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Programme and Financial management
Grant Agreement number: 881677 — I.N.T.I.T. — REC-AG-2019 / REC-RDAP-GBV-AG-2019

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

GUIDELINES
FOR MULTI-AGENCY COOPERATION AND INCORPORATION OF TRAUMA-INFORMED CARE IN CHILD PROTECTION SYSTEMS

Document coordinated by CJD, Germany

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Foreword

This document is part of the activities of the European project INTIT (Integrated Trauma Informed Therapy for Children Victims of Violence)[1], coordinated by the Psychoanalytic Institute for Social Research and co-funded by the European Union. The INTIT project aimed to verify, in each of the partner countries (Spain, Germany, Estonia, Cyprus), the process of adapting the protection systems for minors exposed to trauma to the intervention standards of *Trauma Informed Care (TIC)*. It also aimed to strengthen the capacity of the intervention systems with abused and maltreated children to work with trauma-informed approaches, i.e. with an awareness of the short- and long-term effects of Adverse Childhood Experiences (ACE) on well-being and mental health.

Today there is full awareness that the protection of child victims of violence, abuse and maltreatment accounts for a challenge that requires the intervention of different services and professional specialties according to an integrated working approach oriented towards Trauma Informed Care (TIC). In cases of violence against children, a complex network of actors (justice, law enforcement, social, socio-medical and educational services) is called upon to share responsibility for intervention. This sharing, in order to be effective, requires that the professionals involved also acquire the same language, which is not that of a single discipline, but the language that is built on the common knowledge of the meaning of trauma.

This challenge requires the different professionals involved in the front line of early intervention and reparation to rethink their working practices, not only for a better management of the cases that are reported to them, but to also draw attention to those cases that escape the intervention of the services in charge. In this scope, the minimum standards that Europe expects, some of them codified in the 2012 Directive on crime victims, require that anyone working with minors exposed to violence be informed about trauma, the relevance of the impact it produces and the possible paths of recovery; know how to recognise the signs and symptoms of trauma in minors and families and actively prevent the risks of re-traumatisation.

[1] The European project INTIT, Integrated Trauma Informed Therapy For Child Victims Of Violence - Grant Agreement number: 881677 — I.N.T.I.T. - REC-AG-2019 / REC-RDAP-GBV-AG-2019, coordinated by the Psychoanalytic Institute for Social Research, was co-funded by the European Union - Directorate General Justice and Consumers Programme and Financial management. In the partner countries, the project conducted state-of-the-art assessment activities of the process of adapting intervention systems with minors exposed to trauma and violence to the standards and principles of *Trauma Informed Care*, as well as training and awareness-raising activities addressed to a wide range of professionals. At the European level, it produced and tested training material on the multi-agency and trauma-informed approach for trainers representing the different professional specialties involved in interventions with children exposed to trauma and violence. After a testing phase in the partner countries the material will be made available through https://www.intitproject.eu/.

This document reflects the collaborative activities and findings of the INTIT project which included the review of academic literature, interviews, focus groups, training sessions based the curriculum developed in the project, multi-agency and awareness raising events.

CHALLENGES OF ACTING TRAUMA-INFORMED

In the course of the INTIT project activities professionals have described their insecurities around trauma and obstacles to acting trauma-informed. For one, the knowledge of trauma – and the capacity to speak about trauma – often seems to be predominantly associated with clinical professions. Other professions have expressed their fears of triggering, hurting, damaging or influencing a child or youth when addressing their potential trauma.

