TIP – Safe Places, Thriving Children: Embedding Trauma-Informed Practices in Alternative Care Settings

Scoping Report

1. Introduction

The purpose of the Scoping exercise was to gather information from the six partner countries involved in the *Safe Places, Thriving Children: Embedding Trauma-Informed Practices in Alternative Care Settings* project – Belgium, Bulgaria, Croatia, Greece, Hungary, and Serbia - to inform the development and delivery of the training packages and associated written materials for the project. The Scoping work had two elements: questionnaires, and desk review.

The choice of these methods for gathering information was based on a number of ethical, as well as practical, considerations. Although the scoping exercise was originally intended to include peer interviews between care experienced young people in the six partner countries, there were challenges associated with ensuring that this could be done in a trauma informed and supportive way. The potential use of this approach was also significantly impacted by the global Covid-19 pandemic, which has resulted in restrictions on movement and face-to-face meetings in most affected countries. Recognising the vitally important role of care experienced people's views for this project, we therefore sought to ensure that young people with experience of care in the partner countries were able to express their opinions in a different way, via an online questionnaire. As this would result in a less detailed and interactive approach than originally proposed, further points of engagement with care experienced young adults – particularly those who are part of the project teams in the partner countries – have also been included in the ongoing development plans for the training packages, to ensure that the views of those with lived experience are understood and included as far as possible.

An online questionnaire was also identified as an appropriate method through which professionals and carers could contribute their views anonymously, and in a way which would not place an undue time burden on them. A questionnaire seeking professionals' and carers' views on alternative care, and on the professional development opportunities available to them, was therefore developed for this group.

The desk review questions were intended to gather broader information about children's social care services and systems in individual countries, the overall understanding of childhood trauma and its impacts, and the education and training available to practitioners. Responses to the desk review questions were gathered by partners in individual countries in a variety of ways. Further information about the development and implementation of the Scoping Exercise, the specific questions asked, and about the number of questionnaire respondents from each country, can be found in Appendices 1-3.

This report summarises the main findings from both elements of this work. Since the purpose of the Scoping activity was to inform the development of training materials for use in all partner countries, rather than to compare partner countries with one another, findings from the six partner countries are summarised together. The findings from the questionnaire for care experienced young adults are presented in Section 2, while the desk review and professionals/carers questionnaire findings are together in Section 3.

The following points are important to note when reading this report:

- The questionnaire findings outlined in this report reflect the responses and comments of the 234 individuals who contributed their opinions. Due to the nature of the scoping exercise, this was not a representative sample, and cannot therefore be said to reflect in any way the situation in any partner country as a whole. All comments have been translated into English from their original languages.
- Throughout this report, quantitative responses are reported as a proportion of all respondents who answered that question, i.e. non-responses are excluded. This means that proportions are not based on exactly the same number of individuals for each question. This approach has been used to facilitate comparisons between responses, but in cases where few individuals have responded overall, a very small number of individuals can appear as a substantial change in proportion. We must also recognise that respondents may have been telling us something through their choice *not* to respond to any individual question.
- Some phrases in this report are given in **bold text**. This is to help readers navigate through the different questions and topics that were included in the scoping exercise; they do not indicate a level of importance or emphasise 'highlights'.

2. Care experienced young adults – questionnaire responses

Across the six partner countries, 89 care experienced young adults responded to the questionnaire[1]. The number of respondents in each country ranged from 8 to 24. The ages of the care experienced young adults who responded to the questionnaire ranged from 18-32 years old.

The self-reported age of respondents on their entry into alternative care ranged from 6 months to 18 years. Although respondents were invited to specify months/years, most gave their age in years only. The mean ages of entry into care in individual countries ranged from 5.7 to 13.5 years, indicating that a relatively small number of respondents had entered alternative care during their early childhood.

The shortest overall time spent in alternative care by an individual respondent was 7 months, and the longest, 20 years. It was unclear how many respondents were still living in an alternative care setting at the time of questionnaire completion, although this was specified or implied by a small number of respondents in answer to later questions.

2.1 Placement moves

Research has shown that **placement stability** is an important factor for those in alternative care, as this promotes a feeling of security and provides the opportunity to develop good relationships with caregivers. The questionnaire asked respondents to specify how many places they had lived in, apart from their family home, and about the length of time they spent in individual placements.

Across all respondents from the six partner countries, the **mean number of placements was 2.5** (range of means for all countries was 2.1-3.25). The highest number of placements reported was 8, by an individual who reported a total of 17 years living in alternative care. As described above, the total amount of time spent in alternative care by individual respondents ranged from 6 months to 18 years, and a higher number of placement moves amongst those with longer duration of time in care is not unexpected.

The **shortest duration** of a care placement experienced by respondents was reported as 2-3 days; the **longest** was 19 years. Amongst those who reported having had **only one placement** during their time in alternative care, the shortest duration was 7 months, and the longest was 17 years. There were very few respondents who indicated having had only one placement, and in one country, no respondents reported this.

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[1] This is the number of 'usable responses', defined as those who completed a minimum number of basic questions and at least one other question, and were within the specified age range (18+) for the questionnaire. The total number of responses for individual questions was often lower.

Additional analysis of the information provided by respondents suggests that the overall average (mean) amount of time spent in each placement was 59 months (4.9 years)[2]. The mean durations for all partner countries ranged from 21.2 months (1.8 years) to 97.5 months (8.1 years).

It should be noted that some of the respondents may still have been living in an alternative care placement at the time of their response. Without knowing the detailed personal stories of the individual respondents, we cannot know why or how changes of placement came about, or how these changes were experienced by the individuals themselves. These figures do however suggest that in all six partner countries, while some very short placements were reported, there is the potential for children to experience alternative care placements which last for a number of years, and to have few or no moves during their time in alternative care.

2.2 Overall experience of alternative care

Respondents were asked to rate, on a 5-point scale, their **overall experience of alternative care**. Across the six partner countries, 81 respondents chose to answer this question. The proportions of responses are shown in Figure 1.
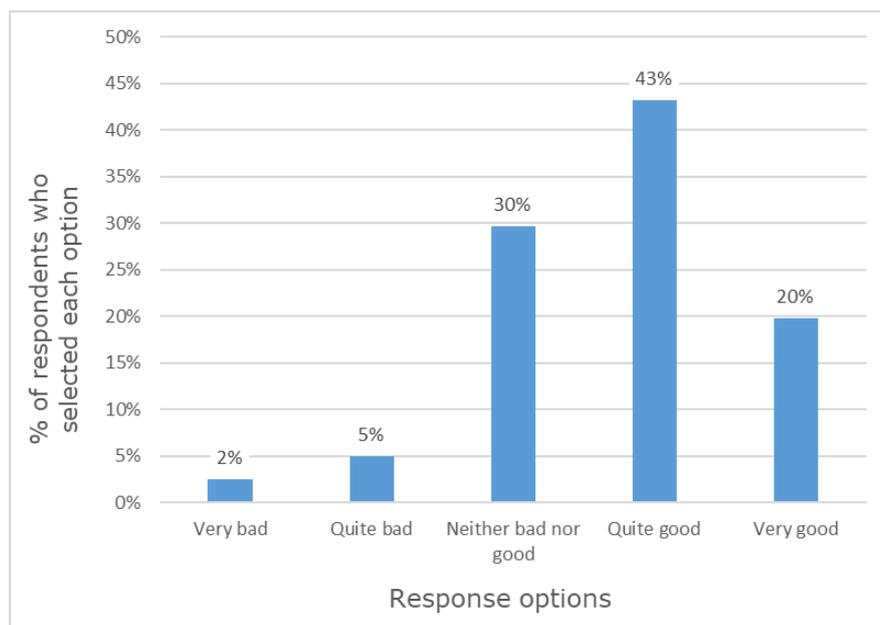

Figure 1: How would you rate your experience of alternative care as a whole?

Generally, respondents felt that their overall experience of alternative care had been good, with 63% selecting 'Quite Good' or 'Very Good' in response to the question. Only 7% (6 individuals) felt that their experience had been 'Quite Bad' or 'Very Bad'. These individuals were from 5 of the 6 partner countries.

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[2] These figures should be interpreted with caution. They are calculated from respondents' reports of their number of placements and total time in alternative care. Most however reported their total time in alternative care in full years, and this has been converted to months for the purposes of this calculation.

Respondents were then asked a series of questions about **specific aspects of their care experience**, reflecting factors such as the importance of good and consistent relationships with caregivers, and a sense of being known, understood, and supported as an individual.

When asked whether they had an unrelated adult, such as a carer, social worker, or teacher who was **in their life throughout all their time in alternative care**, 73% of the respondents reported that they had (ranging from 43% to 91% in individual countries), while 27% indicated that this had not been the case for them. In total, 81 respondents answered this question.

As Figure 2 shows, just over 60% (of 83 respondents) felt that professionals and carers had **helped them to understand and manage emotional issues** quite or very well. Less than a quarter (24.1%) of respondents felt that professionals and carers had done this poorly. Within individual countries, the proportion of respondents indicating that this support was very or quite poorly given ranged from 0% to 50%. Those who felt the support was quite or very well given ranged from 33.3% to 87.5%.
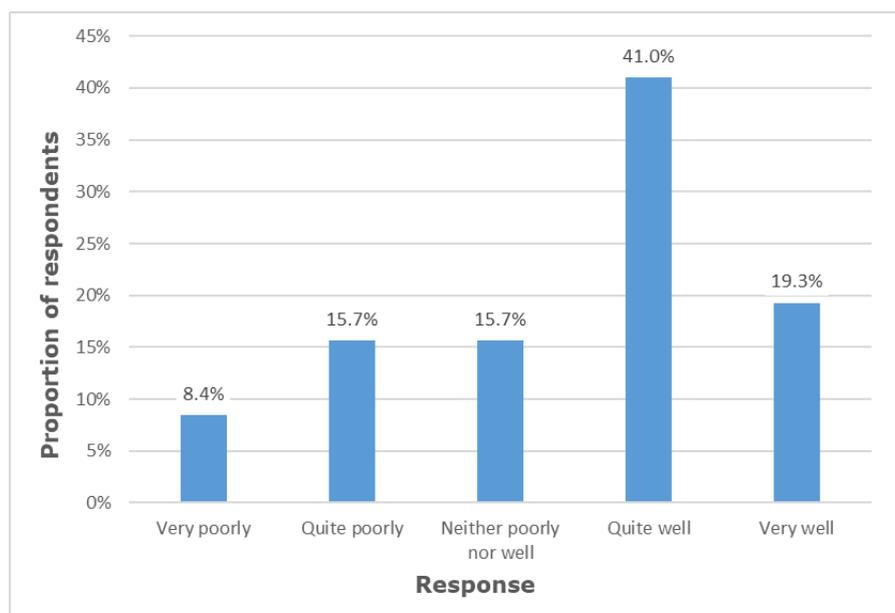

Figure 2: In general, how well do you think professionals/carers in your life helped you understand and manage emotional issues growing up in alternative care?

A later question also asked respondents to consider how professionals and carers could **help children to understand the reasons for their being in alternative care**. Respondents suggested that the best way to help children with this was to talk with them about their circumstances, and that any such conversations should be:

- Truthful, honest
- Sensitive, understanding, gentle

- Responsive to the individual young person's questions, level of interest, and level of understanding.

Respondents also made some clear points about ensuring that any discussion or explanation should fit with the child or young person's needs and wishes – for example, a young person may not wish to know in detail about why they were removed from their family of origin. Caregivers should be sensitive and understanding, and able to share the information with the child or young person at an appropriate time, and in a 'friendly' and supportive way, in tune with what the child wants and can understand. A small number of respondents commented that there should be an emphasis on helping the child to understand that the situation is not their fault.

A few respondents also indicated that professionals did not always have time and attention for the child, a supportive relationship, or the necessary skills and attitudes for this support to take place in the most appropriate way.

> *"I think professionals sometimes underestimate what children can understand. Professionals can sometimes not imagine what children have already had to deal with."*

> *"I can suggest that they should familiarize themselves with the psychological development of the child, as well as with their struggles. They should get to know the child's background as thoroughly as possible. They should be patient and loving with the child. But they should never lie. Not with deeds and not with words, because we can sense it."*

For the next few questions, respondents were asked to focus on their longest care placement. Asked whether they had developed **a sense of 'belonging' or feeling 'at home'** there, almost 78% (of 81 respondents) indicated that they had, while the remaining 22% responded 'No'. Respondents were then asked to consider whether they had **felt they were truly known, understood, and accepted** by their carers in their longest placement. As Figure 3 (below) shows, almost 70% of respondents felt that this was the case most or all of the time.
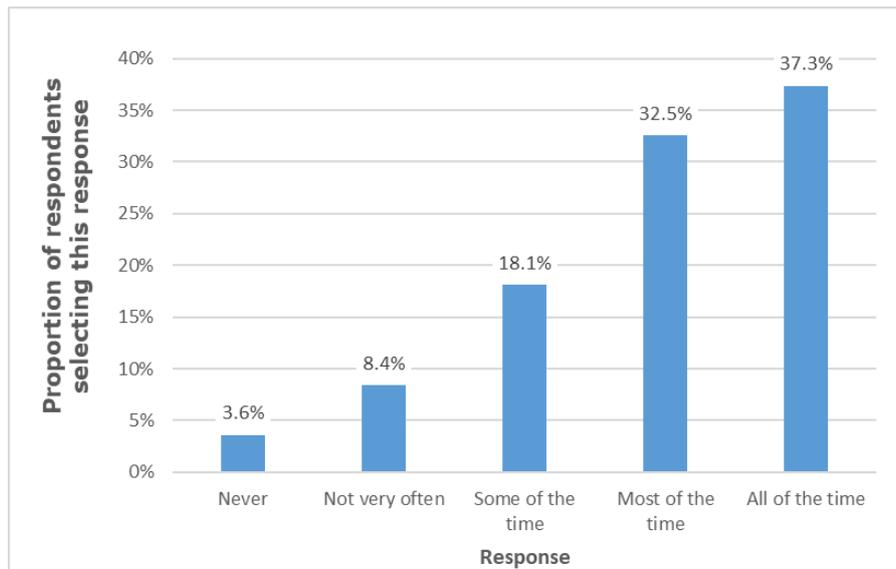
Figure 3: Thinking of your longest care placement, do you feel you were truly known, understood and accepted by your carers?

