: Focus on the person with intellectual disability, working together with family or support people to balance everyone's needs.			
N/A	N/A	N/A	N/A
Recommendation 4: Support health workers to deliver safer care through evidence-based training and resources.			
<i>Formal TIC-specific training coverage is limited and inconsistent, despite strong endorsement that it should be prioritised.</i> Nearly all of Luiselli et al.'s (2024) sample reported "no" to "not much" TIC-specific coursework/supervised practice. Furthermore, 70–80% reported little training, continuing education attendance, or literature engagement, despite 93.8% agreeing TIC should be emphasised in training. A disconnect in training was echoed by findings from Rich et al. (2021) who found that 50% of organisations had trained less than a quarter of their staff, despite only a quarter of the organisations admitting that their staff understood TIC. Inconsistencies around TIC-specific training were found by Presnell et al. (2022) where only slightly more than half the sample felt trauma was covered in their organisation's training, despite 88% having background training in abuse and neglect. Mercer et al. (2023) found a similar picture with 75.2% of staff not receiving trauma-informed care training (though 59.6% had received training in positive behavioural support). Interestingly, PBS or TIC training did not significantly predict staff burnout or secondary traumatic stress once other factors were accounted for.	Luiselli et al. (2025); Mercer et al. (2023); Presnell et al. (2022); Rich et al. (2021)	Low 	The finding started as low due to being observational. There were concerns regarding risk of bias and indirectness. Imprecision was judged as acceptable. Inconsistency could not be measured.
<i>Uptake for practical, coaching-type supports is higher than dedicated wellbeing support.</i> Sullivan et al. (2025) found that behavioural analysts were more commonly emphasising 'skill building' modifications to their practice, followed by self-care (69.71%), self-advocacy (60.82%), then professional development focused on wellness (36.78%) and compensated wellness time (21.63%).	Sullivan et al. (2025)	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision due to small sample size. The finding was therefore rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Certainty in the evidence	Explanation of judgement
<i>Structured training/support interventions show measurable positive impact on staff confidence, attitudes, and capability over time.</i> Keesler et al. (2025) found scales of TIC climate (ARTIC-10 and TICS-10) scores, staff attitudes, and burnout (in unadjusted models) improved significantly over time, though compassion satisfaction and secondary traumatic stress did not improve consistently. Strnadová et al. (2025) found 95-96% of staff endorsed a TIC toolkit as effective and practice-improving, with statistically significant gains in self-reported capability, opportunity and motivation.	Keesler et al. (2025); Strnadová et al. (2025)	Low 	The finding started as low due to being observational. There were some concerns due to risk of bias and imprecision. Inconsistency could not be measured.
<i>Staff wellbeing-support utilisation and outcomes were broadly similar regardless of service type.</i> Webb et al. (2021) found no significant differences between developmental disability (DD) clinic and non-DD staff in psychological need severity, and while non-DD staff were more likely to need onward referral (p=0.02), overall need was low in both groups (DD: 2%; non-DD: 8.5%); return-to-work and TSS re-engagement rates were also broadly comparable between groups.	Webb et al. (2021)	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision and was therefore rated down. Inconsistency could not be measured.
Recommendation 5: Build a culture where everyone feels safer and valued.			
<i>Staff felt their organisation's culture around trauma was improving, but this seemed to be about time passing rather than anything specific to their organisation.</i> Keesler et al. (2025) followed staff at four disability organisations over time and found they increasingly felt their workplace understood and responded to trauma well. But this improvement did not line up with any particular organisation doing better than another, rather it seemed to happen with more time and experience. Experience of TIC was also a key characteristic of Luiselli et al.'s (2024) sample of 65 behaviour analysts who nearly all agreed that building trust and a sense of security is a core part of their job when practising TIC.	Keesler et al. (2025); Luiselli et al. (2025)	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision and was therefore rated down. Inconsistency could not be measured.
<i>Safety practices such as having a clear point to stop a session, or a safety plan, were common, and reduced harm.</i> In a TIC day program, Keesler & Isham (2017) found significantly fewer behaviour reports, fewer incidents, and less use of PRN medication over the course of the program. However, injury rates did not change either way. Specific safety practices were highlighted by Sullivan et al. (2025) who found most of their sample of behaviour analysts to have a clear rule for when to stop a session (82.93%) and a safety plan in place (68.51%). However, far fewer had a way for staff to raise safety concerns anonymously (around a quarter).	Keesler & Isham (2017); Sullivan et al. (2025)	Very low 	The finding started as low due to being observational. It was rated down due to concerns with indirectness and imprecision. There were only small concerns with risk of bias. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Certainty in the evidence	Explanation of judgement
<i>Staff also experience trauma, particularly in disability services.</i> In a survey of 288 staff across 53 organisations, Presnell et al. (2022) found most staff agreed that trauma affects job performance and that staff themselves can be affected by it. About 78% thought colleagues may have experienced trauma themselves, and 81% said the work environment itself affects how well they do their job. Similar findings were reported by Webb et al. (2021) in their sample of 278 staff who used a workplace trauma support service. They found staff in disability services were far more likely to need that support than staff elsewhere and were about twice as likely to be seeking help specifically for a psychologically traumatic event (rather than a physical one), compared to staff in other services.	Presnell et al. (2022); Webb et al. (2021)	Very low 	The finding started as low due to being observational. It was rated down due to concerns with indirectness and imprecision. There were only small concerns with risk of bias. Inconsistency could not be measured.
<i>A trauma-informed organisational climate is directly linked to lower staff burnout and secondary traumatic stress.</i> Mercer et al. (2023) found that staff who experienced their workplace as more trauma-informed had significantly lower burnout and secondary traumatic stress. TIC climate was also one of the strongest predictors of burnout (alongside staff resilience) and was the only significant predictor of secondary traumatic stress.	Mercer et al. (2023)	Very low 	The finding started as low due to being observational. It was judged as having only some concerns with risk of bias, indirectness, and imprecision. Inconsistency could not be measured. The finding was rated down due to only having one study contributing to the finding.
Recommendation 6: Make the service environment more inclusive and accessible.			
<i>Practitioners adjusted services to reduce distress.</i> In a survey of 42 behaviour analysts, Sullivan et al. (2025) found that 76.68% had changed the design of their assessments to avoid exposing clients to distressing conditions for longer than necessary.	Sullivan et al. (2025)	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision due to small sample size. The finding was therefore rated down. Inconsistency could not be measured.
Recommendation 7: Ensure different health workers, services, and systems stay connected and work together.			
<i>Working with other practitioners is common. Shared, standardised resources were seen as something that could improve multidisciplinary collaboration.</i> Sullivan et al. (2025) found the majority of their sample of behaviour analysts had collaborated with a medical or mental health practitioner as part of their trauma-informed practice. A standardised resource could prove helpful for this, as findings from Strnadová et al. (2025) found that clinicians of different disciplines all agreed that a shared, co-designed toolkit was useful for genetic healthcare (and more specifically, TIC) with people with intellectual disability.	Sullivan et al. (2025); Strnadová et al. (2025)	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision. The finding was therefore rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Certainty in the evidence	Explanation of judgement
Recommendation 8: Establish strong, positive leadership and a committed workforce.			
<i>Despite leaders feeling their organisation is handling trauma well, there are barriers to delivering TIC such as staffing and resourcing gaps.</i> Presnell et al. (2022) found that leaders of organisations who were already doing TIC training reported staff turnover as the most commonly cited barrier to implementing it properly. Despite leaders in Rich et al. (2021) believing their organisation was doing well in responding to trauma, there were also barriers at the staff level, which was a lack of confidence in responding to staff trauma. On a more practical level, Sullivan et al. (2025) found the most common barriers to implementing TIC were lack of staff (40.48%), time (33.33%), and space (21.43%), suggesting that the organisation was not providing adequate resources for TIC.	Presnell et al. (2022); Rich et al. (2021); Sullivan et al. (2025)	Low 	The finding started as low due to being observational. There were small concerns with risk of bias and indirectness. Inconsistency could not be measured.
Recommendation 9: Treat everyone with respect, compassion, and kindness.			
<i>A structured practice resource significantly boosted clinicians' motivation to deliver respectful, inclusive care.</i> Strnadová et al. (2025) found clinicians reported statistically significant improvements in their perceived motivation to deliver inclusive genetic health care after using the GeneEQUAL Toolkit, compared to before.	Strnadová et al. (2025)	Very low 	The finding started as low due to being observational. It was judged as mostly having concerns regarding risk of bias due to being the only study, and imprecision. Inconsistency could not be measured. The finding was therefore rated down.

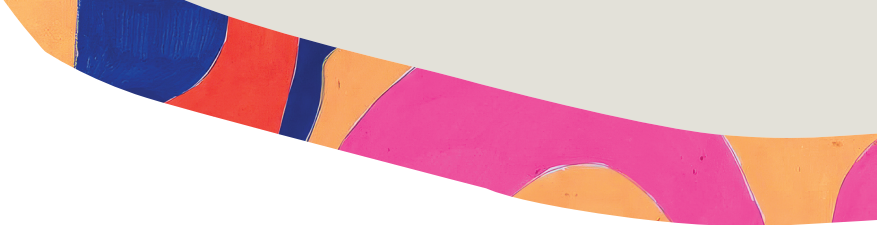


Step 6.2: Shift to trauma-transformative practice

In March 2026, the GDG was introduced to the concept of trauma-transformative practice. Tucci et al. (2024) proposed a paradigm shift from trauma-informed care to trauma-transformative practice, describing it as a set of guiding principles and interpretive frameworks that seek to transform the ways health professionals, organisations, and systems operate with a collective therapeutic intent. The aim is to reduce the ongoing impact of trauma in the lives of victims and survivors and lessen the pain and suffering associated with traumatic experiences over time. The GDG considered this approach to be particularly relevant for people with intellectual disability, whose experiences of trauma are often shaped by intersecting systems of power, marginalisation, and oppression. This broader framework aligned more closely with the group's understanding that trauma is frequently embedded within social, relational, and institutional contexts rather than arising solely from individual experiences.

The shift to trauma-transformative practice was discussed with the Expert Advisory Committees where it was deemed a worthwhile approach to the Trust Guide. As such, the Trust Guide became focused on instigating change across three levels: the individual (health workers), organisational (health services) and system (health systems). The GDG, particularly RDG, found the approach to be representative of the discussion that occurred in the Living Experience-EAC where the responsibilities of health workers and the service were clearly distinguished. Living Experience-EAC members were explicit in their ideas for health workers to be friendly and supporting, and for services to feel safe and accommodating. Therefore, in line with principles of trauma-transformative practice, and the input of the Expert Advisory Committees, the nine guiding recommendations were reorganised to address individuals, services, and systems.

To maximise uptake and accessibility, the GDG developed the nine co-designed themes of the Trust Guide into guiding recommendations in as plain language as possible. Each guiding recommendation would be accompanied by Actions, Monitoring and Resources. Actions refers to the specific, action-focused, implementation points that individuals, services, and systems can follow to implement the recommendation. These would be the de novo or adopted recommendations (further detail can be found in Step 7). Monitoring refers to tips and ideas to evaluate the implementation of the recommendation and Actions. Resources are relevant resources that can be accessed for supporting information.



Step 7: Initial co-designing of Actions

The nine guiding recommendations and related evidence were further co-developed in the third round of Expert Advisory Committee meetings. Once the wording of the guiding recommendations was agreed upon, the source recommendations matched to each theme were adopted into Actions through co-design with the Expert Advisory Committees. Due to the overall lack of methodological detail in the source guidelines, an adoption approach was generally favoured whereby changes were made based on contextualisation requirements and editorial consistencies (National Health and Medical Research Council & Middleton, 2018). Adoption was based upon majority consensus from the Professionals- and Living Experience-EAC, and the evidence synthesis from the source guidelines. Some Actions were developed de novo when the Expert Advisory Committees identified a gap in the source recommendations. New recommendations were discussed in light of available evidence and reached consensus through informal methods of discussion and agreement. In the absence of evidence, de novo recommendations were considered 'Good Practice Statements'.

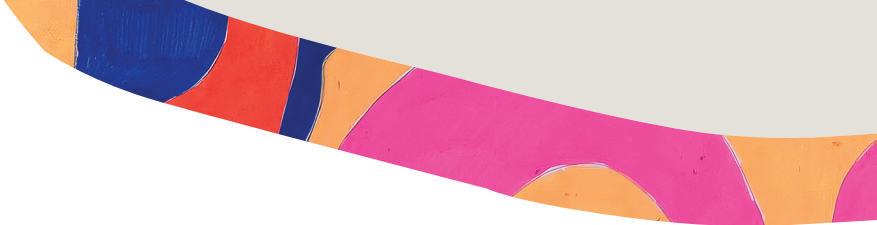
Professionals-EAC (Meeting 3)

In April 2026, the third Professionals-EAC meeting was held. Facilitated by a chair from the GDG, committee members reviewed each recommendation one by one. A strong focus was the source recommendations adopted as Actions. Committee members provided expert consensus and further co-produced the recommendations. Actions were also edited for clarity and consistency. Actions that were better captured by another source recommendation with a stronger evidence base were removed or combined where appropriate. Ideas for Monitoring and Resources were also provided by the committee. The type of recommendation accompanying the Actions was clarified through the consideration of the source evidence (Step 8). The rationale for the co-produced recommendations is integrated into the justification tables (Appendix 1).

When evidence for source recommendations was considered low quality, or absent, the Professionals-EAC contributed their expert opinion. These Actions were considered consensus-based. Expert opinion was structured around, and integrated into, the Evidence-to-Decision frameworks, primarily: values, preferences, acceptability, and feasibility of those involved. The balance between potential harms and benefits was not explicitly considered with the Professionals-EAC, as living experience perspectives from the Living Experience-EAC were favoured. The process was motivated by the desire to see benefits in the lives of stakeholders and improve the equity of healthcare access for people with intellectual disability (Strnadová et al., 2022a).