"We have made the experience that traumatization appears in very different facets and disguises and hides, for example, behind a disorder of social behavior or other symptoms. For our area, it would be a learning process to think about the underlying trauma before I dwell on recognizable symptoms. And if I turn back the wheel and say, I am not exhausting myself to address your dysfunctional social behavior, but instead accept it as a form of expression of your underlying traumatization that is possible for you at this moment, then I can experience a different attitude in myself ... Knowledge also helps here - the more I know about trauma, the more I can change my attitude when I encounter the symptoms presented. "(expert, child and adolescent psychiatry, Germany)

In addition, integrated and trauma-informed care is often hampered by different professional mandates which leads to a "pillarization" of services and self-referential systems. While the need for trauma training for individual professional groups has been widely recognized in Germany, the aspect of interdisciplinary and cross sector collaboration between service providers and systems of care as an important prerequisite for the successful implementation of a trauma-informed care approach has not been fully endorsed. Instead, systemic barriers persist due to different jurisdictions and legal requirements, through strict health insurance parameters, financial concerns and data protection rules. It often happens that intervention practices clash with the limits set by a regulatory and organisational system that fragments interventions by hinging them on different services, instead of integrated and personalised responses that respect the unitary and specific nature of clients in need. In the same way, it constantly emerges that services, in responding to self-referential logics, do not favour the coherence and continuity of the interventions needed in personal and family situations characterised by fragmented life paths, and especially for multi-problem situations, in which various elements of complexity coexist (mental health problems, substance abuse, dysfunctional family relationships, social marginality, etc.).

"If you realize that certain experiences mean a high degree of loss of control, fear, being at the mercy of someone, and everything else that goes along with a traumatic experience, [the goal must be] that one does not reproduce such situations, being at the mercy of someone, not being informed, not being asked, acting beyond you, of course always with the knowledge that you always have to explain what has to be done... "(Expert, Childhood Foundation, Germany)

Participants representing the judicial sector claimed that they are oftentimes the last piece in the chain of care – with limited time spent with the child to properly identify his or her needs. Furthermore, there seems to be an assumption that judicial proceedings with their mandate of impartiality leave “limited space for empathy”. Obviously, extensive court proceedings in child abuse cases as they could be observed in all partner countries do not cater to a trauma-informed objective.

Finally, a heavy workload, staff shortages and high turnover facilitates burn out and compassion fatigue which stands in the way of providing trauma-informed services.

This being said, it is evident that, precisely because of the often 'adverse' conditions in which professionals operate, it is important to open a reflection on the ethical standards of intervention with minors exposed to trauma and violence that shall bring to light and address those organisational and governance aspects that more than others pose barriers and obstacles to interprofessional collaboration. Within the scope of the reflection that led to the drafting of this document, it was acknowledged that these obstacles concern the possibility of the convergence, at various levels, starting from academic training and lifelong education, between specific practices and knowledge but also between ethical principles of different professions so that the best interest of minors can really be pursued.

THE MULTI-DISCIPLINARY APPRAOCH: FROM THE OBSERVATION OF RISK ELEMENTS AND RESOURCES; TO A COMMON ASSESS; TO A COMMON PROJECT

As a result of what has been highlighted in the introduction, it follows that working with minors exposed to trauma and violence requires to carry out an assessment and a project as coherent and adequate as possible in relation to the following elements:

- Possible traumatic experience;
- Characteristics of the minor: experiences, personal skills, vulnerability, significant relationships, interests and expectations;
- Risk indicators, protective factors and family, institutional and community resources;
- Restorative, supportive and curative actions to be identified and implemented, as far as possible, together with the family and the minor.

The assessment of the traumatic dimension is not the exclusive competence of one profession; it requires an integrated multidimensional and multiprofessional approach, including social, educational, pedagogical, relational, clinical and health dimensions. Moreover, places attended by children, young people and adolescents, may be formal and informal in the socio-educational definition and therefore require multidimensional assessments.

The focus of observation is the same for everyone but each professional group applies its own tools and can pick up different signals, in different contexts:

The Psychologist:

The trauma assessment involves both the assessment of the psychological functioning of the minor as well as the quality of the bond with the caregivers. The psychologist collects this information through standardised interviews (e.g. Adult Attachment Interview, AAI) with parents/guardians/caregivers significant in the child's life, observes the parent/caregiver-child relationship and assesses the traumatic experience also through standardised tests. The clinical assessment is carried out on a dual track by listening to both the parents and the child. The assessment of parenting skills highlights the adult's resources and critical issues in his or her educational role, while the assessment of the minor's psychological state allows to work on resources and psychopathologies. The psychological assessment investigates the reactions of the child and the parents/guardians, the changes in the child's behaviour, the resources of the environment to create a stable support and care network around the child and the family, the

quality of the child's primary attachment relationships, the parents' awareness of the difficulties the child is going through, his/her experiences and needs, the degree of parental alliance, the social support network (extended family, reference figures, etc.).

