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

Interprofessional consensus document for integrated protection, safeguard and care interventions for childhood relationships

September 2022

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ORDINE ASSISTENTI SOCIALI Consiglio Nazionale
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REGIONE LAZIO
ASL ROMA 3
Πανεπιστήμιο Κύπρου University of Cyprus
TARTU ÜLIKOOL 1632 UNIVERSITAS TARTUENSIS
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Authors:

- Annunziata Bartolomei, CNOAS Councillor with responsibility for minors, President of the CNOAS Advisory Commission for Lifelong Education
- Erika Tognaccini, CNOAS Councillor with responsibility for minors, Vice President of the CNOAS Ethics and Conduct Commission
- Roberta Bommassar, Contact person for the Childhood and Adolescence Working Group established at the National Council of the Order of Psychologists, Representative of the Order within the Childhood and Adolescence Observatory, President of the Order of Psychologists of Trento.
- Marcella Montemurno, Member of the Childhood and Adolescence Working Group established at the National Council of the Order of Psychologists.
- Enrico Nonnis, Child Neuropsychiatrist, Director UOCI-TSRMEE at ASL RMD, Member of the Lazio Regional Secretariat of the Scientific Association SINPIA.
- Nicola Filippo Titta, National Councillor ANEP-ATS (National Association of Professional Educators - Technical Scientific Association.
- Maria Rita Venturini, Secretary of the Commission of the National Register of Professional Educators of the National Federation of TSRM-PSTRP Orders.
- Giacomina Chiaradia, Office 9 - Protection of Women's Health, Vulnerable Subjects and Fight against Inequalities, General Directorate for Health Prevention, Ministry of Health
- Liviana Marelli, National Executive CNCA (National Coordination of Shelter Communities) with responsibility for juvenile, youth and family policies
- Raffaele Bracalenti, President of the Psychoanalytic Institute for Social Research
- Catia-Isabel Santonico Ferrer, Researcher for the Psychoanalytic Institute for Social Research.

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 childhood adverse experiences (ESI) on well-being and mental health.

In the context of the INTIT project, the Psychoanalytic Institute for Social Research, in collaboration with the Council of the Order of Social Workers, coordinated an interprofessional table, which involved, together with the project partners and delegates of the National Council of the Order of Social Workers (CNOAS) the National Council of the Order of Psychologists (CNOP), the National Association of Professional Educators ANEP, the National Register of Professional Educators of the National Federation of TSRM-PSTRP Orders and the Ministry of Health, Directorate General of Health Prevention. The participants in the round table collaborated, meeting in the period November 2021-February 2022, with the aim of reaching a consensus document indicating how to address the critical issues of multi-agency care of minors exposed to trauma and violence, identifying shared standards of intervention to be disseminated to the members of the professional orders and represented organisations.

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 to what in Europe is called Trauma Informed Care (TIC). In cases of violence against children, a complex network of actors (justice, social, socio-medical and educational services) is called upon to

[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/.
Https://www.intitproject.eu/https://www.intitproject.eu/.

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 the single discipline, but the language that is built on the common knowledge of the meaning of trauma and of the criteria for taking care of clients who have been exposed to it.

This challenge requires the different professionals involved in the front line of early intervention and reparation of the effects of violence on minors to rethink their working practices, not only for a better management of the cases that are reported to them, but to encourage the coming to the surface of a large number of 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.

A central role in this area is played by the social worker, who represents the centre and core of the system since, thanks to his or her transversal knowledge, he or she acts as an interface between several professions and specific knowledge. It is precisely in this direction, that the National Order of Social Workers has been committed for some time, with its institutional interlocutors, to promoting and supporting processes of specialisation of its members on the subject of multi-agency intervention with minors exposed to trauma and violence. However, it is inevitable to forge a dialogue with other professional specialties, especially psychological and educational ones, through the relative orders and associations of reference for a shared reflection on the open challenges and the assumption of the commitment to transmit to their members the awareness of the cultural transformation under way to adapt the trauma intervention system.

