What Works for Children's Social Care

How can we best support children and young people who have experienced trauma?

Thursday 22 October 2020

Aoife O’Higgins

Director of Research

Housekeeping

- We’re recording the webinar
- We have an hour and a half
- We’ll have time for questions at the end
- Please type your questions into the chat box
- We’ll do our best to get to as many as possible, and may group similar questions
- If your question is for a particular panellist, please include this!

Speakers

- **Kirsten Asmussen**, Head of What Works Child Development, Early Intervention Foundation

- **Dr. Mina Fazel**, Associate Professor in Child and Adolescent Psychiatry, University of Oxford; and Consultant in Child and Adolescent Psychiatry, Children's Hospital, Oxford University Hospitals

What Works *for* Children's Social Care

About WWCSC

IMPROVING EVIDENCE FOR BETTER OUTCOMES

How?

- Pulling together what we already know
- Supporting the good work that is already happening
- Commissioning new research
- Giving practitioners, young people and families a platform to share their experience
- Improving the accessibility and relevance of the evidence

Why?

To ensure the best possible outcomes for children, young people and families

Kirsten Asmussen

Head of What Works Child Development, Early Intervention Foundation

EARLY INTERVENTION FOUNDATION

What we do and do not know about ACEs and what should happen next

Dr. Kirsten Asmussen

The Early Intervention Foundation

22 October 2020

Aims of the presentation

- **Describe the work of the Early Intervention Foundation**
- **Summarise the findings from our recent review of Adverse Childhood Experiences**
- **Tell you about our current project mapping the use of trauma-informed care in UK children's social care practice**

Who we are


What Works Network
Education Endowment Foundation
NICE National Institute for Health and Care Excellence
What Works Crime Reduction
CENTRE FOR AGEING BETTER
what works wellbeing
EARLY INTERVENTION FOUNDATION
Public Policy Institute for Wales
Sefydliad Polisi Cyhoeddus i Gymru
what works centre for local economic growth
What Works Scotland
Supporting effective public services in Scotland

What we do

- **Our vision** is that all children are able to achieve their full potential
- **Our mission** is to ensure that effective early intervention is available and is used to improve the lives of children and young people at risk of poor outcomes.
- **By early intervention we mean** identifying and providing effective early support to children and young people who are at risk of poor outcomes.
- **We define effective as** showing evidence of improving outcomes for children and young people.

Principle #1: Do not harm

Primum non nocre
(first, do no harm)

This means ensuring that the interventions that we offer are not harmful

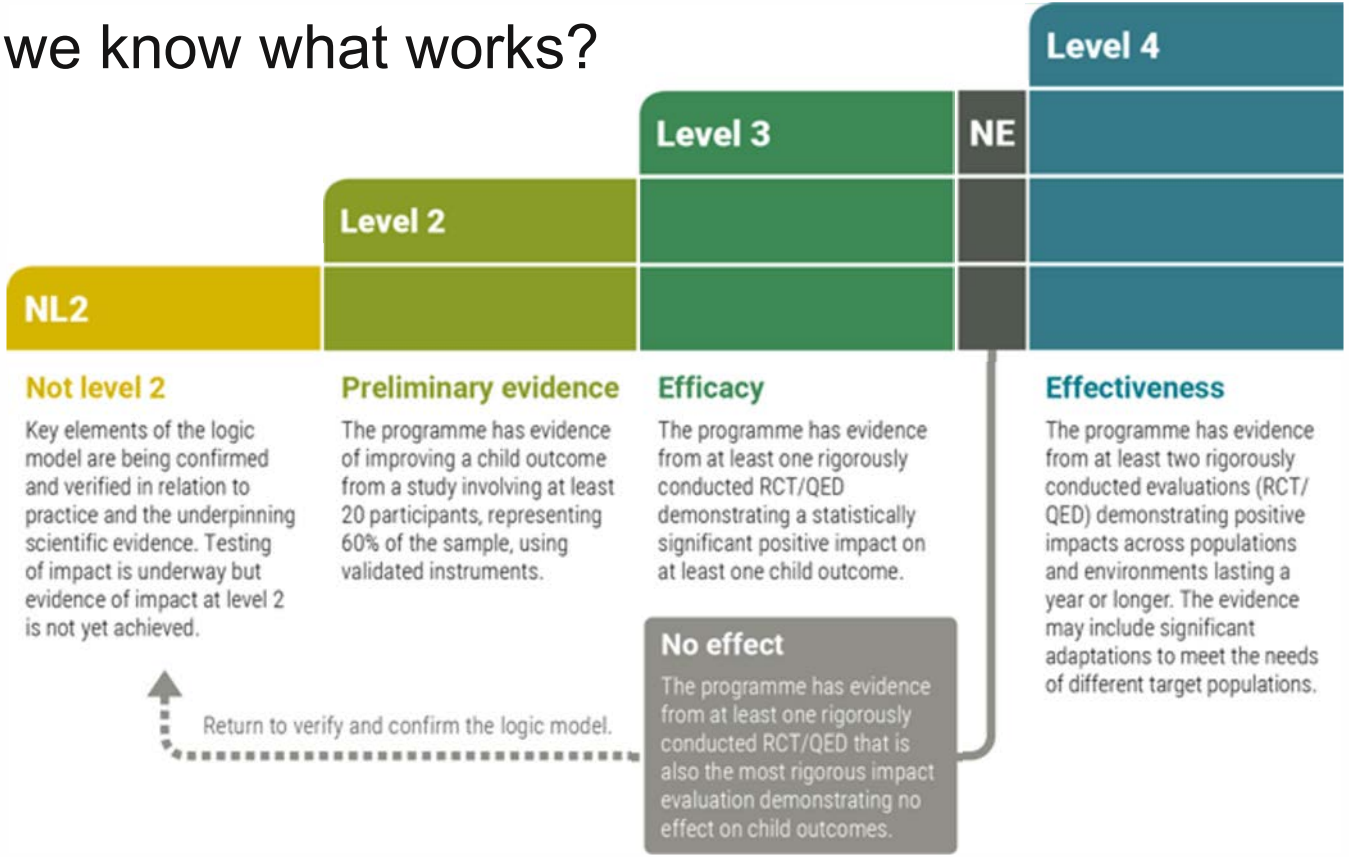
This also means that we reduce the extent to which ineffective interventions deny or restrict access to effective interventions