Looking at individual countries, the highest proportion of respondents who indicated that they 'never' felt this way was just over 13% and the highest proportion who indicated that this was their experience 'All of the time' was just over 58%. It should be remembered however that data for individual countries is based on small numbers of respondents, and caution is needed in understanding the meaning of small percentage differences in this context.

Respondents were also asked to consider **what could professionals and carers do to help a child feel loved and accepted in their care placement?** The main themes which emerged from their responses were:

- Recognise and accept individuality
  - For example, know what makes individual children feel happy; support their personal hobbies and interests
  - A small number highlighted that children should be treated equally while being treated as individuals.
- Build relationships
  - Through, for example, allowing the child time and space to adapt; understanding and acceptance of their background; friendly and informal approach; spending time together/shared activities.
- Attitudes and behaviours
  - Including love for the job/not there just for the pay; genuine interest; supportive and encouraging; respectful in manners and language.

  "Care professionals always give us all their love and they act as if we are their own children, so the children feel loved there and we don't lack for anything."

> *"Show tenderness and affection through their actions. Show their love every moment, because even a small gesture plays a major role."*

Some respondents recognised the potential sensitivity and complexity around discussions of 'love' in care settings.

> *"in a certain sense, love can be given a place in youth care. There's a bit of a taboo on that word in this context and I regret that enormously. It seems important to me that children and adolescents learn how adults can love you in a correct and safe way. […] someone who stands up for you and honestly tells you what they think about something […] Being celebrated and challenged to keep giving the best of yourself is also part of that"*

A small number of respondents also felt that it wasn't possible in an alternative care setting for children to experience this kind of love.

> *"alternative care providers can't give them [the children] that [family] kind of love. That is what children miss the most, but I think that this is a problem that can't be solved, not really."*

Next, respondents were asked to consider their **experiences of education** during their time in alternative care, again with a focus on the importance of understanding and relationships. Asked 'Did your school **teachers show a kind and sensitive attitude** to you, in relation to your being in alternative care?', all respondents who answered this question (n=82) indicated that at least some of their teachers had done so, with 45% indicating that all of their teachers had shown a kind and sensitive attitude.

A number of questions focused on experiences of troublesome feelings for young people in alternative care. Respondents were asked 'During your time in alternative care, did you have adults (e.g. carers, teachers, social workers) who you could go to when you were **worried, scared, anxious, or distressed** about something?' Of the 83 respondents who answered this question, 87% indicated that yes, they had. Looking at countries individually, the proportion of respondents who indicated that they had an adult to go to in these circumstances ranged from 69% to 96%.

Respondents were later asked to describe **what did you do to reduce feelings of worry, fear, anxiety, or stress** during their time in alternative care. The main themes emerging from the written responses were:
- Talking to or with others
  - This included friends, day-to-day carers such as foster parents and residential care staff, professionals such as teachers, and specialists such as psychologists.
- Activities / Keeping Busy

- Respondents detailed a wide range of activities including sport/physical activity, arts/creative activity, and general activities such as studying or spending time with friends.
- Nothing
    - Some respondents indicated that they repressed these feelings, or became withdrawn or isolated. A few respondents reported that such feelings had not happened to them during their time in alternative care.

A subsequent question asked respondents to consider **What could carers/ professionals do to help,** *when children feel worried, scared, anxious, or distressed about something?* By far the most common response to this question was that the adults should talk with the child, and a number of themes emerged about how this should be done. These included:
- The importance of a good relationship between the adult and child. Adults need to know the child well enough to recognise what prompts these feelings for that child, and what their behaviours are communicating about their feelings.
- Talking and healthy discussion should be routine and proactive, not only a response to a problem.
- Attempt to identify the cause of the feelings and work together to address any issues; but recognise that solutions weren't always possible, and the child will still benefit from talking with a non-judgemental listener.

Respondents also highlighted the importance of adults showing their own feelings and modelling how to manage difficult feelings. Other approaches included distraction, spending time together, hugs, and *"grant them a wish".*

Relatedly, a later question explained that *we know that children can sometimes behave in ways that adults struggle to understand (for example, a child might appear to others as if they are angry, but inside they are confused and hurt),* and asked what could help adults **better understand and respond to the distress** behind a child's behaviour?

Some respondents focused their answers on understanding individual children, while others' responses were about understanding children more generally. In relation to individual children, again there was a strong emphasis on having a good relationship, and on talking in a sensitive and empathetic way with the child to explore the causes of the behaviour and work together to find ways to help.

> *"by not avoiding the themes that the youngsters struggle with. Such matters cannot be tackled only at times when things get difficult but rather should be discussed before, so that at the moment of crying or anger, a social worker already has sufficient insight into what works for that young person. Keep asking questions is the message. In addition,*

one should not expect a young person to be transparent. It's a survival mechanism that has worked and will not be deflected in one day."

"Conversation without the child being attacked, criticised or judged. At the end, a hug. ☺"

More broadly, respondents felt that adults needed education and continuous learning to better understand children, their emotions and behaviours. Suggested approaches for this included seminars, training, and reading. One respondent highlighted the importance of adults in this type of work feeling motivated to learn, and to make things better for the children in their care.

Recognising the important difference between placement changes which are planned and purposeful, and those which result from difficulties or crises, respondents were asked **what might help children to stay in their care placements when something goes wrong**, and prevent placements ending in an unplanned way? A number of responses to this question indicated that the question was not sufficiently clear or understandable to respondents. Some referred to issues around 'leaving care', rather than on unplanned placement changes or breakdowns, while others described what would make a comfortable and welcoming place where the child would want to stay.

In relation to actions 'when something goes wrong', again the pattern of responses was similar to previous questions, emphasising:
- the need to discuss, identify problems, work together to find solutions
- the importance of an accepting and supportive, calm and understanding atmosphere
- Accessing help, e.g. from psychologists

A small number of respondents felt that sometimes nothing could be done to prevent 'placement breakdown', and that the change of placement may be the best or only option in some circumstances; or that such changes could not be prevented if this was what the social services or professionals were determined to do.

Next, respondents were asked to consider whether carers had **encouraged them to develop skills, talents, and interests** (such as sports, music, voluntary work, animal care, drama group). Of the 82 who responded to this question, 79% indicated that they had this encouragement from their carers. Within individual partner countries, 'yes' responses ranged from 43% to 100%.

Responses to these questions overall suggested a generally good experience of alternative care amongst this group of respondents, with high proportions reporting consistent adults in their lives, receiving help to manage emotional difficulties and troublesome feelings, and a sense of belonging, being understood and encouraged as an individual by their caregivers. However, there was some

variation between individual countries, with much lower proportions indicating good experiences in some countries than others. Again, caution is needed in relation to the small numbers on which these figures are based; the experiences of the questionnaire respondents in each country may or may not reflect the experiences of the broader population of young people in alternative care in those countries.

In relation to ways in which caregivers can best help children and young people in alternative care with various aspects of their lives, respondents gave a clear and consistent overarching response that talking is a key requirement. They highlighted that adults need to have good, trusting, and ongoing relationships with the young people in their care, in order to know them as individuals and be responsive to their own needs and wishes in conversations. Discussions should be friendly, honest, respectful, sensitive, supportive, and natural - not only initiated in response to a difficulty. Caregivers should be genuinely interested in the young people and in helping them, and not see their role as 'just a job'. They should work openly, show their own feelings, and model healthy responses to difficult emotions. Respondents noted that some professionals and carers are unable, due to time, willingness, or lack of training, to build such open and supportive relationships with young people.

2.3 Relationships with family of origin and friends

The penultimate section of the questionnaire for young adults asked respondents to reflect on their **relationships during their time in alternative care**, including with members of their family of origin, and with friends. For these questions, there tended to be a higher number of individuals who chose not to respond. This may reflect the level of sensitivity of such questions, or simply that towards the end of the questionnaire, respondents were becoming fatigued.

Figure 4 shows the responses to two questions about **relationships with birth parents**: *During your time in alternative care, which of the following best describes your contact with your birth mother?* and '*with your birth father.*' In total 74 respondents answered these questions. Over half had regular or inconsistent contact with their birth mother, and around a third with their birth father.
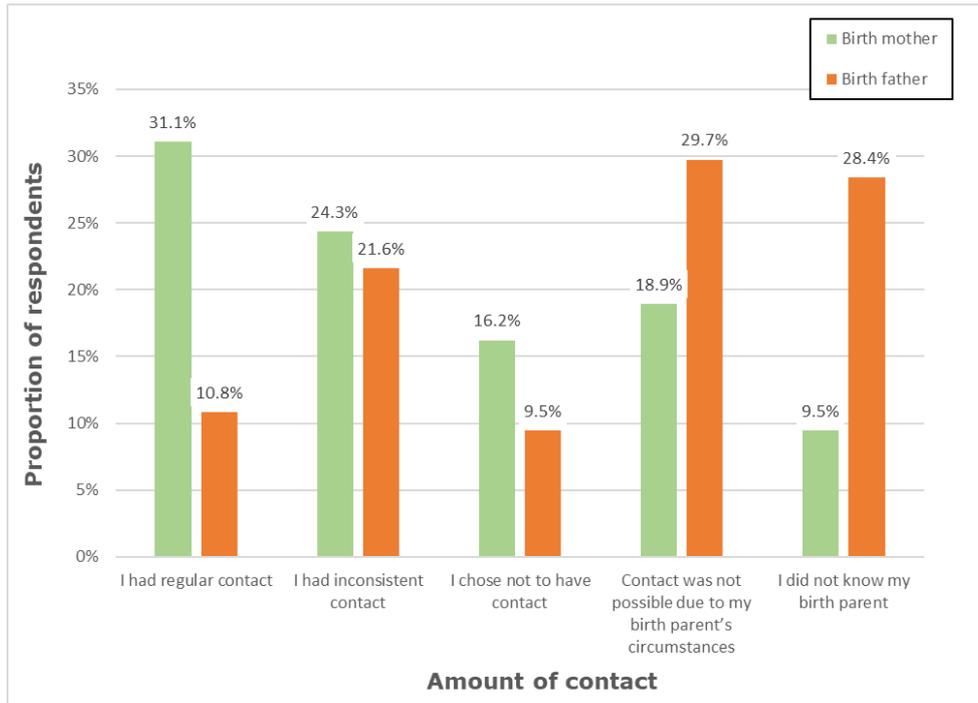
Figure 4: Amount of contact with birth parents

Respondents were also asked a similar question about whether they had any **contact with their brothers and sisters**, and were able to choose multiple response options for this question, reflecting the possibility that individuals may have had different degrees of contact with more than one sibling. Figure 5 shows that across the partner countries, almost 57% of the 74 respondents to this question reported having regular contact with at least one brother or sister, while just over 5% reported not knowing their siblings at all.
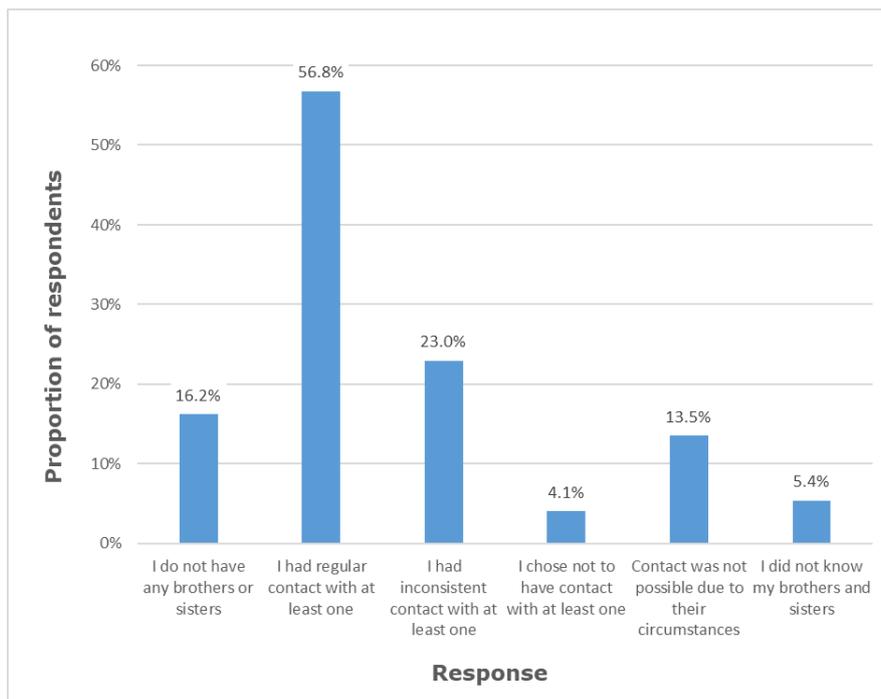

Figure 5: Contact with brothers and sisters

It should be noted however that respondents were not asked to elaborate on how any contact with birth family was arranged, what reasons there were for the amount of contact, or whether they themselves were content with their relationship with birth family members at that time.

Respondents were later asked to consider that sometimes when children come into care, their relationships with birth parents and/or brothers and sisters are difficult. They were asked to reflect on *what professionals and carers do to* **help children and their families repair and improve these relationships***?*

In their responses, the care experienced young adults were emphatic that any ongoing relationship with family of origin should not be forced or encouraged if this is against the wishes or best interests of the child or young person. Instead, the focus should be on developing self confidence and a realistic understanding of the situation, in order for the young person to make good decisions later on about their relationship with their birth family. Comments included:

> *"Sometimes that relationship is toxic and at times it is better that they are not in contact. There is no universal rule that it is always a good thing to remain in touch with your relatives."*

> *"When your birth family causes you more harm than it does you good, then you don't need to stay in touch. You need to know the truth and carry on. If the relationship is good, then the gradual union with the birth family should take place under supervision on both sides, after that things will take their course."*

Where the development and maintenance of a relationship with birth family was appropriate, respondents indicated that there should be support for ongoing communication and the chance to spend time together. This could include practical support for planned family time (e.g. making the plans, financing, arranging transport, supervision), as well as for more casual and spontaneous contacts (e.g. video calls when the young person wants to chat); and emotional support for the feelings raised, both for the young person and for their carers. Access to professional support from, for example, psychologists and mediators, for the young person as well as for members of the birth family, was also suggested, although a small number of respondents felt clearly that the onus should be on the birth family to repair the relationship.