Living Experience-EAC (Meeting 3)

In April 2026, the third Living Experience-EAC meeting was held. This meeting intended to review the nine guiding recommendations. Actions, Monitoring, and Resources were left out of the discussion, as per advice from RDG. Prior to the meeting, RDG assisted in developing an Easy Read version of the nine recommendations that were accessible for people with intellectual disability. This version was presented to the Living Experience-EAC for them to provide their living experience consensus on the recommendations. Recommendations were generally considered useful and impactful, and no changes were made following the meeting. The GDG, including RDG, agreed that a 'saturation' point was reached due to no new emergences of key themes or considerations. Consensus from the Living Experience-EAC was then integrated into the Evidence-to-Decision frameworks.



Step 8: Grading and classification of recommendations

Due to source guidelines not consistently utilising GRADE methodology or providing evidence certainty, a modified approach was conducted to inform a judgement on the strength of the Actions. The balance between rigour and pragmatism is difficult, particularly when working within logistical constraints and outcome urgencies (Browman et al., 2015). In order to develop a rigorous, evidence-based guideline to improve the health care outcomes for people with intellectual disability through trauma-transformative practice, modifications to the methodology were implemented due to the nature of the evidence-base.

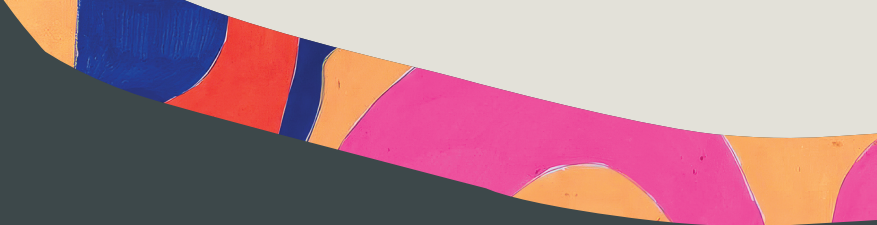
Grading of the recommendations is necessary to promote transparency and reliability. It also provides a starting point for the subsequent updating of the recommendations. Due to the lack of high-quality evidence in the source guidelines, a simplified approach was taken where Actions were judged as 'Strong' or 'Conditional' (Goodall et al., 2023). 'Conditional' Actions were considered equally worth implementing as 'Strong' Actions and only indicated that there are factors to consider during implementation such as resource requirements, barriers to feasibility, or confirming preferences of those with intellectual disability (see Appendix 1, Justification for Recommendations and the full Evidence-to-Decision Frameworks in the supporting document for further information). To enhance the credibility of the recommendations and reflect the co-design process, the 'Type of recommendation' assigned to the source recommendations were updated after adoption and assigned to the Actions. The updated 'Type of action' was considered on the following criteria:

- **Evidence-based:** Action formulated with evidence-informed source guideline recommendations and/or systematic review findings that clearly link to the Action.
- **Consensus-based:** Action formulated in the absence of high-quality evidence, but with Expert Advisory Committee consensus.
- **Good practice statements:** Action co-designed by the Expert Advisory Committees that was formulated outside the scope of the source guidelines and systematic review.

Phase 3: Additional Consultations and Finalisation (Step 9)

Further additional consultations with key stakeholders were sought on the Trust Guide and its guiding recommendations. Feedback was incorporated as community consultation evidence into the Evidence-to-Decision frameworks and used to further inform the co-designed Actions. An Easy Read version of the Trust Guide was also co-developed for people with intellectual disability with the Living Experience-EAC in the fourth meeting. A list of those engaged is as follows:

- National Centre of Excellence in Intellectual Disability Health
 - > Leadership group
 - > Learn and Lead group
 - > Council for Intellectual Disability
 - > The Kids Research Institute Australia
 - > First Nations Advisory Council
- Queensland Centre of Excellence in Intellectual Disability and Autism Health
 - > Leadership
 - > Clinicians
 - > Research team
- Dr Mike Freeland MP MBBS FRACP
- Those with living experience within the community
 - > Families, carers, and support people
 - > People with intellectual disability
- Dr Annette Jackson, Berry Street Yooralla



Section Four: Appendices

Appendix 1: Justification for Recommendations (Evidence-to-Decision Framework Summary)

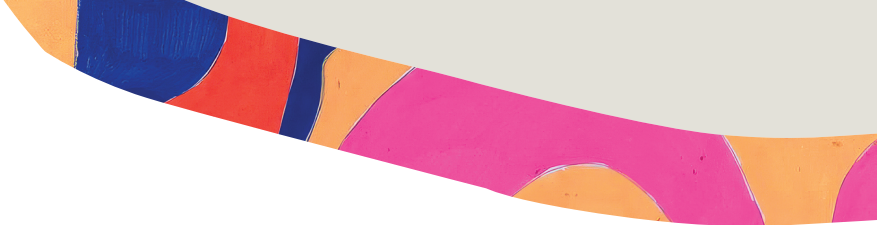
1.1 Know that people with intellectual disability often experience more trauma in their lives than other people.

Criteria	Justification
Balance of benefits and risk	The Expert Advisory Committees anticipated that taking on a trauma-transformative practice approach would lead to better health outcomes and quality of life for people with intellectual disability. However, the specific approach to trauma-transformative practice must be compatible with the person with intellectual disability. The Living Experience-EAC particularly resonated with evidence suggesting that people with intellectual disability are at a risk of feeling blamed, silenced, labelled or dismissed, which could lead to re-traumatisation when care is not trauma-informed (GeneEqual, 2021; Jackson et al., 2015; NICE, 2016; Strnadová et al., 2023, 2025) and agreed that people with intellectual disability valued being 'understood' and 'respected' (Costain et al., 2012; Jackson & Waters, 2015).
Certainty of evidence	A limited body of evidence was identified in the source guidelines and therefore considered consensus-based or good practice statements. Qualitative systematic review evidence was judged as moderate while quantitative findings were judged as very low. Actions were generally judged as 'strong' except for 1e which lacked specific evidence from source guidelines and systematic review; however, it was endorsed by the Professionals-EAC.

Criteria	Justification
Values and preferences	The Living Experience-EAC were clear that health workers needed to be more considerate towards the preferences of people with intellectual disability. <i>"I feel that deep down that they are not being considerate. They don't care about my feelings."</i> This was echoed during community consultations with people with intellectual disability who also added they can feel nervous when seeing someone without a previous relationship. They valued the opportunity to prepare in advance for appointments and appreciated when health workers also prepared.
Resources required	No clear evidence was available regarding the required resources for implementing the Actions. The Professionals-EAC considered that additional funding and resources may be required to improve the awareness of trauma among health workers, however it was maintained that this was not essential.
Equity	There was no evidence explicitly relating to the improvements in equity. The Professionals-EAC considered that people with intellectual disability should be able to access trauma-sensitive care regardless of the service they require or previous experiences of trauma. This is in line with Article 16 of the CRPD (2006) which states that all people with disability should be protected from exploitation, violence, and abuse, and that appropriate measures must be taken to promote <i>"the physical, cognitive and psychological recovery, rehabilitation and social reintegration" in environments that "foster the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs."</i> Professionals-EAC members agreed that being aware of the higher risks of traumatic experiences for this population, and their individualised characteristics and health care needs, would improve equitable access to safe, trauma-transformative health care.
Acceptability and feasibility	Originally, the recommendation was framed around reducing traumatisation and re-traumatisation. The Professionals-EAC considered this too broad to operationalise and suggested reframing the topic to focus on holding an awareness of the risk of trauma. The Living Experience-EAC further commented that having an awareness of the risk of trauma and its impacts among people with intellectual disability was essential in delivering safer health care. Feasibility was generally considered to depend on any funding and resources required.

1.2 Centre the voice and choice of the person with intellectual disability in all health care interactions

Criteria	Justification
Balance of benefits and risk	The Expert Advisory Committees expected that centring the voice and choice of people with intellectual disability would lead to better health outcomes and quality of life for people with intellectual disability. However, some evidence suggested that trauma-informed care principles of choice, collaboration, and empowerment did not meaningfully improve throughout a trauma-informed care program (Keesler & Isham, 2017a). The Professionals-EAC noted that the recommendation was essential to improving outcomes and added that extra care must be taken when support orders or informal decision makers are involved as this may cause distress for the person with intellectual disability. The Living Experience-EAC agreed with qualitative evidence that found people with intellectual disability valued comfortable, non-threatening environments where they were not ignored and their self-determination was encouraged (Jackson & Waters, 2015). Their living experiences aligned with a finding from source guideline evidence that suggested quality of care and imbalance of power was dependent on the mood and attitudes of staff (Griffith et al., 2013; NICE, 2015). This may impact their ability to centre the voice and choice of people with intellectual disability, suggesting that these Actions are needed to benefit people with intellectual disability.
Certainty of evidence	Source guidelines evidence varied in quality from low to high. High-quality evidence was from a qualitative review on experiences of people with a learning disability and behaviour that challenges in relation to received service supports and interventions. However, the evidence required contextualisation to the current setting. Qualitative systematic review evidence was generally of moderate-high-quality while quantitative evidence was judged very low. All Actions were judged as 'strong' except for 2f which the Professionals-EAC considered a delicate situation to manage due to legal obligations.



Criteria	Justification
Values and preferences	Having voice and choice heard largely resonated with the Living Experience-EAC and within further consultations with people with intellectual disability. They found it particularly frustrating when their voice was left out and health workers opted to talk to family and support people before them. However, they also added that <i>“being asked so many questions all at once can get frustrating”</i> and preferred choice to be tailored and digestible. They also valued when communication was transparent and clear.
Resources required	There was no clear evidence relating to the resources required. However, the Professionals-EAC commented that communication supplements may be required such as visual aids and plain language resources to facilitate communication. Furthermore, if cultural or language barriers occur, then additional time and resources may be required to communicate.
Equity	The Professionals-EAC referred to Australia’s ratification of the United Nations CRPD which assumes that all health workers working with people with disability should have <i>“respect for inherent dignity, individual autonomy, including the freedom to make one’s own choices, and independence of persons”</i> towards people with intellectual disability. Furthermore, Article 12 of the CRPD (2006) affirms that people with disability have the right to be supported to exercise their equal legal capacity in a way that respects their will, preferences, and human rights. The Professionals-EAC agreed that alignment of the Actions to these principles suggest that health equity would be improved.

Criteria	Justification
Acceptability and feasibility	Professionals- and Living Experience-EAC members said that centring the voice and choice of people with intellectual disability is essential to providing trauma-transformative practice. They acknowledged that this allowed people to feel safe during health care. The Professionals-EAC agreed that there must be clear recognition of the diverse methods of communication. It was noted that sometimes offering a select few alternatives may be more accessible than a vast range of choice. Either way, choices had to be digestible and tailored. Families and carers added during consultations that it must be recognised that sometimes people with intellectual disability do not always make the safest health decisions and suggested stronger acknowledgements of the role of carers and clinicians in decision-making. While this notion was supported by the Professionals-EAC, they also considered nuances during supported decision making and scenarios where people with intellectual disability may be attending healthcare against their preferences. They maintained that the person with intellectual disability must always be included. This was agreed upon in wider consultations with professional stakeholders who added that it is upon health workers and services to be sensitive to this and adjust their practice accordingly.

1.3 Focus on the person with intellectual disability, working together with family or support people to balance everyone's needs.

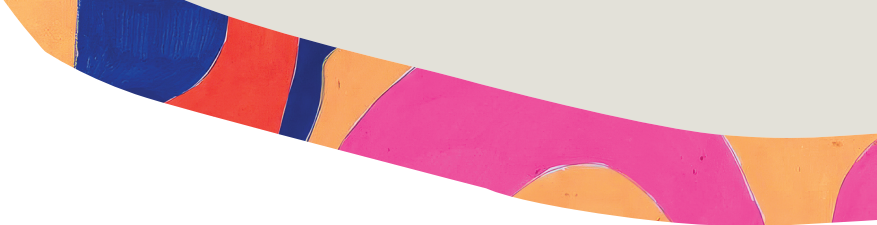
Criteria	Justification
Balance of benefits and risk	The Professionals-EAC considered evidence in the source guidelines that suggested family-centred care can improve depression in families and carers of people with intellectual disability and behaviour that challenges (NICE, 2015), and that families should be involved in care planning where possible and that services should know how to work with the family (NICE, 2018). The Professionals-EAC agreed that involvement should be varied, depending on the needs of the person with intellectual disability. The Living Experience-EAC were also clear in their preference of having a choice over who was involved with their care, further suggesting that the Actions would benefit people with intellectual disability. There was mixed evidence that carers and staff benefitted from wellbeing interventions (NICE, 2015; Sullivan et al., 2025), however guideline developers reached informal consensus that all parents and carers should be made aware of and offered carer's assessment. The Professionals-EAC agreed they were important to offer regardless, as long as it was acknowledged that some families want a lot of help while others do not (National Development Team for Inclusion, 2015; Stenfert Kroese, 2011). The Living Experience-EAC added that health workers should first find out how much help is required by everyone to properly benefit people with intellectual disability
Certainty of evidence	Where GRADE could be applied, evidence was generally considered low or very low due to risk of bias and small sample sizes (NICE, 2015). Systematic review findings were limited, therefore, the Professionals-EAC favoured source guideline evidence and committee consensus.
Values and preferences	Living Experience-EAC members said that people with intellectual disability sometimes want their family involved, and other times do not. It is important to work with the person and their families and carers to determine the involvement of families and carers. Consultations with family and support people said that the voice of carers can sometime be underemphasised, and they sometimes feel intimidated by doctors or during stressful situations.