Principle #2: Do not waste

Since resources will always be limited, we should provide services which have been shown through proper evaluation to be effective

-- Archibald Cochrane

How do we know what works?



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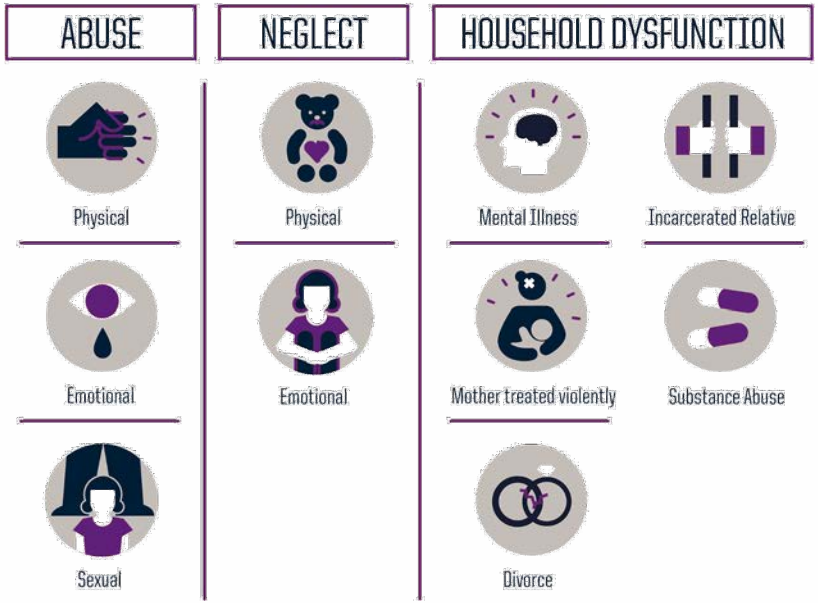
Adverse childhood experiences

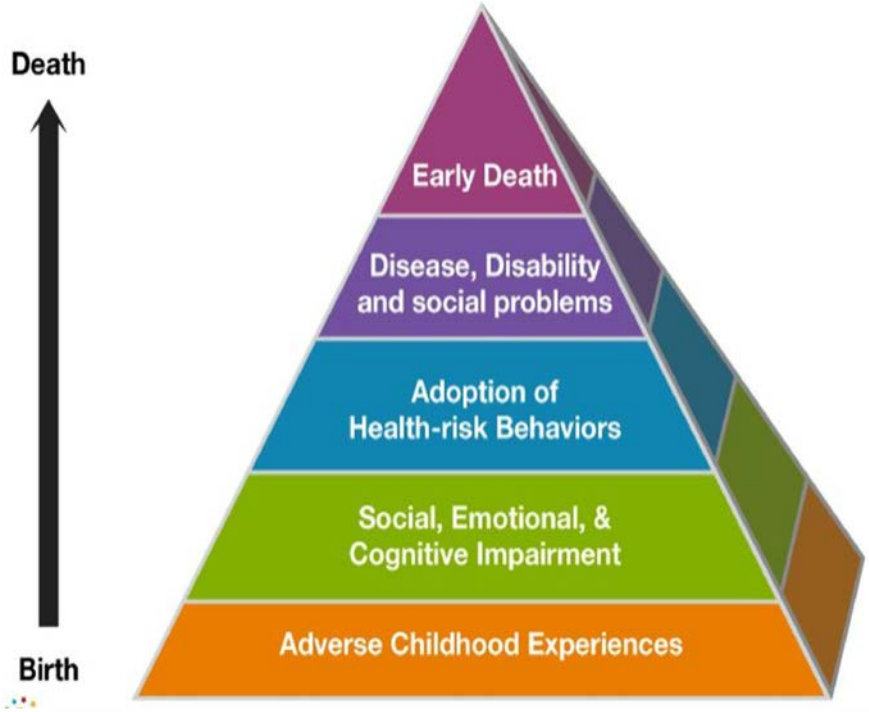
What are Adverse Childhood Experiences?

Adverse Childhood Experiences (ACEs) are traditionally defined as ten categories of child maltreatment and family dysfunction that have been shown through research to be associated with an increased risk of poor adult outcomes.



Background

A landmark CDC-Kaiser Permanente study conducted in the 90's observed that 4+ ACEs increased the likelihood of a wide variety of life limiting physical and mental health problems in adulthood.

