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INTIT
INtegrated Trauma Informed Therapy for Child Victims of Violence
www.intitproject.eu

INTERNATIONAL STATE OF THE ART REPORT

THE MEANING OF TRAUMA INFORMED CARE TODAY

July 2021

REGIONE LAZIO
ASL ROMA 3
Πανεπιστήμιο Κύπρου
University of Cyprus
TARTU ÜLIKOOL
1632
UNIVERSITAS TARTUENSIS
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Svenja Heinrich

with contributions by

Vanja M. K. Stenius
Andreas Kapardis
Anna Markina
Maria Gonzalez
Beata Žarkovski
Jose Prieto
Catia-Isabel Santonico Ferrer

REGIONE LAZIO
SISTEMA SANITARIO REGIONALE ASL ROMA 3
Πανεπιστήμιο Κύπρου
University of Cyprus
TARTU ÜLIKOOL 1632 UNIVERSITAS TARTUENSIS
cid
consensus

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1. Introduction

Childhood exposure to interpersonal violence and related developmental trauma has been identified as a silent epidemic and as a major public health challenge.[1] Over the past years the relationship between experiences of trauma and both physical and behavioral health disorders has increasingly been acknowledged. The need to address trauma is therefore considered a fundamental obligation for service providers and policy makers.[2] The potential for exposure to trauma is manifold ranging from trauma due to war, natural disasters and accidents to trauma resulting from interpersonal violence and abuse. The transnational project I.N.T.I.T. co-funded by the European Union focuses on these latter types of trauma with a particular emphasis on trauma experienced by children and youth due to maltreatment.

Violence against children affects millions of children throughout Europe and internationally. Worldwide, approximately one third of children are estimated to experience physical abuse and approximately one in four girls and one in five boys experience sexual victimization.[3] While official statistics are limited, a 2014 European Parliament report estimates that "around 18 million children in Europe suffer sexual abuse, 44 million suffer physical abuse and 55 million suffer psychological abuse resulting each year in the deaths of at least 850 children under the age of 15."[4]

Children and youth that have experienced violence pass through multiple systems including mental health services, medical services, welfare services, the educational system and, in some cases, the criminal justice system as part of the investigation and prosecution of the offender(s). While individuals react differently to violence and abuse based on varying degrees of resilience and support, it can be assumed that trauma frequently emerges as a consequence of these experiences. The failure to recognize and understand trauma by relevant services providers can magnify harmful and costly health implications.[5]

The "trauma-informed-care" approach has emerged over the last few years as a response to better addressing trauma with early research and development financed by the US based Substance Abuse and Mental Health Services Administration (SAMHSA). Subsequently, a "plethora of theories, models, articles and training providers"[6] has emerged constituting a challenge for practitioners to identify an appropriate approach for their respective setting and translating theory into practical implementation. This position paper intends to highlight the core principles and underlying assumptions of a trauma *informed* approach as opposed to a trauma *specific* approach.

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[1] Kaffman, A. (2009): The silent epidemic of neurodevelopmental injuries, in: *Biological Psychiatry*, 66, p. 624-626.
[2] Substance Abuse and Mental Health Services Administration (2014): SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA). Rockville, MD.
[3] D' Andrea, Wendy et al. (2012): Understanding Interpersonal Trauma in Children: Why we Need a Developmentally Appropriate Trauma Diagnosis, in: *American Journal of Orthopsychiatry*, Vol. 82, No. 2, p. 187-200.
[4] Dimitrova-Stull, Anna (2014): Violence Towards Children in the EU. *European Parliamentary Research Service*. p. 14.
[5] Levy-Carrick, Nomi C. et al. (2019): Promoting Health Equity through Trauma-Informed Care, in*: Family and Community Health*, April-June, Vol. 42, No.2.
[6] Johnson, Dan (2017): Tangible Trauma Informed Care, in: *Scottish Journal of Residential Care*, Vol. 16, p. 1-21.

It also reviews the prevalence of trauma informed care in Europe and with particular focus on the utilization of trauma informed approaches in partner countries of the I.N.T.I.T. project – Italy, Spain, Estonia, Cyprus, and Germany.

2. Defining Trauma

Before focusing on the trauma-informed approach one needs to come to an understanding of trauma itself. The definitions are manifold and will not be discussed at length in this paper, but a common understanding is nonetheless essential. The above-mentioned SAMHSA defines trauma as follows:

> *"Individual trauma results from 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."*[7]

According to DeCandia and Guarino "an event becomes traumatic when it overwhelms the neurophysiological system for coping with stress and leaves people feeling unsafe, vulnerable, and out of control."[8] Bessel van der Kolk has described complex trauma as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g. sexual or physical abuse, war, community violence) and early-life onset".[9] These exposures to violence often occur in a child's care giving system with long-term (behavioral) health implications. Potential consequences of childhood trauma include the disruption of affect regulation, disturbed attachment patterns, rapid behavioral regressions, aggressive behavior towards self and others, as well as self-hatred and self-blame.[10] In his book *The Body Keeps the Score* van der Kolk emphasizes that trauma is stored in the body and for therapy to be effective it needs to take the physiological changes that occur into account.[11] This view is underlined by the landmark Adverse Childhood Experiences (ACEs) study conducted by the Center for Disease Control and Prevention (CDC) in the United States demonstrating that violence in childhood results in a significant increase of health risks for alcoholism, drug abuse, depression, and suicide attempts in addition to an elevated risk of heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.[12] Ultimately these health implications can lead to the early death of those who have experienced violence during childhood.[13]

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[7] SAMHSA, p. 7

[8] DeCandia, Camelia and Kathleen Guarino (2015): Trauma-Informed Care: an Ecological Response, in: *Journal of Child and Youth Care Work*, p. 7-32.