This document outlines, precisely, the outcome of this dialogue that, at the outset, was inspired by the stimuli offered by the operational guidelines document produced by the CNOAS on the role of social workers in protection and safeguard interventions and on the critical issues that emerge in their daily work with children, young people and their families, as well as in their work with other adults who intervene in growth processes and who, through the exercise of different and complementary professionalism and roles, are responsible for their well-being.[2].

This document also collects the outcomes of the reflection on the taking into charge according to a multi-agency and *trauma informed* approach, conducted within the INTIT project, in collaboration with the European partners of the project itself, and originated from different elements. On the one hand, reference was made to the indications coming from the scientific literature on the principles of *Trauma Informed Care* and on the intervention standards of *trauma informed* services, with an in-depth study of the functioning in Estonia and Cyprus of the Barnahus[3] services, which are also at the centre of experimentation in Spain and Germany. On the other hand, an analysis was conducted of the state of the art in Italy of the process of adapting the systems of protection of minors exposed to trauma to integrated, multi-agency and trauma informed (TIC) modalities of taking into charge. This analysis was carried out with the support of the Ministry of Health, and thanks to the involvement of national stakeholders[4]. In Italy, the experience of the GIADA service of the UOSD of Psychology of the Giovanni XXIII[5] Paediatric Hospital and of the Apulian network for the early diagnosis and treatment of forms

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[2] *Indications and operational criteria for social workers in the protection, safeguard and care actions for relationships in the age of development.* The document is the result of the work that the National Council and the Regional Councils of the Order of Social Workers have carried out within the 'Minors Table' starting from the 'Research on the role and quality of the social service in the protection of minors, which has seen the involvement of the entire professional and disciplinary community, in a constant comparison with the Regional Councils and their delegates. https://cnoas.org/news/tutela-e-protezione-dei-minori-indicazioni-per-assistenti-sociali/

[3] The Barnahus (Children's Home) is a service established on the basis of an approach initially developed in Iceland, which quickly spread to the Nordic European countries and more recently to other EU Member States. Barnahus services intervene with child victims mainly of sexual but also physical violence according to the standards and rights defined in Articles 22 (individual assessment) and 23 (victim interviews) of the EU Directive on crime victims, both during investigations and court proceedings. The main objective of Barnahus is to introduce appropriate, coordinated and multi-agency responses to violence against minors, avoiding the re-traumatisation of victims. 'Metodologia per una valutazione individuale e fondata sui diritti e i bisogni dei minorenni vittime di reato' (Methodology for an individual and needs-based assessment of child victims of crime) edited by Defence for Children International Italy (2019), p. 20. http://www.centrostudinisida.it/public/4b54a936-ea43-4379-8d4e-f1296cd30d96.pdf

[4] The contributions that made it possible to produce this analysis were offered by the audience of speakers present at the focus group of 24 November 2020, organised as part of the INTIT project, representatives of a wide range of services and professionals involved in intervention systems with minors exposed to trauma and violence.

[5] The Departmental Simple Operational Unit of Clinical Hospital Psychology of the Giovanni XXIII Paediatric Hospital in Bari is the Reference Centre in the Apulia Region for the early diagnosis and treatment of forms of violence against minors.

of violence against minors, an experience oriented by the principles of *Trauma Informed Care*, was also analysed in depth.

With regard to the Italian context of interventions for the prevention, detection, protection, safeguard and care of minors who are victims of child abuse and maltreatment, the in-depth studies carried out within the INTIT project, allowed to outline the minimum standards of intervention and the foundations of a multi-agency and trauma-informed care system for minors exposed to trauma and violence, standards and foundations this document refers to.