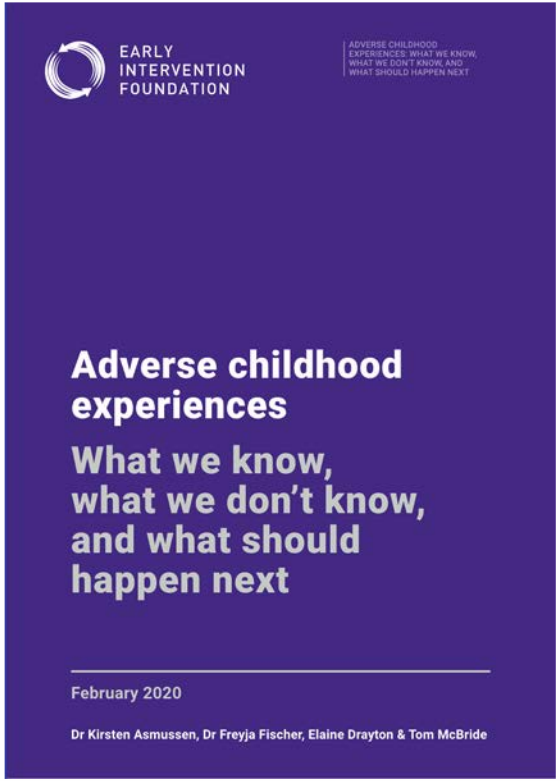


Background

- In 2017, EIF was asked to submit evidence to the UK parliament's Science and Technology Committee's enquiry into the evidence base underpinning ACEs
- The enquiry took evidence from a wide variety of organisations and individuals
- There was a general consensus that ACEs were associated with negative adult outcomes and that ACEs research has usefully increased awareness of this relationship
- There was nevertheless criticism of the research and skepticism regarding many claims
- Some questioned whether the ACEs research methodology was sufficient to support many of the claims
- Some practice audience felt that the current narrative is too deterministic and potentially harmful to children

Aims of the review

- To help our stakeholders become more informed consumers of the ACE evidence base.
- To align what we know about ACEs with what is known about child maltreatment and children's development from the scientific literature more broadly.
- To understand the existing evidence base for many ACE-related practices, including routine enquiry and trauma-informed care.



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What we do and do not know about the prevalence of ACEs and their co-occurring risks

What do we know about the prevalence of ACEs?

We know that ACES are prevalent

But we do not know *how* prevalent

And we know relatively little about their association with other childhood adversities

How robust are the methodologies used to investigate ACEs?

Understanding the frequency of child maltreatment and family dysfunction may well be the most difficult task in social science research – David Finkelhor

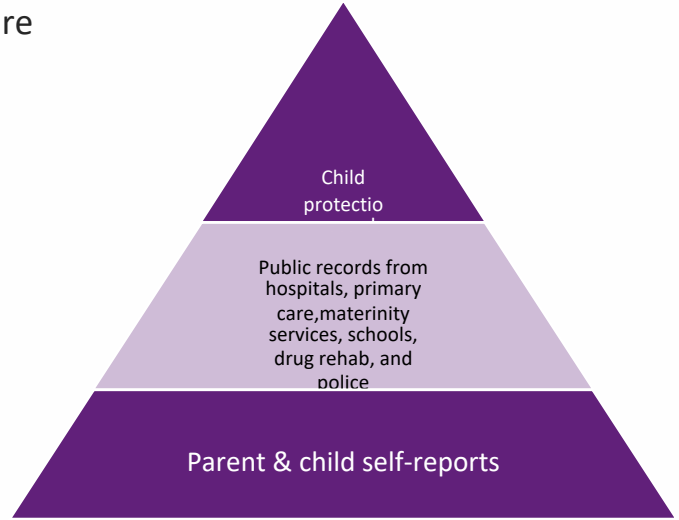
Data collection is fraught with recruitment challenges which reduced representativeness; ethical issues also interfere with disclosure