Criteria	Justification
Resources required	There was no explicit evidence on the resources required to implement this recommendation. The Professionals-EAC did consider that implementing culturally inclusive resources and support services for family may require additional resources if they are not already available.
Equity	Focusing on the person with intellectual disability is expected to improve health equity. There may be barriers if family members or cultural differences are involved. In this case, it is important to work together with everyone throughout health care, so that families and support people also have equitable opportunity. The Professionals-EAC considered the evidence that suggested families and support people may feel overburdened with the care of the person with intellectual disability and agreed that providing them support would likely improve health equity.
Acceptability and feasibility	The Living Experience-EAC were clear on the importance of person-centred care. <i>"...it just depends on the person and that person's needs, right?... everyone's different."</i> This was endorsed by the Professionals-EAC who added that if family or support people are involved, then everyone's needs must be balanced. They acknowledged this may be difficult, particularly if substitute decision makers were involved. The Professionals-EAC added that support orders need to be considered where applicable, as sometimes health care decisions may be left to the guardian. Action 3a originally covered understanding the person's broader life goals. This was considered out of scope by the Professionals-EAC and was contextualised to a holistic health care approach for feasibility.

1.4 Support health workers to deliver safer care through evidence-based training and resources.

Criteria	Justification
Balance of benefits and risk	The Professionals-EAC agreed that proficient training of health workers should lead to better health care outcomes for people with intellectual disability. Evidence found that positive behaviour support training improved staff skills and reduced instances of challenging behaviour (MacDonald & McGill, 2013). The Professionals-EAC acknowledged that challenging behaviour may stem from traumatic experiences, however the finding does not directly relate to the provision of trauma-transformative practice. Providing health workers with sufficient training and supervision for the delivery of trauma-transformative practice was echoed by both Expert Advisory Committees. The Professionals-EAC emphasised the importance of instilling reflective and reflexive practice among health workers, particularly when consistent, high-quality supervision was not feasible.
Certainty of evidence	There was limited evidence supporting the recommendation. Available review evidence from the source guidelines was rated as 'poor' due to the heterogeneity of the included studies' methodology (NICE, 2015). Qualitative systematic review findings were judged moderate-high while quantitative findings were judged very low-low. Only 4b was 'conditional' due to the lack of evidence linking staff wellbeing support with clear outcomes for people with intellectual disability, and the potential need for additional resources.
Values and preferences	The values and preferences of people with intellectual disability were not clearly uncovered within source guideline evidence or systematic review due to the focus being on support for health workers. However, the Professionals-EAC expected that providing support to health workers to increase their capacity for providing trauma-transformative practice is aligned with the values and preferences of people with intellectual disability. The Living Experience-EAC generally agreed with the sentiment, with one member describing a negative healthcare experience when they felt health workers were underprepared. The member said they "<i>almost dropped [their] baby</i>" due to their hidden disability but felt that the health workers did not care enough. They suggested more training was needed so that health workers were able to better accommodate for people with intellectual and hidden disabilities.

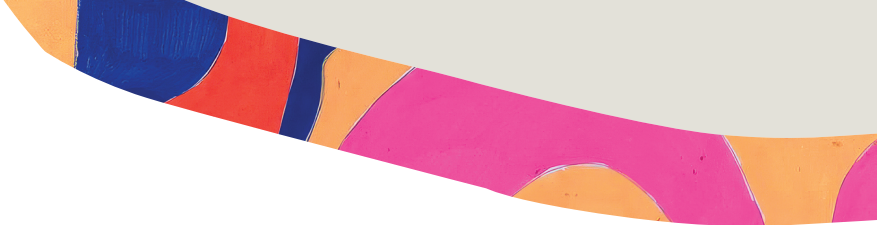
Criteria	Justification
Resources required	Providing additional training, supervision, and time for self-care for health workers would likely come with resource requirements. Those responsible for training must be specified to ensure consistency in training and supervision. The Professionals-EAC noted that while supervision is a desirable process, in practice it can lack priority, especially when resources are constrained. They added that reflective practice must be embedded into health worker processes and clearly distinguished from supervision. Reflective practice is not expected to incur additional resources for health workers unless educational resources are required.
Equity	Evidence for improving health equity of people with intellectual disability was mostly unavailable; however, the Professionals-EAC expected that this recommendation would improve health equity by providing more opportunities for people with intellectual disability to access good quality health care from staff who feel supported which aligns with Article 26 of the CRPD (2006), <i>"Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services."</i>



Criteria	Justification
Acceptability and feasibility	This recommendation is likely acceptable for people with intellectual disability and health workers. Evidence suggests that health workers experience vicarious trauma, fatigue and burnout when working closely with trauma survivors (McNally et al., 2022; Mercer et al., 2023; Truesdale et al., 2019). This was agreed upon by the Professionals-EAC who deemed training, supervision, and self-care as vital for ensuring good health care. Furthermore, reflective practice was highly valued by the Professionals-EAC who said that integrating reflective practice can improve the feasibility of this recommendation in the absence of supervision or other support. They also endorsed that more training was needed and that dedicated teams responsible for training must be clearly specified. Some conflicting evidence for acceptability came from systematic review findings which suggested that health workers may prefer more practical, coaching type supports as opposed to wellbeing support. However, the Professionals-EAC considered both to be important and noted the resources that could be required which could impact feasibility. Additionally, a quick note on language from the Professionals-EAC was that “challenging behaviours” or “behaviour that challenges” as used in the source guidelines was not inclusive language. They discussed adapting relevant recommendations to incorporate more inclusive language such as, “behaviours of concern,” or “behaviours linked to distress and unmet needs” to make recommendations more acceptable.

1.5 Build a culture where everyone feels safer and valued.

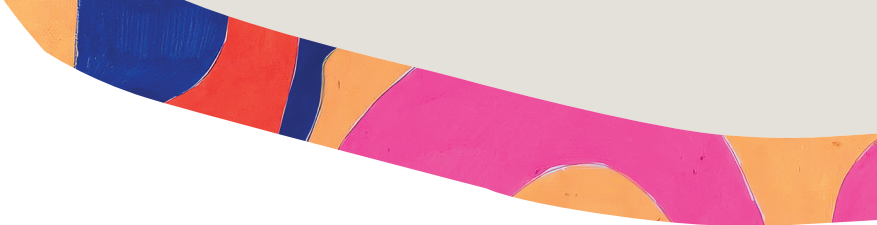
Criteria	Justification
Balance of benefits and risk	The Expert Advisory Committees generally aligned with evidence from the source guidelines and systematic review on the benefits for people with intellectual disability. For example, people with intellectual disability feel frustrated and hopeless when they are in environments with little control (Griffith et al., 2013). Allowing them to feel safer and valued can help them to adapt to a safer world through repeated positive experiences (Perry & Dobson, 2013). This was endorsed by systematic review evidence which found relational factors, trust, and consistency are all important for safety and trauma recovery.
Certainty of evidence	Systematic review evidence from the source guidelines was rated as high-quality (NICE, 2015). Other source guidelines did not utilise GRADE methodology. Source recommendations linked to the review evidence are rated as evidence-based. Qualitative systematic review evidence was judged as high while quantitative evidence was judged as very low. Overall, all Actions were judged 'strong'.
Values and preferences	People with intellectual disability, and their families and support people, valued safe environments. A member from the Living Experience-EAC said, <i>"Like you're walking with a smile on your face, then that could like make the patient think, 'hey, it's gonna be OK, I know what I'm doing, I know what I'm talking about and I'm here to help.... And their body language is really important."</i> When health workers were helpful and respectful, people with intellectual disability had more positive health experiences.
Resources required	No specific evidence was available, however, the Professionals-EAC thought while being respectful and helpful has little cost, health workers may need to commit more time and flexibility to appointments to ensure they are building rapport with people with intellectual disability. Furthermore, those with less experience working with people with intellectual disability may need extra training. Additional resources may also be required to integrate systems that enable safe delivery.



Criteria	Justification
Equity	No specific evidence was available, however, the Professionals-EAC considered evidence suggesting power imbalances during health care were found to be dependent on mood, behaviours and attitudes of staff (Griffith et al., 2013). This could lead to inequitable healthcare for people with intellectual disability. For the health space to be safe for all stakeholders, a safe environment for health workers must also be fostered. The Living Experience-EAC agreed with this sentiment, further suggesting improvement in health equity.
Acceptability and feasibility	Expert Advisory Committee members were generally in consensus that safer environments were needed for all stakeholders. Comments from the health worker perspective said that safer environments are bi-directional and relational and that safe working environments were the foundation for delivering trauma-transformative practice. The Actions were considered feasible if health services took on responsibility for the safety of frontline workers.

1.6 Make the service environment more inclusive and accessible.

Criteria	Justification
Balance of benefits and risk	The Expert Advisory Committees agreed with evidence saying providing reasonable adjustments made the physical environment safer during genetic health care which increased comfort and satisfaction of participants with intellectual disability (Strnadová et al., 2022b). The Living Experience-EAC shared similar sentiments with source guideline evidence describing beneficial reasonable adjustments which included smaller groups, welcoming venues, transport options, open questions to encourage free-flowing conversation, sharing control over topics, and including advocates for participants (Alderson, 2001; Barter et al., 2017; Ward et al., 2002). The benefits of accessible service environments were clear considering that people with intellectual disability feel frustrated and hopeless in environments where they have little control or experience unfair use of restrictive practices (Griffith et al., 2013).
Certainty of evidence	Available review quality was rated as high to adequate, however it required contextualisation to the current setting (Griffith et al., 2013; Griffith & Hastings, 2014). Most of the evidence was from expert consensus from the Expert Advisory Committees. Only limited systematic review evidence was available which mostly aligned with committee consensus. Action 6c was judged as 'conditional' due to it being developed de novo through committee co-design.
Values and preferences	People with intellectual disability valued having health spaces that were responsive to their physical needs. A Living Experience-EAC member gave an example that if a young person came in for health treatment, then they should have a designated room that is age appropriate, for example, "pictures on the wall" or toys.



Criteria	Justification
Resources required	The Professionals-EAC commented that meeting people where they are in safer environments requires flexibility and funding. Professionals-EAC members suggested clear escalation pathways if health workers thought it necessary to implement adjustments that were policy-bound, or developing co-designed environmental audit tools to assess sensory friendliness and suitability separate to traditional workplace health and safety audits.
Equity	There was no clear evidence on the increases to health equity. However, it was expected by the Professionals-EAC that making the service environment more accessible would improve health equity. Both Expert Advisory Committees agreed that flexible healthcare arrangements would improve experience and accessibility for people with intellectual disability. This aligns with Article 9 of the CRPD (2006) which states that appropriate measures must be taken to ensure people with disability can live independently and participate fully in all aspects of life.
Acceptability and feasibility	Professionals-EAC members noted that while health workers may endeavour to provide reasonable adjustments where possible, it may be difficult in practice due to policy-bound barriers. To make flexible health care arrangements feasible, clear escalation pathways were needed for policy-bound barriers. Members commented that <i>“meeting people where they feel safe”</i> may be more acceptable of an approach than simply implementing extensive lists of reasonable adjustments. It was agreed by both Expert Advisory Committees that even small adjustments made big differences for people with intellectual disability.

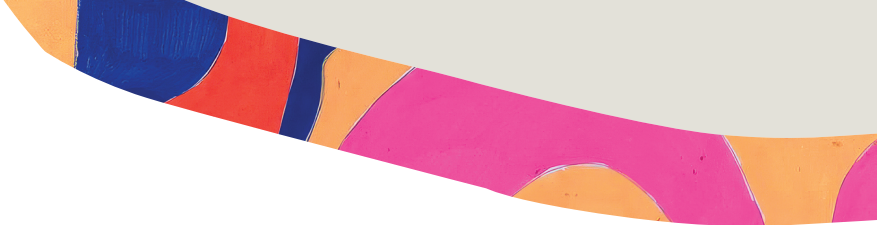
1.7 Ensure different health workers, services, and systems stay connected and work together.

Criteria	Justification
Balance of benefits and risk	There was limited evidence from the source guidelines suggesting that different models of support (assertive vs. intensive vs. standard) had more or less benefits or harms on quality of life, adaptive functioning, or carer uplift/burden (Martin et al., 2005; Oliver et al., 2005). Due to limited evidence, the source guideline committee reached consensus on a service structure to benefit people with learning disability and behaviour that challenges. They endorsed flexible support arrangements and co-locating different service facilities to join up service provision. The Professionals-EAC agreed with this approach and further suggested that partnering with paid consumers/advisors to oversee the coordination of services could benefit people with intellectual disability
Certainty of evidence	Evidence on the coordination of treatment in the source guidelines was rated very low (NICE, 2016). Recommendations from the source guidelines were adapted from the NICE Guideline Common Mental Health Behaviour Disorders (National Collaborating Centre for Mental Health (UK), 2011). The evidence draws from 21 systematic reviews which are mostly concerned with depression and adapted to the context of learning disability and challenging behaviour. The evidence required contextualisation to the current setting by the Professionals-EAC. Systematic review evidence was generally high for qualitative findings and very low for quantitative findings. Actions 7b and 7c were judged conditional, mostly due to feasibility concerns with coordinating care pathways.
Values and preferences	People with intellectual disability valued the importance of consistent care, including follow-up. Living Experience-EAC members said, <i>"make sure doctors are supporting the patient in the after care."</i> A story shared by another member was that after surgery they were left bed-bound for several months. Health workers were not engaged in helping them during this period, <i>"not even for personal care."</i> As a result, they experienced from ongoing health issues.