[9] Van der Kolk, Bessel (2005): Developmental Trauma Disorder: Towards a rational diagnosis for children with complex trauma histories, in: *Psychiatric Annals*, 33(5), 401-408.

[10] Ibid.

[11] Van der Kolk, Bessel (2015): The Body Keeps the Score. Brain, Mind, and Body in the Healing of Trauma. Published by Viking.

[12] Felitti, Vincent et al. (1998): Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults, in: *American Journal of Preventive Medicine*, 14 (4), p. 245; https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html

[13] Felitti et al., p. 256

SAMHSA further points out that trauma has no boundaries with respect to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation.[14] Traumatic experiences can be pervasive across life cycles. Additionally, trauma does not occur in a vacuum, but within contexts characterized by socioeconomic disparity, historical injustice, and cultural complexity.[15] According to Levi-Carrick et al. equitable opportunities for optimal health require deliberate attention to these dimensions realizing that individual trauma occurs in the context of a community. In fact, communities as a whole could also experience trauma[16] such as the structural racism and police brutality facing the African-American community in the U.S. Although incidence and prevalence of trauma exposure vary widely in the population, a recent global general population survey revealed traumatic exposure proportions exceeding 70%, with 30.5% reporting exposure to four or more such events. Trauma and adversity are therefore among the critical social determinants of health that affect not just individuals, but also families, communities, and society.[17] [18]

3. The Concept of "Trauma-Informed Care"

The "trauma-informed care" (TIC) approach has received increasing attention in recent years due to the above-mentioned pervasiveness of trauma and its (mental) health implications. The groundwork for defining and conceptualizing this approach was laid out in partnership with SAMHSA (as a funding body), which developed its framework based on academic research, expertise by practitioners as well as survivors' knowledge.[19] SAMHSA defines a trauma-informed entity as follows:

> *"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**."*[20]

A trauma-*informed* approach is distinct from trauma-*specific* services. While it is inclusive of trauma-specific interventions such as assessment, treatment or recovery support, it also incorporates key trauma principles into the organizational culture.[21] A trauma-informed approach as defined above therefore can be implemented in a wide range of services including but not limited to: behavioral and mental health, education, children and family welfare, criminal and juvenile justice, primary health care, homeless shelters, and the military.

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[14] SAMHSA, p. 2
[15] Levy-Carrick, p. 104.
[16] SAMHSA, p. 17
[17] Levy-Carrick, p. 104
[18] For a more comprehensive review of the meaning and impact of trauma in childhood, please refer to the I.N.T.I.T. position paper by IPRS "Trauma and Minors".
[19] Also view https://pubmed.ncbi.nlm.nih.gov/15780539/ for the U.S. federal *Women Co-Occurring Disorder and Violence Study*, setting the groundwork for the federal direction around trauma-informed care.
[20] SAMHSA p. 9
[21] SAMHSA, p. 9

The TIC approach stems from the realization that public institutions and service systems themselves are often trauma-inducing causing "unintended" re-traumatization by treating a patient or client for behavioral issues (e.g. substance abuse, diagnosis of "conflict disorder" in children) in a vacuum without taking into account the impact of trauma.[22] Recognizing and understanding trauma on the other hand could prevent misdiagnoses that are focused on treating symptoms alone while failing to address the underlying cause of a "mental injury".[23] Children and youth are frequently labeled as "oppositional" and misdiagnosed with ADHD or a bipolar disorder.[24] Adoption of a trauma informed approach reflects the recognition that many individuals experience trauma that in turn influences their behavior and may be exacerbated by an inappropriate response by a service or caregiver.

To comply with a TIC approach, organizations should adhere to the following **four key assumptions**[25]:

- All people within an organization or system have a **basic realization of trauma** and how it affects families, groups, organizations, communities and individuals. There should be an awareness that trauma should be systematically addressed in prevention, treatment and recovery settings;
- All people within an organization or system **recognize the signs of trauma**.
- The program, organization or **system responds by applying the principles of a trauma-informed approach** to all areas of functioning including staff, leadership, policies, manuals and organizational culture;
- A trauma-informed care approach **seeks to resist re-traumatization** of clients as well as staff.

Given the assumptions outlined above, TIC can be viewed as a "universal design for serving trauma survivors"[26] with the entire system being used as a vehicle for intervention. These assumptions imply a significant paradigm shift involving whole support systems that need to broaden their scope of intervention from asking "how can I fix you" to "what do you need to support your development and recovery?"[27]

[22] http://www.traumainformedcareproject.org; DeCandia, Camelia and Kathleen Guarino (2015)
[23] Stenius, Vanja and Bonita Veysey (2005): It's the Little Things. Women, Trauma, and Strategies for Healing, in: *Journal of Interpersonal Violence*, p.2; An example of the failure to recognized the signs of mental injury and misdiagnosis and medication is portrayed in the documentary "Cracked Up: the Darrell Hammond Story" (2018).
[24] DeCandia, p. 15
[25] SAMHSA p. 9-10
[26] DeCandia, p. 8
[27] Ibid. p. 13

Related to the above-mentioned assumptions SAMHSA developed **six core principles** for TIC requiring an organization-wide commitment for putting these principles into practice. It should be noted that these principles are equally important and no priority is assumed in their listing below:[28]

- **Safety**: staff and the people they serve feel physically and psychologically safe;
- **Trustworthiness and Transparency:** organizational operations are geared towards building trust amongst clients, family members and staff;
- **Peer Support:** "Peers" or "trauma survivors" are considered key elements in fostering healing and recovery. In the case of children, peers could be family members who themselves have experienced trauma during childhood;
- **Collaboration and Mutuality**: Everyone in an organization has a role to play in a trauma-informed approach. Power differences between staff and clients and amongst staff are leveled as opposed to replicating a hierarchy of expert knowledge and client compliance;
- **Empowerment, Voice and Choice:** Organizations believe in resilience and the ability of individuals and communities to heal and recover from trauma. Self-advocacy skills are promoted and staff members are considered facilitators of recovery rather than controllers of recovery;
- **Cultural, Historical and Gender Issues[29]:** Organizations are responsive to cultural needs, recognize historical trauma, and are aware of gender-specific needs.