The Social Worker (administrative level at Youth Welfare Office):

The social worker assesses the personal, cultural, relational and affective resources of the reference adults who are most significant in the minor's life; he/she assesses the parental figures' competences in accompanying the minor in his/her developmental tasks; evaluates and monitors the quality of the minor's life context, the quality of care, the ability to understand the child's needs and to respond to them appropriately, providing opportunities and experiences consistent with his/her growth phases and aptitudes; assesses the resources existing in the family context, the quality of the relationships and networks in which both the child and the adults are embedded. These assessment factors contribute to formulating realistic projects and outlining transformative paths in favour of the person in the age of development and his or her life context.

The Teacher:

The teacher observes and monitors the acquisition of cognitive and learning skills in relation to cognitive style and content organisation skills. He/she makes use of discussions with other professionals when he/she considers that there are difficulties in learning processes and in the area of relationships. He/she identifies the degree of motivation and participation in the proposed activities, the quality of communication and language, the degree of autonomy in study, transversal skills (leadership, creativity, etc.). The professional educator observes and assesses the minor's behaviour in class, the quality of relations with adults and peers (relationships, interaction and socialisation) in formal and informal moments, the response to the teacher's requests, the ability to adhere to and respect the rules, the quality of the presence and support that the family offers the minor in his/her school career and the quality of the family's collaboration with the school.

The Professional Educator

The professional educator assesses the degree of autonomy reached by the minor in relation to his or her age, observes and intervenes in the relational dynamics of everyday life, observes and assesses the parenting skills in place and the minor's responses to the caregivers' requests, can directly grasp and assess the effectiveness of the resources available and verify which resources can actually be activated in the family and extended context; observes elements concerning relationships and the ability to learn in contexts other than school.

The Pediatrician:

The paediatrician monitors the child/children's development (through visits and health assessments); he/she may become aware of the presence of signs of physical violence or of disturbances that may appear to be signs of discomfort or trauma; he/she monitors risk situations of children/adolescents, also through follow up of situations that need to be monitored after discharge from hospital or the emergency room; collects observations on the parents' ability to follow the proposed treatment, on the parents' response to stress related to their children's health conditions, on the way the caregiver and the child/young person relate to each other while they are in the office or in the waiting room.

The Social Worker (family caregiver, case worker, and other child support workers)

Social workers tend to be those professionals who, more than others, have the possibility of coming into contact with the minor, because they establish a relationship of trust with him/her within the framework of a support and accompaniment process that often involves daily contact, even of an informal but significant nature. These professionals have a privileged channel of observation of environmental, behavioural, cognitive, emotional signals, but they are often denied access to information on the risk condition to which the minor is exposed, for fear that such information may influence the relationship and lead to a stigmatisation of the child or adolescent; in this way, however, one renounces both the information that these professionals/roles have gathered, which could offer useful elements for the assessment of the case, and the protective function that the relationship with them can offer when making them more aware of the role they play within a multidimensional support project for that minor.

Law Enforcement and Justice

The first contact with law enforcement authorities is crucial and often lays the foundation for the further course of the proceedings. Police officers, however, are trained in interrogations and closed questions and less in the area of child-friendly communication skills, there is a sense that the "system logic" offers little room for empathy.

The justice system stands between the principle of an offender-oriented procedure and the presumption of innocence on the one hand and the question of the best interests of the child on the other. The professional field of justice tends to be associated with rules, procedures and predefined structures that make it difficult to act traumainformed. However, both law enforcement and the justice system play an integral part in preventing re-traumatization and providing children and their families with confidence in the legal process. Such confidence can be fostered by providing transparency on professional roles, legal procedures, next steps, information channels in line with the victims rights layed out in EU Directive 2012/29/EU.