It is well known how the system of intervention with minors who are victims of abuse and maltreatment is articulated, in the national context, on several levels: the level of policies (heterogeneous and poorly coordinated in the various sectors), the level of planning and territorial organisation of services, above all health services and of regional competence, with uneven outcomes in terms of access to LEA (Essential Levels of Care), and, finally, the level of professional practices strongly conditioned by organisational models anchored to performance and therefore categorical logics. 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, addiction pathologies, dysfunctional family relationships, social marginality, etc.). In the light of these challenges, a reflection that mainly concerns the level of professional practices and collaboration among professionals working in different fields, has, thus, limited impact on the system as a whole.

This being said, it is evident that, precisely because of the often 'adverse' conditions in which professionals find themselves operating, 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 interests minors can really be pursued.

We believe that this document can contribute to building integrated professional practices capable of orienting, from the bottom up, the functioning of organisations and also the logic of service provision, on the basis of standards appropriate to the challenges that trauma intervention poses when it is experienced by clients in the age of development.

OPEN CHALLENGES IN WORKING WITH TRAUMA IN CHILDHOOD

Complexity of trauma interpretation

It is now well known that the link between the traumatic event and the impact on the psychological development and the state of well-being of the child/young person is neither linear nor deterministic: it depends on the type of trauma to which the child/young person has been exposed, the resources of the child/young person, the resources and competences of professional caregivers and the environmental context (extended family, presence of services, and their accessibility, etc.).

The concept of trauma from a psychological point of view was introduced by Freud[6] in the early 1900s. Trauma is used to refer to an event in a person's life that may occur suddenly or repeatedly and that is characterised by its intensity, by the subject's inability to respond adequately to it, and by the vivid agitation and lasting effects it causes in the psychic organisation as a whole.

Psychoanalysis has over time been led to reflect on the difficulties of conceptualising the traumatic experience. What a traumatic experience is, even when it concerns children, remains difficult to define, first of all if one considers the extreme variability of traumatic experiences to which they may be exposed (serious accidents, bereavements, social and interpersonal violence, growing-up traumas, etc.) which may be characterised as one-off and occasional episodes, or instead as repeated and constant ones; but also if reference is made to the wide range of violent conducts acted against children, or those they are forced to witness, which occur mainly within the family (sexual abuse, physical violence, psychological violence, neglect).

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[6] Freud S., (1916) *Introduction to Psychoanalysis*. Psychology borrows the term trauma - which in ancient Greek means wound with perforation or laceration - from medicine and surgery, where it indicates a laceration of the skin tissue, or a lesion of an internal organ without perforation of the superficial layers (e.g. so-called 'closed' abdominal or cerebral trauma) as well as, in some cases, the consequences of external violence on the organism as a whole. Psychoanalysis, from its origins, has taken up the idea of trauma, transposing the three meanings this word has in medicine and surgery onto the psychic level: that of violent shock, that of laceration, and that of a set of consequences on the organism as a whole.

It is not even clear how trauma produces its pathogenic effects, nor when it produces them. We do know that a traumatic experience can produce effects at a distance of time that seem to burst into the lives of those who thought they had forgotten (a trauma can become re-actualised with the memory of the painful experience) or those who have no memory of it at all. It is also difficult to define how the pathogenic action is triggered after a traumatic event, i.e. how trauma produces its effects: a painful experience that cannot be processed can activate neuro-physiological responses linked to the suffering, terror and annihilation felt in the trauma, generating a defensive mechanism of fight and flight that is produced even at times when the traumatic value of the events is lower thus leading to a progressive maladjustment of the subject who loses the ability to appropriately respond to situations.

Again, there is no relationship between the extent of the traumatic experience and the effects it produces. We see children exposed to traumatic events of great significance absorb the shock and rework it, showing great resilience, while in other cases, experiences that would appear less significant, show themselves capable of producing major pathogenic effects in those who experience them.

The issues referred to in this paragraph today involve a large part of the research on trauma, in which a singular convergence of the contributions of different theoretical constructs can be observed, coming from neuroscience, cognitivism and behaviourism, the systemic-relational approach, the socio-pedagogical schools, as well as psychoanalysis[7].