4. Becoming Trauma-Informed

The above-mentioned assumptions and principles provide a roadmap for an organization or service to become trauma-informed. However, for the approach to be implemented it needs to be fully endorsed and reflected in all areas of operation.

An integral role in this process is that of leadership which needs to demonstrate its commitment and define clear expectations. Staff training and workforce development are equally important. Given their frequent exposure to complex mental health issues and emotional needs, professional caregivers often suffer from high levels of stress, burnout, compassion fatigue, and vicarious trauma.[30] In a recent study Schmid et al. found that the exposure to TIC practices and training in an organization has a positive influence on reducing the emotional burden of both staff and clients.[31]

[28] SAMHSA, p.11
[29] According to Stenius and Veysey (2005) there is an acute lack of trauma-informed gender specific care for women, p. 2
[30] Levy-Carrick
[31] Schmid, Marc et al (2020): Effect of trauma-informed care on hair cortisol concentration in youth welfare staff and client physical aggression towards staff: results of a longitudinal study, in: *BMC Public Health*,p. 1-11

Staff experience a higher level of fulfillment through improved client engagement and benefit from a higher level of awareness of the risks of (unintentional) re-traumatization and retriggering of clients and patients.[32]

Another cornerstone and key value of TIC is the involvement of trauma survivors, people receiving services, and family members[33] in all aspects of the organization including program design, service delivery, quality assurance, staff training, cultural competence and evaluation.[34] With this focus, affected individuals are given a voice in how services are delivered. This constitutes a power shift from a focus on professional "experts" to valuing and incorporating the experiences of those who can relate and identify. Ultimately, this means a restitution of dignity for service recipients.[35]

An important prerequisite for the successful implementation of a TIC approach is the inter-disciplinary and cross sector collaboration between service providers and amongst systems of care. The lack of inter-agency cooperation could lead to misdiagnosis, false medication, and re-traumatization.[36] However, systemic barriers are often constituted through different jurisdictions and legal requirements, through strict health insurance parameters, financial concerns and data protection. These barriers force clients to repeatedly outline their issues to a multitude of stakeholders, prevent cross-training and lead to interruptions in service delivery due to insurance constraints. As with the implementation of a TIC approach the commitment towards multi-agency cooperation needs to be endorsed by the leadership. Once the notion of multi-agency cooperation is established staff – and clients – benefit from the added values of a common case analysis and from a sense of shared responsibility.[37] [38]

Implementing these core values is an ongoing process due to resistance to change by staff and leadership, high staff turnover within the organization, inadequate training opportunities, and limited financial resources.[39]

[32] Levy-Carrick, Nomi C. et al. (2019)

[33] In the case of services for children, this role could be taken by adults with previous experiences of trauma. Save the Children in Sweden has adopted this approach in their hiring process. https://www.raddabarnen.se/rad-och-kunskap/arbetar-med-barn/tmo/

[34] SAMHSA, p.13

[35] Stenius and Veysey, 2005, p.16

[36] Ibid, p. 2

[37] Heinrich, Svenja and Galina Missel (2018): Jung, delinquent und psychisch auffällig. Ein multidisziplinärer Lösungsansatz der Hilfekoordinierung und der Versorgung, in: *ZJJ* 2/2018, p. 119-125. Article on the challenges of multi-agency cooperation for European Union funded project *Fact for Minors*.

[38] For a more comprehensive review on the merit of inter-agency cooperation please refer to the I.N.T.I.T. position paper prepared by Consensus, Multi-agency Approach".

[39] De Candia, p. 16

5. Prevalence of Trauma-Informed Approaches in Europe

The majority of references around TIC mentioned above derives from U.S. based research.[40] The following chapter discusses the prevalence of TIC in Europe and potential lessons learnt from US practice. Given the scope of the project, this paper will focus on the participating project partners of Italy, Spain, Cyprus, Estonia and Germany and making reference to Sweden as an early implementer of the Barnahus model and country with a high level of TIC implementation.

As noted above, interpersonal violence and neglect are widespread phenomena faced by children in the US and Europe alike.[41] However, with its differences in socio-economic development, its respective political histories and variety of demographics, Europe is also characterized by its diversity in the development of trauma treatment.[42] Although there is growing acknowledgment of the impact of trauma and the relevance of trauma-focused treatments, there is a lack of Europe-wide policies to ensure the availability of treatment to trauma-survivors. Explicit reference to TIC is only made occasionally for individual member states whereas trauma-informed care policies on a European-level have yet to emerge.[43] A step towards a transnational exploration of TIC has been made with the CarePath project focusing on the benefits of TIC for young care leavers in 8 European countries.[44] In addition, the Barnahus Model – a multidisciplinary and interagency model responding to child victims and witnesses of violence or sexual abuse in the context of court proceedings – has been implemented in a growing number of European countries.[45] [46]