INTEGRATING OBSERVATIONS

If, as mentioned above, there is no single point of view that is capable, taken individually, of encompassing the overall assessment of the situation under examination with regard to the risk conditions, the type of trauma, the traumatic condition, the consequences and the most appropriate interventions, it is equally true that it is not enough to 'assemble' the observations collected, as these must be made the object of a shared interpretation. As a matter of fact the following is needed:

- A structuring of the services that would place professional and institutional integration at the centre, and therefore organisational tools that would allow to connect information, points of view, resources and working models such as the „**National Council" on Sexual Violence against Youth and Children** under the umbrella of the German Ministry of Family and Social Affairs, Seniors, Women and Youth (BMFSFJ).[2] The council was established in 2019 and is constituted of over 100 professionals in leadership positions from a wide array of professions including child and youth welfare, psychology, education, police justice and medicine. Between 2019 and 2021 these professionals convened in the thematic working groups of child protection, child assistance, child-friendly justice, protection from exploitation and international cooperation, research and development to develop policy recommendations and to promote inter-agency

[2]

cooperation. This forum for a long-term and interdisciplinary dialogue between political and civil society stakeholders also set out to conduct regular prevalence studies and representative surveys on violence against children to complement the statics of the police crime statistics and reduce the large darkfield in this area;

- **Barnahus/ Childhood Houses**: The Barnahus concept joins police investigators, prosecutors, social services, child and adolescent psychiatrists, and child health and medical care services in one place to avoid re-traumatization through repeated interrogations by multiple stakeholders.[3] 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;
- A cultural and institutional sharing of operational protocols within the system of social, health, socio-health, educational and scholastic services, as well as in the relationships with the judicial authorities also through joint training opportunities. As a result of the INTIT project the **Ministry of Justice of Schleswig-Holstein in Germany** committed to adopt INTIT's curriculum on Trauma Informed Care and hold a two day training for family judges in March 2023. In addition the **Police Academy of Schleswig Holstein** plans a joint trauma-informed care training for police and prosecutors both specialized on sexual violence.

THE CHALLENGES OF COLLABORATION AMONG DIFFERENT PROFESSIONALS

Most of the conditions conductive to adequate collaborative processes rely on the organisation and set-up of the services where individual practitioners operate, and on structured cross-sector cooperative practices. Yet, professional specialties, each in their own area of competence, and in partnership with one another, may effectively bring working standards as close to the ethical principles of Trauma-Informed Care as possible. It is in the interest of both minors and adults that professionals cooperate.

Integration and collaboration prove undoubtedly instrumental in delivering more adequate responses, however they also have a symbolic value for people who are disadvantaged, live on the margins, and have experienced losses and rifts in their lives. These people need to feel welcomed in a context that does not replicate the fragmentation they suffered in their lives and

[3] https://childhood.org/childhood-opens-germanys-first-barnahus-childhood-haus/

that supports them in their efforts to piece together these fragments, restoring in them the power to change their lives.

However, cooperation is a challenging cognitive, relational and evolutionary task, that people can only accomplish if the professionals serving them know how to undertake it. At the same time, this task can prove all the more complex for professionals, when skills are not well defined, formalisation is poor, languages are different and hinder communication. These obstacles are even greater if the professionals called upon to collaborate work in different services and organisations.

An institution's rigid adoption of bureaucratic rules may also be one of the obstacles to a unified approach. If institutions are excessively self-referential and no formalised meeting place exists for services and professionals, then competences may well and easily reproduce hierarchies portraying the social representation of professional specialties.

Thus, the person and their wholeness and specificity are no longer at the centre, nor is the possibility for professionals to promptly share their views and the information gathered by each on the family and the minor, often for reasons of confidentiality. However, as explained in the introduction, these reasons hide difficulties relating to the work practices adopted by the organisations and services concerned, and rule out the possibility of setting up case-specific inter-professional and inter-service teams.