[7] Quoted from IPRS (2022) in the article *Trauma e Minori* (Trauma and Minors) (ed.) Attilio Balestrieri and Raffaele Bracalenti, to which reference is made for a more in-depth discussion on the topic https://www.iprs.it/trauma-e-minori/.

The literature on 'Adverse Childhood Experiences'[8] emphasises how, once an adverse event occurs in a child's life, in the absence of an appropriate *caregiving* context or parenting support interventions during times of crisis, the likelihood that he or she will experience other adverse events increases significantly, which is why a chain of early risks opens up, impacting on people's health throughout the life course (Hughes et al., 2017).

Trauma is a wound that can undermine the balances on which an individual has built and organised his or her experience of himself or herself and others, his or her life, his or her very survival. It can produce in those who experience it a relentless destruction of the sense of continuity of the self, that is, an overwhelming threat to the integrity of the person accompanied by anxiety of annihilation, in situations from which there is no hope of protection, relief or reassurance (Bromberg, 2012)[9].

If, in the case of an adult, trauma can shake or even collapse the balance on which his or her existence rests, in the case of minors exposed to repeated and cumulative traumas during the age of development, such experiences can undermine the conditions for future balance by triggering a series of, first neurobiological and then adaptive changes, with a negative impact on health.

Studies on the effect of exposure to what, in the literature, is referred to as 'complex trauma'[10], show that the areas of impact, and the related signs, are multiple and depend on the age of the child involved: the younger the child is when exposure to such experiences begins, the greater the impact on development. The following areas in which the effects may occur are mentioned: cognitive (attention, concentration, negative thoughts); relational

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[8] In the Adverse Childhood Experiences (ACE) study, conducted by Kaiser Permanente and the US Centres for Disease Control and Prevention, nearly 80,000 adults followed by a health monitoring and prevention organisation (HMO) were asked to answer a questionnaire about adverse childhood experiences, including childhood abuse, neglect and family dysfunction. 11% reported having been emotionally abused as a child, 30.1% reported physical abuse and 19.9% reported sexual abuse. In addition, 23.5% reported having been exposed to alcohol abuse in the family, 18.8% had been exposed to mental illness, 12.5% had witnessed abuse by their mother and 4.9% reported drug abuse in the family. The ACE study showed that adverse experiences in childhood are much more common than what is recognised and that they are strongly related with adult health half a century later. The study confirmed previous investigations that reported a highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity and sexually transmitted diseases. Furthermore, the study showed that individuals who underwent four or more ACEs were 50%-70% more likely to develop mood and anxiety disorders, substance abuse, and impulse control disorders. Felitti VJ, Anda RF. The Relationship of Adverse Childhood Experiences to Adult Health, Well-being, Social Function, and Health Care. Chapter 8 in The Effects of Early Life Trauma on Health and Disease: the Hidden Epidemic; Editors: Lanius R, Vermetten E, Pain C. Cambridge University Press., 2010.

[9] Bromberg, P. (2012) L'Ombra dello Tsunami (The Shadow of the Tsunami), Publisher, Raffaello Cortina Editore.

[10] D'Andrea, Ford, Stolbach Spinazzola and Bessel A. van der Kolk (2012) *Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis,* American Journal of Orthopsychiatry 2012, Vol. 82, No. 2, 187–200.

(family problems, attachment breakdowns, difficulties in emotional relationships); mood (depression, anxiety); behavioural (e.g. repetitive and compulsive behaviour); somatic (sleep disorders, migraine, nocturnal enuresis, eating disorders, attachment, attention and learning problems, etc.). According to the scientific literature - which is continually expanding in the fields of molecular biology, genomics, immunology and neuroscience, social and educational sciences - changes in the neurobiology of the brain are at the origin of these effects. These changes are the result of prolonged exposure to so-called toxic stress generated by adverse experiences during childhood, in the absence of supportive relationships that can mitigate its effects. The same studies also emphasise the greater risk of distress and long-term effects following traumatic experiences, which affects minors who have undergone more adverse experiences.