Criteria	Justification
Resources required	There was no clear evidence on the resources required to implement the recommendation. The Professionals-EAC acknowledged that funding may be required to coordinate care pathways, partner with paid consumers/advisors or promote personal health resources. However, this was not considered essential.
Equity	There was no clear evidence on the increases to health equity. However, the Expert Advisory Committees expected that health workers, services, and systems working together would improve health equity for people with intellectual disability. Article 25 and 26 of the CRPD (2006) state that health services should <i>“prevent discriminatory denial of health care”</i> for people with disability, and that services should be <i>“based on the multidisciplinary assessment of individual needs and strengths,”</i> suggesting the importance of health workers, services, and systems working together.
Acceptability and feasibility	The Professionals-EAC agreed that it was important for health workers and services to closely collaborate for consistency and continuity and called for designated teams and paid consumer experts to assist with this. The stories shared by the Living Experience-EAC highlighted that healthcare was not consistently equitable. For example, they felt nurses, <i>“just don’t bother”</i> when it came to the period following acute episodes of health care. Therefore, increased collaboration and continuity between services and health workers is considered acceptable for people with intellectual disability. Professionals- and Living Experience-EAC members agreed that a tool or resource (e.g. “snapshot about me”) could be implemented to document key personal preferences and needs. These tools must be quickly accessible and concise to be feasible for health workers and services. There was further feasibility concerns related to funding and resources for closely coordinating care services. However, systematic review evidence suggests that practitioners working together is already common.

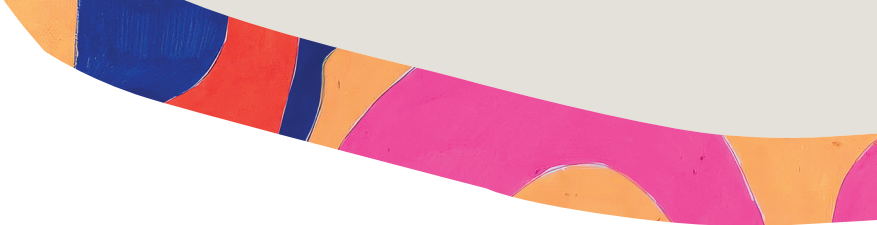
1.8 Establish strong, positive leadership and a committed workforce.

Criteria	Justification
Balance of benefits and risk	There was some evidence to suggest that leadership played a key role in trauma-informed care in residential settings with managers calling for a cultural shift towards trauma-informed care that “ <i>becomes embedded in people’s language</i> ” (McNally et al., 2023). They also highlighted the importance of developing trauma-informed policies and procedures, pathways to speciality services, good communication, and service user involvement in developing services (McNally et al., 2021). There was no explicit evidence on the outcomes for people with intellectual disability. However, the Professionals-EAC upheld that for benefits to occur, true change must occur top to bottom, starting with strong leadership.
Certainty of evidence	There was limited high-quality evidence from the source guidelines. Most evidence was either gathered from formal group consensus (NICE, 2016), or not clearly linked to the recommendations. Other evidence was from qualitative interviews with staff and leadership. However this was in the context of residential care settings and required contextualisation to the current setting (McNally et al., 2022, 2023). Systematic review evidence was limited and mixed from low to high. Only Actions 8a through 8c were judged ‘strong’. Concerns were often related to a lack of perspective from people with intellectual disability and leadership themselves.



Criteria	Justification
Values and preferences	There was limited input from the Living Experience-EAC and people with intellectual disability regarding their values and preferences of the recommendation. It is expected to be consistent with their values and preferences if leadership collaborates with consumers to develop trauma-transformative outcomes and provide consistency in health care. Consultations with families and carers did suggest that the guiding recommendation is consistent with their values and preferences as they often experienced people with intellectual disability falling through gaps in the system due to no one taking ownership.
Resources required	While no clear evidence was available, the Professionals-EAC acknowledged that effective collaboration between health workers may require recruitment and retention of workers with education and/or living experience in trauma. They may be useful in a disability liaison/ombudsmen role to ensure appropriate care and identify deficits in care. Where resources are not available for this role, consultations with stakeholders identified social workers as the next ideal candidate to fulfil this responsibility. The third option was front facing health workers such as nurses or doctors. The Professionals-EAC highlighted that regular auditing from senior staff is necessary to assess effectiveness and accessibility. Resources such as monitoring systems to reinforce safe practice, and data systems to monitor high-impact safety indicators would be helpful. More funding may also be required to implement new policies and procedures that provide safer, accessible care.

Criteria	Justification
Equity	There was no clear evidence on the increases to health equity. However, the Professionals-EAC expected strong leadership and a committed workforce to improve health equity for people with intellectual disability. During community consultation, a professional raised that people with intellectual disability should also benefit from extra services, analogous to people with mobility issues or physical disabilities, but suggested that systems are generally not set up to accommodate this. Such accommodations are highlighted in Article 4 of the CRPD (2006), which posits that all appropriate measures will be undertaken to abolish regulations that discriminate, and to protect and promote human rights measures within policies and programmes. As described by the Professionals-EAC, this must start with strong leadership.
Acceptability and feasibility	The Professionals-EAC said implementing trauma-transformative practice should occur from the top-down. While Actions were mostly considered acceptable, such as embedding values into language, policies, and procedures, involving senior staff in training and discussion, and not overloading front line health workers without system support, feasibility likely relied on leadership buy in and funding.



1.9 Treat everyone with respect, compassion, and kindness.

Criteria	Justification
Balance of benefits and risk	Several source guidelines highlighted that people with intellectual disability valued feeling safe during health care (Kezelman & Dombrowski, 2021; McNally et al., 2023). This was endorsed by the Living Experience-EAC who additionally agreed that a key element of safer health care was genuine, honest and authentic communication. This would benefit people with intellectual disability as evidence suggested compassion and responsiveness build self-regulation skills and expands window of tolerance (Kezelman & Dombrowski, 2021). This was further supported by the evidence which found that adults with intellectual disability experienced a sense of safety when staff were responsive to their needs (McNally et al., 2023) There was also some evidence to suggest that trauma-informed care principles of safety and trustworthiness did not meaningfully improve during the implementation of a trauma-informed care program (Keesler & Isham, 2017a). There was no available evidence outlining risk. The Professionals-Expert Advisory Committee did not expect risks unless representative decision-makers were involved who did not consider the person with intellectual disability. In this instance, working collaboratively with everyone and ensuring the person is fully informed is expected to manage risk.
Certainty of evidence	Evidence from source guidelines was not clearly linked to the source recommendations. The Living Experience-EAC endorsed most of the Actions. Systematic review evidence was of mixed quality and mostly qualitative. Overall, only 9c was judged 'conditional' due to uncertainty around resourcing and feasibility.
Values and preferences	The Actions strongly resonated with the Living Experience-EAC and are expected to be consistent with the values and preferences of people with intellectual disability. For example, people with intellectual disability may prefer seeing a visual indicator of a health worker's accessibility/experience (e.g. sunflower lanyard). Furthermore, some of the ways the Living Experience-EAC described respect was, <i>"don't force them"</i>, <i>"being spoken to directly"</i>, <i>"calmer tone of voice"</i>, <i>"rapport building"</i>, and <i>"open body language"</i>.

Criteria	Justification
Resources required	No clear evidence was available. However, the Professionals-EAC consider compassion and upholding dignity as standard practice among health workers which requires none or negligible resource costs. However, they acknowledged that if additional resources needed to be produced for training purposes, then this requires funding and training.
Equity	There was no specific evidence on how the recommendation would improve health equity. However, it is expected by the Expert Advisory Committees that treating everyone with respect, compassion, and kindness will improve health equity for people with intellectual disability if it improves accessibility, autonomy, and dignity. This is in line with Article 25 of the CRPD (2006) which states health care must be <i>“of the same quality as to others, including on the basis of free and informed consent.”</i>
Acceptability and feasibility	The Professionals-EAC noted that it is crucial to first consider what respect means to people with intellectual disability and operationalise it to ensure it is acceptable and feasible for all stakeholders. The Living Experience-EAC identified several aspects of care that they found acceptable for safe, respectful care (see values and preferences). The recommendation was expected to be feasible, however it was raised that people with intellectual disability may attend health care against their preferences which could impact the operationalisation of the recommendation. In this scenario, clinical judgement and transparency were acknowledged as important. The Professionals-EAC also considered uncertainty around feasibility, mostly due to funding or resources that could be required.

Appendix 2: Rapid Review for Guidelines

2.1. Search strategy

Query	Search terms	Results
Pubmed		
1	"trauma informed" OR "trauma informed care" OR "trauma response" OR "trauma reaction" OR "trauma care" OR abuse OR neglect OR violence	674845
2	"guidelines" OR "guideline" OR "guide" OR "guides" OR "guidance" OR "framework" OR recommendations OR policy OR strategy OR "roadmap"	4705873
3	"Guideline"[Publication Type] OR "guidelines as topic"[MeSH Terms] OR "practice guidelines as topic"[MeSH Terms]	220214
4	2 OR 3	4708362
5	1 AND 4	141843
6	"intellectual disability" OR "intellectual disabilities" OR "developmental disability" OR "developmental disabilities" OR "learning disability" OR "learning disabilities" OR "intellectual impairment" OR "intellectual impairments" OR "mental retardation"	151516
7	"intellectual disability"[MeSH Terms] OR "learning disabilities"[MeSH Terms] OR "developmental disabilities"[MeSH Terms]	153305
8	6 OR 7	200887
9	5 AND 8	1032
filters	2015-2025	515
	English (gross)	508

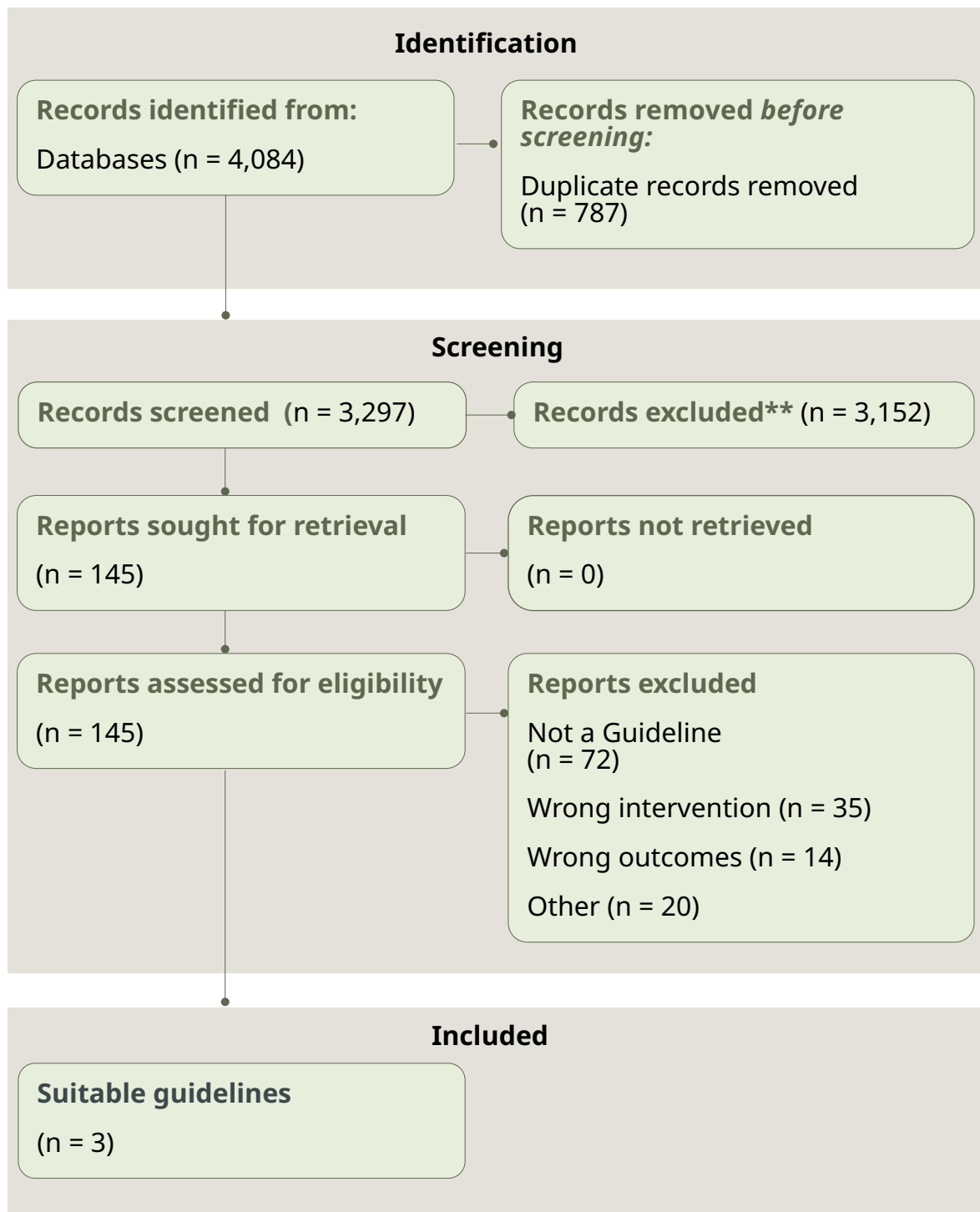
Query	Search terms	Results
Embase		
1	trauma informed' OR 'trauma informed care'/exp OR 'trauma informed care' OR 'trauma response' OR 'trauma reaction' OR 'trauma care'/exp OR 'trauma care' OR 'abuse'/exp OR 'abuse' OR 'neglect'/exp OR 'neglect' OR 'violence'/exp OR 'violence'	720537
2	abuse'/exp OR 'trauma informed care'/exp OR 'childhood adversity'/exp	303749
3	1 OR 2	738801
4	guidelines' OR 'guideline' OR 'guide' OR 'guidance' OR 'framework' OR 'recommendations' OR 'policy' OR 'strategy' OR 'roadmap'	4404437
5	practice guideline'/exp OR 'health care policy'/exp	1073336
6	4 OR 5	4552644
7	intellectual disability' OR 'intellectual disabilities' OR 'developmental disability' OR 'developmental disabilities' OR 'learning disability' OR 'learning disabilities' OR 'intellectual impairment' OR 'intellectual impairments' OR 'mental retardation'	148382
8	intellectual impairment'/exp OR 'learning disorder'/exp OR 'developmental disorder'/exp	850384
9	7 OR 8	887137
10	3 AND 6 AND 9	4054
filters	2025-2015 (gross)	2493