Professionals and, in general, stakeholders who collaborate in care pathways have ethical and professional principles that are not always defined in a codified, collaborative and extensive manner; this can indeed make collaboration more complex. However, every case is compliant with a code of conduct and subject to confidentiality, as per the general confidentiality rules applied by the public administration.

Professions necessarily develop through specific pathways, that define their professional identity, however, opportunities for exchange, knowledge of the respective roles, functions, skills and languages are fundamental to move towards integrated visions and common objectives.

Professional Confidentiality

Professional confidentiality rules often and at times wrongly hinder communication among professionals, thus preventing an exchange of information on aspects that should rather be shared, in order to favour a multi-disciplinary evaluation and interventions that may mobilise all the professional and community resources.

When reflecting on a complex issue such as information exchange, it is essential to consider a number of aspects, including which information should be shared, with what objectives, in

which context and according to which agreed modes and rules, as these are in place to ensure the confidentiality of the people concerned.

As for the first point, i.e. the information to share, it is necessary to recall that when minors are involved, all professionals who gather information have equal responsibility in reporting risk situations and at the same time, they possess knowledge and evaluation tools that allow them to select the information relevant for this purpose.

In the detection and evaluation phase, as well as in the exchanges with other professionals and institutions, respect for confidentiality consists in the ability to tailor professional actions to the persons' needs.

According to this principle, it is evident that information about an existing risk or harm to a minor, a complex family situation that a child or teenager may experience, the need for a parent to be supported in his/her role as carer, etc. should be shared.

The objectives for sharing such information are manifold: firstly, the possibility to promptly involve other professionals and offer support to the minor and family. Sharing information is also an important tool to prevent the risk of re-victimisation, as clients are not forced to repeat their stories several times, and in multiple contexts. It must be pointed out that the need for sharing must be communicated and agreed with the clients in order to establish and nurture a trust-based relationship, but also to let them know that they can be helped by a network of professionals and resources.

Information must be shared in a regular and/or informal work setting, i.e. within the case-specific team and in an agreed manner – even with the signature of a consensus document on the practices to be adopted.

Information must be shared within the team not as a mere transfer of data, rather it must be contextualised in a professional relationship and for its relevance to the specific situation, according to the practitioner's view and the meaning attributed to it by the people concerned.

In concrete terms, information sharing must rely on the knowledge of specific ethical rules and professional practices, as well as on the professionals' capacity to meta-communicate. It can only develop in and nurture an atmosphere of mutual trust and knowledge, while fostering inter-professional work.

For interventions with minors to be effective, not only are the professionals key, but also the educating community. Adults, whatever their role and function, have a duty to report any risk or harm a minor may be subject to. However, these people do not only have the duty to inform, but also the right to be informed and involved in the care network, according to the support they can offer.

It is possible to set rules for correct information sharing that also involve these non-professional stakeholders. An analysis of ethical and professional codes adopted by multi-professional teams pointed out that when professionals without an ethical code of reference are involved, the codes of conduct that apply to psychologists, doctors, social workers and professional educators apply to all members of the team. All those involved in the delivery of the interventions, including family members or other providers of support representing the community, are required to comply with the same codes of conduct.

In such cases, a partnership agreement is entered into to describe the codes of conduct for each role, to clearly specify the rights to be protected (privacy, confidential data), as well as the possible requirements to be complied with (confidentiality of investigations/court proceedings), the framework of the applicable laws:

In any case, integrated work among professionals and organisations requires the following:

- That the client be informed in advance of the usefulness of such cooperation for a better and more effective intervention, and that this entails an exchange of information;
- That the clients be aware that in certain situations, a professional must communicate information concerning them to comply with legal norms;
- The client be correctly informed about the role and practices of the intervention delivered by the other professionals involved;
- Whenever possible, the person concerned should be directly involved in sharing information.

It is important for clients, and especially minors, to know that their information has been properly shared, with transparency and encouraging their involvement; this is important because it means that there is a network of caring adults.