Italy

Data on the incidence of child maltreatment in Italy are generally lacking with data largely limited to a study conducted by Terre des Hommes, AGIA and CISMAI, based on a national sample of social service provision in Italian cities, in which almost 2 in 10 children (77.493) were identified as being victims of maltreatment (in December 31 2018 out of 1,000 resident children and Youth 45 were those in the care of Social Services for different social and economic reasons for a total of 401,766 minors) corresponding to 9 in 1000 of the total population below 18 years old. Of these, 40.7% were due to neglecting as well as over protective or overcontrolling parents (including excessive medical care – this category includes all cases in which caregivers fail to

[40] https://www.nctsn.org/trauma-informed-care National Child Traumatic Stress Network; https://tfcbt.org/

[41] https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/child-sexual-abuse_en, Studies suggest that a significant minority of children in Europe, between 10% and 20%, are sexually assaulted during childhood. This phenomenon is not decreasing and certain forms of sexual violence (like child pornography) are becoming a matter of growing concern.
WHO. *European Status Report on Preventing Child Maltreatment.* 2018.
https://www.euro.who.int/__data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf

[42] Kazlauskas, Evaldas et al. (2016): Trauma treatment across Europe: where do we stand now from a perspective of seven countries, in: *European Journal of Psychotraumatology*, 7:1, DOI: 10.3402/ejpt.v7.29450

[43] Schäfer, I. et al. (2018). Trauma and trauma care in Europe, in: *European journal of psychotraumatology*, *9*(1), 1556553.

[44] https://carepath-project.eu/site/en/news/view.html?id=8

[45] https://www.childrenatrisk.eu/promise/wp-content/uploads/PROMISE-Enabling-Child-Sensitive-Justice.pdf

[46] For a more comprehensive review of the Barnahus Model please refer to the I.N.T.I.T. position paper prepared by the University of Cyprus "The Barnahus Model Across the Broader European Context".

respond to the developmental needs of children); 32.4% witnessing violence, 14.1% psychological abuse, 3.5% sexual abuse, and 9.6% physical abuse[47]. These data need to be interpreted with caution as they are subject to a number of methodological caveats, but are – to date – the only data that include a national sample.

Italy has not adopted the language of trauma informed care and trauma treatment remains largely in the domain of psychiatrists and psychologists[48] as opposed to adopting a more multidisciplinary approach to care. Much of the work on trauma has focused on trauma caused by natural disasters (e.g., earthquakes) with the establishment of the Italian National Trauma Center[49], which has taken some steps towards promoting a trauma sensitive approach adopting well-established diagnostic tools for identifying trauma in partnership with Harvard University. This work, however, has not focused specifically on children.

There remains a general lack of preventive initiatives and early detection assessment tools for post-traumatic stress signs and syndromes. For this reason, the system tends to respond with delay and mainly to traumatization that became complex as a result of missed accurate diagnoses or failure to activate early interventions to reduce risk factors. To proceed with this vision Kazlauskas et al. suggest for the Italian Society of Traumatic Stress Studies (SISST) to adapt the following strategic steps: promote the synergy between clinical work and research to adapt service models accordingly, provide epidemiological studies to determine the actual prevalence and incidence of traumatic events in Italian society and to further expand possibilities of training in psychotraumatology.[50] Amongst the priority target groups in need of care are highly traumatized refugees and unaccompanied minors that entered Italy particularly over the past 5-10 years. Child maltreatment with its burden and consequences is also considered a relevant issue. Nonetheless, this is an area in which cultural and political reflection in Italy is not yet developed so much so that valid tools for collecting information on a national scale have not been set up yet. The absence of data undermines legislative initiatives and the adoption of effective policies in this area, in addition to highlighting Italy's serious delay in comparison with other countries.

A systemic vision for care for traumatized populations, with shared policies and protocols has not yet emerged although a plan for general prevention was provided by the Ministry of Health in 2019 focusing on the “first 1000 days” beginning with conception[51]. This represents a broad recognition of the importance of early intervention and long-term impact of abuse and maltreatment during childhood as well as prenatal issues on child development.

Local focus on trauma can be found in some areas such as the Region of Puglia, which has developed an extensive regional system (Apulian social-health network for the contrast,

[47] Bollini, Andrea, Federica Gianotta, and Antonello Angeli. “Maltrattamento sui bambini: quante le vittime in Italia? Prima Indagine nazionale quali-quantitativa sul maltrattamento a danno di bambini.” https://www.garanteinfanzia.org/sites/default/files/documenti/dossier-bambini-maltrattati-tdh-cismai.pdf AGIADossierMaltrattamento_2021.pdf

[48] Schäfer, I., (2018) https://doi.org/10.1080/20008198.2018.1556553

[49] https://www.intraumacenter.com/index.php

[50] Kazlauskas et al.

[51] http://www.salute.gov.it/imgs/C_17_pubblicazioni_2837_allegato.pdf

diagnosis and early treatment of forms of violence in Childhood) to improve the capacity of social-health services to identify signs and signals of complex trauma in children who are victims of sexual abuse, violence and neglect and provide treatment within a multi-disciplinary framework. The Apulian network constitutes one of the most advanced experiences of Trauma Informed Care in Italy although only in its beginning. The leading organization of this process in the GIADA service[52] (Interdisciplinary Group Assisting Women and Abused Children) of the Giovanni XXIII Children's Hospital in Bari, which acts as the Apulian Regional Reference Center for Early Diagnosis and Treatment of Forms of Violence against Persons under the Age of 18. Initiated in 2016, the Giovanni XXIII Children's Hospital Giada Service represents a significant advancement in the identification and treatment of trauma that includes some elements of trauma informed care and efforts to reduce re-victimization as part of criminal investigations. While providing trauma-specific care to children, GIADA does incorporate the TIC principles in its efforts to improve the regional system capacity to detect signs of trauma, coordinate social and health services in providing parental support and refer cases to proper evaluation and treatment.

