EVIDENCE PRESENTED BY THE INSTITUTE FOR RECOVERY FROM CHILDHOOD TRAUMA

FOR

THE INDEPENDENT REVIEW OF CHILDRENS SOCIAL CARE

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Introduction

The Institute for Recovery from Childhood Trauma (IRCT) is a national charity founded in 2012 which seeks to create and connect networks of professionals throughout the UK and facilitate collaboration to develop and improve best practice for all children who have been traumatized and need help to recover.

Our mission at the IRCT is to ensure recovery from childhood trauma for all children and young people so that they can take their place in their communities with confidence, make mutually satisfying relationships with others and fulfil their potential.

We seek to meet our objectives through:

- Campaigning to influence law, policy and practice at a local and national level
- Disseminating key knowledge to the wider children's workforce in relation to promoting and facilitating recovery from childhood trauma
- Developing principles for recovery focused training for the children's workforce
- Establishing a virtual library and knowledge centre for information and research pertaining to the recovery from childhood trauma and its consequences to enable and facilitate recovery
- Promoting a better public understanding of childhood trauma and its consequences to enable and facilitate recovery
- Commissioning further research into childhood trauma and its consequences and the measures that can be taken to heal and mitigate those consequences
- Delivering seminars, training events and conferences to disseminate knowledge and understanding to improve practice and promote recovery

The IRCT believes it can use its knowledge base and broad experience to make a valuable contribution to the government review of children's social care and welcomes the opportunity to put forward constructive proposals for improving the current system.

We know that children who come into the care system have generally had a poor start in life and are amongst the most vulnerable individuals in our communities. Most will have suffered multiple Adverse Childhood Experiences (ACE). The research base for the longterm effects of Adverse Childhood Experiences is striking and strong. The published research evidence, notably Felitti et al (1998) in the USA and Bellis et al (2014) in the UK, reminds us of the range of experiences which can have an adverse effect on the health and wellbeing of our children, young people, families and adults for a lifetime. Single experiences can have an adverse impact on the child's health and wellbeing but multiple experiences can have a cumulative damaging impact which can compromise the child's prospects of happiness and success for the entirety of their life unless something is done to address this prospect. We know that children in the care system often have poor educational outcomes, difficulties in making solid trusting relationships with others and disproportionate involvement with the criminal justice system.

Although some children overcome early disadvantages and go on to live successful and happy lives many do not and IRCT believes that one important reason looked after children have poorer outcomes is that they have unaddressed trauma. IRCT believes that the proper recognition of the role of trauma in the lives of children in care is essential to provide better outcomes for them. We will argue that a formal objective of the care system should be to assist children to recover from the trauma they have experienced historically and which will have been compounded further by their removal from their familiar home into the care system.

Children and young people can recover from trauma through relationships with trusted adults who are trained, supported and willing and able to hold the child in mind. All services should be “trauma informed”. It is the view of the IRCT that a central aim of the care system should be to organize services in such a way so as to ensure that all children have the best chance to recover from trauma.Furthermore we will argue that this aim should be set out in primary legislation in line with Article 39 of the United Nations Rights of the Child.

Background

One of the significant challenges for societies across the world has been the acknowledgement of the horrible traumatic events that can befall a significant number of the children and families in our societies.

This is particularly relevant to considerations in relation to the development of appropriate care systems to meet the needs of children and young people who have experienced significant adversity.

Looked after children

The core reason for removing children from the birth family's care was under the care and protection from abuse & neglect, with 63 % (49,570) children entering the childcare system for this reason (Office of national statistics, 2019).

Given that it is well established that this population experiences higher levels of emotional distress, behavioural problems, and social disadvantage, and that many psychological models place adverse early experiences at the root of this (e.g., Beck et al., 1979; Bowlby, 1977) it is crucial that these factors are given the appropriate focus in developing care models.

Many children requiring to be looked after have experienced circumstances which most people would agree are likely to be experienced as traumatic. Indeed, it is likely that some children will have had experiences where they believed they or those they love were going to be seriously hurt or even die. A study in 2010 explored the direct experiences connected with children entering care and found that 48% had experienced physical abuse, 37% emotional abuse and 23% sexual abuse (Chambers et al., 2010). However, the consensus is that it should be assumed that all Looked After Children and young people have experienced trauma in some way

Other reasons for children becoming Looked After are also linked to experiences of adversity, namely, family dysfunction 14 (11310), acute stress 8% (6050) and absent parenting 7% (5410). Therefore 92 % of all looked after children could have an element of their childhood experiences which may be helpful to review under the lens of traumaarising from adverse childhood experiences. (Dube, Felitti, Dong, Giles, & Anda, 2003).

