Kibble
EDUCATION AND CARE CENTRE

A BEST FIT MODEL OF TRAUMA-INFORMED CARE FOR YOUNG PEOPLE IN RESIDENTIAL AND SECURE SERVICES

- Findings from a 2016 Winston Churchill Memorial Trust Fellowship

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SUMMARY

This report focuses on how trauma-informed principles can be translated into tangible practice in residential and secure care in the UK.

It suggests that the core components of trauma-informed care, as identified by Hanson and Lang (2016), can be used as a framework to organise practice and ensure services are adhering to trauma-informed principles.

The report focuses on how trauma-informed principles and components have been turned into tangible practice in residential care services in the USA, Norway and Sweden and suggests practical steps practitioners can take in delivering trauma-informed services.

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ABOUT THE AUTHOR

I'm a forensic psychologist and run a psychology service at Kibble Education and Care Centre, a specialist provider of child and youth care services, including residential and secure care. My first job in this sector was as a care worker in small units about 17 years ago and since then I've worked in prisons, universities and numerous residential and secure care centres across Scotland.

I feel privileged to work in residential and secure care. It is not always easy but it feels like there's always the opportunity to do something meaningful. If I had to pin down the core of my role it would be to understand what has made young people who they are and behave in the way they do. Often at the centre of this are the adverse and traumatic experiences they have gone through.

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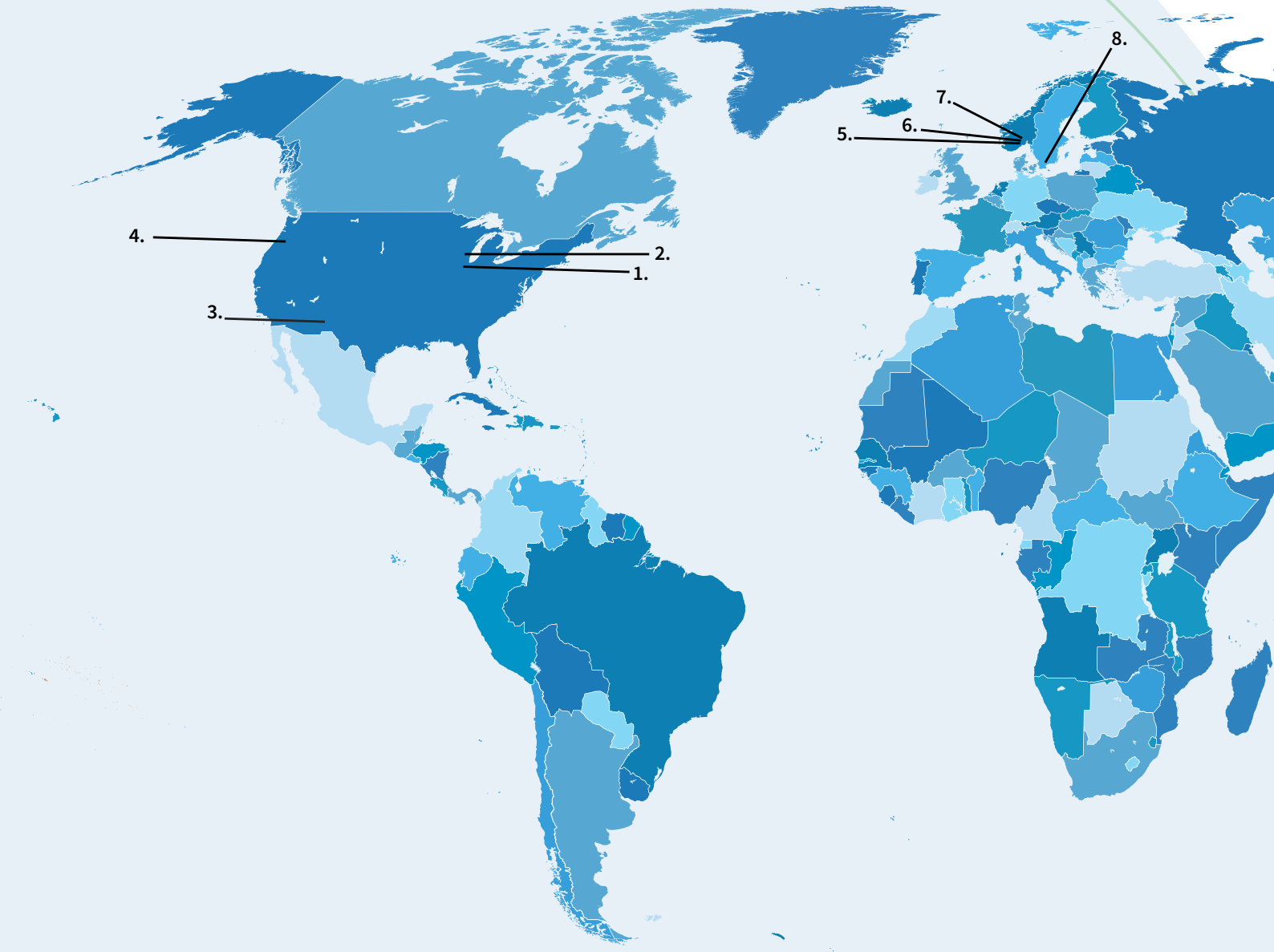

THE TRIP

1. Rush University Medical Centre, Chicago, Illinois. Team researching post-traumatic stress
2. SaintA, Milwaukee, Wisconsin. Family-centred care and educational services for children and adolescents
3. Sandhill Development Centre, Los Lunas, New Mexico. A residential programme for children ages 5 to 14 experiencing significant difficulties
4. Jasper Mountain, Eugene, Oregon. Services include an intensive residential treatment programme with a therapeutic school, a short-term residential centre, treatment foster care programme, community-based wraparound programme and crisis response services
5. Norwegian Centre For Violence and Traumatic Stress Studies, Oslo, Norway. Research team delivering Trauma-focused Cognitive Behavioural Therapy
6. Bakkehaugen ungdomshjem, Oslo, Norway. Residential care home for adolescents
7. Østbytunet Treatment Centre, near Oslo, Norway. A residential treatment facility for children aged 7-13. Many of the children have experienced developmental trauma
8. Magelungen, Stockholm, Sweden. Large care and education centre providing residential, outreach and day education services

WHY TRAUMA-INFORMED CARE?