The final question in this section asked respondents to consider what professionals could do to help **keep families together and so prevent children from needing alternative care***.*

A large number of respondents felt that there is sometimes very little or nothing that can be done to prevent children from needing alternative care, and that alternative care will always be needed for some children. This was often

described as being intergenerational, relating to birth parents' own upbringing and difficulties, as well as to their motivation or ability to change and to access and accept support.

A range of possible supports for families of origin were described. These included:
- financial support
- mental health support, therapy (individual and group/family)
- help with substance use issues
- housing and employment support
- parenting advice and support

Several responses highlighted that support should be given early, from birth in some cases, and should be easy to ask for or access.

Respondents were clear however that not all families would be willing or able to engage with or benefit from any support offered.

> *"This is the state's duty and also a fantasy. Unfortunately, not all are born good parents. This would exist in a perfect society. In that case the parents would be monitored by social workers and of course receive financial and psychological support, because many problems stem from financial weakness."*

> *"Everyone in the family has to want this, you can't just wave a magic wand around, a professional would have to talk a lot, they have to motivate everyone and create conditions."*

Several respondents also suggested that it was sometimes not in the child's best interests, or against the child's wishes, to remain with their family of origin.

> *"I am not in favour of keeping children in abusive families. I know that the goal should be for the child to be able to grow up with their biological families under acceptable conditions, but this is very difficult."*

Reflecting next on their **friendships while in alternative care**, 70% of the 74 respondents to the question *During your time in alternative care, did you have good friends you felt you could rely on?* indicated that yes, they had. Sixty respondents answered *Which of these best describes your friendships while in alternative care?* with most (57%) responding that '*Most of my friends also lived in alternative care'*. Around a third indicated that their friends were a mix of those from their time in alternative care and before the entered alternative care, and 10% indicated that their friends were from before their time in alternative care. No respondents selected the option '*Most of my friends were from my time in alternative care, but they did not live in alternative care'.* In a subsequent question, 79% of respondents (n=62) indicated that they remained good friends with people from that time.

The overall responses to these questions indicate that by and large, respondents growing up in alternative care had relationships with birth family and with friends, as well as with their carers and other professionals. Some level of contact (regular or inconsistent) with birth mothers and with brothers and sisters was a common experience amongst respondents, with much lower proportions having no contact (through their own choice of due to the circumstances of their birth family). In relation to birth fathers, however, not having contact was the more common experience. A high proportion of respondents felt they had had good friendships during their time in alternative care, with a similarly high proportion reporting that these friendships continued.

The scoping questionnaire did not seek to explore in depth the sensitive issue of relationships with birth family and friends, the reasons behind the amount of contact, or the young person's own satisfaction with this. The responses however demonstrate that for a high proportion of respondents, relationships with birth family members and with friends were a possibility.

Finally, care experienced young adult respondents were asked for their advice to the team developing the training packages. A wide range of topics and skills for inclusion were suggested. Broadly, these were:

- Trauma; what is it, how it happens, how to prevent and address it
- Children's behaviour and what underpins it; supporting children's mental health; behaviour management approaches to avoid (violence; punishment without explanation; isolation)
- Real-life stories and examples; hear from care experienced individuals; include positive stories to show that care experienced young people *are neither strange nor shameful"*
- How to show or build acceptance, understanding, empathy, love, trust, feelings of safety and security
- Treating children and their families individually; not making assumptions or taking actions which might make things worse
- Collaboration with other professionals
- Developing young people's self confidence, independence, resilience, talents and interests
- Family support and keeping families together
- Recruitment of those who are there for the right reasons / not 'just a job' / have some personal experience and understanding (e.g. care experienced themselves)

"A traumatised child is extra vulnerable. Understand this."

"Humanity – this job should really be done with love. This is what we as children need more than anything else in moments of weakness."

3. Professionals and Carers Questionnaire, and Desk Review responses

A total of 143 individuals from the 6 partner countries responded to this questionnaire[3]. The lowest number of responses from an individual country was 9, and the highest was 46.

Overall, most respondents identified their working role from the list provided to them. Around 23% of respondents indicated that their role was 'Psychologist/ Psychotherapist', while almost 20% were Social Workers. Residential Care Workers and House Parents made up just over 15% of respondents, and smaller proportions of respondents were Social Pedagogues (7.7%), Lawyers/Legal Professionals (7%), Teachers/Educators (4.9%), and Youth Workers (4.2%). A total of 26 individuals, or just over 18% of respondents, indicated that their role was something other than those listed. These included Child Protection roles, Speech Therapists, other roles supporting young people and care leavers, and a small number who specified that their role was in management.

Respondents were also asked to indicate the type of organisation they worked in, in their main role. Overall, 44.8% worked for the municipal or state authority, 39.2% for an NGO, and 16.1% reported working for a private organisation.

3.1 Professional Knowledge

Questionnaire respondents were asked to rate their **personal knowledge on a series of topics**. Their responses are shown in Figures 6-9, below. Overall, most respondents considered themselves to be 'Somewhat' or 'Very' knowledgeable on all the listed topics.
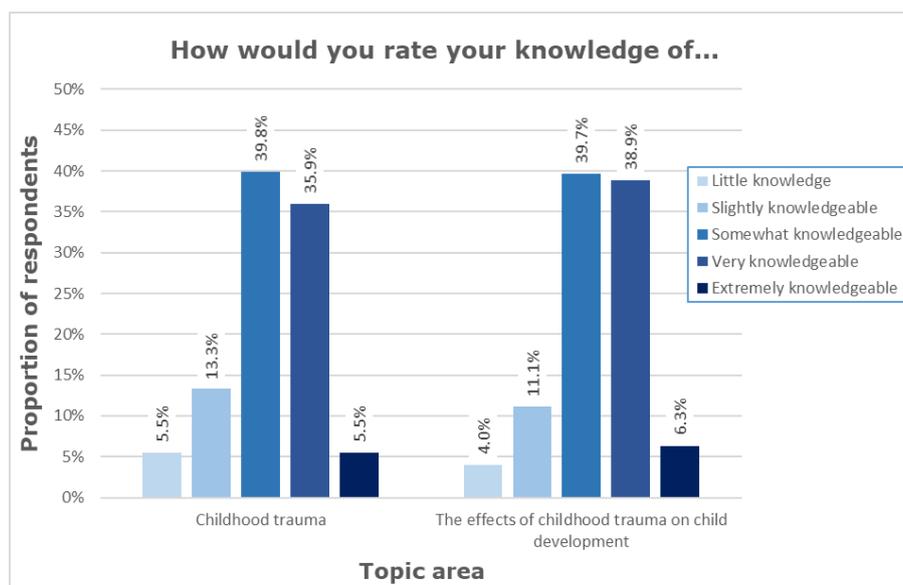

Figure 6: Knowledge of Childhood Trauma, and of its effects on child development

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[3] As above, this is 'usable responses', i.e. respondents who answered four demographic questions and at least one further question. Number of respondents to individual questions was sometimes lower.
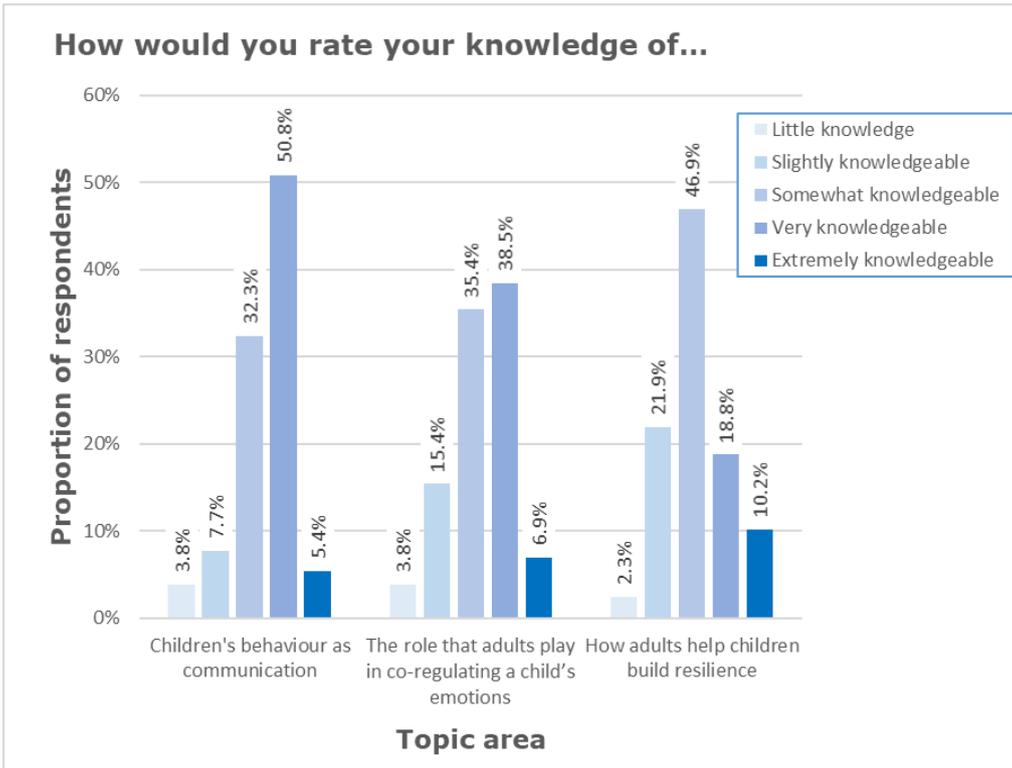
Figure 7: Knowledge of Behaviour as Communication, Adults role in co-regulation, and helping children build resilience
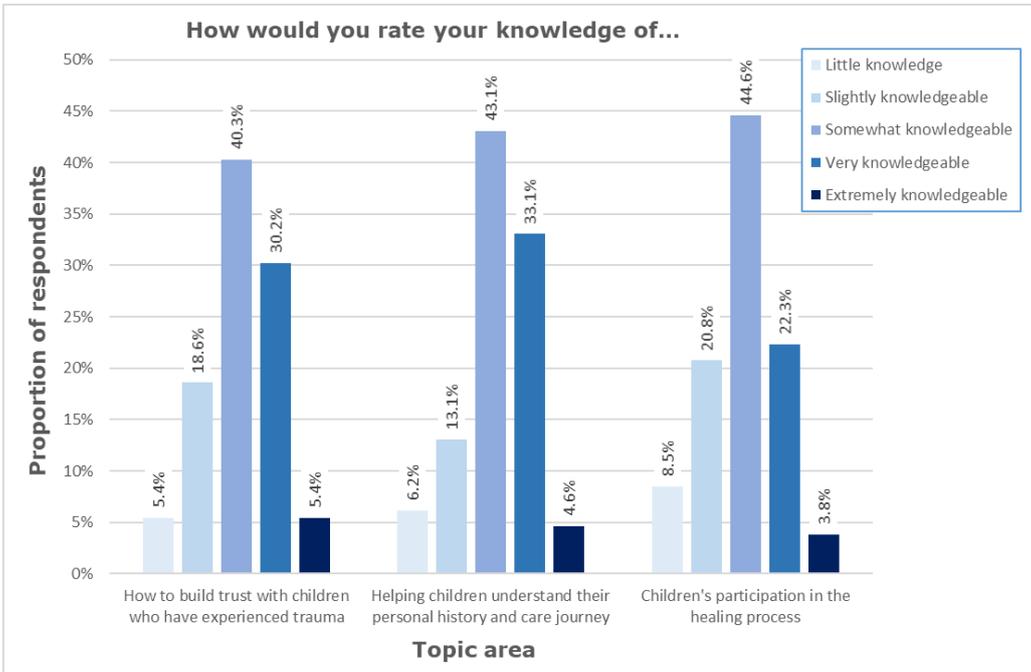

Figure 8: Knowledge of Building Trust, Helping children understand their past, Healing process
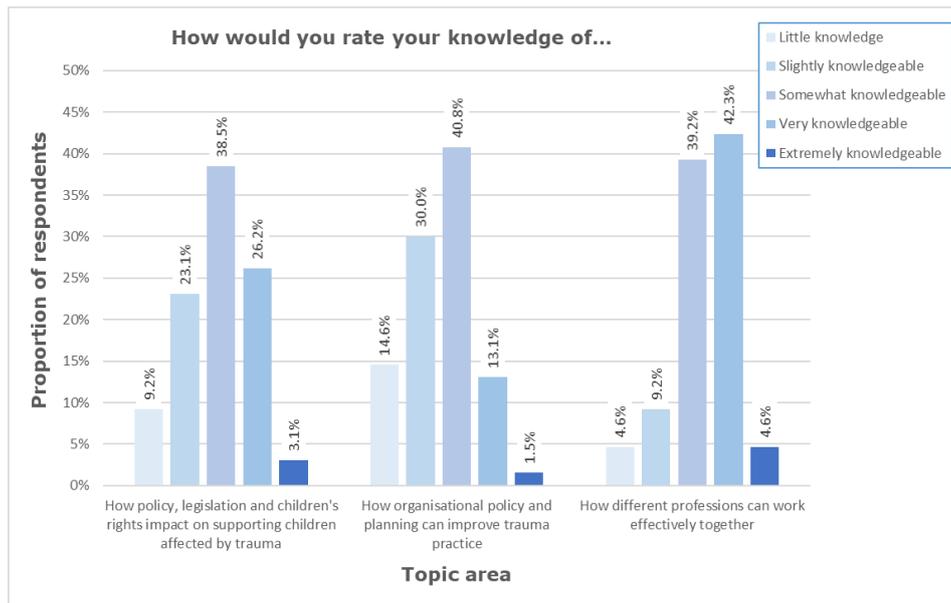
How would you rate your knowledge of...

Figure 9: Knowledge of policy/legislation, organisational planning, working together

The topic for which the highest proportion of respondents (14.6%) felt they had 'little knowledge' was *How organisational policy and planning can improve trauma practice.* The topic on which the highest proportion of respondents (10.2%) felt they were 'Extremely knowledgeable' was *How adults help children build resilience.*

As part of the desk review, we asked contributors to reflect on *the **understanding of trauma within child protection and alternative care systems*** within their countries. Contributors indicated that there is generally some level of awareness, but often:

- There is a narrow conceptualisation, with little in-depth knowledge or understanding of the impacts, consequences, or behaviours which may result from trauma.
- Terminology is used without an established definition or shared understanding and consensus on what this means.

