



TRAUMA, NERVOUS SYSTEM & TRAUMA-INFORMED SUPPORT

Safety in Trauma-Informed Care

Understanding physical, emotional, psychological and relational safety without promising that every difficult experience can be prevented.

The key idea

Safety is supported through environment, communication, boundaries, dignity and proportionate responses to risk. Feeling safe and being objectively safe can overlap, but they are not always the same thing.

Safety is multidimensional

Physical safety concerns protection from injury and environmental hazards. Emotional and psychological safety include experiences such as freedom from humiliation, intimidation and unnecessary fear. Relational safety concerns whether interactions feel reliable, respectful and appropriately bounded.

Objective and perceived safety

A service may meet formal safety requirements while an individual still experiences threat because of previous experiences, sensory conditions, communication barriers or uncertainty. Conversely, feeling comfortable does not prove that a situation is objectively safe. Both perspectives matter.

Important clinical point

A setting can be objectively low-risk while still feeling unsafe to a person. Both actual risk and the person's experience of safety matter; neither should automatically cancel out the other.

Environment and sensory load

Noise, alarms, lighting, crowding, smells, seating, locked doors and waiting arrangements can affect distress. Sensory adjustments can benefit autistic people, people with migraine, pain, trauma histories and others; they should not require disclosure of trauma.

Touch, bodily autonomy and personal care

Explain what will happen before touching or beginning a procedure. Preserve privacy and offer realistic choices about positioning, pacing, pauses, chaperones or supporters where possible. Consent should remain an active process where consent is required.

Emotional and psychological safety

Ridicule, moral judgement, dismissiveness and unnecessary confrontation can increase threat. Validation can acknowledge that an experience is difficult without confirming an interpretation that is unsupported or clinically inaccurate.

Relational safety and boundaries

Clear boundaries can increase rather than reduce safety. People benefit from knowing the professional's role, what contact is possible, how decisions are made and what happens if a boundary is reached. Trauma-informed care is not boundary-free care.

Predictability

Explain who is present, what the appointment is for, approximate duration, likely steps and what might happen afterwards. When plans change, give the reason and new information rather than expecting the person to absorb an unexplained change.

Power, coercion and restrictive practice

Some services hold authority and sometimes restriction is necessary. Trauma-informed practice aims to minimise unnecessary coercion, use proportionate and least-restrictive approaches, protect dignity and preserve involvement even when the overall decision is not optional.

Recognising escalating load

Possible signs include increased agitation, rapid speech, withdrawal, reduced language, repetitive questioning, pacing, tearfulness or difficulty processing information. These signs are non-specific; ask what is happening rather than assigning a cause.

De-escalation

Reduce unnecessary verbal demands, slow the pace, clarify the immediate issue, consider sensory input, offer realistic choices and avoid crowding. A calm tone can help, but scripted reassurance is not a substitute for addressing the actual problem.

Dissociation and grounding

Dissociation can involve detachment, unreality, memory disruption or reduced connection with surroundings. Grounding options include orientation to place and time, external sensory details, movement or familiar objects. Breath and body-focused exercises are not universally helpful.

Important to remember

Grounding is not universally helpful. Some people find sensory or body-focused techniques uncomfortable or activating, so strategies should be collaborative and adapted.

Communication and accessibility

Eye contact, stillness, facial expression and speech volume are poor universal indicators of safety or engagement. AAC, interpreters, writing, visual information, extra processing time and reasonable adjustments may be essential.

After a difficult event

Review what happened before, during and after escalation. Ask what helped, what worsened the situation and what could change next time. Repair may include acknowledgement, apology, clarification or alteration of the plan.

Example

A patient repeatedly asks when they can leave a waiting area. Rather than interpreting this as demanding behaviour, staff explain the delay, offer a quieter waiting option and agree how updates will be provided. The intervention changes uncertainty and sensory load rather than trying only to change the person's behaviour.

Practical safety check

Does the person understand what is happening? Is privacy protected? Is touch explained? Are choices genuine? Are sensory and communication needs considered? Could the same outcome be achieved with fewer surprises, less force or less public exposure?

References & Further Resources

These resources provide useful starting points for further reading. They serve different purposes, from evidence-based clinical guidance to trauma-informed service frameworks and accessible educational material.

NHS England

Provides national NHS information and service-improvement resources relevant to personalised care, patient experience, safeguarding and trauma-informed approaches in England.

NICE

Publishes evidence-based clinical guidance for England and Wales. Relevant guidance can help distinguish trauma-informed principles from recommended assessment and treatment for specific conditions.

SAMHSA

The US Substance Abuse and Mental Health Services Administration publishes a widely cited trauma-informed framework covering safety, trustworthiness, peer support, collaboration, empowerment and cultural, historical and gender considerations.

UK Trauma Council

Provides evidence-informed resources about childhood trauma, traumatic bereavement and supporting children and young people. Particularly useful for accessible explanations of trauma-related research and practice.

How to use these resources

Trauma-informed approaches should be used alongside current professional standards, safeguarding procedures, consent and capacity requirements, and condition-specific clinical guidance. Guidance and resources can change, so check the most recent version before relying on them in practice.