For those working in residential and secure care it quickly becomes clear that the vast majority of young people there have experienced chronic, varied and severe adversity. This includes chaotic and violent families and homes, exposure to substance and alcohol abuse, the loss of key care givers and physical, emotional and sexual abuse. Not to mention being removed from their families and placed into care.

These experiences then continue to affect who they are in the present, and to be important in many of the harmful and concerning behaviours they do. As with any of us, their experiences shape and form who they are, the beliefs they have and the ways they cope with life. When these experiences are harmful, terrifying and overwhelming they can contribute to hostile and counterproductive beliefs about the world and others, harmful ways of coping and overwhelming emotional states. In some children and young people, the experiences are even more powerful as they continue to be live and salient long after the event, causing distress in the present.

For me these observations meant that I sought something that could 'work' for these young people. I trained in a variety of therapies and treatments, became obsessed by books on the subject and sought out a few gurus who I thought may have the answers. Disappointingly nothing really seemed to have the answers that I was looking for or live up to the promises it made. In parallel to this it became increasingly clear to me that those children and young people who did actually begin to feel better often did so because of the hard, consistent and dedicated work of the core care team in their unit. It was the relationships with these people that was facilitated by the safety and stability of their environment that really seemed to help.

While this was encouraging, it was too vague for a psychologist hoping to help spread such practice. The ideal would be to find something that had a sound theoretical basis, that could give practical and tangible guidance instead of vague principles, and that could be evaluated so that it could be replicated elsewhere. This is where my obsession with trauma-informed care began: it purports to acknowledge the harmful experiences of young people in care, to use this to explain their behaviour and then, importantly, to suggest ways to respond to this in a helpful manner. As someone said to me one day: "the holy grail then?"

However, some perhaps predictable difficulties came when attempting to implement trauma-informed care. Firstly, there is a plethora of models, approaches, assessment tools, books, and definitions etc. It was difficult to work out which one was a best fit for the young people and services I worked with. Many seemed to overlap and duplicate the other, while some offered specific elements that seemed good but perhaps did not cover all the requirements we had of it.

Secondly, all the models struggled to provide the tangible and practical advice needed by those working directly with children and young people. As a key worker said to me:

> **“I know what I need to do, I just have no idea how to do it.”**

The theory and concepts were great, and fit with my experience and service, but seemed to sometimes become vague and intangible when trying to use them to help young people with extremely complex, distressing and rejecting behaviour.

In addition to this, every time we tried to implement a new initiative, really practical or banal obstacles got in our way: staffing issues, rotas, access to resources etc. Problems that could be easily overcome once we knew what they were, but that had significantly delayed or distracted from the project.

I found myself wishing that there was some way to see how other people had implemented and run trauma-informed care, to learn the lessons they had without making the same mistakes, and to focus on the practice rather than the theory and gurus. Thankfully an old memory surfaced of Kibble’s chief executive at the time describing his Churchill Fellowship, and I realised that this could be the perfect way to answer the questions I had.

AIMS OF THE FELLOWSHIP

My Fellowship therefore had two core aims:

1. To identify a model of trauma-informed care that was best fit for UK residential care:
    - to see how different models were applied to services to see which would fit best with the UK sector
    - to see how these services had overcome implementation problems and to take lessons learned
2. To focus upon where the model and theory were turned into practical and tangible practice

A BEST-FIT MODEL OF TANGIBLE TRAUMA-INFORMED CARE

Trauma-informed Care (TIC) has been increasingly discussed, promoted and implemented across child care services in the last decade as high rates of trauma and adversity have been recognised.

There is a plethora of theories, models, articles and training providers. Many overlap but some also concentrate on different aspects of care e.g. individual treatment compared to organisational policy. The huge amount of material available can provide a challenge for practitioners in care settings looking to choose an applicable model or approach.

Becker-Blease (2017), Hanson and Lang (2016) and Bath (2017) highlight a number of criticisms with TIC. It by no means should be seen as a panacea. Many of the principles overlap with other care approaches, it has been accused of displacing other useful approaches such as attachment driven practice, and has been applied in counterproductive ways (see Bath, 2017). That said, it does currently offer the clearest and most applicable response to the acknowledged adversity and trauma that young people in care have experienced (see Johnson, 2017).

A key criticism is that there is a disproportionate focus in the literature on theory and core principles rather than the tangible practice they suggest. There is a gap about how practitioners can turn the theory and principles into daily practice and then evaluate their effectiveness.

The intention was to review the literature on each model that had promise, including the neurosequential model of therapeutics (Perry, 2006), sanctuary model (Bloom, 2013), and neurological reparative therapy (Ziegler, 2011). Then to visit sites that had implemented them to review their effectiveness and to take practical ideas to implement in the UK. The hope was that one of the many approaches would have both the anecdotal and research evidence to suggest it would be best for residential care in the UK.

FINDING 1:
NO SINGLE MODEL WILL DO

At the end of the Fellowship the conclusion was that no single approach fulfils all that a UK residential placement needs from it – no one model answers all the questions that a residential care setting asks. For example, most of the models work at different levels: some focus upon the organisational and milieu level, while others focus on individual assessments and the implications of these. While many touch on several aspects, they provide most guidance only at one particular level, and less at others, particularly when compared to an alternative approach. In turn, all contain useful guidance and strategies, there is worth in all.

The best fit model appears to be a strategy whereby a residential service utilises the guidance and tools from a range of approaches, one that takes the most useful and salient of these for their own specific service.

This has potential costs though: how does a service ensure that there is integrity to trauma-informed principles and that this inclusive approach does not become disorganised and inconsistent?

A solution is to use an over-arching framework that can provide a core definition of trauma-informed care that can then organise the guidance from different models *within* it. A framework that can provide a structure to ensure that practice remains trauma-informed.