Prevalence studies

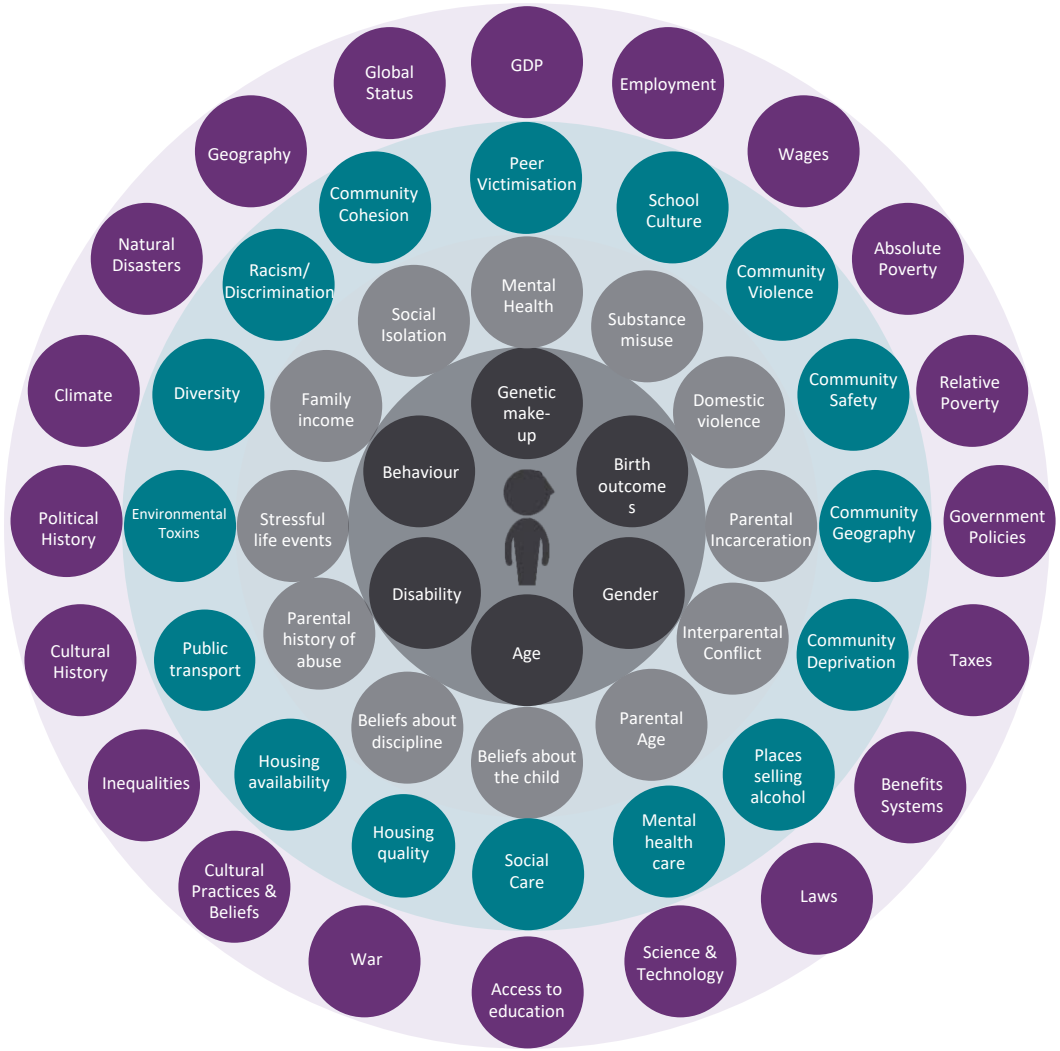
- Conducted retrospectively with adults to avoid challenges with disclosure
- Studies show that some adults forget; others remember
- Recall is highly associated with adults current circumstances
- Adults experiencing poor mental/physical health may over-report ACEs
- Difficult to track differences in prevalence over time

Incidence studies

- Primarily involve service records and findings from panel surveys
- Service records demonstrate 'tip of the iceberg' and local reporting methods
- Panels surveys are brief, participants may not be representative & not disclose
- Potentially useful for tracking differences in service reporting over time



The traditional ACE categories are highly correlated with each other and a wide variety of other childhood adversities, including poverty, community violence and racial prejudice.



Implications for policy, practice and research

- Inaccurate or imprecise knowledge about prevalence makes it very difficult to plan an appropriate service response
- And exclusive focus on the ten original ACE categories risks missing other children who may need help
- Much of the current ACE research is insufficient to understand the potential causal relationship between ACEs and adult outcomes.

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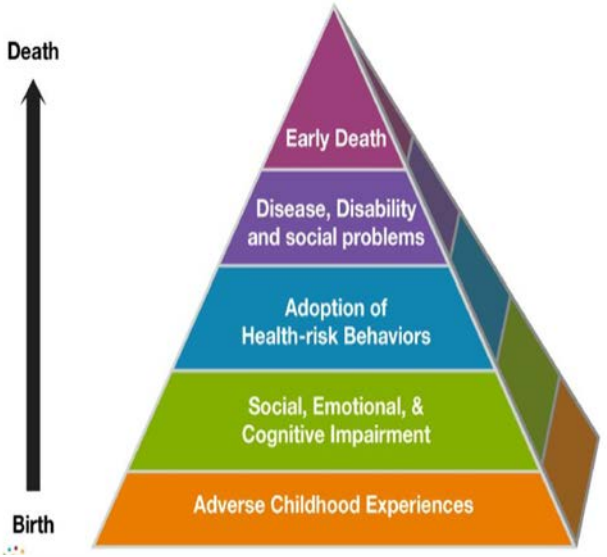
What we do and do not know about the impact of ACEs on adult outcomes

How strong is the relationship between ACEs and adult outcomes?

4+ ACEs in comparison to no ACEs (Hughes et al., 2017)

- Doubles the risk of obesity, physical inactivity and diabetes
- Triple the risk of smoking, cancer, heart disease or respiratory disease
- Quadruple the risk of sexual risk taking, mental health problems and problematic alcohol use
- Increase the risk of problematic drug use and interpersonal and self-directed violence by seven.
- Increases the risk of intravenous drug use by ten times
- Increases the risk of suicide by 20 times



How strong is the relationship between ACEs and adult outcomes?

Relative risk is not the same as absolute risk!

Original ACE study:

n = 8,002

0 ACEs = .3% of 3855 or 11.56 people

4+ ACES = 3.4% of 540 or 18.36 people

How strong is the relationship between ACEs and adult outcomes?