Desk review contributors were also asked to consider *knowledge among professionals of **how trauma manifests in children** – and that it is different from the way in which it manifests in adults* in their country.

Again, contributors generally felt that this knowledge was limited amongst professionals. Most felt that there was some understanding of trauma in children, but this was not always a deep level of understanding, and tended not to distinguish between adults and children.

Generally, contributors reported that there was a more detailed and coherent definition and understanding amongst the most highly qualified professionals or experts, and especially in particular groups of professionals, such as those in the

18

health sector (including psychiatrists and psychologists). Lower levels of understanding were attributed to a lack of in-depth teaching or training.

3.2 Professional training, learning and development

Almost 89% (n=127) of all questionnaire respondents indicated that they had a certificated professional qualification in relation to their work with children and families. These respondents were asked some further questions about the content and usefulness of their professional training.

Respondents were asked *Overall, how well do you think your **professional training prepared you to respond to the effects of trauma** that you see in your practice?* In total, 111 of the 127 respondents who were asked this question chose to answer. Their responses, as shown in Figure 10, indicate that overall around half felt that they were prepared 'somewhat well' by their professional training. This largely reflects the pattern of responses in the individual partner countries, where 'somewhat well' was the most commonly selected response in all but one country (where 'slightly well' was the response of the highest proportion of respondents).
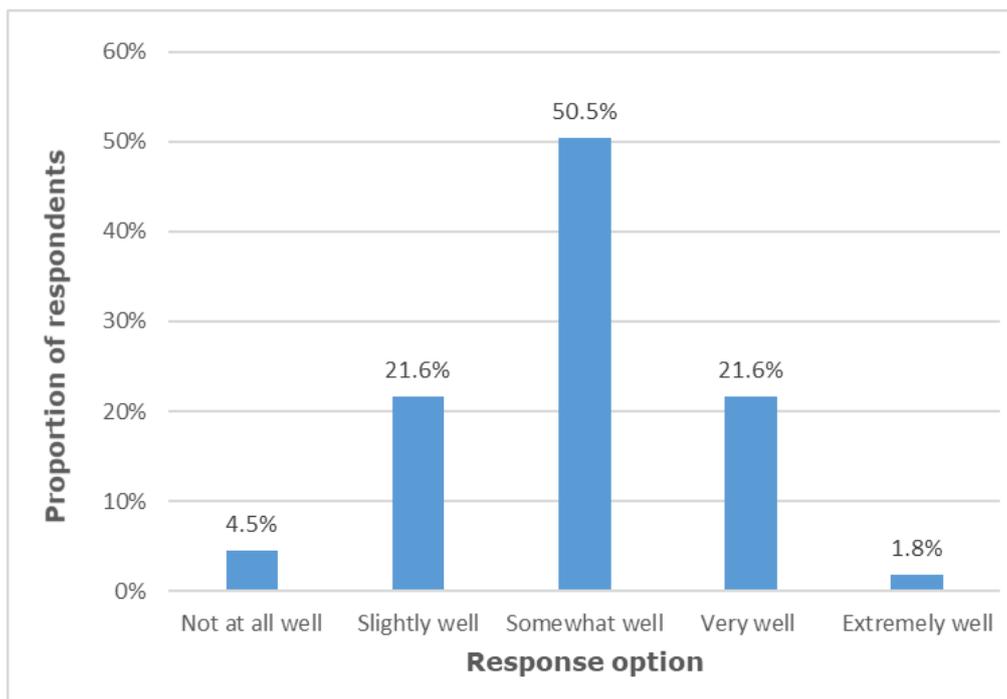

Figure 10: Overall, how well do you think your professional training prepared you to respond to the effects of trauma that you see in your practice?

Respondents were then asked about the **amount of teaching** they had received on a range of relevant topics as part of their professional training.
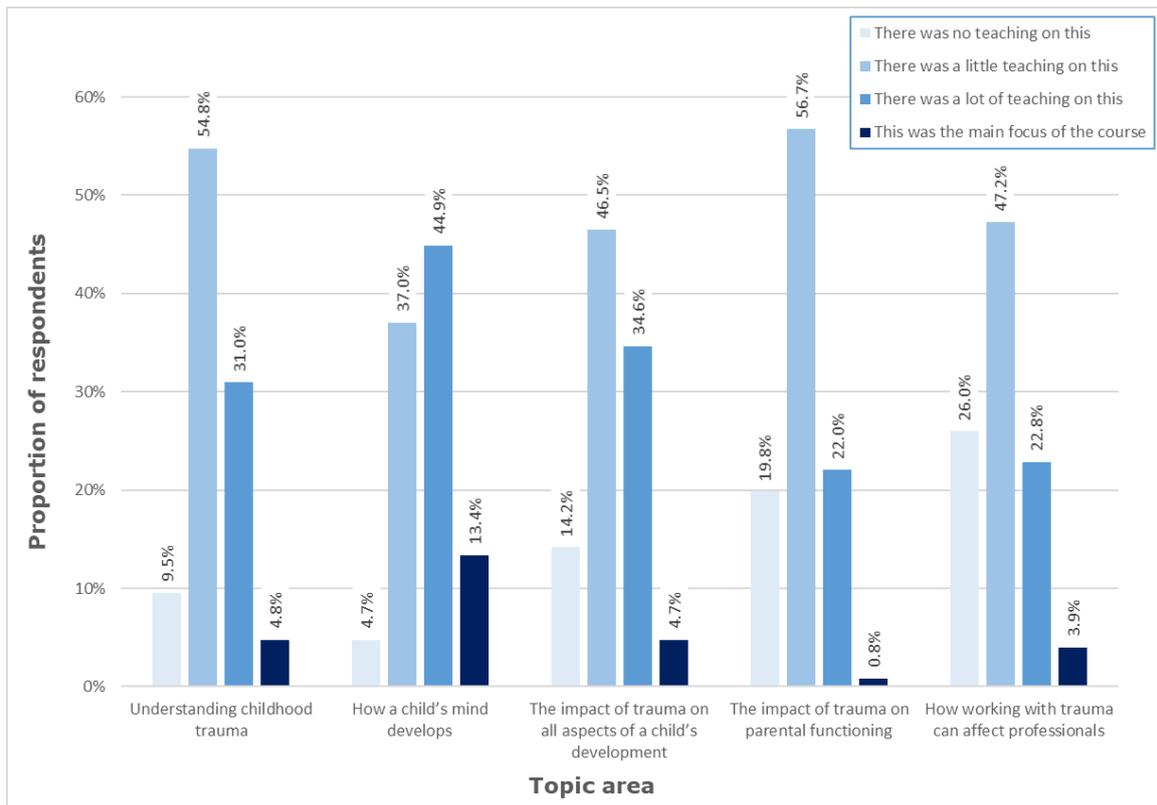
Figure 11: Amount of training received on various topics

As Figure 11 shows, respondents tended to report that they had received 'a little' or 'a lot' of teaching on the specified topics. *How a child's mind develops* had been a main focus of teaching for 13.4% of respondents overall, but almost one fifth of respondents had received no teaching at all on *the impact of trauma on parental functioning*. Furthermore, over a quarter of respondents (26%) had received no teaching on *the effects on professionals of working with trauma*.

Respondents were then asked to describe which three elements of their professional training had been **most useful to them in their current practice**. Although the respondents came from varied professional backgrounds, a number of distinct and also inter-related themes emerged. The three most prominent themes were:

Psychology and therapeutic knowledge/skills

- Including basic knowledge; and different theories, approaches, and interventions.

Impact of trauma

- On brain development; on child development and functioning
- On parental functioning
- On professionals

Behaviour

- Understanding children's behaviour

- "Link with behavioural problems in children and the trauma they have experienced"
- Professional responses

Respondents also identified a range of other learning that they had found useful. This included understanding risk, recognising abuse; child development, developmental stages, attachment theory; loss and grief; self-reflection.

Some respondents described that the most useful learning for them had been around systems and processes (such as children's rights, welfare systems, laws and regulations), and practical skills such as working with groups, report writing, communication, IT. Some also noted the value of learning about their role as a professional, and appropriate professional behaviours (such as "…not to pity the service users but rather to have a proper professional outlook on trauma").

A small number of respondents indicated that they felt unable to answer this question; for example, because their training had been so long ago and they had undertaken other learning since, that it was difficult to remember what was learned when; or that their initial training was poor and they relied on later learning for their current role.

All respondents, including those who indicated that they did not have a professional qualification, were asked to reflect on the **formal learning opportunities that had been available** to them throughout their working lives. They were asked to indicate how often they had been offered an opportunity to learn about a range of topics.
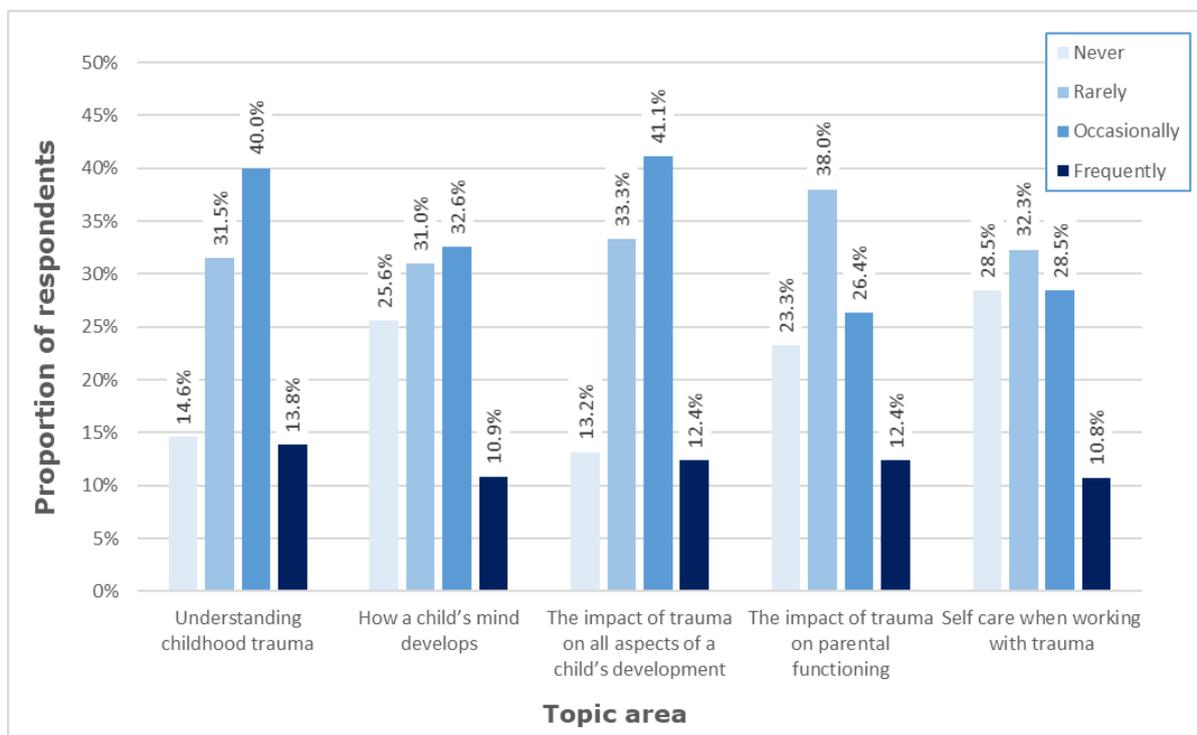

Figure 12: How often have the organisation(s) you have worked for offered formal opportunities to learn about these topics?

As Figure 12 shows, around a quarter of all respondents had never had an opportunity to learn about *How a child's mind develops* (25.6%), and similar proportions reported never having had an opportunity to learn about *The impact of trauma on parental functioning* (23.3%) or *Self-care when working with trauma* (28.5%). Only about a tenth of respondents reported having had frequent opportunities to learn about any of the topics asked about, although more than half of all respondents reported having had either 'Occasional' or 'Frequent' opportunities to learn about *Understanding childhood trauma* (53.8%) and *The impact of trauma on all aspects of a child's development* (53.5%)*.

Respondents were also asked to provide three examples of topics or skills which were not included, or which they felt had not been well covered, in their learning and development activities. In response to this question, four main themes emerged. These were:

Collaboration

- between institutions, departments, different professions
- how to work in partnership
- Communication and building trust (with children, families, colleagues, other professionals)

Trauma

- Recognising signs; identifying causes
- Consequences (for adults; impact on parental functioning; impact on learning / in the classroom)

One respondent explained,

"In my training, I was never told how childhood trauma has an impact on the child's development and adult life. Adapting the organisation's policy to children with trauma is therefore unprecedented territory."

Therapeutic responses to trauma

- Psychological approaches; counselling skills; other therapeutic approaches
- Supporting children to process trauma; involving children in their recovery
- Helping children develop resilience

The professional self

- Protecting oneself; Preventing or delaying burnout
- Self-reflection

A wide variety of other topics areas were also mentioned by respondents, including some quite specific or detailed, perhaps reflecting the range of professional backgrounds represented amongst respondents. Additional topics were around legal and political aspects (such as legislation and its gaps,

professionals' legal knowledge), public policy (function and gaps), and whether and how these systems help children; and responses to specific situations or working with specific groups (Examples included Child attacked by dogs, victim of sexual violence, victim of domestic violence, children on Autistic spectrum, children with addictions, responding to colleagues who display unhelpful attitudes to children/ victim blaming; Supporting children who don't have any/regular contact with parents; Intergenerational working; "cultural peculiarities").

As part of the desk review, partners to explore the **education and learning available within their country** on childhood trauma and its impacts.

Discussing the extent to which childhood trauma is covered in university professional education, contributors to the desk review indicated that this is generally not included in initial social work or education courses, or only included in a limited or fragmented way, with elements in a range of courses but no specific course focusing especially on trauma awareness. Childhood trauma is sometimes included as a core part of specific courses (such as psychology, psychiatry), but is sometimes an elective course which not all students would choose. The response from one country noted a course on working with traumatised people which was available to members of the police service, and was intended to be extended to social work students.