As mentioned above, the responsibility for processing and coping with trauma lies not only with the child/adolescent and his/her abilities, but also with the context in which the child/adolescent is placed. An adverse event that affects a child placed in a relatively well-functioning relational and affective network capable of facilitating the overcoming, elaboration and mentalisation of the traumatic experience, by the child experiencing it, is quite different from the trauma that occurs when caregivers cannot offer this support.

Parental care patterns may be inadequate for two reasons: caregivers may be responsible for the trauma as active subjects (of abuse and mistreatment, etc.), or as passive subjects because they are unable to interpret and meet the needs of their children (through neglect, inability to protect them, educational inability, etc.), i.e. what Ferencenc Ferenc defines as: 'failure to help', an element that, as we said, significantly contributes to, and often causes, the event or events to which the minor has been exposed to actually have a traumatic impact.

In such cases, it can happen that the adverse experience, to which the minor is exposed, also generates a disruptive effect on the family, which is directly affected by this traumatic dimension to such an extent that it is necessary, as sometimes happens, to remove the minor from his or her parents, in order to safeguard him or her at a time when both the minor and the family are at their most fragile state and to allow the support systems to take care of both the minor and his or her family.

This reaction of the system of relationships around the child is extremely significant in determining what impact the trauma will have on the child's well-being, that is, whether this impact will be significant or whether the child will be able to produce a resilient response. As is well known and as underlined by studies on childhood adverse experiences and by reference theories for the analysis of the ecosystem in which children grow up[11], the significant context for the child does not only coincide with the family, but also involves that network of contexts and actors that are part of the protection system in which professionals operate (school and out-of-school, territorial social services, child neuropsychiatry services, socio-educational communities, educational agencies, services for combating gender violence, judicial authorities, etc.).

Given that the concept of trauma is so complex, precisely because it is difficult to create a direct relationship between the type of trauma and the kind of consequences produced in the minor and in the family network, the issue of assessment is also very complex.

In situations of violence involving children and adolescents, the professionals in charge of the case are often called upon to assess whether a trauma has occurred and what effects it has produced.. The effects of trauma can be seen in the type of response given by the child or adolescent, who will express some kind of discomfort, some form of suffering, which may be linked to social and relational dimensions, to a diminished capacity to pursue developmental tasks (stunting in language acquisition, oppositional behaviour, etc.) or learning (decline in school performance, difficulty in concert, attention difficulties, etc.), and relational (isolation, social withdrawal, self-exclusion from the outside world, etc.).

A traumatic event will disrupt one or more of these dimensions, and it is here that the trauma becomes visible. Although also children often show themselves capable of expressing their psychic pain, of becoming aware of it, even to the point of asking for help, because of their age, their degree of discernment, the possibility of trusting and relying on adults, more frequently they express this suffering in other ways (through play, drawing, in their way of acting and interacting, etc.). This is why we are used at recognising such suffering in the dysfunctional behaviour they engage in, in the difficulties they experience along their growth processes and in achieving an adequate management of relationships and affectivity.

[11] Brofenbrenner's (1979, 2006) ecological model of child development quoted in AGIA (2022) 'La dispersione scolastica in Italia: un'analisi multifattoriale. Documento di studio e di proposta' (School drop-out in Italy: a multifactorial analysis. Study and proposal document).

The professionals involved are, however, not only called upon to grasp and assess the elements of risk. Resilience factors are equally relevant.