Odds ratios do not hold up in all prospective studies

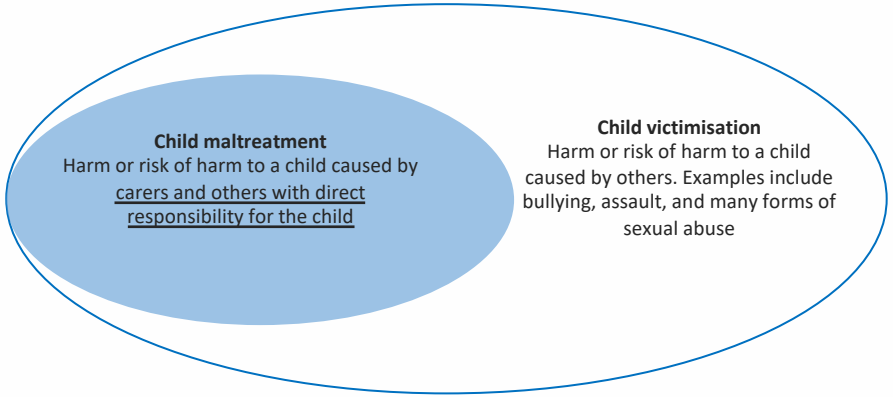
	ORs Prospective†	ORs Retrospective†
Physical Health		
Heart attack, stroke, any cancer, diabetes, obesity, and self-reported health		No association to 3.9
Obesity and self-reported health	No association to 2.2	
Health Risk Behaviour		
Drug abuse	3	7.1 to 10.9
Alcohol abuse and smoking	1.4 to 2.3	2.1 to 7.4
Sexual risk behaviours (STI, unintentional pregnancy)		2.5 to 30.6
Depression, general mental health	2.2 to 2.5	3.5 to 4.6
Suicidality		6.6

† Odds ratio for 4+ ACEs relative to none

How strong is the relationship between ACEs and adult outcomes?

The ACE child maltreatment categories compromise one domain of child victimisation embedded in a broader domain.

Other forms of child victimisation, including child bullying and racial prejudice, are also highly prevalent and associated with poor adult outcomes.



How strong is the relationship between ACEs and adult outcomes?

Additional childhood adversities also associated with poor adult outcomes

1. Physical abuse
2. Sexual abuse
3. Psychological/emotional abuse
4. Physical neglect
5. Emotional neglect
6. Witnessing of domestic violence
7. Family member with a substance misuse problem
8. Family member with a mental health problem
9. Parental separation
10. Family member who has been incarcerated

1. Low birthweight
2. Childhood disability
3. Low family income
4. Parental history of ACEs
5. Adolescent parenthood
6. Peer victimisation (bullying)
7. Exposure to community violence
8. Neighbourhood deprivation
9. Housing insecurity
10. Other sources of trauma, including natural disasters

How strong is the relationship between ACEs and adult outcomes?

The relationship between ACEs and poor mental health outcomes is strong

The relationship between ACEs and physical health outcomes is ***unknown***, and may be better explained by other co-occurring adversities, such as poverty

Knowledge about population risks is ***insufficient*** for determining or diagnosing individual risk

Implications for policy, practice and research

- Strategies aimed at preventing and reducing the traditional ACEs will have the strongest impact on mental health outcomes
- Populations estimates of relative risk are inappropriate for predicting risk or diagnosing problems for individual children or adults

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What we do and do not know about the biological and social processes linking ACEs to poor adult outcomes

What processes explain the link between ACEs and poor adult outcomes?

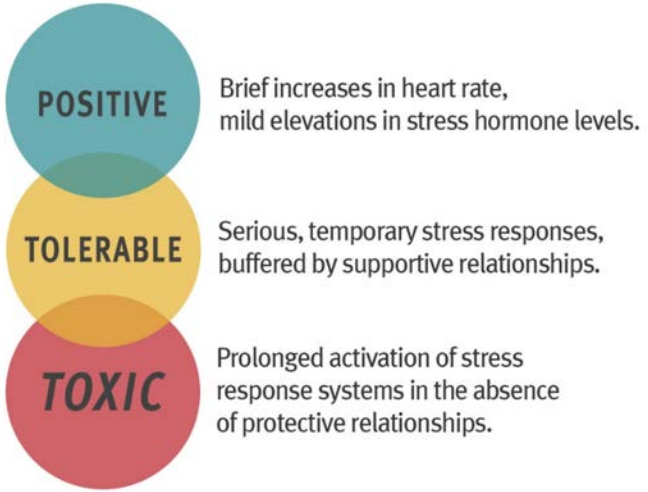
We know a great deal about the social processes linking ACEs to poor adult outcomes

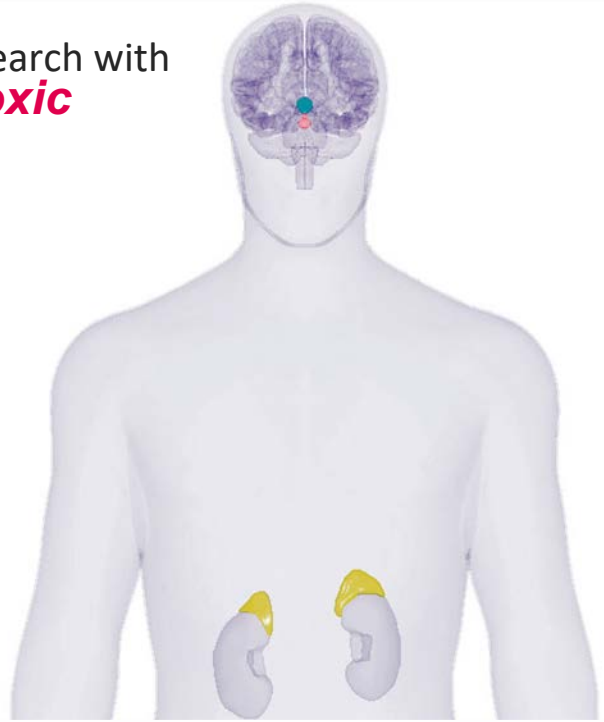
We ***know little*** about the biological mechanisms linking ACEs to poor adult outcomes

We ***know little*** about the role of resilience for mitigating the effects of ACEs

What processes explain the link between ACEs and poor adult outcomes?