Hanson and Lang (2016) perhaps provide such a framework. In their critique of trauma-informed care they reviewed numerous approaches and identified those themes that were core and important to all. They concluded that there were 15 core components of trauma-informed care for children and young people. These components were organised into three levels: workforce development (WD), trauma-focused services (TFS) and organisational delivery (ORG). Abbreviated versions of each component are provided below:

Table 1. Components of trauma-informed care services from Hanson and Lang (2016)

LEVEL	COMPONENT
WD	1. Required staff training in the impact of trauma
WD	2. Measure staff proficiency in knowledge of impact of trauma
WD	3. Processes to prevent and help with staff secondary trauma
WD	4. Staff knowledge about when and how to access trauma-focused therapy
TFS	5. Use of standardised and evidence-based assessments of trauma history and symptoms
TFS	6. Include child's trauma history in file and care plan
TFS	7. Availability of trained, skilled clinical providers in evidence-based, trauma-focused therapies
ORG	8. Collaboration and information sharing *within* the agency related to trauma-informed services e.g. between care and education
ORG	9. Collaboration and information sharing *with other* agencies related to trauma-informed service e.g. CAMHS and social work
ORG	10. Procedures to reduce risk for re-traumatisation of children
ORG	11. Input from children and purchasers in service planning and development of a trauma-informed system
ORG	12. Provide services that are strength-based and promote positive development
ORG	13. Provide a positive, safe physical environment
ORG	14. Written policies that explicitly include and support trauma-informed principles
ORG	15. Presence of a defined leadership position or job function specifically related to TIC

Hanson and Lang (2016) acknowledge the difficulty for those attempting to navigate the competing models and theories. Their 15 components can provide practitioners within residential care the flexibility to include a range of models while maintaining integrity and anchoring to trauma-informed principles. The strengths of each model can be taken and the limitations avoided.

The following section gives a brief rationale for the inclusion of each component followed by examples of how they can be translated into tangible practice. This includes where specific models and approaches can give guidance and be used to meet a particular component.

CASE STUDY 1. SANDHILL DEVELOPMENT CENTRE, NEW MEXICO, USA

Sandhill is based in an old villa surrounded by beautiful New Mexican countryside. The centre looked after about 30 kids and the environment of the whole centre and surrounding countryside was spacious, quiet, warm and calming.

The treatment lead was a psychologist who had been working in the sector for decades and had championed trauma-informed practice for many of these. A particular slant of this was a focus on the body as well as the mind. The service had a range of supports, activities and services to care for both. For example, there were horses and other animals that the young people cared for. There were exercise machines and physical activities accessible and available in all areas of the living space. There was also a huge breadth of sensory supports from a flotation tank, swings and a squeeze machine as designed by Temple Grandin. These too were available and accessible to young people.

There was an understanding that helping the body heal was a primary and necessary part of any treatment or healing and this was evident in different aspects of the young people's day. A memory that sums this up was leaving a classroom to see a group of children and their carers doing yoga on the lawn while another group did an exercise class.

Challenges for UK Implementation

An unexpected finding for me from Sandhill was just how important the environment was to the way the centre delivered its education, care and treatment. This included the shape and available space of the buildings, the land it was surrounded by, and the climate. The indoor and outdoor space was used in a way that enabled frequent regulation and exercise. There are some challenges to this in the UK. There are significant costs to space and design, and pre-existing buildings often do not meet this specification. A key focus for services developing trauma-informed environments will be focusing on the often underestimated importance of environment. Educating providers and managers on this importance will hopefully in the least enable consideration of how best to use available space and environment.

FINDING 2: TRAUMA-INFORMED PRINCIPLES CAN CREATE TANGIBLE PRACTICE

The descriptions that follow are sourced from the anecdotal evidence of services that have implemented trauma-informed care for a number of years. They do not represent the findings of any research trials or similar evaluation. Nor do they include a review of the literature and evidence base that informs such practice. Instead, they are themes derived from the learning of a range of practitioners, services and countries including the USA, Norway and Sweden. The hope is that the reader can take this learning to inform how they may implement the components of trauma-informed care within their own services.

Many of the examples may already be known to staff, and may be viewed simply as good child care. One criticism of trauma-informed care is that it recommends what should occur for all children, whether they have experienced traumatic experiences or not (Hanson & Lang, 2016). This article is inclusive and describes numerous practices that may be used without a trauma rationale in order to highlight how many existing practices can be consistent with trauma-informed care, and to inform those who are not already using them. If they are already known to the reader it is also hoped that they will confirm practice and provide a rationale for their use.

With the introduction of any new intervention or strategy there are consequences that are both positive and negative. In places some of the potential drawbacks of implementing the strategies are noted. For some, implementation involves additional costs and staff resources and it is acknowledged that this is particularly difficult given the pressure on resources and funding.

COMPONENT 1
REQUIRED STAFF TRAINING IN THE IMPACT OF TRAUMA

The rationale for knowledge in this area is self-explanatory but how best to achieve it is less clear. Services found that a range of approaches had been useful.

- All services found that it was important to give staff time to be taught by a knowledgeable trainer out of the usual demands of their job. It would not be appropriate to review different training providers, but services noted that there was a significant amount of free online training available if training is difficult to source. **For more information see: https://www.crisisprevention.com/Blog/April-2012/Top-10-Recommended-Trauma-Informed-Care-Online-Res**

- Many services felt that a focus on training in the milieu had the greatest value. This was described as many things, but may perhaps be best captured as 'mentoring', (Foster-Turner, 2005). For example, in one service each shift had a member of the training team present throughout and acting as a member of staff. They had a supervisory role where they would model good practice, provide feedback and help staff adhere to the model and ethos of the service. These trainers would regularly meet with a senior manager and discuss challenges to the implementation of trauma-informed care and examples of good practice. The role was more than a manager as it had the explicit aim of helping the service adhere to the trauma-informed framework both at the individual staff level and at organisational level

- In many UK services the direction of training is usually one way – the 'experts' or professionals from a different discipline train care staff. In one service, all new professionals e.g. therapists, trainers, teachers and managers were required to do a high number of shadow shifts within a unit in order to understand both the realities of the role of frontline staff and how the principles behind the services were translated into practice

COMPONENT 2
MEASURE STAFF PROFICIENCY IN KNOWLEDGE OF IMPACT OF TRAUMA

Ensuring staff are competent and proficient are important in aspects of making trauma-informed care real, rather than token. The ways in which services measured staff proficiency were varied and included online training with tests and competency-based assessments. This is one component where there are clear things to learn from the UK. Currently in Scotland NES, the NHS education aims to create a knowledge and skills framework which hopes to achieve highly effective and evidence-based training and skills development for all those who have contact with survivors of trauma. **See here for more detail: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx**

It may help increase continuity and transparency regarding trauma knowledge and skills if those in the care sector align themselves with this process and also inform it from a care perspective.