As Masten and Reed (2002) point out in their Handbook of Positive Psychology, the most striking conclusion that emerges from all the research on resilience in the developmental age is that children's extraordinary resilience derives from ordinary processes. Evidence gathered suggests that resilient children have protective systems that work in their favour. Resilience does not derive from rare and special qualities, but from the functioning of social systems, children's minds and bodies, their relationships in the family and community, schools, the religions they adhere to and cultural traditions: these systems and their interactions are as much at the root of good adaptation and development as resilience. It is not possible to prevent all risks that may compromise the well-being of children and young people. Therefore, it is up to the adults and professionals in the field to learn how to preserve, protect and recover the competences for good adaptation and development, a balance that may have been undermined by exposure to adverse events that have weakened precisely these competences, but which is destined to be continually threatened by the adversities and risks each of us is exposed to in life[12].

In the authors' definition, resilience represents a dynamic process of positive adaptation despite adversity. In the developmental perspective, it means that, despite adverse experiences, the child achieves the salient goals of his or her stages in an age-consistent manner[13]. For children, resilience pathways are based on the possibility of experiencing safe, stable, affective, and continuous relationships over time; and of being placed in a growth context in which they can play, explore and be exposed to a variety of opportunities and activities necessary for the acquisition of skills, knowledge, and competences. In promoting resilience, children need to be able to experience challenging experiences adequately supported and protected.

[12] Masten, A. S., & Reed, M.-G. J. (2002). Resilience in development. In C. R. Snyder & S. J. Lopez (Eds.), Handbook of positive psychology (pp. 74–88).
[13] Ibidem page 76

Multiple points of observation without forgetting the context

From what has been highlighted above regarding the complex definition of trauma and the detection of its effects, risks and protective factors, it follows that it is important to entrust the observation and assessment of the case to several professionals, each working with their own tools in the different contexts of people's lives, and this because of:

- The multiplicity of signals to be read in a multidimensional key of the person and the family system, with particular regard also to their living contexts. Taken individually, the signals represent only a fragment, therefore not exhaustive, of a more complex situation that produces adaptive and/or reactive behaviours, which have to be grasped and assessed for their interconnections;
- The different contexts in which signals are produced, which require specific observation according to the respective competences and professional tools;
- The temporality in which the manifestations of distress occur, the places where they arise and are acted upon;
- The fact that different contexts shall provide flexible responses, relying on an identity of role and awareness of the specificity and complementarity of the functions each one performs;
- The multiple needs that must be met at the same time, in a shared planning, where resources and specific accompanying paths converge, both for the minor, in the respect of his/her developmental tasks, and for the adult(s), in the support and recovery of care responsibilities;
- The fact that in every context clients must be welcomed according to their vulnerabilities but also to their resources and potential;
- The fact that clients have the right to be welcomed in their complexity and wholeness and to actively and directly participate in the processes that affect them.

The multi-disciplinary approach: from the observation of risk elements and resources, to the unitary assessment, to the 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 of the person and personal networks.

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

- Psychologist: the trauma assessment cannot elude the double level of assessment of the psychological functioning of the minor and 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 psychic 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: 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 observes and monitors the acquisition of cognitive and learning skills in relation to cognitive style, mnestic 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 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 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 (he/she visits the child undressed) 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, Social Care Worker (OSS) and other child support workers). As much as other adults, such as the sports trainer/coach, social workers are 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.

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 facts 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, by way of example, variable-geometry teams throughout the territory, community houses, case management (these are tools that are currently envisaged in the planning of health and socio-medical services, in various guidelines, in the LEA (Essential Levels of Care) and LEPS (Essential Social Service Levels), in the governance models contained in the National Action Plan of the Italian Child Guarantee, in the Fifth National Plan for Childhood and Adolescence).
- 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.

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, especially when they work with individuals exposed to trauma, thus building positive contexts for collaboration. This paper considers these types of qualified work.

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, rather it 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 secret and privacy

Professional secret and privacy 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 (even if only as adults) 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[14], doctors[15], social workers[16] and professional educators[17] [18] 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 (i.e. in Italy, the law on privacy, the breach of pre-trial secrecy, articles 326, 379-bis C.C.).