In some cases, teaching on this topic would depend on the knowledge and experience of individual lecturers, and might extend only to basic and potentially outdated theoretical information.

Some respondents to this question noted that there may be opportunities for professionals to undertake more in-depth postgraduate courses or to learn more about childhood trauma and its impacts once they start working 'in the field'. However, desk review respondents were also asked to reflect on the extent to which childhood trauma is covered in organisational CPD, and highlighted:

- A lack of available good quality courses
  - May not be regularly or routinely available, or easy to find
  - Often very limited number of attendees
  - Not all high quality
  - May be only online / in foreign languages
- Funding difficulties
  - to run the course
  - to pay to attend

Responses to the desk review indicated that undertaking ongoing professional development activity was not part of the professional culture in all countries. Even where good opportunities were available, often accessing these depended on individual practitioners' own interests, willingness to attend, and ability to pay. Employers were not always proactive in offering time off and financing for these purposes.

Overall, indications from both the desk review and questionnaires suggest that professionals and carers have some access to opportunities for learning about specific aspects around childhood trauma, but that there are a range of barriers facing those who wish to enhance their understanding, including limited provision and financing issues.

3.3 Experiences of current organisation/place of work

Next, questionnaire respondents were asked to reflect on their experiences in their current place of work, by indicating how frequently specific support and development opportunities were available to them.
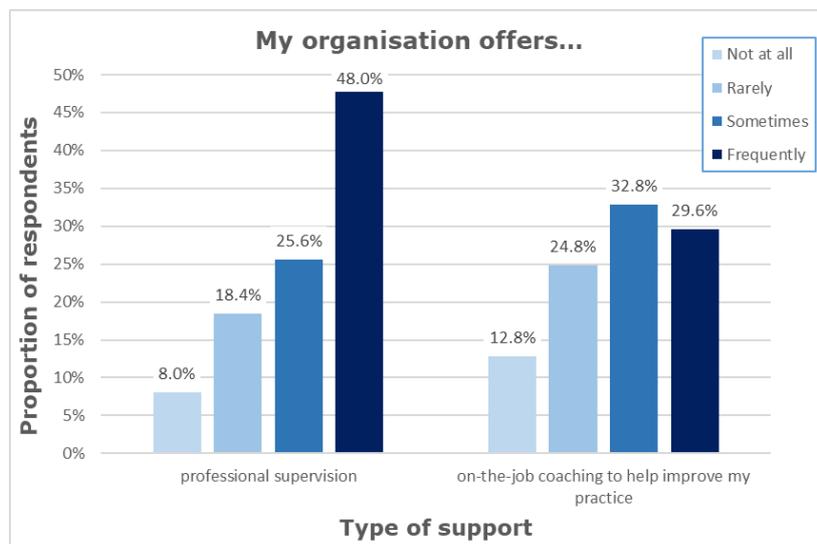

Figure 13: My organisation offers professional supervision; on-the-job coaching

As Figure 13 shows, almost half of all respondents indicated that they had frequent opportunities for **professional supervision**, however there was more of a mixed picture around the availability of **on-the-job coaching** for respondents.

Similarly, as shown in Figure 14 (below), half of all respondents reported frequent **opportunities to reflect with colleagues** on team and organisational practice, but there was a wider spread in relation to respondents being asked to **contribute to new policy or guidance**.
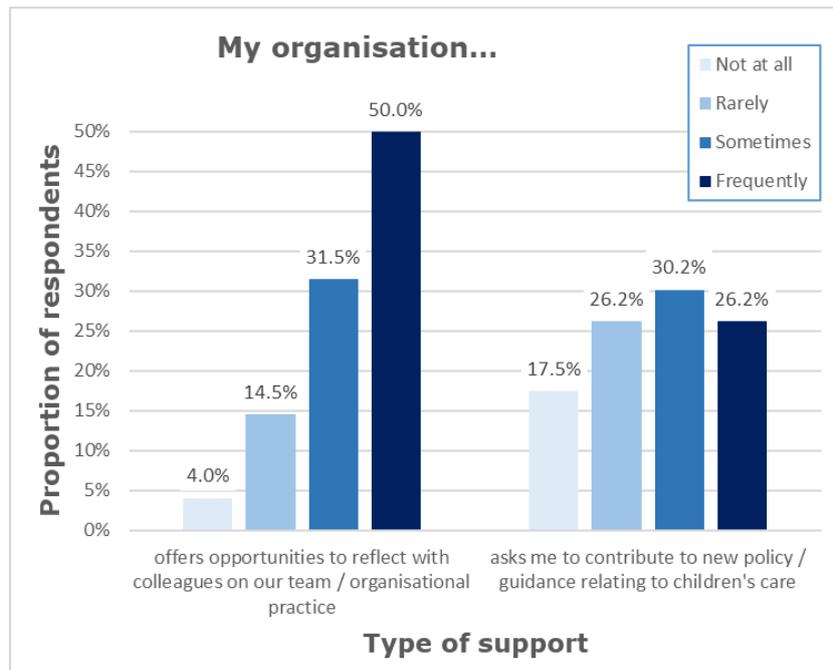
Figure 14: My organisation offers opportunities to reflect; asks me to contribute to policy

Respondents were also asked about their own **feeling of being supported and cared for** by their organisation. As Figure 15 shows, around 11% of all respondents agreed or strongly disagreed with the statement *I feel supported and cared for by my organisation, to carry out the job I am doing*, while over 60% agreed or strongly agreed with the statement.
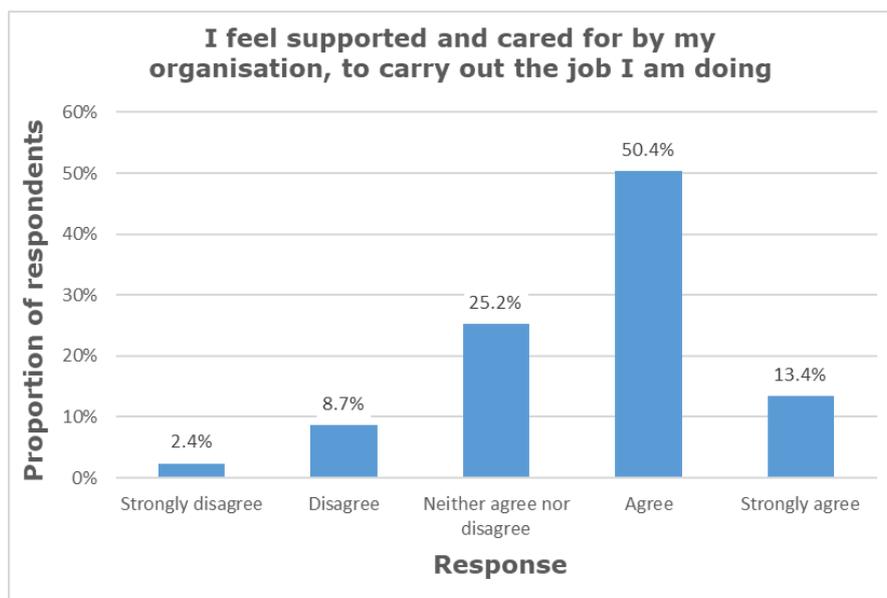

Figure 15: I feel supported and cared for by my organisation, to carry out the job I am doing

Respondents were also asked to reflect on the culture around **understanding childhood trauma in their place of work**. As Figure 16 (below) shows, almost half of all respondents disagreed or strongly disagreed with the statement *Childhood trauma is not very well understood in my organisation.* Just under a quarter agreed or strongly agreed with the statement.
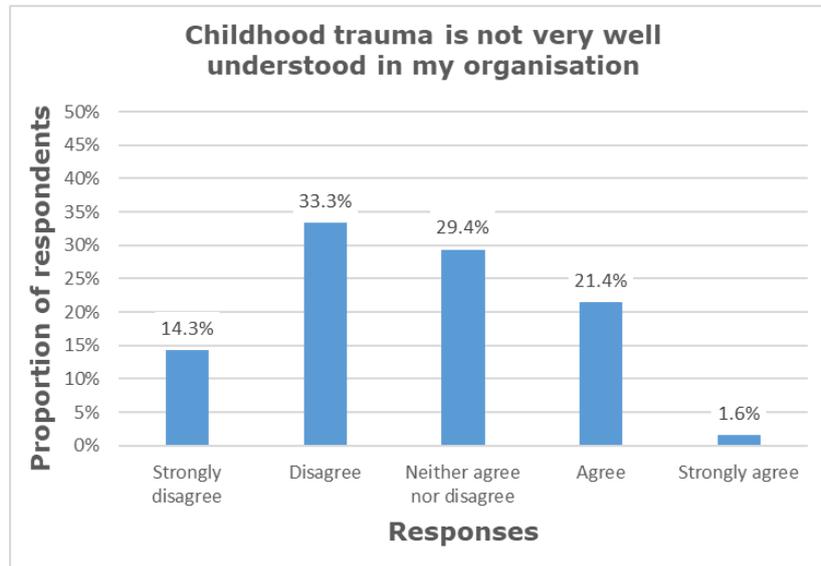

Figure 16: Childhood trauma is not very well understood in my organisation

Well over half of all respondents agreed or strongly agreed with the statement *My organisation has a good understanding of the impact of childhood trauma* (Figure 17)*.*
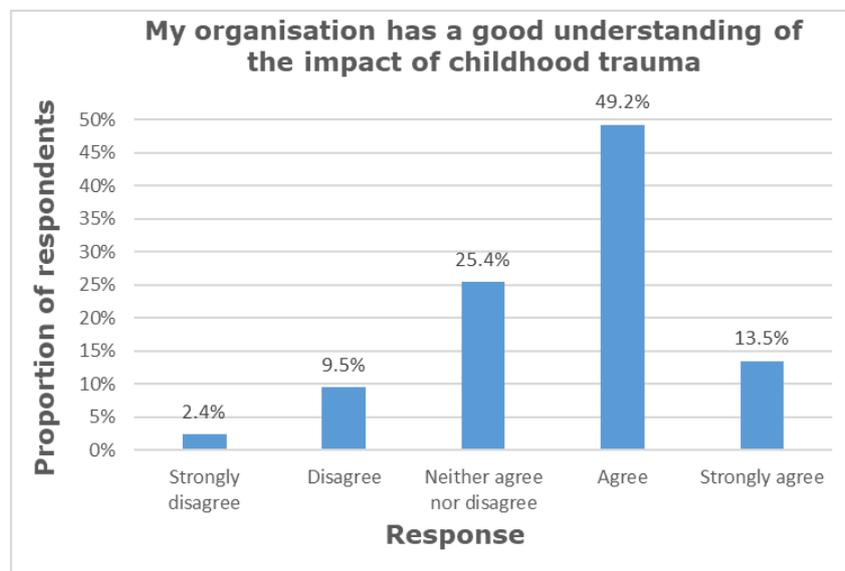

Figure 17: My organisation has a good understanding of the impact of childhood trauma

Generally, respondents reported having opportunities for supervision, and to reflect with colleagues. They felt that their organisations had a good understanding of childhood trauma and its impacts, and they felt well supported by those organisations. Responses suggest however that opportunities for professionals and carers to engage with coaching, and to contribute to policy formation, were more limited.

3.4 Views on country's systems and practices

Respondents were next asked to reflect on the **situation in their country as a whole**, and to give their views on how systems and practices incorporated an understanding of childhood trauma. A number of the questions in this section were in two parts, with respondents being asked to select initially from a number of response options provided, and then to explain their choice.

In total, 116 respondents answered the question *In general, how well do your country's child-care systems and practices reflect an understanding of trauma on children in alternative care?* Their responses are shown in Figure 18.
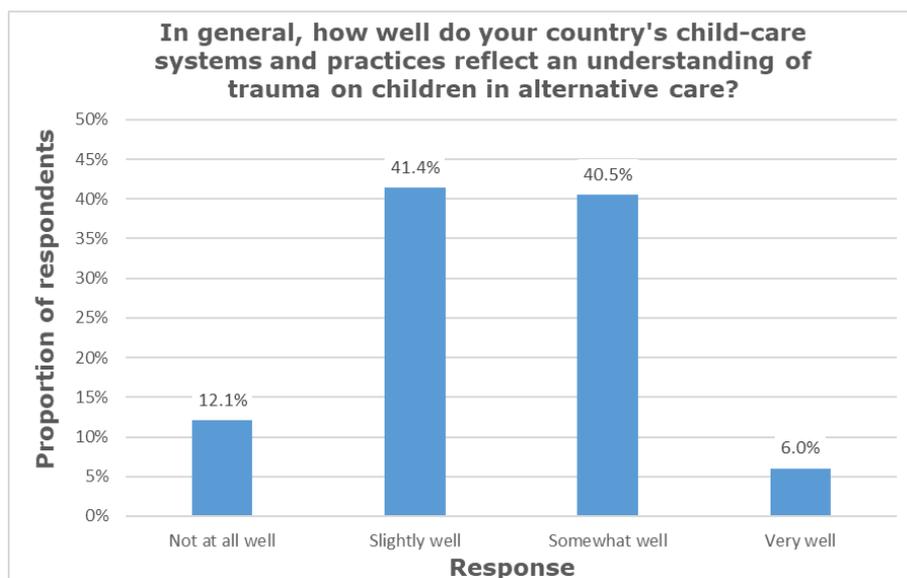
Figure 18: In general, how well do your country's child-care systems and practices reflect an understanding of trauma on children in alternative care?

Over 80% responded 'slightly well' or 'somewhat well', and 77 individuals went on to explain their answer. Overall, respondents tended to explain their responses in terms of what they perceived to be the deficits or challenges within their countries. These included systems and practices which were characterised as lacking:

- A focus on the needs of individual children and families – limited attempts to understand birth families or the children themselves, instead systems are driven by the needs of the institution

- An understanding of trauma - too much focus on external behaviours; focus is on basic care and behaviour management rather than responding to trauma; alternative care placements can result in further trauma;
- Resources (including financial; access to therapy or suitable qualified professionals; access to facilities and suitable placement options; prevention measures and parenting support)
- Support for professionals, e.g. in relation to numbers and stability, caseload size, burnout, appropriate remuneration, training and development, autonomy
- A collaborative approach (between different institutions, sectors and organisations)

Respondents' comments included:

"There are almost no opportunities for real therapeutic help. As a result, the trauma in these children's lives goes virtually untreated."