Germany

In 2020, the German child and youth welfare offices reported 60.551 cases of endangerment of the well-being of a child, which constitutes an increase of 5000 cases compared to 2019. This 10% increase for a third consecutive year led to an unprecedented level of child endangerment cases. A particular increase (+17%) was observed in the category of psychological abuse.[53] While overall numbers of child abuse increased the number of custodial cases involving unaccompanied young refugees has decreased since 2018.[54] Amongst this latter target group between 17-62% of boys and up to 71% of girls are estimated to have evolved some symptoms of post-traumatic stress disorder (PTSD). Between 20-30% of unaccompanied minors are estimated to have developed comprehensive signs of PTSD.[55]

The Covid-19 pandemic has further amplified the risk of child abuse with families being isolated and schools and other institutional care facilities being closed. This trend is confirmed by the recently published police crime statistics (PKS) 2020 according to which the number of registered cases of child abuse has increased by 10,78% to 4.542 cases between 2019 and 2020. 152 children lost their lives in 2020 due to abuse and violence – 115 of them younger than 6 years. The rate of sexual abuse increased by 6,18% to 16.921 registered offenses.[56]

[52] http://www.giadainfanzia.it/

[53] https://www.destatis.de/DE/Presse/Pressemitteilungen/2020/08/PD20_328_225.html

[54] https://www.destatis.de/DE/Presse/Pressemitteilungen/2019/08/PD19_308_225.html;jsessionid=5A2E1B7EFAEEA70E9D8D9B6B568726D9.internet8722 (Statistisches Bundesamt 2018)

[55] Sukale, T., Hertel, C., Möhler, E. et al. (2017): Diagnostik und Ersteinschätzung bei minderjährigen Flüchtlingen. *Nervenarzt* 88, 3–9. https://doi.org/10.1007/s00115-016-0244-4

[56] Bundeskriminalamt (2021): Vorstellung der Zahlen kindlicher Gewaltopfer. Auswertung der polizeilichen Kriminalstatistik 2021. file:///C:/Users/HEINRI~1/AppData/Local/Temp/pm210526_kindGewaltPKS-1.pdf

In addition, there was an increase of 53% in the distribution, production and possession of materials of so-called child pornography in 2020. Given the large darkfield, it is assumed that 1-2 children in each classroom have become victims of sexual violence. [57]

The prevention and treatment of trauma in different care settings remains a challenge in Germany.[58] According to Fegert stress related disorders in children and youth often remain hidden as children adapt to their respective environment. Consequently, trauma frequently remains unidentified and trauma specific care is only sought after in cases of high latency. The health system has not paid sufficient attention to potential histories of trauma leading to symptom-focused as opposed to trauma-focused approaches to treatment.[59] Amongst the target groups that are particularly vulnerable to becoming exposed to interpersonal violence are children in foster care, children in government custody and residential facilities, children with disabilities, children of parents suffering from mental illness, and unaccompanied minors.

Following the comprehensive disclosure of sexual abuse in religious and youth care institutions, in 2010 the German government established an independent commissioner to address child sexual abuse.[60] In addition, substantial funding was provided for research and preventive activities in this domain. However, the introduction of designated trauma-informed practices in the realm of youth welfare or residential care has been limited. The term “trauma-informed care” is rarely used in Germany to date, instead practitioners speak of “trauma-sensitivity” and “trauma pedagogy”.[61] Although these concepts acknowledge the importance of addressing trauma, they do not entirely reflect the holistic, systemic approach of TIC and its related means of intervention.

In 2018, Germany opened its first childhood house (Barnahus) in Leipzig. By 2022 childhood houses in 7 additional cities including Berlin, Hamburg, Düsseldorf and Flensburg have followed with locations in other German states in the planning stages. The concerted objective is to join police investigators, prosecutors, social services, child and adolescent psychiatrists, and child health and medical care/forensic medicine services to avoid re-traumatization through repeated interrogations by multiple stakeholders.[62]

57 https://beauftragter-missbrauch.de/presse/pressemitteilungen/detail/vorstellung-der-zahlen-kindlicher-gewaltopfer-auswertung-der-polizeilichen-kriminalstatistik-pks-2020

58 Kazlauskas et al. (2016)

59 Fegert, J. (2016): Folgekosten von Vernachlässigung und Misshandlung in der Kindheit: Verbesserung im Kinderschutz als gesellschaftliche Herausforderung. *Tagung Traumapädagogik überwindet Grenzen*, 19.11.2016 in Dornbirn

60 https://beauftragter-missbrauch.de/, Unabhängiger Beauftragter für Fragen des Sexuellen Kindesmissbrauchs UBSKM

61 https://ecqat.elearning-kinderschutz.de/, online training on the concept of trauma therapy and trauma pedagogy

62 https://childhood.org/childhood-opens-germanys-first-barnahus-childhood-haus/

Spain

In Spain the concept of trauma-informed care is familiar to some professionals and organizations but there is no widespread knowledge.

In Catalonia, the first Barnahus was launched in Tarragona, in 2020, as an integrated care unit for children and adolescents who are victims of sexual abuse, with the purpose of later replicating the model to a greater extent.[63] The Autonomous Communities of Navarra, Cantabria and País Vasco are preparing to implement a Barnahus soon and iIn other Autonomous Communities the possibility of implementing the Barnahus model is also being studied.