In 2021, the new Child and Youth Empowerment Law placed an increased emphasis on multi-agency cooperation. Concrete measures of cooperation are mentioned in § 4 and § 50 SGBVIII. In § 4 SGBVIII which is devoted to the transmission of information between relevant stakeholders it is stated that medical professionals will receive a feedback on the progress of the child protection case from the youth welfare office after having reported a case of suspected endangerment of the child.4 § 50 SGB VIII regulates the involvement of the youth welfare office in family court proceedings. As a newly introduced rule, the youth welfare office is requested to

[4] Brummelman, Maike (2021): SGBVIII Reform – Was hat sich verändert?, CJD Zentralbereich Angebote, September 2021. It has been criticized that other professsionals such as day care workers or social service professionals are not included in this rule for transmitting information.

submit the intervention plan for assistance (Hilfeplan) in court. This rule is viewed with mixed perceptions and reflects the challenges of cooperation which could entail a compromise on confidentiality. On the one hand it fosters cooperation and shared information between justice and child welfare on the other hand the rule bears the risk that certain facts might no longer be disclosed in an assistance/intervention plan by beneficiaries because of the fear of repercussions through the family courts.

Intervision as a tool to protect operators and guarantee families and minors

Work in multi-disciplinary teams offers a space where personal echoes can be expressed, a place where practitioners can process the emotions they feel when confronted with situations of violence and ill-treatment towards children and adolescents. Collaboration is therefore necessary to share and make proper use of the emotional dimension featuring this care procedure.

Thanks to the process of intervision that characterises team work, professional identities and competences are strengthened in the relationship with other professionals, with positive cascading effects on care processes.

The fact that any decision on a case is taken by several professionals is also an ethical guarantee for the family and the minors themselves against the risks of partial and discretionary evaluations.

Active prevention of re-traumatization and re-victimization risks

The collaboration among professionals is one of the key tools that help reduce re-traumatization and re-victimization risks. As mentioned above, it is thanks to this collaboration that clients may avoid repeatedly telling their stories, re-living traumatic memories, enduring the pressure of a relationship with an institution that is made up of different professionals, languages, practices, places; in fact, all this entails a major cognitive and emotional effort, especially on the part of those who experience times of particular vulnerability.

Therefore, collaboration must take place in such a way as to engage each professional according to the principle of shared and non-delegable responsibility. No agency, or professional involved may delegate their responsibilities on a case on pain of spoiling the intervention, even though they can delegate certain functions. Everyone must fulfil their duties so that the overall intervention is not jeopardized and the minor and family are not exposed to the risk of re-traumatisation and secondary victimisation.

However, it is worth emphasising that re-traumatisation risks are not only due to the lack of shared practices or protocols in multi-professional and multi-agency interventions, in fact, they are also due to the working methods of individual professionals who do not adequately recognise signs of trauma and factors that may expose to new risks, or who coerce, discriminate or label clients more or less consciously.

PRINCIPLES OF TRAUMA-INFORMED COOPERATION

The above considerations show how working with children and adolescents exposed to trauma and violence engages professionals in such a complex process that it has an impact on both the role and the social representation of the professions involved.

In view of protecting both professionals and their clients, it is necessary to reiterate some principles that acquire relevance depending on the cultural, organisational and methodological impact that the trauma-informed approach has.

Addressing obstacles to cooperation will require legal adjustments so that cooperation will be anchored on a structural level as opposed to relying on individual contacts. Protocols and procedures need to be developed for cooperation to be sustainable beyond the engagement of individual professionals. At the same time systems of care need to further develop their sensitivity for the mandate of the respective other system, its limitations and challenges but also its potential for better serving children and youth who have experienced violence. Confidence about one's own decision-making is fostered through better understanding the other support systems and through trusting in safe transitions between systems of care. A sense of shared responsibility will also alleviate the burden of secondary-traumatization.