"In my country there is no adequate understanding of children, let alone of the trauma!"

"It is common for partner organizations, such as educational ones or the police, to be completely unprepared to deal with traumatized children."

Respondents also described systems in their countries as fragmented, with poor collaboration, and driven by political concerns rather than the needs of children and families. Some suggested that law and policy in their country was adequate but not implemented, while others felt that their country's laws were outdated or patriarchal.

"They treat children's upbringing, not just the trauma, as part of a patriarchal system. A biological father's privileges far outnumber his actual parental competencies. The children are subordinated in their families, as well as in both the care and legal systems. A large portion of child protection professionals do not receive training and practical opportunities to help traumatised children/mothers. Systematic victim-blaming attitudes and lack of empathy are typical."

"The child protection system is well thought out, but the constant lack of resources, inadequate number of good professionals, limited consideration for the child's needs, lack of good foster families or well-functional care homes, lack of appropriate child psychiatric care in the country, lack of child psychiatric institutions for girls that would house them for longer periods, lack of well-trained psychologists in the country, insufficient training for foster parents and care homes with regard to this topic, care and upbringing are not integrated into the everyday operation of the system."

Respondents who identified elements of positivity within their own countries also sometimes noted that there was still scope for improvement. This included:

- Professionals with appropriate knowledge/skills/training do exist, but access is limited
- Where there is understanding of trauma, this is limited or basic

Other positive reflections included the mix of community-based social services available to support children in overcoming the trauma, and team work and supervision.

The next two questions asked respondents to consider *In general, how well systems and practices in your country reflect an understanding of how adults' **unresolved trauma can affect their functioning as parents**?* In total, 116 respondents selected a response option, with almost half indicating that in their country this was done 'slightly well', and a very small proportion that this was done 'very well', as shown in Figure 19. Of these respondents, 69 individuals gave a written explanation of their response.
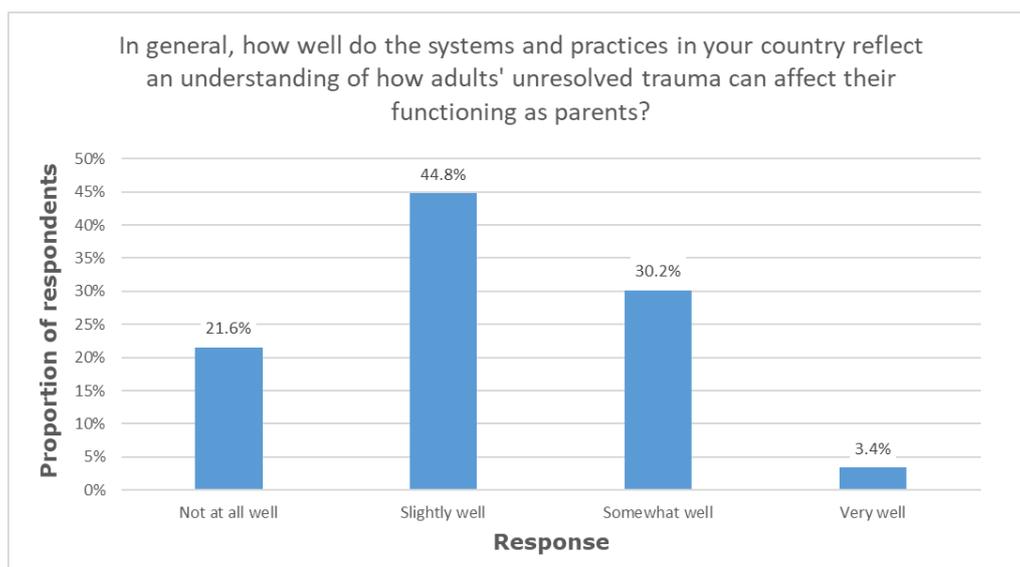
Figure 19: In general, how well do the systems and practices in your country reflect an understanding of how adults' unresolved trauma can affect their functioning as parents?

Again, respondents' explanations focus tended to be on the difficulties within the system, and many of the emerging themes were overlapping or inter-related. Respondents highlighted that without therapeutic input for children, their unresolved trauma and a lack of parenting support would make it more likely that their own children would need alternative care in the future. This pattern was described as often inadequately recognised or addressed, and sometimes professionals were not well enough trained or supported to recognise or respond to this issue. Respondents highlighted a lack of support for care experienced young people and care leavers, including family planning advice and

contraception, and parenting advice or support to develop parenting skills. This was seen as contributing to a generational cycle of children needing alternative care.

> "The majority of children in [alternative] care will go on to have children who themselves grow up in [alternative] care, a pattern which makes parenting very difficult for such children, and this is very rarely addressed in the system."

> "I have not noticed anything being taking into consideration beyond 'they come from problematic families themselves, so this is par for the course'."

Respondents suggested that there was too little understanding of or attention to the impacts of trauma across the life course, or on 'behaviour as communication'. A few noted the cycle of children in alternative care having frequent placement moves due to carers feeling unable to manage their behaviour, meaning that the children did not have opportunities to develop secure trusting relationships and start to process their earlier trauma.

> "Children are often belittled, and their behaviour is judged. If there are too many problems with them, they will get sent to a different family or a different care home. Or if they stay in the original foster family, the foster parents will burn out, and get tired, and the relationship becomes dysfunctional. Children's emotional injuries are not processed, but rather just swept under the rug."

Several respondents also highlighted a lack of understanding amongst the general public of trauma and its impacts, including their own unresolved trauma, leading for example to widespread mental health difficulties and parenting issues. The lack of awareness and potential for stigma would lead to adults not seeking help in dealing with their trauma. There was some suggestion that there needed to be a wider societal understanding of the impact of trauma. One respondent described that the parenting support that is available tends to focus on 'positive parenting' but does not help parents recognise and address their own unresolved trauma which may be impacting on their parenting. This respondent felt that another approach to parenting support was needed.

Reflecting some of the themes emerging from previous questions, these issues were attributed to lack of training/education for professionals; lack of resources/ funding, e.g. for therapeutic support; little prevention work or long-term thinking; policies and protocols which exist on paper but are not followed or implemented; a fragmented system; and too much emphasis on theory rather than practice.

Those respondents who described some of the features of the system in their country which they felt were going well also noted the challenges that prevented practice from becoming even better. Some respondents felt for example that professionals' understanding of and willingness to learn about the impacts of

trauma was good, but that (as described above) their response was hampered by a lack of resources and support options. Access to therapeutic inputs, particularly in rural areas, was highlighted as a particular challenge.

Relatedly, respondents were then asked to reflect on *how well do you think your child care systems and practices are able to respond consistently to the **emotional and mental health needs of children** in alternative care?* Figure 20, below, shows that almost 55% of respondents felt that this was done 'very' or 'quite' poorly in their country, while just over 22% felt that this was done 'quite' or 'very' well.
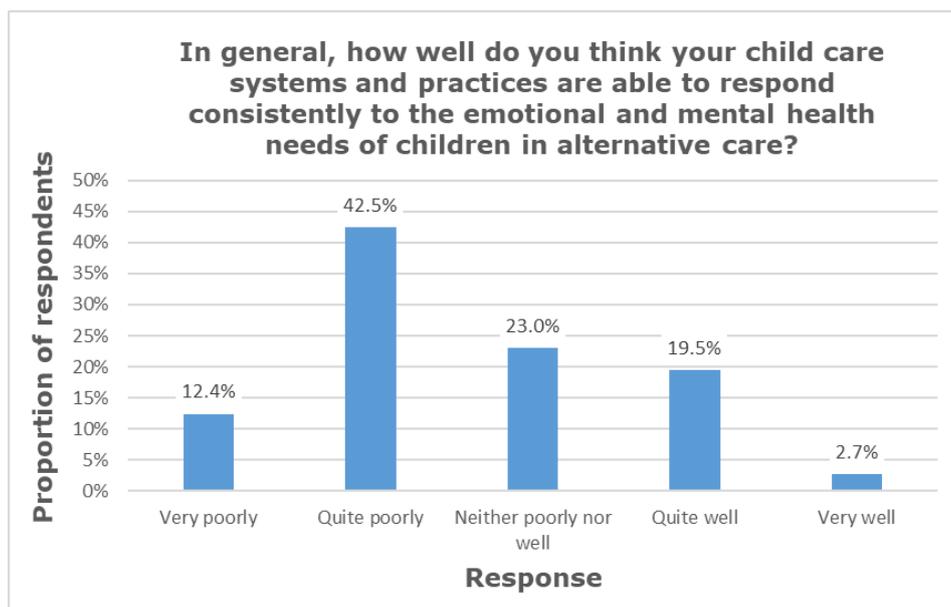

Figure 20: In general, how well do you think your child care systems and practices are able to respond consistently to the emotional and mental health needs of children in alternative care?

Desk review contributors were asked to reflect *on the degree to which impact of trauma on children in alternative care is discussed or evident in **planning, policy and decision making*** in their country. This question was answered primarily from the perspective of care planning, with contributors from two countries noting that trauma is not included in official policies due to unfamiliarity with the concept of trauma and its consequences.

Where the impact of trauma was reflected in care planning, this was attributed to the knowledge and interest of individual professionals responsible for care plans. Generally, however, this was not considered to be a feature of care planning, even where trauma was recognised and discussed. Contributors largely described systems in which trauma, if identified, was only considered in a brief or superficial way, and planning tended to be short-term and focused on practical issues such as accommodation.

Also included in the desk review was a question on *The degree to which the* **impact of trauma on parental functioning** *is discussed or evident in child care planning, policy, decision making*. Generally, this was considered to be evident in very few instances, described by one contributor as "extreme cases". Some contributors noted that sometimes the focus was only on the child, but even when there was recognition of the need to support parents, this was rarely in relation to their own trauma. Where parental trauma was recognised, systems and processes did not often enable this to be addressed. Costs and level of priority for this work were considered to be barriers, although some contributors noted increased work in this area and around prevention and the provision of parenting support.

Desk review contributors were also asked to describe *how mental health services for children and families **understand and respond to trauma***. Some contributors described mental health services for children as recognising and understanding trauma, but noted that these could be difficult to access due to limited capacity. Largely contributors felt that mental health services did not have a good understanding of trauma, and the ways in which services could best respond.

Involvement of different professions
Questionnaire respondents were then asked to consider *how often a **range of professionals** worked with children in alternative care* in their country.

Figure 21: In your experience, how often do the following professionals work directly or indirectly with children in alternative care?

As Figure 21 shows, around half of all respondents indicated that Child and Youth Psychologists worked frequently with children in alternative care. Over half indicated that Play Therapists were never or only rarely involved in this work.

A broader perspective on this question was gained from the responses to the desk review question, which asked contributors to identify *the **main staff members that work directly with children and families** affected by trauma* in their country. Some contributors identified a wide range of professionals who would come into contact with children and families affected by trauma, including teachers and other school staff, health workers including mental health professionals, and other professionals within universal services and wider society. Others focused on carers and mental health professionals, and sometimes educators.

Most contributors noted the wide variation in the level of experience or specialised qualification of those working with children and families affected by trauma, and particularly the variation in whether they had college or university level qualifications for their role, or not.

Desk review contributors were further asked to consider *how systems work together*. They described that **multidisciplinary and multi-sectoral approaches** on the issue of childhood trauma are generally not common, though there are some examples of professionals and systems working together. In some instances, multidisciplinary working is a legal or policy requirement, but this tends to be only in very specific circumstances. Where this is the case, it can sometimes mean a basic exchange of information, rather than genuine collaboration, and tends not to happen in cases which are not covered by the legislation or policy. Some contributors noted that there are some good examples of individual workers or organisations being able to create networks with others, but these tend to be informal or not focused specifically on issues around trauma.

Preparation and support for those providing alternative care
Still considering the overall picture in the country in which they were based, respondents were next asked a series of questions around the **preparation and support available for those directly providing alternative care**, such as foster carers, house parents, and residential care workers.
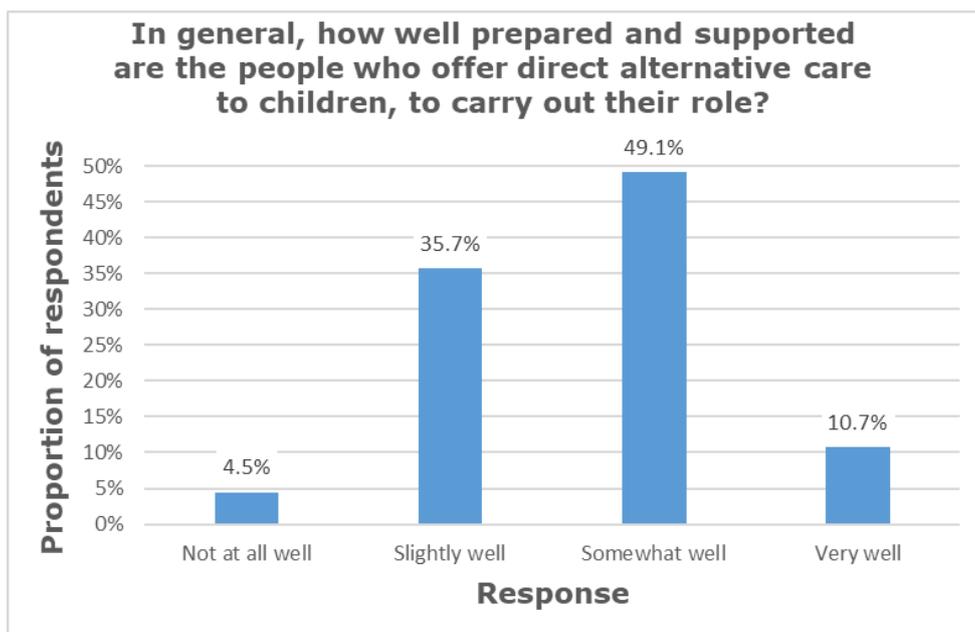
Figure 22: In general, how well prepared and supported are the people who offer direct alternative care to children (e.g. foster carers, residential staff, house parents, etc.) to carry out their role?