Query	Search terms	Results
CINAHL		
1	"trauma informed" OR "trauma informed care" OR "trauma response" OR "trauma reaction" OR "trauma care" OR abuse OR neglect OR violence	208098
2	MM "Psychological Trauma+" OR MM "Emotional Abuse" OR MM "Violence+"	67835
3	1 OR 2	211930
4	"guidelines" OR "guideline" OR "guide" OR "guidance" OR "framework" OR "recommendations" OR "policy" OR "strategy" OR "roadmap"	915166
5	MM "Practice Guidelines" OR MM "Health Policy+"	92246
6	4 OR 5	930810
7	"intellectual disability" OR "intellectual disabilities" OR "developmental disability" OR "developmental disabilities" OR "learning disability" OR "learning disabilities" OR "intellectual impairment" OR "intellectual impairments" OR "mental retardation"	55383
8	MM "Intellectual Disability+" OR MM "Persons with Intellectual Disabilities" OR MM "Developmental Disabilities" OR MM "Learning Disorders+"	49578
9	7 OR 8	67740
10	3 AND 6 AND 9	461
filters	2025-2015	236
	English language (gross)	235

Query	Search terms	Results
PsycINFO		
1	"trauma informed" OR "trauma informed care" OR "trauma response" OR "trauma reaction" OR "trauma care" OR abuse OR neglect OR violence	404224
2	SU "Trauma-Informed Care" OR SU "Trauma" OR SU "Violence" OR SU "Patient Abuse"	148169
3	1 OR 2	446920
4	"guidelines" OR "guideline" OR "guide" OR "guidance" OR "framework" OR "recommendations" OR "policy" OR "strategy" OR "roadmap"	976103
5	SU "Treatment Guidelines" OR SU "Health Care Policy"	23914
6	4 OR 5	976103
7	"intellectual disability" OR "intellectual disabilities" OR "developmental disability" OR "developmental disabilities" OR "learning disability" OR "learning disabilities" OR "intellectual impairment" OR "intellectual impairments" OR "mental retardation"	115254
8	SU "Intellectual Development Disorder"	46232
9	7 OR 8	123228
10	3 AND 6 AND 9	1046
<i>filters</i>	2015-2025	409
	English language (gross)	402

Query	Search terms	Results
Web of Science Core		
1	TS="trauma informed" OR TS="trauma informed care" OR TS="trauma response" OR TS="trauma reaction" OR TS="trauma care" OR TS=abuse OR TS=neglect OR TS=violence	752318
2	TS="guidelines" OR TS="guideline" OR TS="guide" OR TS="guidance" OR TS="framework" OR TS="recommendations" OR TS="policy" OR TS="strategy" OR TS="roadmap"	7,574,996
3	TS="intellectual disability" OR TS=" intellectual disabilities" OR TS="developmental disability" OR TS="developmental disabilities" OR TS="learning disability" OR TS="learning disabilities" OR TS="intellectual impairment" OR TS="intellectual impairments" OR TS="mental retardation"	122,778
4	1 AND 2 AND 3	694
<i>filters</i>	2015-2025	458
	English only (gross)	446
Totals		
	Gross	4084
	Duplications removed	787
	Net (uploaded to Covidence)	3297
	Duplications removed by Covidence	0
	Subject to title and abstract screening	3297

2.2. PRISMA flowchart



2.3. AGREE II scores

	Domain 1			Domain 2			Domain 3							
Item	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Taking Time Framework	7	6	7	7	7	7	4	2	3	3	5	5	7	1
NG11	7	7	7	7	7	7	7	7	7	7	7	7	7	7
NG54	7	7	7	7	7	7	7	7	7	7	7	7	7	7
NG93	7	7	7	7	7	7	7	7	7	7	7	7	7	7
GeneEQUAL Toolkit	6	4	6	7	7	7	7	7	7	5	6	6	7	3
BKF: Disability Guidelines for Trauma Informed Practice	6	6	6	6	7	5	2	2	3	1	2	5	6	4
A Framework for the Implementation of TIC in Residential and Supported Living Services for Adults with a Learning Disability	6	3	6	7	7	7	7	7	6	4	6	5	6	3

Note. NG11 = Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges; NG54 = Mental health problems in people with learning disabilities: prevention, assessment and management; NG93 = Learning disabilities and behaviour that challenges: service design and delivery; BKF = Blue Knot Foundation; TIC = trauma-informed care

Appendix 3: Research Question Prioritisation

3.1. Questions scores and theme categorisation

Question	Score	Theme
1. What can health services do to reduce the traumatisation and re-traumatisation of people with intellectual disability accessing health services?	6.88	Reduce traumatisation/ re-traumatisation
26. How can health service staff and systems prioritise the voice of people with intellectual disability and trauma?	6.75	Prioritising voice, choice, and control
25. How can health service staff and systems maximise the choice and control of people with intellectual disability and trauma?	6.63	Prioritising voice, choice, and control
9. How can these guidelines facilitate compassion and responsiveness towards the right to dignity of people with intellectual disability and trauma?	6.50	Facilitating compassion, responsiveness, dignity
12. What knowledge and skills need to be embedded in ongoing training and development for health service staff regarding trauma-informed practice when working with people with intellectual disability and trauma?	6.50	Capacity building and staff support
19. How can health service staff and systems ensure emotional/psychological safety for people with intellectual disability and trauma?	6.38	Emotional/ psychological safety
27. How can health service staff and systems ensure they are delivering a person-centred approach when working with people with intellectual disability and trauma?	6.38	Person/ family centred approach
3. What support do health service staff need to use trauma-informed practices more effectively when working with people with intellectual disability and trauma?	6.25	Capacity building and staff support

Question	Score	Theme
13. How can the physical environment of health service facilities be adapted to promote safety for people with intellectual disability and trauma?	6.13	Physical/ environmental safety
18. How can health service staff and systems ensure physical safety for people with intellectual disability and trauma?	6.13	Physical/ environmental safety
20. When working with people with intellectual disability and trauma, how can health service staff and systems ensure trustworthiness through relationships?	5.88	Facilitating compassion, responsiveness, dignity
24. When working with people with intellectual disability and trauma, how can health service staff and systems ensure collaboration?	5.88	Systemic/ organisational collaboration
16. What internal policies and procedures can be established within organisations that reflect trauma-informed practice and models of health care for people with intellectual disability?	5.75	Systemic/ organisational collaboration
17. What would be necessary to implement on an organisational or leadership level to ensure an ongoing commitment to trauma-informed practice for people with intellectual disability?	5.75	Systemic/ organisational collaboration
15. What resources (educational, logistical etc.) are needed to promote safety in physical and social environments for people with intellectual disability and trauma?	5.63	
10. What foundational values underpin effective, trauma-informed care for supporting people with intellectual disability?	5.63	
11. What guiding principles should underlie the trauma-informed care that health services provide, as well as the broader organisational system?	5.63	
6. How can the responses of primary health systems (e.g. allied health, GP, community clinics) be better integrated with specialised health services to become more trauma-informed?	5.00	

Question	Score	Theme
7. How can health service staff enhance the quality of life of people with intellectual disability and trauma who access health services?	5.38	
8. What would enable health service staff and society, to benefit from the contributions of people with intellectual disability?	5.13	
21. When working with people with intellectual disability and trauma, how can health service staff and systems ensure trustworthiness through task clarity?	5.25	
23. When working with people with intellectual disability and trauma, how can health service staff and systems ensure trustworthiness through interpersonal boundaries?	5.00	
2. How can health services more effectively facilitate healing from past trauma?	4.75	
4. How can health service staff working with people with intellectual disability and trauma strengthen the way they reflect on their practice?	5.00	
14. What influence do health service staff have on the social environment of people with intellectual disability and trauma and how could that promote safety?	4.88	
22. When working with people with intellectual disability and trauma, how can health service staff and systems ensure trustworthiness through consistency?	4.88	
5. How can health service staff who work with people with intellectual disability and trauma improve their self-care approaches to resist vicarious trauma?	4.63	

3.2. Initial research questions adapted from the priority guideline to inform the Trust Guide

Theme	Question
<i>Reduce traumatisation and re- traumatisation</i>	P: People with intellectual disability accessing health services I: Implementation of trauma-informed care principles in health services (safety, trust, choice/control, collaboration, empowerment, culturally/historically responsive) Co: Health services How are trauma-informed care principles implemented and experienced and what are the outcomes in health services providing care to people with intellectual disability?
<i>Prioritising voice, choice, and control</i>	P: People with intellectual disability accessing health services I: Amplifying the voice and empowering people with intellectual disability to be heard and have a say about their health care. Co: Health services What practices used by staff can amplify and prioritise the voice, choice, and control of people with intellectual disability when accessing health services?
<i>Facilitating compassion responsiveness, and dignity</i>	P: People with intellectual disability accessing health services I: Compassion, respect, dignity, responsiveness Co: Health services What can health services do to facilitate compassion and responsiveness towards people with intellectual disability that actively promotes dignity when accessing health services?
<i>Capacity building and staff support</i>	P: Health service staff working with people with intellectual disability I: Trauma-informed care training and development, training related to communication and embedding reasonable adjustments, organisational support, peer supervision Co: Health services How can trauma-informed training, development, and support, improve health workers capacity to provide trauma-informed care to people with intellectual disability in health services?

Theme	Question
<i>Emotional and psychological safety</i>	P: People with intellectual disability accessing health services I: Upskilling health workers on how to provide emotional and psychological safe services Co: Health services How can health service staff provide emotional and psychological safe health care to people with intellectual disability accessing health services?
<i>Person and family-centred approach</i>	P: People with intellectual disability accessing health services I: Person-centred approach, family-centred approach Co: Health services How are person-centred and family-centred approaches used to deliver trauma-informed care to people with intellectual disability in health services?
<i>Physical and environmental safety</i>	P: Health service staff working with people with intellectual disability I: Reasonable adjustments, physical safety, environmental safety Co: Health services How can reasonable adjustments and changes to the physical environment contribute to trauma-informed care for people with intellectual disability in health services?
<i>Systemic / organisational collaboration</i>	P: Multidisciplinary health teams working with people with intellectual disability I: Relevant policies and procedures, collaboration, organisation structure Co: Health services, community support services How can policies, procedures and organisational processes improve trauma-informed care for people with intellectual disability accessing health services?
Note. P = population, I = interest/intervention, Co = context	

Appendix 4: Systematic Review for Evidence Updates

4.1. Search strategy (February 2026)

Query	Search terms	Results
Pubmed		
1	("trauma informed"[tiab:~4] OR "trauma awareness"[tiab:~4] OR "trauma focused"[tiab:~4] OR "trauma centered"[tiab:~4] OR "trauma centred"[tiab:~4] OR "Trauma-sensitive"[tiab:~4] OR "ACE informed"[tiab:~4] OR "ACEs informed"[tiab:~4] OR "violence informed"[tiab:~4]) OR "TVIC"[tiab]	9984
2	"Stress disorders, Traumatic"[MeSH] OR "adverse childhood experiences"[MeSH Terms] OR "trauma"[tiab] OR "traumas"[tiab] OR "post-traumatic"[tiab] OR "traumatised"[tiab] OR "traumatized"[tiab] OR "safe*"[tiab] OR "violence"[tiab] OR "abuse"[tiab] OR "neglect*"[tiab] OR "trust"[tiab] OR "ACEs"[tiab]	2151205
3	"care"[tiab] OR "approach*"[tiab] OR "practice*"[tiab] OR "framework*"[tiab] OR "model*"[tiab] OR "system*"[tiab] OR "service*"[tiab] OR "intervention*"[tiab] OR "program*"[tiab] OR "pathway*"[tiab] OR support[tiab] OR supporting[tiab] OR "best practice*"[tiab] OR "person centred"[tiab] OR "person centered"[tiab] OR "family centred"[tiab] OR "family centered"[tiab]	15788597
4	2 AND 3	1293070
5	1 OR 4	1294192

Query	Search terms	Results
6	"Intellectual Disability"[MeSH Terms] OR "Persons with Intellectual Disabilities"[MeSH Terms] OR "Developmental Disabilities"[MeSH Terms] OR "Learning Disabilities"[MeSH Terms] OR "intellectual disabil*"[tiab] OR "intellectual developmental disabil*"[tiab] OR "intellectual and developmental disabil*"[tiab] OR "IDD"[tiab] OR "developmental disabil*"[tiab] OR "learning disabil*"[tiab] OR "mental* retard*"[tiab]	193938
7	5 AND 6	4076
8	Filters: 2015-2026, English only	2203
Embase		
1	(trauma NEAR/4 informed):ab,ti OR (trauma NEAR/4 awareness):ab,ti OR (trauma NEAR/4 focused):ab,ti OR (trauma NEAR/4 centered):ab,ti OR (trauma NEAR/4 centred):ab,ti OR (trauma NEAR/4 sensitive):ab,ti OR (ACE NEAR/4 informed):ab,ti or (ACEs NEAR/4 informed):ab,ti OR (violence NEAR/4 informed):ab,ti OR (TVIC):ab,ti	10535
2	'posttraumatic stress disorder'/mj OR 'trauma informed care'/exp OR 'psychotrauma'/mj OR 'sexual trauma'/mj OR "trauma":ti,ab OR "traumas":ti,ab OR "post-traumatic":ti,ab OR "traumatized":ti,ab OR "traumatised":ti,ab	512616
3	"care":ti,ab OR "approach*":ti,ab OR "practice*":ti,ab OR "framework*":ti,ab OR "model*":ti,ab OR "system*":ti,ab OR "service*":ti,ab OR "intervention*":ti,ab OR "program*":ti,ab OR "pathway*":ti,ab OR support:ti,ab OR supporting:ti,ab OR "best practice*":ti,ab OR "person centred":ti,ab OR "person centered":ti,ab OR "family centred":ti,ab OR "family centered":ti,ab	20145580
4	2 AND 3	294383
5	1 OR 4	295441