Commitment to a multi-agency and trauma-informed approach

Anyone in the field of justice, social, health, educational and school services, working with children and adolescents who have experienced trauma is called upon to do the following:

- To consider the importance of recognising the traumatic impact of adverse childhood experiences. Childhood trauma represents a hidden epidemic. Working with minors exposed to unacknowledged trauma exposes professionals to the risk of misinterpreting the signs of ongoing trauma that may result in dysfunctional behaviour (e.g., oppositional behaviour, addiction problems); such behaviour may expose minors to increased risk. If this is not interpreted and connected to trauma correctly, interventions may end up addressing the symptoms - often misunderstanding them - rather than their causes;

- To recognise the impact that working with trauma-exposed clients has on professionals, as well as the stress they are exposed to when they are confronted with stories of violence and suffering involving minors and must take up the responsibility for making decisions on a case;
- To acknowledge the importance of multi-agency work with minors exposed to trauma and violence, starting from the analysis of risk and protection factors that must necessarily be multi-disciplinary, in that it requires the contributions and views of all the professionals and agencies involved in the case, but also during the intervention stage. In this case, collaboration must draw inspiration from the principle of shared and non-delegable responsibility and prevent re-traumatisation and re-victimisation risks;
- To make children, adolescents and families protagonists of the care process, trusting in the resilience of trauma-exposed minors and their families, seeing families as a resource and not just a problem, and valuing meaningful relationships.

Adhering to trauma-informed care principles[5][6]

The groundwork for defining and conceptualizing the trauma-informed approach was laid out by the *U.S. Substance Abuse and Mental Health Services Administration* (SAMHSA), which developed its framework based on academic research, expertise by practitioners as well as survivors' knowledge. SAMHSA developed **six core principles** for TIC requiring an organization-wide commitment for putting these principles into practice. Resulting from INTIT project activities the following recommendations around these principles were generated:

Safety:

- ⇨ In the area of safety, the protection of staff still remains situational. Therefore, a standardized provision and implementation of risk analysis is recommended;
- ⇨ Ensure a welcoming and child-friendly atmosphere in offices, court rooms, waiting areas; install playrooms;

[5] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, SAMHSA's Trauma and Justice Strategic Initiative July 2014, p. 9, https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

[6] For a more in-depth discussion of these principles see the postion paper developed in the INTIT project: Svenja Heinrich, Vanja Stenius, Andreas Kapardis, Anna Markina, Maria Gonzalez, Jose Prieto, Catia-Isabel Santonico, Ferrer (2021). "The meaning of trauma-informed care today".

- ⇨ To provide for emotional safety of both clients and staff take into consideration sitting arrangements, staff gender ratio, etc. – "mindset and setting";
- ⇨ Involve psychosocial assistants to accompany the child in court procedures;
- ⇨ Cooperation and safe transitions between systems provide psychological safety for both staff and clients;
- ⇨ Ensure that judicial staff is sufficiently trained to conduct video recorded interrogations and that technical facilities are in place in courts.

Trust and Transparency:

- ⇨ Present the steps of an intervention plan for the family in a clear and transparent way;
- ⇨ Judicial professions have limited time to develop a connection with the child. Use the following means of communication to foster trust: open questions, listening, summarizing and taking clients' concerns seriously[7];
- ⇨ Talk *to* rather than *about* clients;
- ⇨ Explain the professional roles of prosecutors and judges in a court proceeding;
- ⇨ Explain and prepare for each step in a court proceeding;
- ⇨ Assure a child victim of violence that it is not his or her fault.

Peer Support:

- ⇨ Further strengthen and expand the implementation of family conferences (Familienrat) in youth welfare and child protection cases;
- ⇨ Encourage support through psychosocial assistants or other trusted individuals in court proceedings.

[7] View the NICHD Protocol as a supportive tool for investigative interviewing of children; NICHD Protocol | International Evidence-Based Investigative Interviewing of Children

Cooperation and mutuality:

- ⇨ Promote networking;
- ⇨ Define respective responsibilities;
- ⇨ Carefully plan and prepare family assistance plan discussions and follow up with team;
- ⇨ Provide staff with regular opportunities for intervision.