Cortisol helps the body respond fight or flight situations. Research with adults shows that a build-up of cortisol, also referred to as ***toxic stress*** is associated with poor health outcomes.





What processes explain the link between ACEs and poor adult outcomes?

- Studies with animals suggest that environmental stress has the potential to trigger changes in ***epigenetic modulation*** that influence the ways in which important genes are ultimately expressed.
- Studies involving rats observe that certain nurturing parenting behaviours trigger an increase in their pups' production of serotonin– a neurotransmitter implicated in feelings of calm and wellbeing , as well as resilience to stress.
- Higher levels of serotonin are believed to initiate a sequence of neurobiological events which permanently alter the genetic code responsible for regulating the pups' stress response.

Robust studies with humans have failed to replicate these findings!

What processes explain the link between ACEs and poor adult outcomes?

Evidence of the intergenerational transmission of ACEs and other negative childhood experiences is not new

- There is strong and consistent evidence showing that aggression and health harming behaviours is learned through the *observation* of caregivers and peers.
- There is also strong and consistent evidence showing that dysfunctional behaviours can be unlearned through effective interventions

What processes explain the link between ACEs and poor adult outcomes?

Polyvictimisation

- Studies consistently show that children who are victimised at home are at increased risk of victimisation outside of the home
- Boys who have been victimised are more likely to be perpetrators
- Girls who have been victimised are at increased susceptibility of further victimisation in future romantic relationships
- These are social processes, with studies showing that schools and communities create opportunities for polyvictimsation to occur

What processes explain the link between ACEs and poor adult outcomes?

The term ***resilience*** is applied to children who *have developed positively despite exposure to significant threat, severe adversity, or trauma that typically constitute major assaults on the processes underlying biological and psychological development*

Researchers observe that evidence of resilience points to the existence of self-righting tendencies in human development which work to protect children who must cope with extreme adversities

What processes explain the link between ACEs and poor adult outcomes?

- We also know that ***health harming*** behaviours lead to poor adult outcomes
- There is evidence that both neurobiological and social processes contribute to this
- Social processes are amenable to intervention

Implications for policy, practice and research

- Knowledge of the biological mechanisms linking ACEs to poor adult outcomes is useful, but currently insufficient for understanding when and how to intervene
- Knowledge about the social mechanisms contributing to ACEs should be maximised to design and implement effective interventions
- Interventions with evidence of stopping the intergenerational transmission of aggressive and health harming behaviours should be implemented more widely
- Interventions that specifically target vulnerable children and teach them resilient coping skills should be developed and tested.

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What we do and do not know about the effectiveness of practices and interventions for preventing and reducing ACEs.

What we know about the effectiveness of interventions for preventing and reducing ACEs

An increasing number of interventions now have evidence of preventing or reducing the social processes contributing to the perpetration of ACEs

We currently know little about the effectiveness of routine enquiry and other ACE screening practices for identifying ACE-related trauma and referring children and adults to effective services

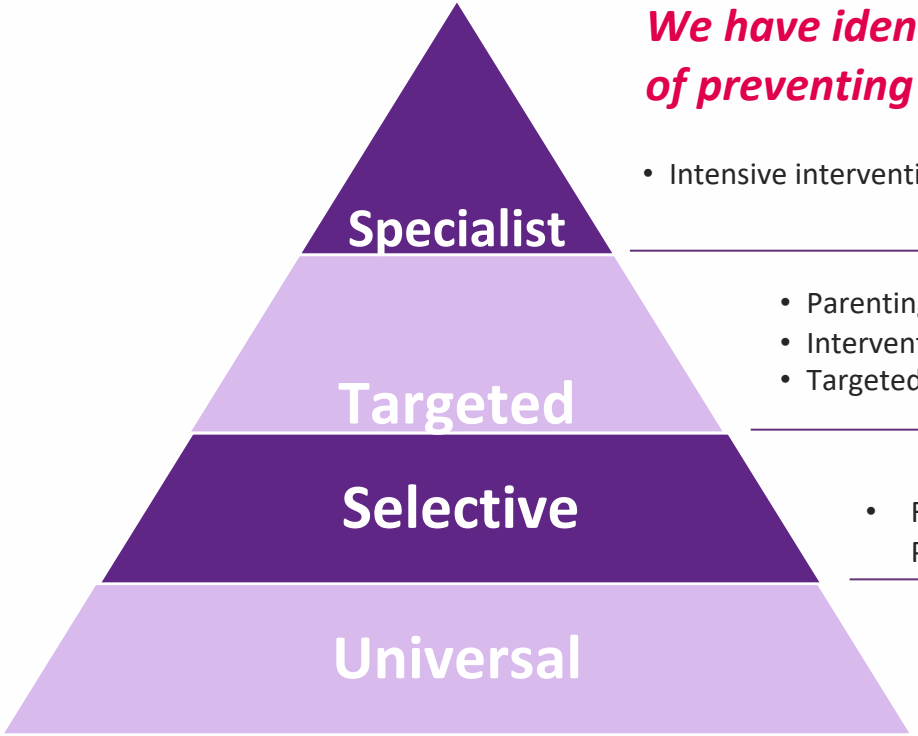
The definition of trauma-informed care is variable across services and many of its intended outcomes remain untested