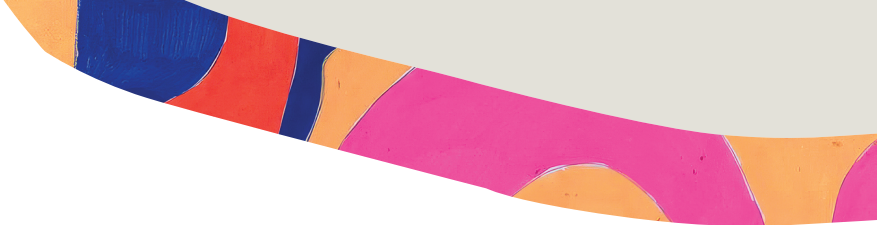
Query	Search terms	Results
6	'intellectual impairment'/mj OR 'mental retardation malformation syndrome'/mj OR 'mental deficiency'/mj OR 'developmental disorder'/mj OR 'learning disorder'/ mj OR 'intellectual disabil*':ti,ab OR 'intellectual developmental disabil*':ti,ab OR 'intellectual and developmental disabil*':ti,ab OR 'idd':ti,ab OR 'developmental disabil*':ti,ab OR 'learning disabil*':ti,ab OR 'mental* retard*':ti,ab	157349
7	5 AND 6	992
8	Filters: 2015-2026, English only	681
9	8 NOT ('conference abstract'/it)	412
CINAHL		
1	XB (trauma N4 informed OR trauma N4 awareness OR trauma N4 focused OR trauma N4 centered OR trauma N4 centred OR trauma N4 sensitive OR ACE N4 informed or ACEs N4 informed OR violence N4 informed OR (TVIC))	6133
2	MH "Historical Trauma" OR MH "Psychological Trauma" OR MH "Sexual Trauma" OR MH "Adverse Childhood Experiences" OR XB ("trauma" OR "traumas" OR "post-traumatic" OR "traumatized" OR "traumatised" OR "safe*" OR "violence*" OR abuse OR "trust*" OR "ACEs")	635470
3	XB ("care" OR "approach*" OR "practice*" OR "framework*" OR "model*" OR "system*" OR "service*" OR "intervention*" OR "program*" OR "pathway*" OR support OR supporting OR "best practice*" OR "person centred" OR "person centered" OR "family centred" OR "family centered")	3552614
4	2 AND 3	385669
5	1 OR 4	386405

Query	Search terms	Results
6	(MH "Developmental Disabilities" OR MH "Intellectual Development Disorder" OR MH "Learning Disabilities") OR XB ("intellectual disabil*" OR "intellectual developmental disabil*" OR "intellectual and developmental disabil*" OR "IDD" OR "developmental disabil*" OR "learning disabil*" OR "mental* retard*") AB ("intellectual disabil*" OR "intellectual developmental disabil*" OR "intellectual and developmental disabil*" OR "IDD" OR "developmental disabil*" OR "learning disabil*" OR "mental* retard*")	12713
7	5 AND 6	424
8	Filters: 2015-2026, English only	285
PsycINFO		
1	XB (trauma N4 informed OR trauma N4 awareness OR trauma N4 focused OR trauma N4 centered OR trauma N4 centred OR trauma N4 sensitive OR ACE N4 informed or ACEs N4 informed OR violence N4 informed OR (TVIC))	10142
2	(DE "Trauma" OR DE "Trauma Screening" OR DE "Trauma Measures" OR DE "Posttraumatic Stress Disorder" OR DE "Trauma-Informed Care" OR DE "Stress and Trauma Related Disorders" OR DE "Trauma Treatment" OR DE "Complex PTSD" OR DE "Stress" OR DE "Experiences (Events)" OR DE "Adversity" OR DE "Trauma Reactions" OR DE "Traumatic Experiences" OR DE "Childhood Adversity" OR DE "Trauma Exposure" OR DE "Stress") OR XB ("trauma" OR "traumas" OR "post-traumatic" OR "traumatized" OR "traumatised" OR "safe*" OR "violence*" OR abuse OR "trust*" OR "ACEs")	620938

Query	Search terms	Results
3	XB ("care" OR "approach*" OR "practice*" OR "framework*" OR "model*" OR "system*" OR "service*" OR "intervention*" OR "program*" OR "pathway*" OR support OR supporting OR "best practice*" OR "person centred" OR "person centered" OR "family centred" OR "family centered")	3403066
4	2 AND 3	428631
5	1 OR 4	429387
6	(DE "Developmental Disabilities" OR DE "Intellectual Development Disorder" OR DE "Learning Disabilities") OR XB ("intellectual disabil*" OR "intellectual developmental disabil*" OR "intellectual and developmental disabil*" OR "IDD" OR "developmental disabil*" OR "learning disabil*" OR "mental* retard*")	102812
7	5 AND 6	4532
8	Filters: 2015-2026, (LA English)	2012
Totals		
	Gross	4912
	Duplications removed	1081
	Net (uploaded to Covidence)	3831
	Duplications removed by Covidence	5
	Subject to title and abstract screening	3826

4.2. Inclusion/exclusion criteria

Category	Inclusion criteria	Exclusion criteria
Review focus	Evidence on trauma-informed, trauma-responsive, trauma- and violence-informed, or trauma-transformative approaches for adults with intellectual disability in health-care settings.	Studies without an explicit trauma-informed or related framing.
Population	Adults aged 18 years and over with intellectual disability.	Studies focused only on children or populations without intellectual disability.
Mixed disability samples	Included where participants with intellectual disability could be clearly identified.	Excluded where intellectual disability participants could not be separated or clearly identified.
Professional group	Health workers involved in delivering, implementing, evaluating, or receiving training in trauma-informed care for adults with intellectual disability.	Studies not involving health workers or healthcare delivery.
Approach / intervention	Practices, policies, interventions, programmes, service models, or training related to trauma-informed, trauma-responsive, trauma- and violence-informed, or trauma-transformative care.	Studies describing general good care only, without explicit trauma-informed framing.
Setting	Primary care, tertiary care, allied health, mental health, and other settings where health care was delivered.	Residential, community support, or education-only settings without a health-care component.



Category	Inclusion criteria	Exclusion criteria
Outcomes of interest	Outcomes aligned with the Trust Guide, including trauma awareness, voice and choice, person- and family-centred care, workforce training and support, emotional and psychological safety, reasonable adjustments, multidisciplinary collaboration, organisational leadership, respect, compassion and kindness.	Studies focused only on trauma-specific psychological or pharmacological treatment outcomes.
Publication type	Published primary research.	Reviews, editorials, case studies, conference papers, letters, books, dissertations, and other non-primary research outputs.
Language	English-language publications.	Non-English publications.

4.3. GRADE-CERQual assessment of certainty in the evidence of synthesised qualitative findings

Qualitative Findings	Studies contributing to the theme	Methodological limitations	Relevance	Coherence	Adequacy	Overall confidence rating	Explanation of judgement
Awareness of trauma							
<i>Recognising trauma's pervasiveness requires staff understanding of its causes - and that understanding also protects staff.</i>	Keesler (2016); Keesler & Isham (2017); McNally et al. (2023); Mokoena-de Beer et al. (2024); Punzi et al. (2026); Strnadová et al. (2025)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are related to setting and study location.	No or very minor concerns	Minor concerns Concerns are related to sample size of some studies, however, there are several studies contributing to the review.	Moderate	Rated down one level due to minor concerns about methodological limitations, relevance, and adequacy of data.
<i>Trauma is easy to miss, and standard practice itself is not yet consistently equipped to catch it.</i>	Keesler (2016); Luiselli et al. (2025); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026); Truesdale et al. (2019)	Minor concerns Concerns are related to data analysis methods of Luiselli et al. (2025) which were not adequately described.	Moderate concerns Concerns are related to setting and study location. Some concerns related to the relevance to review aims which do not require documented exposure to trauma.	Minor concerns Concerns are related to the	Minor concerns Concerns are related to sample size of some studies, however, there are several studies contributing to the review, and the richness of data contributing to the synthesised finding.	Moderate	Rated down one level due to minor concerns about methodological limitations, adequacy of data and moderate concerns about relevance.

Qualitative Findings	Studies contributing to the theme	Methodological limitations	Relevance	Coherence	Adequacy	Overall confidence rating	Explanation of judgement
Centring choice and voice							
<i>Choice and autonomy support empowerment and inclusive practice.</i>	Keesler (2016); Keesler & Isham (2017); McKenzie & Charlton (2025); McNally et al. (2023); Rich et al. (2021); Strnadová et al. (2025)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are related to setting.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Genuine choice depends on relational trust and communication.</i>	Keesler (2016); McConnell & Phelan (2022); McKenzie & Charlton (2025); McNally et al. (2023)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are related to setting.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Restricting or invalidating autonomy causes harm and conflict.</i>	McKenzie & Charlton (2025); McNally et al. (2023)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are related to setting.	No or very minor concerns	Minor concerns Concerns are related to only 2 studies contributing to finding and smaller sample sizes.	Moderate	Rated down one level due to minor concerns about methodological limitations, relevance, and adequacy of data.
<i>Genuine voice requires active effort against disbelief and opportunities for disclosure.</i>	O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026)	No or very minor concerns	Minor concerns Concerns are related to setting and exposure not being specifically TIC, rather a response to violence and trauma.	No or very minor concerns	Minor concerns Concerns are related to richness of study findings contributing to synthesised finding.	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Methodological limitations	Relevance	Coherence	Adequacy	Overall confidence rating	Explanation of judgement
Person-/family-centred care							
<i>Person-centred care is recognised by health professionals as a defining feature of trauma support through the way it can be adapted to support each person's individual identity and context.</i>	McConnell & Phelan (2022); Punzi et al. (2026); Truesdale et al. (2019)	No or very minor concerns	Moderate concerns Concerns are related to setting and exposure not being specifically TIC, rather a response to violence and trauma.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Non-judgemental, empathic, connection-focused approaches reduce vulnerability and isolation.</i>	McKenzie & Charlton (2025)	No or very minor concerns	Moderate concerns Concerns are related to setting (forensic setting).	No or very minor concerns	Moderate concerns Concerns related to only one study contributing to finding and small sample size.	Low	Rated down two levels due to only one study contributing to the finding, and moderate concerns about relevance and adequacy of data
Staff training and resources							
<i>Effective training must be specialised, dual-focused, and embedded from the tertiary through to leadership level.</i>	Keesler (2016); Luiselli et al. (2025); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026); Truesdale et al. (2019)	Minor concerns Concerns are related to data analysis methods of Luiselli et al. (2025) which were not adequately described.	Moderate concerns Concerns are related to setting (not all specific to healthcare).	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Methodological limitations	Relevance	Coherence	Adequacy	Overall confidence rating	Explanation of judgement
<i>Training alone is insufficient without ongoing organisational support and attention to staff wellbeing.</i>	Keesler (2016); McNally et al. (2023); McNally et al. (2023); Mokoena-de Beer et al. (2024); Rich et al. (2021)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Moderate concerns Concerns are related to setting not being specific to healthcare and study location.	No or very minor concerns	No or very minor concerns	Moderate	Rated down one level due to minor concerns about methodological limitations, and moderate concerns about relevance.
Service culture							
<i>Trust, consistency, and emotional safety are central to a trauma-informed culture and to recovery.</i>	Keesler (2016); McNally et al. (2023); McNally et al. (2022); O'Malley et al. (2020); O'Malley et al. (2019)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are related to participants with intellectual disability not being represented as much as staff.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Relational factors can build or remove a sense of safety.</i>	Keesler (2016); McConnell & Phelan (2022); McKenzie & Charlton (2025)	No or very minor concerns	Minor concerns Concerns are related to study setting	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>A trauma-informed culture must extend safety to staff as well as service users, and is shaped by structural and cultural barriers.</i>	Keesler et al. (2025); Keesler (2016); Mokoena-de Beer et al. (2024); Rich et al. (2021)	No or very minor concerns	Moderate concerns Concerns are related to participants, setting, and study location.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Methodological limitations	Relevance	Coherence	Adequacy	Overall confidence rating	Explanation of judgement
Environment adjustments							
<i>Create more accessible environments (imagery, visual techniques, flexible pacing, and non-verbal approaches) that support sensory and communication needs.</i>	Keesler (2016); McNally et al. (2023); O'Malley et al. (2019); Punzi et al. (2026)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are related to participants (mostly staff), and setting	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Reasonable adjustments are a necessary, practical component of trauma-informed care, and staff benefit from structured support to deliver them.</i>	Keesler (2016); Strnadová et al. (2025); Truesdale et al. (2019)	No or very minor concerns	Minor concerns Concerns are related to exposure, which was not specifically TIC, rather it was an element of a larger approach.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
Collaboration and coordination							
<i>Coordinated pathways across services, professions and sectors are needed to prevent people falling through gaps.</i>	Keesler (2016); McNally et al. (2023); McNally et al. (2022); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026); Truesdale et al. (2019)	No or very minor concerns	Moderate concerns Concerns are mostly related to participants (mostly staff), and exposure (TIC was an element of a broader exposure).	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Methodological limitations	Relevance	Coherence	Adequacy	Overall confidence rating	Explanation of judgement
<i>Collaborative model encouraged cross-organisation learning and integration of TIC across clinical, residential, behavioural, and leadership systems.</i>	Keesler (2016); Keesler & Isham (2017); Mokoena-de Beer et al. (2024)	No or very minor concerns	Moderate concerns Concerns are related to setting and study location.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Sustaining collaboration requires dedicated organisational structures and addressing community-level barriers</i>	Keesler (2016); Keesler et al. (2025); Rich et al. (2021)	No or very minor concerns	Minor concerns Concerns are related to setting and participants (staff only)	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
Leadership and workforce							
<i>Leadership engagement, buy-in and style were either facilitators or barriers to TIC</i>	Keesler (2016); Keesler et al. (2025); Keesler & Isham (2017); McNally et al. (2023); Rich et al. (2021)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are related to participants.	No or very minor concerns	minor concerns Concerns related to richness of data.	Moderate	Rated down one level due to minor concerns about methodological limitations, relevance, and adequacy of data.
<i>Sustaining TIC requires adequate workforce structures, staffing, and governance, not leadership commitment alone.</i>	Keesler (2016); Mokoena-de Beer et al. (2024); O'Malley et al. (2020)	No or very minor concerns	Minor concerns Concerns are related to setting and study location.	No or very minor concerns	Minor concerns Concerns related to richness of data.	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.