There are other multidisciplinary models, such as the pilot plan carried out in Las Palmas de Gran Canaria, in the first Spanish Court specialized in violence against children and adolescents. This plan includes a Good Practices Guide for children, a reception protocol and accompaniment to the underage victims, conditioned waiting rooms and a Gesell room. They have received a national award for the quality of Justice for their improvements in the field of child protection

In Galicia there is a new protocol for action in sexual crimes, which has been drawn up in Santiago by a multidisciplinary team led by Judge Ana López-Suevos Fraguela, created with the aim of being applied throughout Galicia. In Santiago, the main Administrations and institutions that participate in the investigation of sexual crimes and support for victims have already joined, such as the Police, the Bar Association, the Health Service, the Government of Galicia, the Santiago City Council and the Mayors of Ames, Teo and Boqueixón.

The Observatory of the Spanish Ministry of Social Rights reported in 2020: 1.375 cases of sexual violence, 5952 cases of emotional violence, 3.463 cases of physical violence and 8755 cases of neglect of children and youth under 18.[64]

According to the Unicef Spain Report- Impact of The Covid-19 Crisis on The Most Vulnerable Children, [65f] Frontline entities identify the COVID 19 lockdown phase as a phase in which exposure to domestic violence has increased substantially, along with increased barriers for children to seek help or for violence to be detected by professionals.

Recently, the Parliament commissioned the Ombudsman to prepare a report on complaints of sexual abuse within the Catholic Church, with an Expert Advisory Commission, a Dialogue Forum with victims' associations and a Technical Unit for victim assistance that will support the investigations.

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63 https://dixit.gencat.cat/es/detalls/Noticies/servei_pioner_atencio_integral_infants_adolescents_victimes_abusos_sexuals.html

64 Boletín nº 23 de datos estadísticos de medidas de protección a la infancia. Datos 2020. p. 162. Secretaría de Estado de Derechos Sociales Dirección General de Derechos de la Infancia y de la Adolescencia - Observatorio de la Infancia. https://observatoriodelainfancia.vpsocial.gob.es/estadisticas/estadisticas/home.htm

65 INFORME UNICEF ESPAÑA- IMPACTO DE LA CRISIS POR COVID-19 SOBRE LOS NIÑOS Y NIÑAS MÁS VULNERABLES (2020) pp.26,43.https://www.unicef.es/sites/unicef.es/files/comunicacion/COVID_infanciavulnerable_unicef.pdf

In June 2021, a new Law for the Comprehensive Protection of Children and Adolescents against Violence was approved. It adopts a comprehensive and multidisciplinary approach that includes changes related to the following topics:

- Extension of the term for the prosecution of crimes: The age from which child abuse begins to prescribe at 35 years;
- Establishment of the pre-constituted evidence as mandatory up to the age of 14 so as not to re-victimize;
- Elimination of Parental Alienation Syndrome (PAS);
- Reinforcement of the duty of all citizens to report any indication of violence against children;
- Specialization of judicial bodies, prosecutors and technical teams; and
- Protection of minors during the complaint process.

Estonia

The most recent research in Estonia on sexual abuse of minors and young adults (16 to 26 years old) was conducted in 2019-2020.[66] According to the results of the study 18% of youth aged 16 to 19, have experienced some form of sexual violence during their life.

Nearly half of those young people, who have experienced sexual violence, have told someone about the incidence. Young people usually turn for support to their friends (34%), boyfriends or girlfriends (12%), or mothers (9%). Only 2% have reported the case to the police. The primary reason for not reporting the case to anyone was that the young person thought the case was not serious enough (1/2 of all victims) or s/he felt ashamed (1/3 of the victims). Only one in ten said they did not know who they can talk to.[67] These research findings demonstrate insufficient information and limited awareness of young people both about the essence of sexual abuse and professional help. At the same time these results tell us about limited trust to professionals working in the field of child protection and other helping services.

In Estonia, the general quality of the services provided for children improved with the adoption of the amendments to the Victim Support Act (which entered into force on 1 January 2017).[68]

[66] Pärnamets, R., Hillep, P. A Study of Attitudes and Experiences of Sexual Abuse of Children and Young People. Available: https://www.kriminaalpoliitika.ee/et/study-attitudes-and-experiences-sexual-abuse-children-and-young-people
[67] Ibid., 63-69
[68] Victims Support Act (Ohvriabi seadus). Available: https://www.riigiteataja.ee/akt/106052020022?leiaKehtiv

Of the integrated services for children in need, child trauma is most often considered in Residential Care Home (*ravikodu*) [69] and Children's House (*Barnahus*) services. The rights and best interests of children are respected in the Closed Child Institution Service (in Estonian *KLAT*) but as referral is through the courts and the child cannot voluntarily leave the service, the impact of the trauma-informed approach is questionable.

A pilot project of Children's House (in Est. *lastemaja)* was started in Tallinn in January 2017. This was done as part of the PROMISE project and the model of *Lastemaja* is based on the Barnahus model. In Estonia, the Children's Home service is provided by the Social Insurance Board. It was seen as important to expand the service to other regions, and already a year later, in 2018, a southern Children's House was opened in Tartu and in 2020 an eastern Children's House in Jõhvi. In the second half of this year (2022), a western Children's House will be opened in Pärnu. The service is open to all children across Estonia.

The Children's House service regulated by Social Insurance Bord celebrated its fifth anniversary in January and during these five years has helped 1,737 children who have been or are suspected of being sexually abused[70]. Until now the Children's House clients are children who have been or are suspected of having been sexually abused, however, in the future a special service will also develop for underage sex offenders.