Related to this are some self-evaluation tools that allow services to assess how trauma-informed they are and to structure their planning, including the *Creating cultures of trauma-informed care (CCTIC): a self-assessment and planning protocol* (Fallot & Harris, 2009). **More examples can be found here: https://www.ncbi.nlm.nih.gov/books/NBK207183/**

COMPONENT 3
PROCESSES TO PREVENT AND HELP WITH STAFF SECONDARY TRAUMA

The demands of working with young people who have experienced trauma is well documented (Salloum, Kondrat, Johnco, & Olson, 2015). Hanson and Lang (2016) focus on the concept of secondary trauma (i.e. experiencing trauma symptoms as a result of exposure to another's traumatic experiences and symptoms). Importantly though there is an additional and real risk of primary traumatisation through exposure to the violence, self-harm and other concerning behaviour children in residential care can present.

A number of services had prioritised staff well-being with the understanding that staff were the most important resource and that they would be most effective in supporting children and young people when they themselves were supported. Some tangible examples of staff support included:

- Time and space for reflection. This was a core element of different services and highly valued by all staff. This included a daily meeting where staff were able to reflect and raise concerns or good practice prior to a shift start. It also prompted discussion about how to respond in a trauma-informed way to children who were presenting with a new behaviour. There was a focus on making this discussion safe, reflective and non-punitive

- Availability of free and anonymous external counselling

- A psychologist or similar professional who was linked to a specific unit and who could identify where additional support may be required

- Implementation of trauma-informed debriefing including psychological first aid processes after incidents, (La Greca & Silverman, 2009)

- Peer support groups where workers (e.g. foster carers) were encouraged to share experiences and collaboratively problem solve in a safe environment

COMPONENT 4
STAFF KNOWLEDGE ABOUT WHEN AND HOW TO ACCESS TRAUMA-FOCUSED THERAPY

There are many trauma-focused therapies including trauma-focused CBT (Cohen, Mannarino, Kliethermese, & Murray, 2012), eye movement desensitisation and reprocessing (Diehle, Opmeer, Boer, Mannarino, & Lindauer et al., 2015) and narrative exposure therapy (Crombach & Elbert, 2015). There are other interventions that if not specifically trauma-focused have the potential to overlap with this by exploring children's previous experiences e.g. life story work (Gray, De Clerck, Wild, Crouch, Price, Tokunaga, & Marques, 2017).

While for many the recovery from a traumatic event occurs within the family, system or care environment this may not be the case for some and therapeutic support may be helpful. In all services there was trauma-focused therapy available and the staff were knowledgeable about how and when to access this. This knowledge was built through close and integrated working with trauma therapists who had provided awareness to staff on this area in addition to their regular case work. This is discussed in more detail under component seven.

COMPONENT 5
USE OF STANDARDISED AND EVIDENCE-BASED ASSESSMENTS OF TRAUMA HISTORY AND SYMPTOMS

Using standardised and evidence-based assessments can help ensure staff understand the experiences of children, uncover unknown experiences and measure the degree of symptoms — all important factors in an effective care plan. Milne and Collin-Vézina (2015) review some of the key measures and assessments used and useful sources can be found at **https://www.childwelfare.gov/topics/systemwide/assessment/family-assess/childneeds/trauma/**

There was no single favoured assessment used by services. In general there was a preference for those that were brief and accessible, given the learning needs and concentration difficulties of many young people. The Child Revised Impact of Events Scale (Perrin, Meiser-Stedman, & Smith, 2005) has evidence of being a valid screening measure with children in residential care in the UK (Morris, Salkovskis, Adams, Lister, & Meiser-Stedman, 2015). Measures that did not directly ask the children and young people and that relied upon observations were also widely used to avoid intrusion and over-assessment. Kisiel, Conradi, Fehrenbach, Torgersen and Briggs (2014) provide a useful review of many measures with a focus on their use in practice.

There were also some other heuristic methods used i.e. those that did not provide a formal measurement of history or symptoms but that provided a framework for understanding the child. The primary example was the Neurosequential Model of Therapeutics Metric (Perry, 2013). This requires the practitioner to review the child's adverse and relational developmental history and also rate the child's current functioning. Services felt that this tool had been useful in encouraging understanding of a child's history and the key domains to target. Although they felt the tool had some limitations regarding standardisation and sensitivity they felt it had been a useful aspect of trauma-informed practices.

COMPONENT 6
INCLUDE CHILD'S TRAUMA HISTORY IN FILE AND CARE PLAN

The inclusion of a child's history in core documents aims to ensure that all care staff are informed about the child's background and can understand their concerning behaviour in light of the child's experiences. The hope is that this prompts the most helpful response from staff avoiding those which trigger symptoms and distress. Some practical examples of this included:

- Placing key anniversaries of traumatic or difficult events in a file and diary available to all staff
- Initial assessments that obtain the child's own views of what were their difficult experiences (often by a mental health professional) and this being communicated with key staff
- Collaborating with the child to list things that scare or make them anxious. This could include places, types of people, events, dates, times of the day etc.
- Agreeing what language to use when an event needs to be discussed or mentioned. For example, a child may prefer a different word to 'abuse' or 'rape' and this can be represented in the file

CASE STUDY 2. JASPER MOUNTAIN, OREGON, USA

Jasper Mountain is a large care, education and treatment centre in a beautiful Oregon forest. It was initially opened by a husband and wife whose story is pretty inspirational. A few decades ago they were practicing therapists who were frustrated by the systems they worked in. They decided to live by their principles and drew up a list of criteria for the ideal place to create a centre that cared for children. They toured the USA to find the right place and ended up spending their life savings to buy Jasper mountain and build a home there. They approached local services and asked them for the children that others would not care for and began trying to provide them with the education, care and treatment they needed. For decades the couple were, as they described it, 'all in' and lived, ate and slept in the centre in a way similar to the European shared living approach.