An increasing number of interventions with evidence of preventing or reducing the social processes associated with ACEs are available

What we know about the effectiveness of interventions for preventing and reducing ACEs

Serious concerns have been raised about the ethicality of screening in the absence of a clear referral pathway to evidence-based treatment

What we know about the effectiveness of interventions for preventing and reducing ACEs



We have identified 33 interventions with robust evidence of preventing or reducing ACEs

- Intensive interventions for children at the edge of care

- Parenting interventions
- Interventions for separating parents
- Targeted therapies

- Family Nurse Partnership

- Perinatal mental health screening
- Intimate Partner Violence screening during pregnancy
- Co-parenting support
- School-based social and emotional learning interventions

We also believe that policies and initiatives are necessary to address the wider determinants of health, which also contribute to poor child and adult outcomes

Implications for policy, practice and research

- The use of routine enquiry should be critically examined, in light of current concerns about the lack of evidence and specificity of the methodology.
- Trauma-informed care may provide some practice advantages, but these must be clearly specified an evaluated.
- Current responses to ACEs should include increased access to evidence-based interventions
- These activities will not have a lasting or sustainable impact unless embedded within system-wide approach which also considers adversities in addition to the original ACEs, as well as structural issues contributing to the ‘causes of causes’

Final thoughts

- Child maltreatment and related adversities are wrong, full stop
- ACEs research has done much to raise awareness of this issues
- The ACEs agenda could go farther in making interventions with known evidence of preventing and reducing ACEs more widely available

Next steps include:

- Deepening our understanding of ACEs, in terms of their prevalence, co-occurring risks risk and association with poor adult outcomes
- Deepening our knowledge of the biological mechanisms linking ACEs to poor adult outcomes
- Increasing the availability of interventions with evidence of addressing the social mechanisms of associated with ACE
- Not forgetting the wider determinants of health (i.e. the causes of causes) and addressing these as well.

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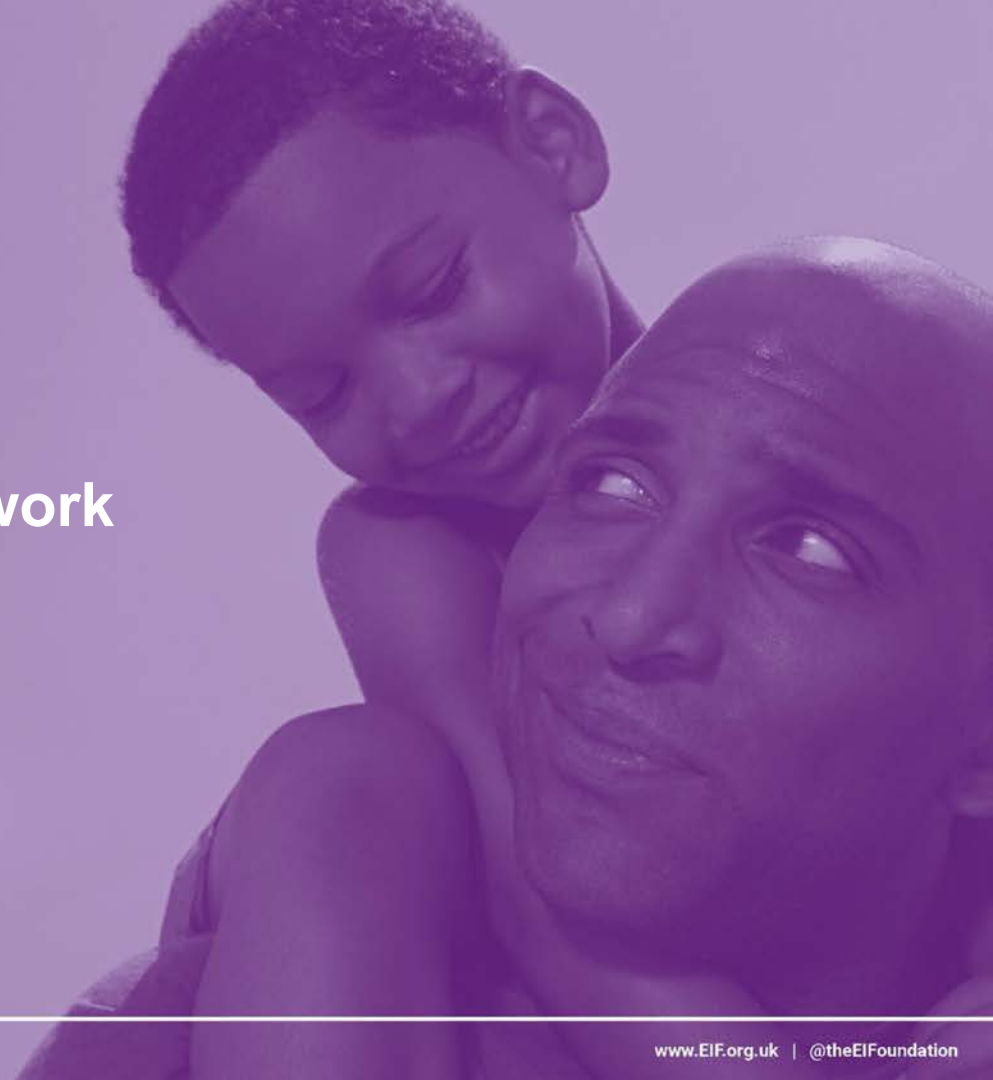
Mapping the use of trauma-informed care in UK social work practice



What is trauma-informed care?