Figure 22 shows the responses to the question *In general, how well prepared and supported are the people who offer direct alternative care to children (e.g. foster carers, residential staff, house parents, etc.) to carry out their role?* Respondents generally felt that this was done well, with almost 60% suggesting that in their country this was done 'somewhat' or 'very' well.

Respondents were then asked to describe *What three things are done well in your country to prepare and support alternative carers?* One main theme, training, emerged clearly from the responses to this question, with a further two themes – structure and guidelines, and relationships - frequently mentioned. Training was described in terms of both initial and ongoing training, and in some cases coaching and supervision, and recruitment and selection, were also included in the description of what is done well. Some respondents noted however that good training and supervision are not always consistent within and between organisations or 'client groups', for example training might be of high quality for foster carers, but less good for adoptive parents. A small number of respondents suggested that the quality of training is variable within their countries, and that high quality training and supervision are more likely in NGOs than other providers. One respondent highlighted importantly that while the training itself may be good, there may be a lack of evidence on how well the learning is implemented or used by learners in the context of their work.

In relation to structures and guidelines, respondents referred to a move from institutional placements to an increased use of foster care, and to good social benefits systems. Relationships were discussed in a number of ways, including:

- between professionals and 'clients'

- Collaboration between different professional groups/organisations
- Between services and foster families
- Support groups

A small number of respondents highlighted improvements in resourcing such as facilities, equipment, and number of staff, in their countries.

Respondent were then asked to consider *What three things could be done better in your country to prepare and support alternative carers?* Many of the themes identified in the previous question as things that are done well, were also apparent in responses to what could be improved. The most prominent were Recruitment, Training and Supervision; and Pay and Conditions/financial supports.

In relation to Recruitment, Training and Supervision, respondents suggested a need for:

- More training to include child development and trauma; attachment and trauma should be foundational training for everyone involved in alternative care
- An expectation that this is a lifelong, ongoing learning process
- availability of training on specific issues/specialised training
- opportunities to access this without leaving children unattended
- Improved supervision; regular; supportive and accessible; encourages reflection
- Recruitment of genuine, motivated people

Suggestions around pay and conditions included better financial supports/ rewards/ salaries, an increase in paid annual leave, reduced workloads for carers and fewer 'cases' for the professionals supporting them, and a support network for staff/carers.

Although the focus of this question was on preparation and support for alternative carers, a number of respondents described improvements in support for the children and young people too. These included:

- Improved access to counselling/therapy (e.g. art, play therapy) for the children as well as the carers/professionals; More professionals to provide this type of support; better geographical spread
- More activities for children and young people; opportunities for participation
- "Provide free treatment for children in care who have health and mental problems"

A small number of other themes emerged less prominently, which included the need for clear policies/guidelines, and the involvement of front line professionals in creating policy/ legislation; systematic monitoring and evaluation; and improved public perceptions (of the services and also of the children who need them).

Preventing the need for alternative care

The next questions focused on working with birth families, and the extent to which **reducing the need for alternative care** is addressed by a country's systems and practices. As Figure 23 shows, half of all respondents felt that this was done 'slightly well' in their country, but only very few respondents felt that this was done 'very well'.
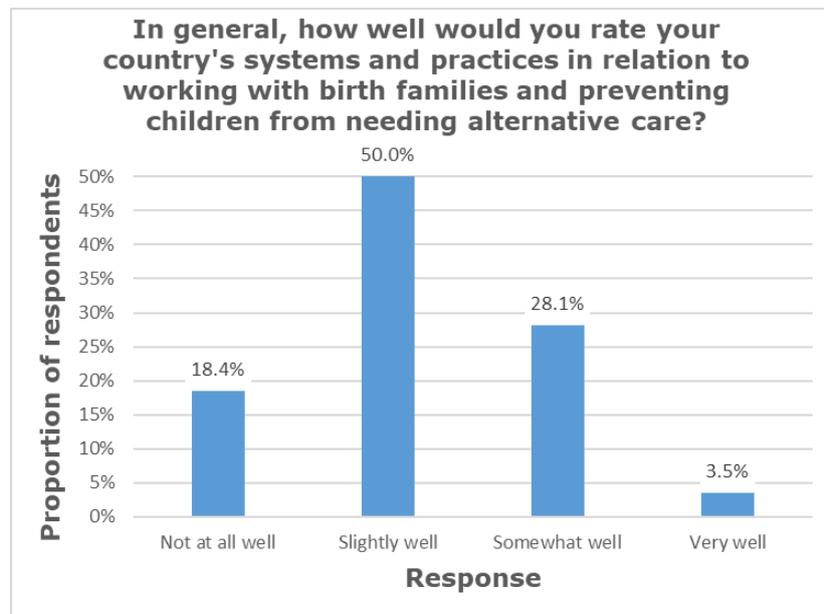

Figure 23: In general, how well would you rate your country's systems and practices in relation to working with birth families and preventing children from needing alternative care?

A total of 114 respondents answered this question, 70 of whom provided an explanation for their answer. Those who indicated that this was done 'not at all well' or 'slightly well' in their country shared some consistent views on the work done with birth families. They described this as being rare, inadequate, insufficiently staffed, unequally distributed (geographically), not clearly the remit of any particular professional(s), underfunded, and low priority for the state. Respondents felt that there was very little or no attempt to engage or support birth families, either before the removal of their child, or after the child's removal in an effort to facilitate their return.

> *"The biological family is the most neglected aspect of the system. They don't get proper respect or understanding, everyone just blames them for the change. They are not treated as the fragile and vulnerable people they are."*

Support for families after a child is removed, to support the return of the child, was described as:

- Rare
- Inadequate
- Superficial

36

- Ineffective
- May be provided by NGOs, rarely by the state
- May be available from various organisations, but "their methods are very outdated"

Respondents attributed this to a lack of focus and priority on providing support and on low availability of prevention programmes, but largely to professionals unable to do their best for families, due to being overburdened/too few in number, underpaid, disillusioned, and demotivated.

> "The child protection system in [my country] is catastrophic. […] Some enthusiastic, dedicated professionals carry the burnt, ruined system on their backs. It's not worth it to write anything about this system anymore. Basically, everything must be changed – the money, the expertise. We need well-trained professionals both on the front line and in politics. Right now, one can already burn out during their education about this system."

One respondent felt that there had been some good work in this area, but negative public attitudes to this approach had hampered its development. Others felt that there had been improvements in their countries but that progress was slow due to a lack of supportive legislation, funding, or priority.

Amongst those respondents who felt that prevention work was done 'somewhat' or 'very' well, some reflected the views described above, while others suggested that there may be too little focus on work with parents, due to the focus being more on the children; however, others felt that help for the children is lacking due to focus on working with the adults.

Some respondents noted strong efforts and good intentions to reintegrate children into their families, but that there remain "*too many gaps in practice*".

> "When it comes to placing children in care, there is not always an effort to work with the family on creating conditions to reunite the child with the family. This is mostly due to social welfare case workers handling too many cases at once, which causes them to move on quickly to the next family because 'the previous child is in the safe place' and no more time can be set aside to work further with that particular child."

Where elements of systems and practices were considered to be working well, this was generally attributed to the efforts and dedication of individual professionals.

> "The system works well given the financial and professional constraints within which it has to operate, mostly as a result of conscientious professionals."

Finally in the questionnaire, respondents were asked to reflect on **What could be done better in your country** *to prevent children from needing alternative care?* Their responses fell in to three broad categories; Changes for birth families, Changes for Professionals and Carers, and broader changes.

The changes needed for birth families included:

- Raise living standards; financial support; address poverty and poor housing
- Parenting support
    - A small number suggested this should be mandatory, either universally or for those at risk/with children removed from their care
- Psychological support
    - Generally
    - Mandatory family therapy for those with children removed
- Improve/increase the number of prevention programmes
- Sanctions for neglectful/abusive parents

Changes for professionals and carers reflected the themes which emerged from several of the previous questions, and focused on:

- Better selection and training of professionals (social workers)
- Increased number of social workers, with better pay and conditions
- Education – embed care professionals in schools; train preschool workers in early recognition of risk; therapeutic groups in schools.
- Improving multidisciplinary working/collaboration- social welfare, legal and justice, education, health

The broader changes suggested by respondents included improved financial support for vulnerable groups including care leavers; family planning support and information; free contraception – for care leavers, those with large families, adolescents; general parenting classes - as routine in school, for adolescents, or for vulnerable groups. One respondent suggested that the broadest change was needed:

> "A functioning economy and a developed civil society"

3.5 Implementation

The topic of implementation was mentioned by respondents in a number of ways in their questionnaire responses, predominantly in relation to implementation of legislation and guidance, and to applying learning from training and development in practice. As part of the questionnaire, professionals and carers were asked to reflect on the implementation gap between what organisations and policies set out to achieve, and what actually happens in practice. This included questions about their experiences of their own organisation, and their perceptions of what happens more broadly.
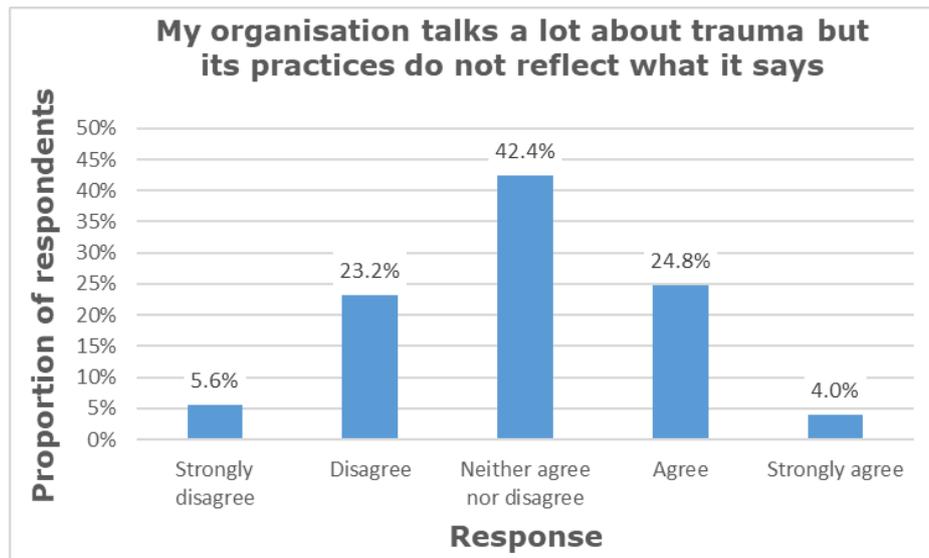
Figure 24: My organisation talks a lot about trauma but its practices do not reflect what it says

As Figure 24 shows, responses to the statement *My organisation talks a lot about trauma but its **practices do not reflect what it says*** were fairly evenly split, with around 29% agreeing or strongly agreeing, and around 29% disagreeing or strongly disagreeing. That over 40% of respondents indicated that they neither agreed nor disagreed with this statement might suggest that the question was too broad or complex to capture respondents' views on implementation within their own organisations.

Respondents were asked *Sometimes, there can be a gap between what an organisation wants to do, and what happens at the front line of service delivery. What would you suggest could **help bridge this implementation gap***?

They suggested the following areas for change:

Communication and collaboration

- Within and between organisation and professionals doing the work; listen to professionals' views on what's needed; more meetings of all employees in organisation; different levels working more effectively together; joint working groups of academics and professionals
- Clearer expectations
- Training/workshops (including jointly with other professionals) and regular follow up

Planning/strategy

- Improvements in this generally
- Involve those in direct work in developing strategy
- Faster and more flexible organisational response to issues and challenges
- Based on needs assessment (individual; community; professional groups)
- Clear goals and continuous evaluation

Legal aspects

- In children's favour
  - *"Giving more rights to children rather than to parents, children's time is wasted while parents are being given new chances."*
- To clarify legislation
- Based on or incorporating professionals' views

Structural

- Decentralisation
- High quality expert team at the heart of the organisation
- More professionals (e.g. psychologists and psychotherapists)
- Better connections between support systems
- Alignment of practices, documents, and regulations
- Groups of co-workers to support each other

Other suggestions included:

- Financial improvements (in the system as a whole; professional remuneration)
- More professional autonomy
- Action research, including people who have experienced trauma, adopters, foster carers, birth families

While many respondents noted that this was a challenging and complex question, most were able to offer some suggestion about how the implementation gap could be bridged. However, a small number felt that this was an unrealisable ambition.

> *"The truth is that this gap is so big, I don't see how it could be bridged. The system requires a fundamental restructuring, a paramount amalgamation of resources, and a change of approach, in order for the children to truly be protected."*

The routine collection, analysis and publication of standardised data can help to identify gaps in implementation, and to monitor the impact of any changes to policies, systems, and practices. As part of the desk review, partners were asked to outline whether there is any **systematic data collection** at a local or national level, and how any such data are used to support and improve systems. Contributors were asked, *what data is collected and published that can help build a picture about trauma, and how experiences of children, young people, birth parents and carers are gathered to contribute to this picture?*

In response to this, partners tended to describe research and individual instances of data collection, rather than routinely collected and published data or official statistics. This type of information gathering was considered the most likely to involve children and families themselves, who otherwise were not generally asked for their views.

A range of different organisations were mentioned, many of which publish their own reports, sometimes at routine intervals, but contributors described these as focusing on numbers of events or instances (for example, of neglect, or of violence) rather than on trauma specifically. Some were nevertheless thought to provide a useful insight into the situation in the country. It was noted that the lack of an agreed and accepted shared definition made it challenging for such information to be routinely collected. Furthermore, public concerns about the misuse of sensitive data, and ensuring compliance with GDPR/data usage laws, were considered in some instances to make the collection of such data challenging. Where there was routine data collection, desk review contributors indicated that it was not often useful for service planning, due to the timing of publication, or information not being routinely published – although some may be available using access to information laws.

4. Conclusions

The questionnaire responses described in this scoping report were given by 89 care experienced young adults and 143 professionals and carers in the six project partner countries (Belgium, Bulgaria, Croatia, Greece, Hungary, and Serbia). While their responses are invaluable in helping us to learn about individual's experiences in each of the partner countries, these were not representative samples of the populations of care experienced young adults, or of professionals and carers, in these countries. For this reason, caution should be used in understanding what this information does and does not tell us. These findings do not necessarily reflect the experiences and opinions of all or most care experienced young adults, or professionals and carers, in each country, and we cannot generalise about the overall experiences or opinions of these groups.