In Estonia, the trauma-informed approach is relatively new. The term Trauma Informed Care was first used in the TBRI trainings organised by the NGO Igale Lapsele Pere. The topic of trauma is briefly introduced in training sessions ran by the Institute for Health Development for kindergartens' teachers and child protection workers.[71] In parallel to the INTIT project, a trauma-informed care training programme for the substitute care system is in process of developing by researchers from the University of Tartu and Tallinn University on behalf of the Institute for Health Development.[72]

Despite the efforts that are being made to raise awareness of trauma-informed care, there is still a great need to reinforce trauma-informed principles among all people working with children, and the dissemination of the training material developed by the INTIT project is now urgently needed.

[69] The treatment is based on the principles of milieu therapy. Milieu therapy is a round-the-clock, facility-based rehabilitation service provided by milieu therapists, whose overall aim, in addition to helping the person undergoing therapy, is to provide systemic support to the person's immediate family. The therapeutic environment is created as a form of organisation in which children, therapists and educators are equally involved partners in daily activities (e.g. shopping, cleaning, treatment planning, etc.) https://ravikodu.ee/miljooteraapia/

[70] https://sotsiaalkindlustusamet.ee/et/uudised/lastemajadest-viie-aastaga-abi-saanud-ule-1700-lapse

[71] Lapse Vaimse tervise toetamine lasteaias. Juhendmaterjal (2015) Tallinn: Tervise Arengu Instituut. https://intra.tai.ee/images/prints/documents/14452415546_Lapse%20vaimse%20tervise_2015.pdf

[72] Sindi I, Strömpl J, Lust M. Traumateadlik asendushooldus. Kirjanduse, koolitusprogrammide ning laste otseste hooldajate kogemuste uuringu aruanne. (2022)Tallinn: Tervise Arengu Instituut. Available: https://mail.google.com/mail/u/0/#search/judit.strompl%40ut.ee?projector=1

Cyprus

In Cyprus the relevant service entities are familiar with the concept of ''trauma informed care''. The notion of trauma informed service delivery has been implemented through the introduction of the Home of the Child (Barnahus) in 2016 in Cyprus.[73] Regarding child abuse statistics in Cyprus, as reported by the Association for the Prevention and Handling of Violence in the Family (SPAVO) in 2020, 63% of the children attended or were subjected to domestic violence. In terms of forms of violence against children, 30% of the children were victims of psychological violence or witnesses of violence, 9% suffered physical abuse and psychological abuse, 1% were neglected, 0.8% were abused sexually. The above statistics relate to cases of domestic violence in 2020 that involved witnesses or children as victims. In the period of March 16, 2020 - June 30, 2020, the hospitality premises that provided housing, protection, and security for victims of domestic violence hosted 370 children. According to the latest statistics, there were 228 children in shelters in the year 2019, i.e., the year before the pandemic and the ensuing lockdowns. Therefore, it is evident that domestic violence involving children has increased due to the pandemic as well as the restrictive measures taken. As can also be seen from the statistics of the Office for the Management of Victims of Domestic Violence, Crime Against Children, Juvenile Delinquency & Anti-Discrimination, child violence incidences increased during the pandemic.

In Cyprus, representatives from Ministry of Labor, Welfare and Social Insurance with the cooperation of Social Welfare Services, Cyprus Police, Ministry of Health and Ministry of Education and Culture meet weekly at the House of the Child/Barnahus. The Interdisciplinary Services under the same Roof comprise social support and rehabilitation, family therapy, forensic interview, multi-disciplinary/ interagency case management, psychological support and therapy, medical examination, and psychological evaluation to sexual assault child victims. On the basis of the agreed protocol that is based on European Operating Standards, these service-representatives Representatives for the above services to children victims of sexual assault meet once a week with Children's House/Barnahus chairing and discuss existing and new cases and arrive at a group decision which detail's each one's role and contribution in handling the case in such a way as to ensure the best interests of a child, on the basis of the protocol agreed. Finally, protocol challenges include when families do not cooperate with Barnahus, when children do not trust the services or the Barnahus professional who chairs the meeting, court delays, the neutrality of the professional and burnout of the professional.

[73] For a more in-depth review of the Cyprus Barnahus see the I.N.T.I.T. position paper "The Barnahus Model Across the Broader European Context".

Sweden

Data from Sweden indicates recent increases in the number of maltreatment cases reported to the police with a 6% increase between 2018 and 2019 with 25.500 reported cases in 2019. The capacity to investigate and prosecute, however, remains problematic. While 93% of cases for children between ages 0 and 6, and 70% of cases for children ages 7 to 14 were investigated, the perpetrator was only identified in 5% of cases for children under age 6 and in 10% of cases with children between ages 7 and 14[74]. There is a general recognition by the national crime statistics agency – BRÅ – that much violence and maltreatment of children remains undetected despite. At the same time, the severity of the violence has decreased following the 1979 law criminalizing the use of corporal punishment for children[75] [76].