Level of trauma in the children in care population

We can never know the complete truth or reality about child abuse and neglect in any society.

Research has begun to illustrate the need for all professionals involved in the care of looked-after children to have an in-depth understanding of the far-reaching impact of trauma resulting from childhood adversity (ACEs)

Information that has been gathered about infants, children and young people who are removed from parental care by social services because of neglect and abuse has allowed the identification of a number of common presenting issues.

These studies (Ford et al., 2007; Minnis and Del Priore, 2001; Monteith and Cousins, 2003; Sempik et al., 2008) illustrate that looked-after children and young people have a higher incidence than non-looked-after children of:

- mental health problems;
- post-traumatic stress;
- attachment disorders;
- emotional and behavioural problems (leading to potential criminality); and
- poor educational outcomes.

Evidence illustrates that there are high levels of post-traumatic stress disorder (PTSD) *symptoms* are seen within groups of looked after children in the UK from 75 per cent up to 86 per cent depending on the research study (Perry and Azad, 1999; Morris et al, 2015). In the USA children in foster care have been found to have undetected PTSD at rates of between 25 and 60 per cent, compared to a rate of 14 per cent in Vietnam veterans (Pecora et al., 2005; Dubner and Motta, 1999).

Therefore, many children who enter the care system are at higher risk of experiencing mental health-related struggles (Pecora et al, 2009; Owusu-Bempah, 2010; Ward, Munro, & Dearden, 2006, Ford et al., 2007) and face more significant difficulties in their emotional, behavioural and academic development than the general population.

Such high levels of adversity can result in very poor long-term outcomes that have significant cost implications not only for the individuals concerned but for society (Bachmann et al., 2019) if the correct supports are not provided.

Current Situation

It is positive that as a nation we have a framework of current rules, guidance, regulation and legislation in a bid to ensure that our children are safeguarded and that professionals across the board are held accountable for their actions when things do go wrong. However, there is no systematic recognition of the issues in central or local government and we have not, as yet, incorporated the UNCRC (and in particular Article 39) into domestic legislation meaning that our children have no right to recovery, something IRCT considers to be a serious omission.

Whilst Local Authorities are the body which bear the primary responsibility of discharging duties imposed by the safeguarding guidelines it is important to recognize that if we want to make a significant improvement to children's services the problems cannot be laid at the door of Social Services alone. The problem is a systemic one starting with the government policies and legislation and including the many other services for children including health, education and the law.

The Working Together to Safeguard Children Guide aims to promote multidisciplinary collaboration and recognizes the need for the different services to cooperate, share information and work together to safeguard children and promote their wellbeing but this still appears to rarely work in practice and this needs to be understood. For years, Public Inquiries and Serious Case Reviews have been recommending better communication (Reder, Duncan &Gray 1993; Reder& Duncan1999) and coordination between the professional disciplines with little real improvement being achieved. If anything, the situation has deteriorated as all the services have struggled with decreasing budgets and resources and become pre-occupied with the need to satisfy government targets they have been set related to their core functions. This has tended to create defensive practice and has completely undermined any sort of joined up thinking.

Lack of resources and government directives could be said, for example, to have led to revised intake criteria for acceptance by Child and Adolescent Mental Health Teams, meaning that they are often only able to accept referrals for children with diagnosable mental illness or those who are suicidal, leaving those with emotional and behavioural difficulties (symptoms which are frequent in those suffering complex trauma resulting from chronic exposure to adverse childhood experience) on long waiting lists, sometimes until they are deemed too old for the service altogether.

Schools find themselves having to focus increasingly on satisfying educational targets and standards imposed by OFSTED. To maintain their position in league tables many schools simply exclude vulnerable children with complex trauma to prevent them from disrupting classes and skewing performance results. The most vulnerable children who need the most support then find themselves rejected and traumatised again rather than being emotionally supported and contained to give them a better chance of fulfilling their potential.

The support services within the police force are also over-stretched and funding for specialized units to work preventively with children and young people and to work alongside other disciplines to safeguard children and promote their well-being are also being compromised. The judicial timescales mean that there is often insufficient time to undertake comprehensive assessments at this stage once things have gone badly wrong for a child and lack of public

funding means that parents are only given limited support to defend their child's right to family life and to be supported to be able to achieve this under guidance.

The lack of resources for therapeutic and support services when professionals are first alerted to problems within families means that more and more children are suffering adverse childhoods for longer periods and sustaining more damage. It also means that a larger proportion end up in crisis and subsequently in state care.