Of all the centres I visited this was the most established trauma-informed practice I had seen and the most tangible. There were so many examples of where an understanding of the children's experiences and the effects of this on them had influenced practice. For example, the main residential building was a castle: it had a keep, large central hall and even a draw bridge. It had been built like this as children had said this was the structure they would prefer and in which they would feel most safe. The education building had no internal corridors and was instead linked by external walkways that were covered but still open to the surrounding forest. This enabled young people to quickly access sensory areas or walk in amongst nature without concerning other young people. In contrast to other services that had an isolated and sterile 'quiet room' Jasper showed me a walkway that lead from the school to a raised platform in the forest. Here young people could express distress or dysregulation without distressing anyone else.

The training model here was also impressive. Instead of an isolated training team that only delivered didactic lectures, trainers were present during each shift to coach and mentor staff teams. This enabled more consistency and fidelity to the model of care. This immersive approach was seen in other ways too: all new therapists shadowed numerous residential shifts so they got to know young people and the model of care.

Challenges for UK Implementation

Jasper Mountain were able to offer a broad range of intensive and effective supports without a prohibitive cost due in part to some operational differences to the UK. For example, instead of having their own bedroom, young people slept in dorms of three beds. To keep young people safe, staff alarms were triggered if a young person left their bed. Young people were only in their room immediately before and after sleep, and spent the rest of their time in other communal areas. In the UK there are times that young people in care will share rooms but dormitories do not fit national care standards and clash with principles of privacy. That said, the achievements of Jasper were impressive and their service gave perhaps the most tangible and measurable example of trauma-informed care that has formed a powerful model for me.

COMPONENT 7
AVAILABILITY OF TRAINED, SKILLED CLINICAL PROVIDERS IN EVIDENCE-BASED, TRAUMA- FOCUSED THERAPIES

As noted in component four, sometimes trauma-focused therapies may be beneficial. In the UK the assumption and perhaps the ideal is that the health service provides this service to all young people, be they in care or not. Unfortunately, the reality is that health services often lack the resources to do so or have referral criteria that exclude those without a specific diagnosis of a mental disorder. Those young people who have experienced adversity and traumatic experiences that in part drive mental health difficulties and concerning behaviour are sometimes excluded. Where they do meet criteria, it is often very difficult for a NHS service to work with the staff and milieu to a significant degree, to the frustration of many health clinicians. The responsibility for supporting, if not 'treating', a young person's mental health needs can therefore lie with the staff that care for them.

In all services visited, even in those in countries that provide universal health care, there were in-house clinicians who were integrated within the service. In some, they were linked to a particular unit and were there daily, both providing support to individual children and also working at the level of the milieu or life space. This was described as more effective than other models where children and young people were taken to external clinics, although at a higher cost of resources.

A full review of all trauma-focused treatments is not feasible here but it should be noted that there was use of various methods with practitioners believing that an integrated, phased and multimodal model was most appropriate.

COMPONENT 8
COLLABORATION AND INFORMATION SHARING WITHIN THE AGENCY RELATED TO TRAUMA-INFORMED SERVICES

Having a consistent approach towards a child has been seen as an important part of child care for many years (Gardner, 1989). Services reported difficulties achieving this, sighting various reasons such as communication challenges and differences in opinion between services such as care and education departments that may sound familiar to those working in the UK.

There were some tangible examples of ways to increase collaboration and information sharing in the services, including:

- An individual in the organisation who was responsible for the implementation of trauma-informed practices. See component 15 for further discussion on this
- Daily liaison between care and education staff to give information on that night or day's events and the approach staff were taking with recommendations for continuity
- Representation from each service at departmental reflective meetings
- A single daily log that all services use and complete (often kept electronically). This was often extended to a single child's file, again accessible to all staff

COMPONENT 9
COLLABORATION AND INFORMATION SHARING WITH OTHER AGENCIES RELATED TO TRAUMA-INFORMED SERVICES E.G. SOCIAL WORK SERVICES

As above, ensuring a trauma-informed, consistent response from all those supporting a child is important. Some examples to achieve this with external agencies included:

- An initial assessment that provided a description of the child's experiences and the related symptoms which was shared with key services. This also made initial care and treatment recommendations
- A liaison role for the trauma-informed lead professional who communicated the approach the service was taking and the rationale why. This included awareness and training to services
- Initial planning meetings that explicitly reviewed the known adversity and traumatic experiences the child had experienced from which a narrative/chronology was prepared for the child's file

COMPONENT 10
PROCEDURES TO REDUCE RISK FOR RE-TRAUMATISATION OF CHILDREN

The term re-traumatisation has been used to mean both further exposure to traumatic events and also where children are vulnerable to new experiences triggering the overwhelming feelings and reactions associated with a previous traumatic event (Kammerer & Mazelis, 2006).

There are numerous events, interactions, and contexts in residential care that could serve as a trigger, including staff responses to the child and being exposed to other children's concerning behaviours such as violence and self-harm.