Sweden, as one of the main actors in the development of Barnahus after their initial development in Iceland, has adopted a trauma informed care, translated as "traumamedveten omsorg" or TMO, thanks to work done by the Swedish branch of Save the Children, which has made TIC central to its work.[77] [78] TIC is now a part of services provision[79] and schools[80] [81] [82] with an array of courses available to professionals and caregivers. Schools in particular are seen as a key contact point for working with traumatized children. Sweden was one of the first European countries to open a Childhood House – today the country has established around 30 Barnahus children houses.[83] Some Barnahus centers have also explicitly adopted TIC within their work with children.[84]

[74] https://www.bra.se/statistik/statistik-utifran-brottstyper/barnmisshandel.html
[75] https://www.bra.se/statistik/statistik-utifran-brottstyper/barnmisshandel.html
[76] https://www.barnombudsmannen.se/barnombudsmannen/i-fokus-just-nu/en-samlad-handlingsplan-for-att-motverka-vald-mot-barn/vald-mor-barn-i-familjen/
[77] https://www.raddabarnen.se/rad-och-kunskap/arbetar-med-barn/tmo/
[78] https://resourcecentre.savethechildren.net/library/one-year-transforming-care-annual-report-about-save-childrens-trauma-informed-care-programme
[79] https://www.uppdragpsykiskhalsa.se/asylsokande-och-nyanlanda/om-vara-utbildningar/utbildning-i-traumamedveten-omsorg-tmo/
[80] https://www.skolverket.se/skolutveckling/kurser-och-utbildningar/tmo-utbildning-i-traumamedveten-omsorg
[81] http://pedagogiskpsykologi.se/tag/traumamedveten-omsorg/
[82] https://www.vanersborg.se/utbildning--barnomsorg/nyheter-utbildning--barnomsorg/nyheter-grundskola-barnomsorg/2018-09-06-traumamedveten-omsorg---utbildning-for-skolpersonal.html
[83] https://childhood.org/childhood-opens-germanys-first-barnahus-childhood-haus/
[84] Barnafrid. 2019. *Slutrapport Utvärdering av Barnahus.* S2018/00212/FST.

6. Ways Ahead: Benefits and Challenges of Trauma – Informed Care

The above chapter suggests that the approach of TIC is not yet as prevalent in European health and social services as it is in the U.S. However, recognition of and interest in the approach are growing in Europe as well. In closing, this paper will therefore summarize some of the benefits and challenges that could inform possible adaptations to a European context taking into consideration the recent "hype" that has developed around TIC.[85]

The benefits of TIC are manifold. The approach constitutes a relatively low cost and high yield investment to address the needs of clients and patients who have experienced trauma.[86] By recognizing the implications of trauma, misdiagnoses are reduced and mislead medication can be avoided. In addition, the participatory approach of involving trauma victims themselves has the potential to better tailor services towards clients' needs and improve program retention rates. An increase in inter-agency cooperation in TIC can enhance early identification of trauma while reducing re-traumatization through repeated questioning and interaction with multiple stakeholders. The TIC approach also has the potential to alleviate emotional stress and vicarious traumatization of staff through training and through conveying the notion of shared responsibility between colleagues and systems.[87]

On the other hand, TIC is not a "panacea" to the difficulties facing children who have experienced trauma. Amongst the key criticisms of the approach is the limited amount of evaluation that has been conducted so far to demonstrate the effectiveness of TIC. In addition there are concerns about how to translate the theory of TIC into practice.[88] As stated by Becker-Blease "even the most experienced clinician or researcher cannot rely on intuition alone to create trauma-informed care."[89] Although a wide range of cost-intensive TIC trainings is currently emerging there is hardly any research on the quality of these trainings and participants' ability to translate the training into their respective work environment. In fact, some providers have voiced fears of opening Pandora's box by addressing trauma and consequently creating needs that cannot be met by their existing services.[90]

Another area of criticism revolves around the focus on trauma itself and individual trauma in particular. Critics have argued that TIC bears the risk of being deficit-oriented and focusing on treating individual pathologies rather than fostering possibilities of well-being.[91]

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[85] Becker-Blease, Kathryn (2017): As the world becomes trauma-informed. Work to do, in: *Journal of Trauma and Dissociation* 18:2, p. 131-138. The author traced google entries on the subject and has found a substantial increase in recent years.
[86] DeCandida (2015)
[87] Levy-Carrick, Nomi C. et al, p.105
[88] Johnson, Dan (2017): *Tangible trauma-informed care*, in: Scottish Journal of Residential Child Care, No.16, No. 1, 1-22; Berliner, Lucy and David Kolko (2016): *Trauma-Informed Care: A Commentary and Critique*, in: Child Maltreatment, Vol. 21 (2), 168-172. Hanson RF, Lang, J. (2016): *A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families*. Child Maltreatment;21(2):95-100.
[89] Becker-Blease, Kathryn (2017) p. 135
[90] DeCandida (2015)
[91] Berliner and Kolko (2016)https://medium.com/@ginwright/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

While this is a valid concern, it should be noted that one of the core elements of TIC is the focus on healing and recovery from trauma.[92] Becker-Blease stresses the importance of critical engagement with the systems behind the trauma-informed movement to avoid "perpetuating the same victim-blaming, silencing, shaming, and retraumatizing" practices of the past.[93] Therefore, the above mentioned key principle of understanding trauma in its broader societal context of social inequality and oppression needs to be recognized as an integral part of delivering services in the TIC framework.

The above-mentioned criticisms of the TIC approach can be summarized along the following lines: the lack of evidence-based evaluation to date, misunderstandings around the core principles of the approach and the challenges of putting it into practice. In an attempt to adopt the approach of TIC in Europe stakeholders need to be aware of these challenges and need to carefully customize TIC to their particular setting since a "one-size-fits all" template will not do justice to the sensitivity of trauma. Once these notions are kept in mind the creative and empowering approach of TIC could provide considerable opportunities for both victims of trauma as well as for professional care takers.

[92] SAMHSA (2014): p. 11
[93] Becker-Blease, Kathryn (2017) p. 132

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