Qualitative Findings	Studies contributing to the theme	Methodological limitations	Relevance	Coherence	Adequacy	Overall confidence rating	Explanation of judgement
Respect, compassion, and kindness							
<i>Respect and compassion are enacted through relational practices that build the trust needed to manage distress and foster belonging.</i>	Keesler (2016); McConnell & Phelan (2022); McKenzie & Charlton (2025); McNally et al. (2023); O'Malley et al. (2020); O'Malley et al. (2019); Punzi et al. (2026)	Minor concerns Concerns are related to data collection methods of McNally et al. (2023) which used secondary data.	Minor concerns Concerns are mostly related to setting.	No or very minor concerns	No or very minor concerns	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.
<i>Compassion needs organisational support. A lack of either was experienced by people with intellectual disability.</i>	Mokoena-de Beer et al. (2024); Strnadová et al. (2025)	No or very minor concerns	Minor concerns Concerns are related to study location.	No or very minor concerns	Minor concerns Concerns are related to only 2 studies contributing to finding and lack of depth in findings.	High	Limited concerns regarding methodological limitations, relevance, coherence, and adequacy of data.



4.4. GRADE assessment of certainty in the evidence of narratively synthesised quantitative findings

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Awareness of trauma								
<i>Trauma is widely recognised as relevant and impactful, but is not consistently translated into consistent understanding or implementation.</i>	Luiselli et al. (2025); Presnell et al. (2022); Rich et al. (2021); Sullivan et al. (2025); Webb et al. (2021)	Four studies were conducted in broader community and support services, and one was conducted in a forensic psychiatric setting (8), suggesting these results may not be transferable to healthcare. All studies were cross sectional and relied heavily on self-reported data which may biased the findings. All studies but one (8) were conducted in trauma informed services, which may have positively skewed perceptions and awareness of trauma.	The studies were conducted in broader settings to just healthcare (direct support (5, 6), behavioural and functional analysis (3, 7), inpatient psychiatric forensic (9). All but one (9) focused on the provision and experience of trauma-informed care with people with intellectual disability. The other focused on how trauma was experienced by staff and the uptake of trauma support services. The implementation of TIC was assessed using varied scales and surveys that were all self-reported.	Participants across the four studies was ~800. All studies reported frequency counts with percentages. One study (9) also used non-parametric analysis that included several significant and non-significant results. Some of the results, however, were related to services that did not include people with intellectual disability.	Only one study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was rated down due to risk of bias and concerns around indirectness and imprecision. The finding was therefore rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
<i>Awareness was unevenly distributed by role. Frontline staff were less aware than clinical/managerial staff.</i>	Presnell et al. (2022)	The study compared direct support professionals to healthcare professionals using non standardised measures and self-reported data. Direct support professionals generally had less awareness of trauma compared to professionals, suggesting a bias due to training and background.	The study was conducted with direct support professionals and healthcare clinicians. The exposure was TIC and measured how staff perceived it to be implemented, their knowledge and familiarity, and perceived challenges and barriers.	The study had 288 respondents and only reported descriptives and frequencies.	This study did not include any measures of effect size.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as having only small concerns regarding indirectness and imprecision. Inconsistency could not be measured. Due to only one study being included, the risk of bias was high. Therefore, the finding was rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Centring choice and voice								
<i>Choice/shared governance is broadly endorsed in principle, but implementation is partial and dependent on procedural burden.</i>	Luiselli et al. (2025); Sullivan et al. (2025)	Both studies were conducted on behaviour analysts. One used participant who were published researchers and presenters in the field (7). The other recruited board-certified staff from a single organisation with a mixed understanding and background of trauma and trauma-informed care (3). Both studies utilised single timepoint surveys with self-reported data. Both studies reported broad findings, however, these were from the perspectives of the staff only, not people with intellectual disability.	The population of the studies were not directly related to healthcare. Both were within the context of behavioural analysis which has little directness to the Australia healthcare context. Both studies did observe the implementation of TIC with people with intellectual disability. The studies had some variability in the outcomes but were broadly relevant to the aims of the review.	The studies had 67 (3) and 42 (7) respondents. Both studies only reported descriptives and frequencies.	No studies included any measures of effect size.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was rated down due to risk of bias and concerns around indirectness and not being able to measure inconsistency. Inconsistency could not be measured.

[illegible]

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Staff training and resources								
<i>Formal TIC-specific training coverage is limited and inconsistent, despite strong endorsement that it should be prioritised.</i>	Luiselli et al. (2025); Mercer et al. (2023); Presnell et al. (2022); Rich et al. (2021)	The three studies observed training in broader support contexts, not specifically health care. One study (3) reported that self-report data may have been biased positively towards trauma informed care. One study (5) reported potential recall bias of staff and sampling bias. Another study (6) reported limitations in sample size and consistency in the position of participants which may have skewed perceptions of TIC training coverage (6). The last study (4) reported potential sampling bias due to the sensitive nature of the topic.	The studies were conducted in broader settings to just healthcare (direct support (4, 5, 6), behavioural and functional analysis (3). Three focused on the provision and experience of trauma-informed care with people with intellectual disability. One was less direct (4) and was primarily focused on staff ACEs and their perceptions of the TIC climate. Measurements were varied but were broadly relevant to the aims of the review.	The four studies had ~590 respondents. Three only reported descriptives and frequencies. Only one study additionally reported (4) reported correlation, regression, mediation and moderation analyses which controlled for key confounds, however the data relevant to this finding were descriptive only.	Only one study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Low 	The finding started as low due to being observational. There were concerns regarding risk of bias and indirectness. Imprecision was judged as acceptable. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
<i>Uptake for practical, coaching-type supports is higher than dedicated wellbeing support.</i>	Sullivan et al. (2025)	The study had a low response rate and a small final sample of 42 respondents, mostly highly experienced behaviour analysts with doctoral-level qualifications and expertise in trauma-informed approaches.	The population was not directly related to healthcare and was within the context of behavioural analysis which has little directness to the Australia healthcare context. The study provided direct evidence to the implementation of TIC with people with intellectual disability but only from the perspective of the behavioural analysts.	The study had 42 respondents and only reported descriptives and frequencies.	This study did not include any measures of effect size.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision due to small sample size. The finding was therefore rated down. Inconsistency could not be measured.



Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
<i>Structured training/ support interventions show measurable positive impact on staff confidence, attitudes, and capability over time.</i>	Keesler et al. (2025); Strnadová et al. (2025)	One study (1) was conducted during COVID-19 and had high attrition due to staff turnover and general uncertainty. It was conducted in a trauma-informed specific service which may have impacted perceptions of TIC and relied primarily on self-report data. The other study (8) utilised self-report data of a potentially biased sample, due to the cross-sectional nature of the study, who may have viewed toolkits and TIC favourable. Furthermore, the sample size was relatively small (n = 74) and had large attrition following initial consent (n = 120 consents). Statistically significant measures of capability, motivation, and opportunity to deliver the toolkit was non-standardised and self-reported, however, it did observe strong Cronbach's alpha scores.	One study (1) was conducted across a range of disability services including several health-related services. TIC was delivered as an organisational initiative which aligned with the aims of the review; however, this was an online learning collaborative that did not observe outcomes of those attending the program. The other study (8) was specific to genetic healthcare and did not provide direct evidence on the implementation of TIC, rather it focused on staff's experiences with engaging with a trauma-informed toolkit. There were limited data on how it actually improved their practice.	One study (1) had 172 respondents at follow up (baseline n = 374). It used descriptives and linear mixed models to analyse data. No primary models showed significant relationships, however, there were mixed results in models that were unadjusted for covariates. These data were interpreted with caution given the presence of covariates. The other study (8) had ~70 respondents and also utilised paired t-tests and Cronbach's alpha for internal consistency. It reported significant findings relating to some outcomes; however, these numbers were not reported.	Only one study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Low 	The finding started as low due to being observational. There were some concerns due to risk of bias and imprecision. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
<i>Staff wellbeing-support utilisation and outcomes were broadly similar regardless of service type.</i>	Webb et al. (2021)	The study used retrospective service evaluation data from one internal trauma support service in a single secure psychiatric hospital organisation. It included only staff who accessed the Trauma Support Service, so it cannot tell us about staff who experienced trauma but did not seek support. Furthermore, the staff compares results across several services, not just intellectual disability services.	The study was conducted in a niche setting, however, was related to health care. The intervention was not specific to TIC but instead observed staff outcomes relating to a trauma support service for exposure to violence and trauma. The outcomes also included trauma support as a result of trauma experienced outside of work, however this proportion of the findings were small.	This study evaluated retrospective data from 378 staff. Only 39 of those were in the intellectual disability service. Non-parametric tests were used due to normality violations. Categorical data were measured with contingency tables. Results were varied between services depending on outcomes and therefore judged with caution.	Only one study, therefore effect size could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision and was therefore rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Service culture								
<i>Staff felt their organisation's culture around trauma was improving, but this seemed to be about time passing rather than anything specific to their organisation.</i>	Keesler et al. (2025); Luiselli et al. (2025)	One study was conducted in a trauma-specific service which may have positively skewed staff's perception of TIC culture (1). This sample had high attrition which may conflict with the notion that organisation culture improved over time. The study was conducted during COVID-19 which may have also contributed to further confounds that skewed perception of improvement over time. The other study (3) observed participants from one behaviour analyst organisation suggesting it may not be generalisable to the broader population and health care.	The studies were conducted across a range of disability services including several health-related services. One (3) was specific to behavioural analysis. One study (1) delivered TIC as an organisational intervention while the other observed the presence of TIC in usual practice. As such, outcomes were varied but broadly covered the implementation and experience of TIC approaches.	One study (1) had 172 respondents at follow up (baseline n =374), the other had 67. They both relied on descriptive data and one (1) also employed linear mixed models. No primary models showed significant relationships, however, there were mixed results in models that were unadjusted for covariates. It was not possible to further synthesise the evidence given different analysis methods.	Only one study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision and was therefore rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
<i>Safety practices such as having a clear point to stop a session, or a safety plan, were common, and reduced harm.</i>	Keesler & Isham (2017); Sullivan et al. (2025)	One study (2) was conducted in a TIC specific service which may have biased this finding due to general understandings of TIC principles. Furthermore, this sample size was small and had a relatively high staffing ratio, suggesting additional resources to endorse safety practices. The other study (7) was a sample of 42 respondents who were relatively highly experienced in trauma-informed approaches. They reported outcomes relating to their own practice and perceptions of their organisation's practice.	The studies were not directly related to healthcare but included components of healthcare services. They both studied the implementation of TIC with people with intellectual disability, one being through a trauma-specific day program. Outcomes were assessed similarly in terms of experience, attitudes and challenges of TIC, despite being in different contexts/ interventions.	The sample size of each study was relatively small (~30 (2) and 42 (7). One study (2) conducted t-tests despite the sample size and found only one significant finding related to TIC principles, and mixed findings related to behaviours of individuals with intellectual disability. The other study analysed frequency data.	Only one study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was rated down due to concerns with indirectness and imprecision. There were only small concerns with risk of bias. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
<i>Staff also experience trauma, particularly in disability services.</i>	Presnell et al. (2022); Webb et al. (2021)	Both studies had large sample sizes of disability professionals with a range of experiences from direct support, clinicians, and leadership. Both studies observed results from several organisations, however one study included non-intellectual disability services (9). This study did not include data on the number, severity, or type of incidents experienced across services, so it cannot suggest that all trauma was experienced within the workplace. Furthermore, both studies used self-reported data on trauma and related psychological symptoms.	Both studies were conducted in intellectual disability settings and focused on staff perspectives. However, one study (5) observed experiences of TIC within the organisation, while the other (9) observed staff outcomes relating to a staff specific trauma support service for exposure to violence and trauma across several services (not just intellectual disability). Both studies assessed experiences and implementation of the relevant intervention. One study also assessed data on the uptake and outcomes of the staff support service (9).	One study (5) had 288 respondents and only reported descriptives and frequencies. This other (9) evaluated retrospective data from 378 staff. Only 39 of those were in the intellectual disability service. Non-parametric tests were used due to normality violations. Categorical data were measured with contingency tables. Results were varied between services depending on outcomes and therefore judged with caution. Results could not be further synthesised given data analysis and was therefore judged to have some imprecision.	Only one study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was rated down due to concerns with indirectness and imprecision. There were only small concerns with risk of bias. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
<i>A trauma-informed organisational climate is directly linked to lower staff burnout and secondary traumatic stress.</i>	Mercer et al. (2023)	The sample was relatively large (n = 110). Most had received training in positive behaviour support while most did not have training in TIC, potentially contributing to confounds in TIC perceptions. Furthermore, measures relied on self-reported data.	The population sample was relevant to the review aims in that it was conducted with multiple agencies supporting people with intellectual disability. Evidence lacked some directness given only few key findings are actually relevant to the Trust Guide themes. Furthermore, it lacks specificity in TIC measures.	The sample was relatively large and reported descriptives, correlation, regression, mediation and moderation analyses which controlled for key confounds. Measures of ACEs, secondary trauma, professional QoL and TIC climate showed moderate-good internal consistency. There were minimal missing data.	Only one study, therefore effect size could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as having only some concerns with risk of bias, indirectness, and imprecision. Inconsistency could not be measured. The finding was rated down due to only having one study contributing to the finding.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Environment adjustments								
<i>Practitioners adjusted services to reduce distress.</i>	Sullivan et al. (2025)	The sample was intentionally drawn from people publishing functional analysis research or presenting on trauma-informed care, so it likely overestimates how common these practices are in the wider field. It had a relatively small sample size (n = 42) and was based on self-report that did not observe actual practice outcomes, particularly relating to their clients with intellectual disabilities.	The population was not directly related to healthcare and was within the context of behavioural analysis which has little directness to the Australia healthcare context. The study provided direct evidence to the implementation of TIC with people with intellectual disability but only from the perspective of the behavioural analysts.	The study had 42 respondents and only reported descriptives and frequencies.	This study did not include any measures of effect size.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision due to small sample size. The finding was therefore rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Collaboration and coordination								
<i>Working with other practitioners is common. Shared, standardised resources were seen as something that could improve multidisciplinary collaboration.</i>	Sullivan et al. (2025); Strnadová et al. (2025)	One study (7) had a sample of mostly published functional analysts and those who have presented on trauma-informed care. It is possible this relatively small sample (n = 42) of professionals were linked through industry, potentially biasing the finding of practitioners working together. The other study (8) utilised self-report data of a potentially biased sample, due to the cross-sectional nature of the study, who may have viewed toolkits and TIC favourable. Furthermore, the sample size was relatively small (n = 74) and had large attrition following initial consent (n = 120 consents).	One study was directly related to healthcare, albeit specific to genetic healthcare (8). The other was healthcare within the context of behavioural analysis which has little directness to the Australia healthcare context (7). Only one study provided direct evidence to implementation approaches of TIC (8). The other study (7) was less direct given it observed staff's reactions to engaging with a trauma-informed toolkit, but not how they implemented it.	One study (7) had 42 respondents and only reported descriptives and frequencies. The other study (8) had ~70 respondents and utilised paired t-tests and Cronbach's alpha for internal consistency. It reported significant findings relating to some outcomes; however, these numbers were not reported.	Neither study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as having concerns with risk of bias, indirectness, and imprecision. The finding was therefore rated down. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Leadership and workforce								
<i>Despite leaders feeling their organisation is handling trauma well, there are barriers to delivering TIC such as staffing and resourcing gaps.</i>	Presnell et al. (2022); Rich et al. (2021); Sullivan et al. (2025)	All three studies involved a high percentage of disability workers in a range of services other than direct healthcare. This may have biased findings given that organisations are managed very differently. Furthermore, one study (6) gathered data from leadership themselves which may have positively skewed perceptions of how organisations are handling trauma. Another (7) study had highly experienced behaviour analysts with doctoral-level qualifications who were potentially in leadership positions, however this was not reported.	The studies were conducted in broader settings to just healthcare (direct support (5, 6), behavioural and functional analysis (7). They focused on the provision and experience of trauma-informed care with people with intellectual disability. Measurements were varied but were broadly relevant to the aims of the review given they studies how it was implemented and experienced.	The three studies had ~460 respondents and only reported descriptives and frequencies.	Only one study included measures of effect size, therefore inconsistency could not be measured across studies.	Publication bias was not suspected due to systematic search strategy.	Low 	The finding started as low due to being observational. There were small concerns with risk of bias and indirectness. Inconsistency could not be measured.