Nevertheless, the views and experiences of the respondents who gave their time and effort to share their opinions via the questionnaire can provide a 'snapshot' of these particular groups at this particular time, and contribute in a meaningful way to the design and content of the training packages which are currently in development. Informing the development of these is the overarching purpose of this scoping work.

The young adult respondents were generally quite positive about their overall experiences of alternative care. Often they reported having a consistent adult throughout their time in care, support to understand and manage their emotions, and encouragement to engage in hobbies and interests. Respondents also tended to report that in their longest care placement, they had a feeling of belonging and acceptance. Many reported having been able to maintain a relationship with members of their birth family (although this was less often the case with birth fathers than with mothers, brothers and sisters), and to have had good friendships during their time in alternative care.

In addition, some important themes emerged from the care experienced young adults' responses to the questions in which they were asked to reflect on how best young people in alternative care can be supported. The most prominent of these was the importance of talking, but with recognition that this needed to be in the context of a trusting and understanding relationship with adults who were able to be their authentic selves and relate to young people respectfully. Some respondents indicated that such experiences had not been available to them during their time in alternative care.

Relatedly, the young adults made a number of key points in relation to the type of people who are best suited to working in alternative care, and their attitudes and approaches to the children in their care. They were clear that adults who blamed or shamed young people for expressing troublesome feelings through their behaviour were not best placed to help young people recover from their trauma. Generally, the young respondents suggested that training could help with this, but that those undertaking the training needed to be genuinely motivated and interested in helping, rather than just in need of paid work.

The professionals and carers reflected on training and learning in a number of ways through their questionnaire responses, and a number of the themes emerging from their comments were reflected in the desk review responses. While in some instances training was thought to be good, it was sometimes difficult to access high quality training, for a range of reasons. There were also concerns around the extent to which learning could be used in practice.

Overall, these respondents reported that there was little in-depth shared understanding of trauma and its impacts in their countries, and that services for children and young people, and for parents, were generally reflective of this. Some respondents highlighted improvements in this which are already underway, but also noted challenges with embedding this sort of understanding, including lack of policy support and resourcing.

As part of their questionnaire, professionals and carers were asked to identify elements of their training which had been most useful to them; and later, whether they felt there had been any gaps. Very similar topics were noted in response to both these questions, and these aligned well with the key topics suggested by the care experienced young adults for inclusion in any future training for professionals and carers. These include the impact of trauma on development, how this can relate to children's behaviour, and therapeutic responses or how to help children and young people recover. Key to this for the young people was the availability of a trusted adult with whom they could develop a good relationship; and for professionals and carers, the resourcing and support to implement good practice. The alignment of these responses suggests a shared understanding around the most important themes emerging from this scoping work.

The development of questions for both questionnaires and for the desk review were undertaken by the team at CELCIS, with the primary aim of gathering the information which would be most useful to inform the development of the training packages and written materials.

The questionnaire questions were discussed and revised amongst the team. These included questions intended for qualitative, as well as quantitative, analysis. The questions seeking free-text responses for qualitative analysis allowed a more descriptive and detailed contribution from respondents than quantitative questions alone. Feedback was then sought from care experienced young adults, particularly on the tone and wording of the questions, and from professionals.

After thorough testing, the questions were provided in English to partners for translation into the relevant languages, and the translations were then uploaded by the CELCIS team to the Qualtrics online survey platform. The translated questionnaires were then tested for accuracy and functionality by partners. The questionnaires were 'live' for two weeks, from 22nd June 2020 until 5th July 2020, and partners in the individual countries were able to invite potential respondents to complete the questionnaires using a hyperlink. A protocol was also developed for paper-based responses but this approach was not used by any partners.

As part of the introductory text, potential respondents were also invited to share the link with others who were eligible to contribute, meaning that there was also an element of 'snowball sampling' in the approach to respondents.

Analysis of the quantitative elements of the questionnaires used MS Excel to determine what proportion of respondents to each question has chosen each response. Qualitative analysis of questionnaire and desk review questions was a high-level thematic analysis through multiple readings and manual coding.

Questions for Care Experienced Young Adults
(Those in italics asked for a written response, all others involved selecting from provided response options.)

Q1 In which country do you live now?

Q2 What age are you now?

Q3 What age were you when you first entered alternative care?

Q4 In total, how long did you live in alternative care?

Q5 During your time in alternative care, how many different places did you live in, apart from your family home?

Q6 How long was your longest care placement?

Q7 How long was your shortest care placement?

Q8 In general, how would you rate your experience of alternative care as a whole?

Q9 Did you have any unrelated adults (e.g. carer, social worker, teacher) who were in your life throughout all your time in alternative care?

Q10 In general, how well do you think the professionals/carers in your life helped you understand and manage emotional issues growing up in alternative care?

Q11 Thinking of the care placement you were at the longest, did you develop a sense of 'belonging' or feeling 'at home' there?

Q12 Again, thinking of your longest care placement, do you feel you were truly known, understood and accepted by your carers?

Q13 Looking back, did your school teachers show a kind and sensitive attitude to you, in relation to your being in alternative care?

Q14 During your time in alternative care, did you have adults (e.g. carers, teachers, social workers) who you could go to when you were worried, scared, anxious, or distressed about something?

Q15 When you were growing up, did your carers encourage you to develop skills, talents, and interests in your local community (for example. sports, music, voluntary work, animal care, drama group, etc.)?

Q16. When you were in alternative care, what did you do to reduce feelings of worry, fear, anxiety, or stress?

Q17. We know that sometimes children do not fully understand why they are in alternative care. What could professionals and carers do to help children understand why they had to come in to alternative care?

Q18. What could professionals and carers do to help a child feel loved and accepted in their care placement?

Q19. What could carers/professionals do to help, when children feel worried, scared, anxious, or distressed about something?

Q20. We know that children can sometimes behave in ways that adults struggle to understand (for example, a child might appear to others as if they are angry, but inside they are confused and hurt). What could help adults better understand and respond to the distress behind a child's behaviour?

Q21. What might help children to stay in their care placements when something goes wrong, and prevent placements ending in an unplanned way?

Q22 During your time in alternative care, which of the following best describes your contact with your birth mother?

Q23 During your time in alternative care, which of the following best describes your contact with your birth father?

Q24 During your time in alternative care, which of the following best describes your contact with you brother(s) and sister(s)?

Q25 During your time in alternative care, did you have good friends you felt you could rely on?

Q26 Which of these best describes your friendships while in alternative care?

Q27 Are you still good friends with any of the people who were your friends when you lived in alternative care?

Q28. Sometimes when children come in to care, their relationships with birth parents and/or brothers and sisters are difficult. What could professionals and carers do to help children and their families repair and improve these relationships?

Q29. What could professionals do to help keep families together, and so prevent children from needing alternative care?

Q30. And finally, some advice for us... We are going to produce development and training materials for staff at all levels of an organisation, to help them improve their responses to childhood trauma. What do you think are the most important things we should include?

Questions for Professionals and Carers

(Those in italics asked for a written response, all others involved selecting from provided response options.)

Q1. In which country do you work?

Q2. Which of the following best describes your current role?

Q3. Which of the following best describes the sector or organisation in which you currently work?

Q4. Have you gained a certificated professional qualification in a subject that supports your work with children and families? (Q5-7 only asked of those responding 'yes'.)

Q5. Overall, how well do you think your professional training prepared you to respond to the effects of trauma that you see in your practice?

Q6. In your professional training, how much teaching did you receive on the following topics?

- Understanding childhood trauma
- How a child's mind develops
- The impact of trauma on all aspects of a child's development
- The impact of trauma on parental functioning
- How working with trauma can affect professionals

Q7. What 3 things from your professional training have been most useful for your current practice?

Q8. How often have the organisation(s) you have worked for offered formal opportunities to learn about the following?

- Understanding childhood trauma
- How a child's mind develops
- The impact of trauma on all aspects of a child's development
- The impact of trauma on parental functioning
- Self care when working with trauma

Q9. How would you rate your knowledge of the following?

- Childhood trauma
- The effects of childhood trauma on child development
- The role that adults play in co-regulating a child's emotions
- How to build trust with children who have experienced trauma

Q10. How would you rate your knowledge of the following?

- Helping children understand their personal history and care journey
- Children's behaviour as communication
- How policy, legislation and children's rights impact on supporting children affected by trauma
- How different professions can work effectively together

Q11. How would you rate your knowledge of the following?

- How organisational policy and planning can improve trauma practice
- Children's participation in the healing process
- How adults help children build resilience

Q12. Please provide three examples of topics / skills which have not been included or covered well in the learning and development you have undertaken?

Q13. Which of the following best reflects your experience in your current job?

- My organisation offers professional supervision
- My organisation offers on-the-job coaching to help improve my practice
- My organisation offers opportunities to reflect with colleagues on our team / organisational practice
- My organisation asks me to contribute to new policy / guidance relating to children's care

Q14. Sometimes, there can be a gap between what an organisation wants to do, and what happens at the front line of service delivery. What would you suggest could help bridge this implementation gap?

Q15. Please indicate how much you agree or disagree with the following statements about your current job and workplace

- I feel supported and cared for by my organisation, to carry out the job I am doing
- My organisation has a good understanding of the impact of childhood trauma
- My organisation talks a lot about trauma but its practices do not reflect what it says
- Childhood trauma is not very well understood in my organisation

Q16. In general, how well do your country's child-care systems and practices reflect an understanding of trauma on children in alternative care?

Q17 Please explain your answer to the above question.

Q18. In general, how well do the systems and practices in your country reflect an understanding of how adults' unresolved trauma can affect their functioning as parents?

Q19 Please explain your answer to the above question.

Q20. In general, how well do you think your child care systems and practices are able to respond consistently to the emotional and mental health needs of children in alternative care?

Q21. In your experience, how often do the following professionals work directly or indirectly with children in alternative care?

- Child / youth psychologists
- Psychotherapists
- Child psychiatrists
- Play therapists

Q22. In general, how well prepared and supported are the people who offer direct alternative care to children (e.g. foster carers, residential staff, house parents, etc.) to carry out their role?

Q23. What three things are done well in your country to prepare and support alternative carers?

Q24. What three things could be done better in your country to prepare and support alternative carers?

Q25. In general, how well would you rate your country's systems and practices in relation to working with birth families and preventing children from needing alternative care?

Q26. Please explain your answer to the above question.

Q27. What could be done better in your country to prevent children from needing alternative care?

Desk review questions

1. Understanding of trauma
1.1 Within child protection and alternative care systems, how is 'trauma' understood? Is there a consensus in this understanding across professional disciplines?
1.2 Is there an understanding among professionals in your country that the way in which trauma manifests in children is different from the way in which it manifests in adults?
1.3 To what degree is the impact of trauma on children in alternative care discussed / evident in child-care planning / policy / decision-making etc.?
1.4 To what degree is the impact of trauma on parental functioning discussed / evident in child-care planning / policy / decision-making etc.?

2. Professional learning & development
2.1 To what extent is childhood trauma covered in university professional education?
2.2 To what extent is childhood trauma covered in organisational continuing professional development (CPD)?

3. Service responses to trauma
3.1 How is 'trauma' understood and responded to by your country's mental health services for children and families?

3.2   Who are the main staff members who work directly with children and families affected by childhood trauma?

3.3   Are there sufficient dedicated capacities for traumatised children and families in all of the organisations, how can they work with them?

4. Data collection

4.1   What kind of routine data is collected in your country that could build a picture about the prevalence and impact of childhood trauma? For example, national child abuse and neglect statistics, existing research regarding prevalence of childhood trauma or adverse childhood experiences, etc.

4.2   Of the data that is collected, what is published, and what is accessible?

4.3   How are the experiences of children / young people / birth parents / carers gathered to contribute to this picture?

5. How well systems work together

5.1   How well do the various professional groupings and child-care systems work together around the issue of childhood trauma? For example, is there a multidisciplinary approach, and if so, how does it work? If not, are there professionals groups that routinely work together?

Appendix 2: Respondent Numbers - questionnaires

The number of responses received from each country to both questionnaires was high. However, this was not intended to be a representative survey, and some responses may have come via 'snowball sampling' (i.e. respondents sharing the link with others). It is not therefore possible to say what proportion of the relevant populations (i.e. the population of care experienced young adults, or of professionals and carers, in each country) responded to the questionnaires.

The number of usable responses[4] received from each country for the questionnaires was:

Table 1: Number of usable responses from each country

	Care Experienced Young Adults	Professionals and Carers	TOTAL
Belgium	8	9	17
Bulgaria	13	36	49
Croatia	15	19	34
Greece	24	19	43
Hungary	12	46	61
Serbia	16	14	30
TOTAL	**89**	**143**	**234**

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[4] Number of respondents who answered basic demographic/screening questions and at least one other question.

The desk review questions were sent to partners in the six participating countries, who were asked to provide an overview of the situation in their own country. They were invited to use any sources that they chose, in order to answer the questions, including personal knowledge, informal interviews of discussions with relevant individuals, and research or other publications.

An indication of the sources used in each country is given below:

Belgium

- Websites and research reports
- interviews with 10 stakeholders in a range of roles, including participants:
    - working in SOS Children's villages
    - in both Flanders and Wallonia regions
    - Directors of relevant services
    - Professionals including psychologist, psychiatrist, lawyer

Bulgaria

- Interviews with:
    - professionals working directly with children in youth facilities and/or with experience of working in child protection/social assistance
    - Programme director in a NGO
    - Foster parents

Croatia

- Interviews with:
    - professors and assistant professors
    - heads of pedagogical and mobile teams (psychologists)
    - psychologists and social pedagogues working in education and health with children who experienced trauma
- Review of studies, reports and legislation

Hungary
- Interviews with 21 stakeholders, including professionals working in different fields of services and education for children and families, including some relevant public services, NGOs, charities, universities.

Greece

- Self-completed responses from mental health professionals (Child Psychiatrists, Psychologists, Social Workers, etc.) working in social services in Municipalities, child care sectors, hospitals, psychosocial support services etc., in both public and private child protection sector.

Serbia

- interviews with professionals from social care system and from health system, from a range of different institutions and positions