There are of course examples of good service but more generally professionals working across the services are themselves exasperated by the difficulties they encounter in being able to provide the help they thought they would be providing to promote the wellbeing, healthy development and happiness of children and young people when they entered their various professions. Professionals want to be able to draw on their core knowledge base and skills to make informed decisions about how best to help those with whom they are working but find themselves tied up in knots of bureaucracy and paperwork having to demonstrate that they have complied with procedures.

What needs to be done?

Training

Training of all key members of child service networks should and could prepare them for a future role as a professional and not just as practitioners with specific technical competencies. The need to maintain high ethical and practical standards to think through a case at different levels and to arrive at an informed and independent judgements are all essential requirements of this work. Even though pre-qualifying courses of the various professions will contain different areas of knowledge, theoretical premises and practical skills we believe that a 'dialetic mindset' and/or a 'reflective practice' model is a way of thinking that should be central to the work of all members of children's services and apply across all professional boundaries.

Everybody working within the children's services networks must have training on trauma informed practice.

Multidisciplinary Assessments

There needs to be a comprehensive multi-disciplinary assessment of families at the first point of contact when concerns are raised initially about the safety or well-being of children. This is the only way to enable there to be the best services possible offered to address the individual needs of all the children, give them the best chance of a right to family life if possible while also doing the everything possible to protect them from and overcome any adversity they may have suffered and to facilitate their recovery from any complex trauma which may have suffered. There must be more resources directed into early interventions to help to keep children out of care and able to remain safely within their own families.

Creating Safety.

Children and families referred to Social Services are, by definition, a cause for concern and there is always a need to assess for risk from a safeguarding perspective. Families tend to have a distinct mistrust of professionals who are working with them in this context, even those who have admitted they need help and have sought this voluntarily, and why wouldn't they when social workers have a dual agenda of both of assisting a family with to address problems while also collating evidence to build a case evidentially should there be a need to take legal action. They tend to be anxious and fearful. This is a dilemma as everyone needs to feel safe if they are to be able to trust someone else and make themselves more vulnerable by admitting their problems. Being in crisis or a constant state of survival makes it hard to think, to understand or to be rational and this is often misunderstood as recalcitrance or resistance to help. Building safety at the outset is essential and taking the time to really understand difficulties families are experiencing from every perspective is the best way to build the sense of trust needed. This cannot be left to Social Services alone and there must be a multidisciplinary approach.

Trauma Informed Practice

Understanding the impact of complex trauma is essential for all professionals in all service areas working with children, young people and their parents to be able to make sense of their actions rather than to condemn them for their bad behaviour or their inadequacy. Working together with a shared hypothesis about the meaning of an individual's behaviour can enable each

professional within a network to consider the best strategies within their context to provide a therapeutic response to facilitate recovery and change. This endeavour requires professionals to be trained and then supported.A consultation model using mental health services such as CAMHS to provide oversight and consultation to other service providers through regular network consultations can be an economical, efficacious and efficient use of time and resources. These ideas need to be incorporated into the Working Together Guidelines

The best therapeutic resources for children are those individuals who provide for their daily needs such as their carers and teachers provided that these individuals are appropriately trained and supported. A mental health consultation service which can support trauma informed practice needs to be available to all on a regular and longterm basis as a right and not just on a crisis intervention basis.

Summary of Recommendations

1. The UNCRC (and particularly Article 39) should be incorporated into domestic legislation

2. A central aim of children's services should be to help children recover from trauma, and this aim should be set out in primary legislation. All services involved in working with children including not only social services but also education, health and legal services, need to work together to achieve this aim. This objective should underpin the Working Together Guidelines

3. The training for all personnel working within any children's services must include how to assess, recognise and understand the impact on the development and well-being of children and young people and what steps need to be taken to address these needs in their particular service.

4. Training on the importance of addressing the trauma needs of children should also be provided for managers of services and elected members of government to ensure that appropriate levels of funding can be secured to meet the need.

5. The statutory reviewing process should routinely look at trauma recovery in each review. Ofsted inspectors should receive training on these issues and every inspection of local authorities and other organisations involved in the care system, should include consideration of their approach to addressing trauma.

6. For a wider multidisciplinary network to be able to work together most effectively to promote recovery from trauma a dedicated team within the CAMHS services should provide an advice/support/consultation service for frontline workers dealing directly with traumatised children within their day to day roles.

7. Every local authority should have a designated person responsible for trauma recovery. The duties of this person should extend to consideration of services for children in need of protection and children in needas well as children in careThis person would be responsible for an audit of local services and identifying measures to fill the gaps as well as monitoring progress. They should also have responsibility for ensuring thatmulti-disciplinary training on trauma recovery is available within the local authority for personnel at all levels of involvement.

APPENDIX

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