The area that perhaps received most attention from services was the method with which children were held by staff when they were at immediate risk of harm to themselves or others. Encouragingly, many services felt that the implementation of trauma-informed principles had lead to a significant decrease in holding children to the benefit of both children and staff. They suggested that this was because of:

- A better understanding of the child's behaviours and the factors driving it. This was in part due to the sharing of the child's experiences and symptoms as noted in component six and the training received

- A better recognition of potential triggers, (including internal trauma symptoms such as intrusive memories or images), and greater emphasis on frequent and numerous strategies to help the child regulate and prevent emotional dysregulation building to difficult levels for the child. A tangible sign of this were documents that were often collaboratively designed with the child that identified key triggers, preferred responses from staff and coping skills they were attempting. These were similar to behavioural support plans that staff may be familiar with but also included triggers such as dates, places, context, facial expressions, how close they preferred others to be and anything else that could trigger symptoms and dysregulation

CASE STUDY 3. MAGELUNGEN, STOCKHOLM, SWEDEN

Magelungen is a large organisation that has rapidly grown in recent decades to include outpatient care for psychiatric patients, day education and a service that engages young people who refuse school. Perhaps uniquely, Magelungen is owned entirely by its employees: all are given the same amount of shares in the organisation regardless of position and only employees can own shares. I had heard this before my visit and wondered if this meant employees were either profit-oriented business people or instead dedicated to the organisation's cause and clients. Fortunately, the latter was true and there was a real ethos of equality and working for the common good.

This equality was seen particularly in their residential service for adolescents who had mental health difficulties. There was a real emphasis on no one role being more or less important than another. The equality meant that there was also high overlap between roles. Although there were different professionals working there e.g. care workers, head of treatment and psychologists, their roles were much less defined and rigid than I was used to. For example, when I arrived the head of treatment was preparing breakfast for young people. Psychologists worked the same shifts as the care staff including night shift and also did the daily care tasks that are traditionally taken up by care staff such as giving lifts, going shopping and facilitating family visits. This was more than helping out young people on their caseload, instead it was them working as an integral part of the care and treatment milieu.

The psychologists working there were clear about the benefits: they felt that the service was orientated to the needs of the young people and could respond to them when the young people requested it, more so than the traditional office hours model.

Challenges for UK Implementation

There was a lot that could be taken from Magelungen. The ethos of equality seemed to encourage collaboration and value between roles. Their model was innovative and enabled some great client-lead service delivery. Predictably though it was also expensive. One of the managers there highlighted how they had to justify the model and had recently considered employing specific night shift staff to avoid the relatively expensive psychologists covering this. Services in the UK would need to consider how to obtain some of the benefits of this approach without incurring such high costs. This could mean, for example, psychologists spending more time in the life space and beyond 5pm in order to be more accessible and responsive to young people's needs. The boundaries and limits to this would need to be clear, but if so it could enable greater engagement with often hard-to-engage young people.

COMPONENT 11
INPUT FROM CHILDREN AND PURCHASERS IN SERVICE PLANNING AND DEVELOPMENT OF A TRAUMA-INFORMED SYSTEM

There is growing literature on the benefits of involving children and service users in the design and development of services (Worrall-Davies & Marino-Francis, 2008). The perspective presented by children can often be difficult for staff and adults to anticipate and can provide valuable guidance.

There are a number of examples involving children throughout this paper, including children designing the actual building of a service. There were also services that involved children in many different aspects of service delivery, including how to deliver trauma-focused therapies and how to complete initial assessments. Some practical ways to achieve this included:

- Weekly meetings between staff and young people
- A young people's council where the group would have a chance to meet managers and staff
- Representation of children on working groups where appropriate
- Qualitative analysis of children's views completed within formal research projects

COMPONENT 12
PROVIDE SERVICES THAT ARE STRENGTH-BASED AND PROMOTE POSITIVE DEVELOPMENT

This is the component that perhaps had the most number of tangible examples. There was an understanding in all services that children's development had been affected by the adversity and trauma they had experienced and that this meant the child had not developed important capabilities, skills and attributes. They viewed their task as promoting development across all domains where development had been affected. The services felt that an area of key importance was to support and develop emotional regulation abilities given the difficulty children had with this and the often severe concerning behaviour emotions could trigger. All children need to cope with emotions and find ways to release stress and tension. The difference for children who have experienced adversity is that they often do not have the skills, knowledge and capacity to regulate the emotions, particularly as they are so powerful (see Blaustein & Kinniburgh (2010) for more discussion on this). There were a number of tangible examples of how staff supported emotional regulation:

A. Educate children about emotions, emotional dysregulation and trauma models

Providing education to children about what traumatic experiences were, how they affect us and how to cope with them was an important aspect of many services. There were some practices that seemed most effective:

- Not labelling the experiences as 'trauma' to avoid it becoming another diagnostic label but instead talking about 'bad things', 'worse things' or similar
- Using the many online videos available e.g. about trauma, the fight and flight response, how emotions work and emotional dysregulation and tension
- Range of apps that look at emotional regulation
- One service had visual explanations of trauma concepts and emotions that were visible around the unit and in communal areas

B. Have a range of regulation activities and make them accessible

The activities listed on the pages that follow are a fraction of those available and are noted because they were commonly highly valued by services.

Figure 1. A random assortment of fidgets

FIDGETS

All services reported the positive effects of 'fidgets'. These are simply objects that the child can handle and manipulate to help them regulate themselves. They are not given when the child is in difficulty, but are encouraged when the child is seeking something to manipulate or fidget with. They should therefore always be available as they are most likely to be useful when the child is at a low level of difficulty.

In classrooms there were often fidget boxes that had a range of textures, malleability, colour, weight, and size. Children were able to chose one or two and have them on their desk. There was more than one of each object to avoid possessiveness. Services reassured that they were not thrown often as the children had chosen the object and wanted to keep it.

RESISTANCE

Materials that resist pressure and force can be useful to release tension and frustration. There were many creative and innovative ways staff had implemented this idea ranging from encouraging children to push against walls to bands around the legs of chairs so they could push their feet onto them. Some children also 'wore' a hoop of lycra around their body both for the resistance and sensory experience.

BALANCE

Services reported that engaging children in tasks that required them to balance could help them focus, distract them from anxious thoughts and help their underdeveloped sense of balance. As one teacher noted, it allowed pupils to tip back their chairs and balance in class. Staff also noted yoga balls and rocking chairs could fulfil this function and were also reported to have a soothing effect.