[14] https://www.psy.it/codice-deontologico-degli-psicologi-italiani
[15] https://portale.fnomceo.it/wp-content/uploads/2018/03/CODICE-DEONTOLOGIA-MEDICA-2014.pdf
[16] https://cnoas.org/wp-content/plugins/download-attachments/includes/download.php?id=6048
[17] The Register for Professional Educators was recently established by Law 3/2018. It is part of the Multi-professional TSRM - PSTRP Professional Association (Medical Radiology Health Technicians and Technical, Rehabilitation and Prevention Health Professions), which comprehends no less than 19 health professions and has a Code of Conduct (CC) valid for all the professions represented. https://www.tsrm.org/wp-content/uploads/2021/07/Costituzione-Etica-7-LUGLIO-2021.pdf
[18] The specific Code of Conduct for Professional Educators was drawn up in 2015-2016 by the largest National Association of Professional Educators ANEP (now the Technical Scientific Association). This Code was adopted by the Federation of TSRM-PSTRP Professional Associations; together with the Ethical Constitution. All registered Professional Educators must adhere to it. https://www.tsrm.org/index.php/codici-deontologici-tsrm-e-pstrp/

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.

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 to 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 ON WHICH PROFESSIONALS HAVE REACHED CONSENSUS

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.

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.

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[19].

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.

- 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.

- 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.

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

Organizational principles

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

GLOSSARY

"*If the limits of my language mean the limits of my world* - as Wittgenstein so aptly puts it - *we can also infer that the limit of my world is defined by my language, referring not only to vocabulary but, more extensively, to the order of discourse.*"[20]

The focus on language is vital to create and spread a shared culture that gives rise to a 'professional approach'. Such approach helps not only understand each other but also co-construct shared operational settings.

Therefore, the construction of shared settings also means overcoming certain lexical ambiguities, that correspond to cultural ambiguities, in that they risk fuelling communication and operational difficulties between professionals and systems.

Sharing the meaning that each part of the system attributes to specific professional terms results in better communication. The glossary used can better clarify the boundaries and characteristics of a role, while fostering better collaboration and respecting professional autonomy[21].

Special care must be taken with the language used in written communications among services and among institutions.

Below are some of the concepts (antinomies) identified in the framework of a national research work entitled "Indicazioni e criteri operativi per gli assistenti sociali, nelle azioni di protezione, tutela e cura delle relazioni in età evolutiva" (Operational guidance and criteria for social workers active in the protection, safeguard and improvement of developmental relationships), conducted by the National Board of the National Association of Social Workers in 2021.

Other terms - concepts among the most frequently used in the different disciplines - are listed below with the aim of contributing to the co - construction of a common and shared language.

[20] Vergani E., op.cit. pag. 31

[21] "Indicazioni e criteri operativi per gli assistenti sociali, nelle azioni di protezione, tutela e cura delle relazioni in età evolutiva", CNOAS 2021.

Social evaluation vs investigation

Both terms refer to a fact-finding activity relative to a certain situation.

Social evaluation indicates both the initial operation of getting to know a personal, environmental situation, with the aim to identify the most suitable intervention project, and the monitoring of the intervention itself, as well as the final reconstruction of the process and the professional opinion on the results achieved, that must be shared with the protagonists of the process.

This approach is characterised by being hypothesis-driven and project-oriented, it does not end in a mere description of the family and personal situation, rather it integrates other professional opinions in a synthesis of all the knowledge base available, always in the full respect of the person as a whole. Respect for complex situations requires the expression of different, partial views within a participatory process.

It cannot merely respond to a magistrate's request.

Consequently, the conduct and the tools to adopt are chosen autonomously by the professional, on the basis of professional knowledge. Tools, such as the interview at the service premises or at home, have multiple purposes: to build the relationship, to collect elements for analysis and evaluation, to build a path shared with the minor and their family. What emerges from the evaluation is observed in the full respect of the feelings of the people involved, it becomes food for thought and raises awareness about the real situation, and it involves the people concerned, in order to agree on objectives for change and ways to achieve it.