Quantitative Outcomes	Studies contributing to finding	Risk of bias	Indirectness	Imprecision	Inconsistency	Publication bias	Certainty in the evidence	Explanation of judgement
Respect, compassion, and kindness								
<i>A structured practice resource significantly boosted clinicians' motivation to deliver respectful, inclusive care.</i>	Strnadová et al. (2025)	This study may have been biased through the voluntary nature of recruitment among genetic health care professionals. Furthermore, the sample size was relatively small (n = 74) and had large attrition following initial consent (n = 120 consents). Furthermore, statistically significant measures of capability and motivation to deliver the toolkit was non-standardised and self-reported, however, it did observe strong Cronbach's alpha scores.	They study was directly related to healthcare, albeit specific to genetic healthcare. It did not provide direct evidence on the implementation of TIC, rather it focused on staff's experiences with engaging with a trauma-informed toolkit. There were limited data on how it actually improved their practice.	The study had ~70 respondents and utilised paired t-tests, Cronbach's alpha for internal consistency. It reported significant findings relating to some outcomes; however, these numbers were not reported.	This study did not include any measures of effect size.	Publication bias was not suspected due to systematic search strategy.	Very low 	The finding started as low due to being observational. It was judged as mostly having concerns regarding risk of bias due to being the only study, and imprecision. Inconsistency could not be measured. The finding was therefore rated down.

Note. 1 = Keesler et al. (2025); 2 = Keesler & Isham (2017); 3 = Luiselli et al. (2025); 4 = Mercer et al. (2023); 5 = Presnell et al. (2022); 6 = Rich et al. (2021); 7 = Sullivan et al. (2025); 8 = Strnadová et al. (2025); 9 = Webb et al. (2021)

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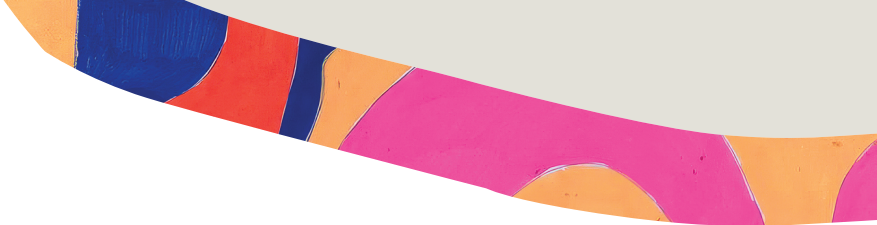
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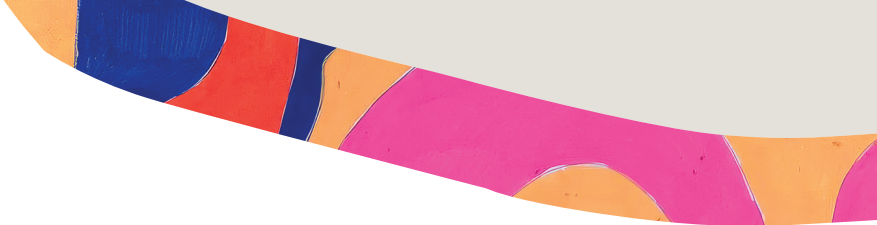
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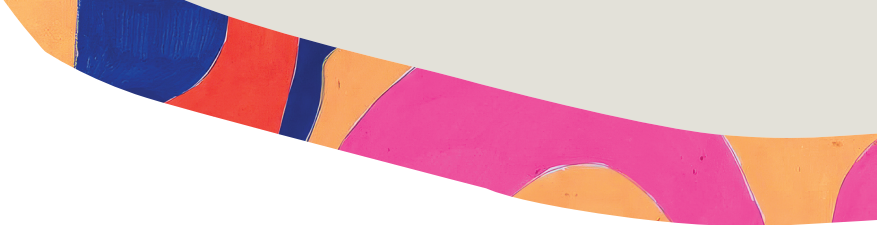
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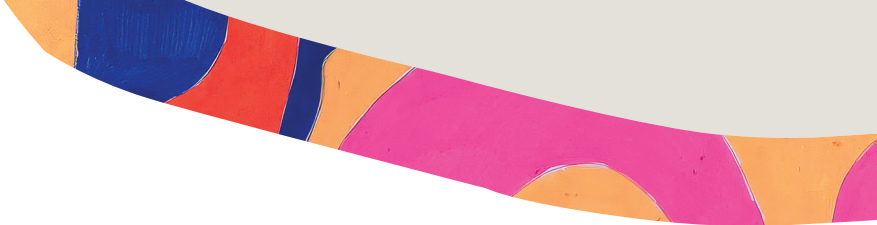
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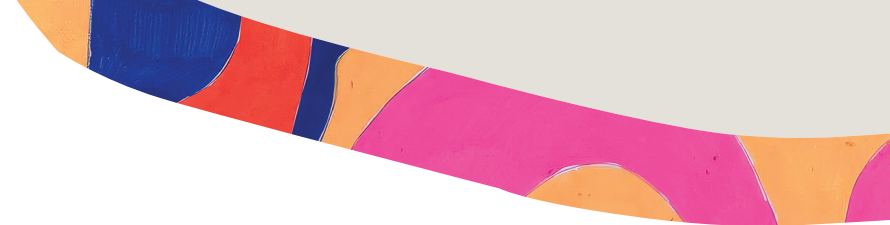
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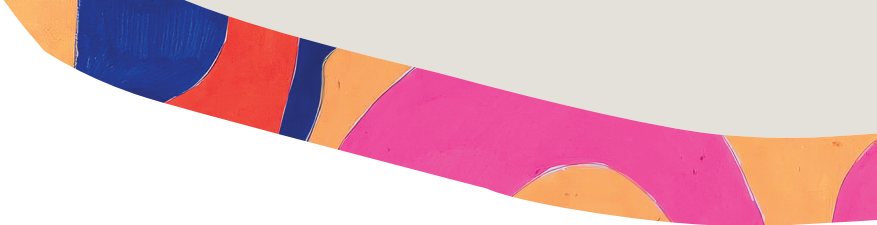
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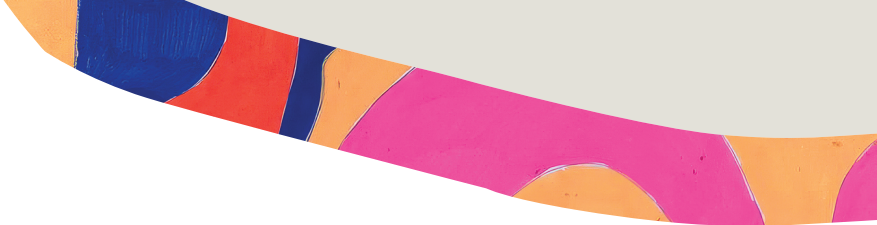
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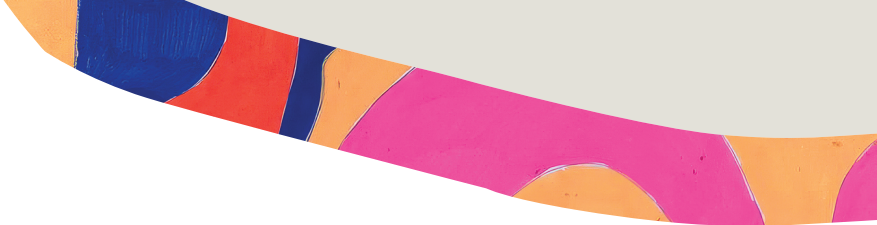
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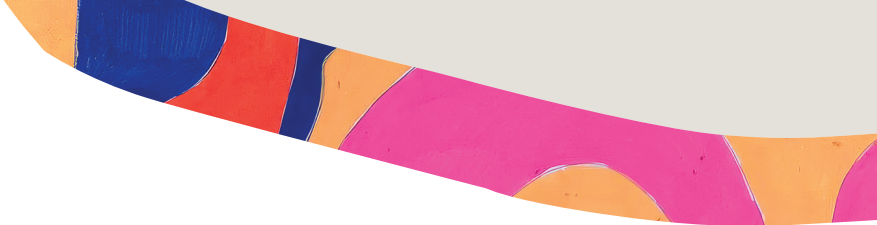
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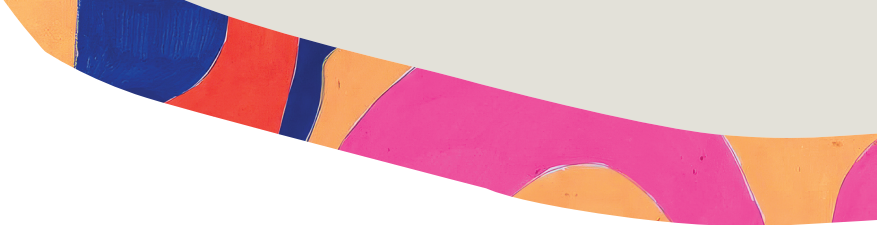
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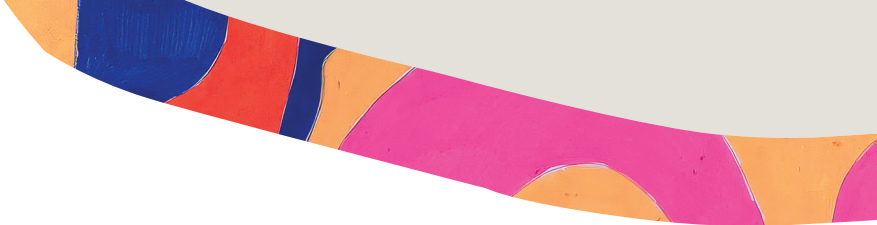
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