EXERCISE

There is evidence that physical exercise can help children's executive functioning and self-regulation (Best, 2010). There are significant practical difficulties to encouraging children to exercise when they do not want to that are not often discussed in the literature. While many services will admirably have physical education classes and sports teams, these do not cater for some children. There were many examples in services where exercise and activity were encouraged in different ways:

- Accessible within the life space: ranging from gym equipment, climbing walls, ladders to climb and soft-play blocks
- Outside play parks at close access. Many services had these immediately outside the residential unit
- Games that include staff such as tag, assault courses inside and outside, and piggy in the middle
- Adolescents often respond more to joint activity with key care givers, such as trips to the gym with staff, rather than being left to attend on their own
- Asking individual children to complete their pre-agreed strategies. For example, one child in class would repeatedly go into the hallway and do star jumps when he wanted to or the teacher suggested it to him

Staff also noted that many exercises and games had the potential to excite children and increase emotional dysregulation and could then be difficult to manage. To avoid this, these activities were completed within a structure and boundaries, as with any other activity for these children. For example, one group of eight children had a gym class in an empty hall. The rules were given at the beginning when the children were calm (i.e. the game is tag, only touch the shoulder, and a five minute warning before the game ends). There was then a gradual increase in activity e.g. stretching before the game began and was played for the period. Before the children returned to classroom work the staff member gradually reduced the children's emotional dysregulation by doing a cool down followed by the children lying down and taking deep breaths.

Figure 2. An example of a room that had many functions including exercise

GAMES

The role of play in development and learning has been discussed in many areas of child care (Kolb, 2014). There are many games that can help children develop skills in a way that would be difficult to do without the element of play. For example one service had a daily hide and seek game in the school for primary aged pupils. This included having the lights turned out in one room, adults playing with the children and pupils taking turns to be the hider or the seeker. Staff noted how children had to learn to regulate their excitement in order to avoid discovery and that staff had used this to teach them deep breathing amongst other strategies. It also gave children the option to explore the dark in a safe way, but only if they chose this place to hide. While not all children will take part in these activities, services reported that engagement was higher where both staff and young people took part and were more effective than direct attempts to teach emotional regulation skills.

SENSORY SOOTHING

Many services felt that considering young people's sensory needs had been helpful in supporting their regulation. Services suggested that the high emotional dysregulation levels, symptoms and stress that children can experience can contribute to sensory sensitivity. An example given was how after prolonged stress lighting can seem bright, noises sharp and loud etc. Staff felt that this sensitivity could in turn trigger further stress or anger. To respond to this, services had implemented the following:

- Had both bright and dark places in the unit that children could choose to be in
- Had minimised sharp overhead lighting
- Had both loud and quiet areas of the unit e.g. music and TV were allowed in the lounge but the kitchen was quieter
- Many of the items noted previously including fidgets, lycra, resistance bands, blankets and cushions were available
- Bathing with scents was encouraged in the evening to wind down
- Over-ear headphones were available in class as well as the unit to dampen noise
- Children were asked about their preferences including food and smells they found aversive/pleasant
- Some units formally assessed sensory needs using standardised assessments e.g. sensory profile (reference)
- Staff helped children put together a soothing box tailored to their own preferences. This could include anything that the child felt helped them soothe including paint brushes, feathers, stress balls, scents, photos, music etc.

MASSAGE

Massage can be a powerful way to reduce emotional dysregulation and there are numerous care services in the UK that source this for children. It is a potentially controversial area and there are powerful attitudes to touch in general with children in care (Steckley, 2011). In the services visited there was a consensus that it could be an extremely useful and effective way to help children regulate. There were many ways this was delivered, ranging from professional masseuses visiting units to staff being trained in basic approaches and delivering this on a daily basis. For example, in one unit children reported that their favourite thing about living there was getting a foot massage before bedtime. Again, the appropriateness of this is to be deemed by each individual service.

CASE STUDY 4. ØSTBYTUNET TREATMENT CENTRE, NEAR OSLO, NORWAY

Østbytunet is a 32-bed treatment centre for children under 12 in rural Norway. This too was an extremely useful and enlightening visit. The service had invested heavily in implementing trauma-informed care and had trained a high number of staff and visited different services around the world. There were tangible examples of trauma-informed principles throughout the service, from an emphasis on sensory and physical regulation activities in the life space to the language staff used. Again, the space and environment was orientated towards this and seemed to be appreciated by all.

The service employed a senior psychologist whose sole role was to promote and implement trauma-informed care across the organisation. This was the only service that had such a specific position and role. Many others had similar but not so specific and purposeful. The psychologist had a remit across all levels and areas of the organisation and appeared to have had a significant and tangible effect on practice. Staff I spoke to valued this role highly and highlighted many 'soft' outcomes from it, for example they noted higher collaboration between education and care services and a more common language used across the service.

Next Steps

There has been a surge in interest in trauma-informed care in the last twelve months and the residential care sector has been a key part of this. My organisation was fortunate to receive funding from the Scottish Government's Children, Young People and Families Early Intervention Fund and Adult Learning and Empowering Communities Fund to develop trauma-informed practice. I am lucky enough to have been seconded to lead this project for a year and hope to implement the findings of my fellowship to enable tangible trauma-informed practice both in my organisation and across the sector. The first step to this will be to develop a strategic plan however some actions already taken include:

- Sharing my findings through conference presentations, training and publications, including an article in the Scottish Journal of Residential Child Care (Johnson, 2017)
- Qualitative research into young people's views on what they think a trauma-informed service and trauma treatments should be
- Self-evaluation across the organisation about development of trauma-informed care
- Training of several members of staff in NMT phase 1
- Routine enquiry about adversity and trauma with all young people accommodated into my organisation
- Collaboration with a local authority school to measure levels of adversity and trauma and to develop trauma-informed practice there

COMPONENT 13
PROVIDE A POSITIVE, SAFE PHYSICAL ENVIRONMENT

Safety is a universal theme across all trauma-informed care models and frameworks. Every service visited had this at the core of their practice. It has a clear rationale: how can carers hope to help children regulate emotions and develop alternative coping strategies if that child continues to feel fear? They are unlikely to move away from the coping strategies they developed in a dangerous environment until they believe the threat has ended.