This is communicated to the judiciary, though in a different language.

The term *investigation* evokes an activity of environmental reconnaissance, and information collection, intended for the use of others. According to the term used by the judiciary, an investigation of any nature - social, family, socio-environmental, psycho-social-environmental – aims at informing the decision that will be taken during the civil proceedings (and will add up to the other sources used by the judiciary), that will determine the most suitable legal conditions also according to the living standards identified.

However, the decision will not only refer to normative interventions, it will return back to the professionals who evaluated the initial situation and will accompany the family towards a mitigation of the identified risk conditions.

Assignment vs Mandate

In judicial protection proceedings, social workers operate within the institutional, social, and professional mandates of their profession and the request of the judiciary amounts to an assignment, defined by virtue of the relationship existing among different institutions that collaborate with equal dignity, complementary roles and professional specialties.

The assignment is complete when the required task is finished: at times, social workers act as auxiliary judges as per the provisions of Article 68 of the Code of Criminal Procedure, and at times as stakeholder of a more general protection effort or in specific conditions. This highlights the need for a revision of these rules arising from an institutional set-up that has been profoundly modified by the regulatory evolution of the last fifty years.

In fact, social workers shape their actions and interventions within a broader methodological and professional framework that goes beyond a specific assignment. In addition, the objective that the two systems share is child welfare: no matter how divergent, the paths that the two systems follow are complementary and interdependent, and any risks can be reported by either to the other party. The effectiveness of the measures and the purpose of the judicial procedure cannot be separated from an effort to produce change.

Monitoring vs control

Awareness of the specific context in which the two systems collaborate is crucial in determining a specific monitoring activity.

In the judicial context, monitoring a family situation has a direct impact on the more or less restrictive adoption of the legal provisions governing family and parental responsibilities towards minors: it is therefore focused on people's behaviour and conditions.

For a social worker, ongoing evaluation or monitoring is oriented towards understanding the effectiveness and adequacy of a project, as part of the care process. It is not only useful for detecting progress or stumbling blocks, but is also, and above all, an opportunity for sharing, awareness-raising, social learning from the experience underway, and this concerns all the stakeholders in the relationship.

The social services' core function is to protect and promote family relationships, even within the judicial framework. This function persists, and if necessary should be reinforced, even if the initial assessment, the monitoring of the events that unfold during the protection process and the social worker's evaluation of the outcome, contribute to forming the ruling of the magistrate, who orders the measures aimed at controlling and limiting behaviour, on the basis of this 'judgement'.

Trauma-informed care:

When we mention Trauma-Informed Care, we are not referring to a specific service or treatment, but to an overall approach that guides service provision. The model relies on the awareness that childhood interpersonal trauma is a complex, cumulative trauma, at the origin of forms of adult psychopathology, which still remains a hidden, under-diagnosed, under-recognised, and under-treated epidemic, especially in the service sector. The concept of Trauma Informed Care (TIC) was developed in the United States, with the support of research funded by the US Substance Abuse and Mental Health Services Administration (SAMHSA).

Partly borrowing from SAMHSA definition, a programme, an organisation or a system may be defined trauma-informed in the following cases:

- If it is "aware" of the central importance of traumatic aspects in leading interventions;
- If it considers the impact that traumatic experiences have on people's lives and is aware of possible paths to recovery;
- If it recognises the signs and symptoms of trauma in clients, families, staff and others involved in the system, and shares responsibility for the relative intervention;
- If it responds by fully integrating trauma knowledge into policies, procedures and practices and actively seeks to resist re-traumatisation[22].

[22] 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

TIC systems with child victims of abuse and maltreatment aim to detect the signs and effects of trauma before they affect child development and to formulate early inter-disciplinary and integrated diagnosis and care plans in a network with other health, social and judicial institutions and bodies.

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