Empowerment, voice and choice:

- ⇨ Empowerment and participation are explicitly mentioned and desired in § 4a of the new Child and Youth Strengthening Act and should be widely implemented;
- ⇨ Include the clients' perspective more strongly and to recognize their participation and expert knowledge as an important contribution;
- ⇨ Establish parent representatives and youth councils in all youth welfare offices;
- ⇨ Critically reflect on “parent bias” in youth welfare and judicial proceedings and ensure that the child is given a voice;
- ⇨ Ensure that all questions are understood correctly in a judicial interview;
- ⇨ Question reasons for refusal to testify and outline the consequences.

Culture, history and gender:

- ⇨ Increased flight and immigration has led to new (post) migrant family constellations that require increased awareness;
- ⇨ Establish teams that reflect the demographics of children and their families;
- ⇨ Promote training on intercultural competencies and network with migrant organization.

Methodological principles

In their respective settings and with the tools available, each professional specialty has the responsibility to verify the existence of trauma, the quality of the resources and the possible

interventions that can be adopted both in their respective organisations and according to the specific professional sector.

Therefore, every situation requires an assessment that results from a comparison among the different approaches and contexts of observation, and in doing so, the perspective of each receives equal dignity and importance.

For any perspective to contribute effectively to an integrated interpretation of a situation, it must be offered in a context in which different professionals and organisations acknowledge one another, where there is a shared language, collaborative methods, a clear identification of the "object" on which to operate[8].

Professional secrecy, and privacy, must not hinder any exchange of information on aspects that should be shared in order to favour a multi-disciplinary evaluation and interventions that may also involve the resources of the educating community.

1. It is necessary to make minors and their families protagonists of the care process, accompanying them in every stage, from the moment they come into contact with the institutions, and enhancing existing resources as much as possible. Where the risk exposure of the minor involves the judicial bodies, it is necessary to accompany the family during the various stages of the procedure, so that they understand the new context in which they find themselves and can exercise their rights, on the strengths of the information they received.

Depending on the phase of the intervention underway and their role in the minor's experience, parents must always be supported and involved, as natural caregivers, to participate in overcoming trauma and its effects.

2. Every context of the life of a trauma-exposed minor can help promote resilience: anyone who contacts the minor in such settings can be an active “intermediary” of resilience.

Organizational principles

1. Trauma-informed thinking needs to be extended to the whole organisation or system=> to reach this objective “somebody needs to do it” and take the initiative.

2. It is necessary to put professionals in a position to assess situations in acceptable timeframes and manners, considering both the operational assessment protocols of individual professional specialties and the objects of the evaluation who actively interact in the assessment process.

[8] Vergani E., (2022), Multi-agency. Gruppi collaborativi nella complessità. Maggioli, Sant’Arcangelo di Romagna.

3. To carry out multi-disciplinary work, a case manager must be assigned to each specific case, and given the responsibility to coordinate and link all the stakeholders involved, according to the prevailing needs, the intervention phase, and the organisations concerned.

4. It is desirable for professionals to have mental and organisational spaces where they can collect the observations that each brings to an integrated evaluation: this is not merely a summary of different views, but a synthesis of all the observations and interpretations offered.

5. Information on a case should be shared within a regular and/or informal work setting, i.e. the team that forms to address a case, according to shared and formalised procedures, possibly through the signature of an institutional agreement and professional consensus document on the practices to be adopted.

6. It is necessary to enable exchanges and intervention protocols (memoranda of understanding) among the various institutions that are frequently involved in traumatic situations for minors, such as hospitals, law enforcement agencies, family centres, the judiciary, social and health services, and municipalities.

7. It is necessary to promote systematic opportunities for integrated and multi-disciplinary training, as well as constantly strive for a shared language that promotes joint work and adequate support to families and minors in the most delicate and complex phases and circumstances of their lives. It is recommended to provide trauma-informed care training on a local level (rather than regional or national) to bring together stakeholders within the same geographical scope. Also, training on trauma-informed care should be incorporated into university curricula for teachers, social workers and judges to secure awareness in their educational process.

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Funded by
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The project was supported by

Ministero della Giustizia
DIPARTIMENTO GIUSTIZIA MINORILE E DI COMUNITÀ