The principles of all child care are applicable here: no aggression or violence from carers and instead calm, empathic and warm caregiving. There were also other ways that may not have been developed without a trauma-informed rationale. For example:

- One service had involved children in the design of their unit building and built a large castle-like building based on the children's design. While this may be beyond the resources of most services it highlights how important some services prioritise safety for children
- Having many well-lit areas including outside e.g. in car parks etc.
- Having the ability to lock their door away from other young people (while staff remain to have access)
- Ensuring the staff team can protect children from each other i.e. intervening quickly in any conflict between children
- One service felt that high surveillance of children ensured safety. This was made tangible by movement sensors in their room that would alert staff if a child left his/her bed. The intrusion on privacy and individual rights is a significant one and it is not presented here as a recommendation, only as an example of high supervision in some services
- The sanctuary model has been promoting safety as a core aim of services for many years and has a number of practical examples of this in practice including safety plans. **An example can be found at: http://sanctuaryweb.com/Portals/0/2010%20PDFs%20NEW/2010%20Bloom%20Safety%20Plans.pdf**

PREDICTABILITY

Creating consistency, structure and continuity was a core aim of all those services visited. This is probably best described collectively as creating a predictable environment. Service providers argued that creating a routine and structure that is predictable and safe can enable the child to expect that this will continue and that harm is unlikely. Without predictability like this the child may have difficulty predicting how the future will be and therefore base any expectation of their future on their past i.e. previous traumatic experiences. If they expect more traumatic experiences to occur then they are likely to remain in a distressed state that leads to concerning behaviour.

One of the most valuable findings of the Fellowship was that predictability, structure and routine was possible to achieve at a level that appeared to significantly help children. There were factors that seemed to make this more likely: young children i.e. pre-adolescent, a controlled environment e.g. not in an urban setting where external factors such as other young people could disrupt plans, and a high staff to child ratio. There are services in the UK that also appear to have achieved this partly due to the high levels of staff and minimal external factors, such as with secure care.

To provide the reader with some tangible examples of how predictability was provided there is a description below of the morning routine of one unit that looked after approximately twenty children in a single unit.

At the same time each morning the staff group would meet in the communal area and discuss whether there was any specific information that needed to be shared regarding young people before they were woken. Staff knew their role and would do this at the same time i.e. the same member of staff would wake the same group of children. The lights were dimmed and staff spoke quietly while they woke the children up. Each child was woken and then given feedback on what they did well the previous day and what was expected of them for that day i.e. a target for improvement. The children then went through the same order of routine; bathroom including washing and teeth, then dressed, then breakfast. The children were staggered into groups and had a specific amount of time to complete the tasks. The same person served breakfast and the children then walked to the education department in the same staggered groups as they were woken. All throughout the staff kept the volume and lights low and praised and reinforced any child's positive behaviour.

This is an extreme example and is only described to illustrate how structured and routine care can be. There are obviously both negatives and positives to such a rigid level of structure and routine and many practitioners may question whether this risks institutionalisation and sacrifices spontaneity. The balance is difficult and only individual services can decide upon what is appropriate for them.

COMPONENT 14
WRITTEN POLICIES THAT EXPLICITLY INCLUDE AND SUPPORT TRAUMA-INFORMED PRINCIPLES

Services that had fully embraced trauma-informed principles had this as a running theme throughout a number of policies. This was perhaps most visible in policies on assessment, treatment and holding safely. The policies explained the rationale for procedures and protocols through a trauma model. As an example, in one transition policy it noted how many children had negative expectations of the future given their difficult past and therefore should be informed in detail about their future placement through a number of ways including meeting staff, visiting on numerous occasions, being given information (e.g. pictures, videos, literature etc.) and being asked to express anxieties they have about the placement. This often meant that, where appropriate for the individual child, children had a period of numerous weeks transitioning to a placement rather than a quick and uninformed transition.

COMPONENT 15
PRESENCE OF A DEFINED LEADERSHIP POSITION OR JOB FUNCTION SPECIFICALLY RELATED TO TIC

In each service visited there was a lead for trauma-informed care. This person was usually a therapist or psychologist. There were numerous titles given to the role but they all provided the same role: translating the theory of trauma into practice, and ensuring integrity and adherence to the principles.

They often provided an important link between services and essentially provided a common language with which to discuss young people, their experiences and their behaviours. Anecdotally this significantly increased collaboration within the services and resulted in a greater consistency and continuity of care.

In addition, the role meant that the individual had the responsibility to develop and drive a project plan to implement trauma-informed care across a service. Many of the services reported using guidance from implementation science, for more information, see Mitchell (2011).

CONCLUSION

This report suggests that residential and secure care organisations who wish to implement trauma-informed care can do so by following the core components listed by Hanson and Lang (2016). There are numerous approaches that can be implemented within this framework including the neurosequential model of therapeutics and the sanctuary model in addition to specific tools and standardised assessments.

Many of the practical examples can be implemented with relatively limited cost or may already exist in some services. However, translating all components into practical and tangible actions and processes presents a challenge to practitioners working in difficult environments, with challenging children and limited resources.

Trauma-informed care does not present a panacea to the difficulties facing children who have experienced trauma. A key criticism of the approach is that it has been subject to very limited evaluation and little is known about whether it can increase the effectiveness of care in meeting the needs of young people who have faced traumatic experiences. However, there was strong anecdotal evidence from carers and services that trauma-informed care had improved the care children receive. Services report that it provided useful explanations of children's concerning behaviour that can help carers respond in confident and helpful ways.

As residential care implements trauma-informed principles in more settings there will be significant tests to how the theory is translated into practice. Becker-Blease (2017, p.137) argues that 'even the most experienced clinician or researcher cannot rely on intuition alone to create trauma-informed settings' and highlights how attempts to be trauma-informed may end up having unforeseen negative consequences. This will be an important area of study as the field develops and more practice becomes trauma-informed.

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