- Is often viewed as an ethos aimed at decreasing clients' experience of trauma and increasing their choice
- A diverse range of definitions have been used to describe trauma-informed care
- Trauma-informed care also encompasses a wide range of practices and interventions – some of which are supported by robust evidence and other less so.

TABLE 6.3

Primary aims of trauma-informed care

Workforce development	Trauma-focused services	Organisational change
Training of all staff on the impact of abuse or trauma	Screening/assessment to identify trauma history and symptoms	Collaboration, coordination and information sharing (internal and external)
Measuring staff knowledge/ practice	Child's trauma history included in case record/plan	Procedures to reduce risk for client retraumatisation
Strategies/procedures to address/reduce traumatic stress among staff	Availability of evidence-based trauma-focused practices	Promotion of consumer engagement
Knowledge/skills in accessing evidence-based services		Provision of strengths-based services
		Safe physical environment
		Written policies that include/ support TIC principles

Source: Hanson & Lange, 2016

TABLE 6.2

The three E's and the four R's of trauma

The three E's of trauma
Events: Circumstances and events may include the actual or extreme threat of physical or psychological harm (for example, natural disasters or violence) or severe, life-threatening neglect that imperils healthy development. These events and circumstances may occur as a single event or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as 'trauma and stressor-related disorders' to include exposure to a traumatic or stressful event as a diagnostic criterion.
Experience: An individual's experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic.
Effects: The long-lasting adverse effects of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. In some situations, the individual may not recognise the connection between the traumatic events and the effects.

The four R's of a trauma-informed approach
Realisation: In a trauma-informed approach, all people at all levels of the organisation or system have a basic realisation about trauma and understand how trauma can affect families, groups, organisations and communities as well as individuals. People's experience and behaviour are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past, are currently manifesting, or are related to the emotional distress that results in hearing about the first-hand experiences of another.
Recognition: People in the organisation or system are able to recognise the signs of trauma. These signs may be gender, age or setting-specific and may be manifested by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance and supervision practices.
Resist the retraumatisation: A trauma-informed approach seeks to resist the retraumatisation of clients as well as staff. Organisations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the wellbeing of staff and the fulfilment of the organisational mission. Staff who work within a trauma-informed environment are taught to recognise how organisational practices may trigger painful memories and retraumatise clients with trauma histories.

Source: SAMSHA, 2014

TABLE 6.1

Principles underpinning trauma-informed approaches

1.	Seeing through a trauma-informed lens, meaning that there is an understanding and acknowledgment of the links between trauma and mental health.
2.	Adopting a broad definition of trauma extending beyond PTSD, including recognising social trauma and the intersectionality of multiple traumas.
3.	Making trauma enquiries sensitively and with knowledge about how to respond.
4.	Referring people to evidence-based, trauma-specific support, where indicated.
5.	Addressing vicarious trauma and retraumatisation.
6.	Prioritising trustworthiness and transparency in communications, such as limiting the professionals a person is required to repeat their traumatic history to.
7.	Moving towards collaborative relationships and away from helper–helpee roles, based on trust, collaboration, respect and hope.
8.	Adopting strengths-based approaches that reframe symptoms as coping adaptations, such as dissociation as an adaptive strategy to escape unbearable experiences.
9.	Prioritising emotional and physical safety for service users and providers.
10.	Working in partnership with trauma survivors, for example to design, deliver and evaluate services.

Source: Sweeney & Taggert (2018)

Trauma-informed care

- Begins with practitioner training involving the ACE narrative — especially the impact of toxic stress
- Practitioners are encouraged to start conversations with clients by asking ‘what happened to them’ not ‘what is wrong with you’
- Is adopted in a wide range of service settings
- Has not yet been rigorously tested
- Does not always involve methods for preventing ACEs or treating symptoms of trauma
- There is some preliminary evidence (Level 2) suggesting it could provide some benefits for adults and children.

Trauma-informed care mapping

1. The prevalence of TIC training in current social work practice
2. The nature of this training in terms of its content and related activities
3. The extent to which new practice models and service redesigns occur as a result of this training
4. The support children's social care services receive from providers in implementing TIC practices
5. The interface between training, accreditation and previous practitioner qualifications and experience in implementing TIC activities
6. The time and money social work teams spend on TIC training, consultation and service redesign
7. The perceived value of TIC training and practice models from the perspective of practitioners, children and families
8. Mapping the common features of TIC practice models currently used in children's social care services
9. The identification o f promising practice models suitable for more rigorous evaluation, in the form of a feasibility study or comparison group trial.

Trauma-informed care mapping

- Questionnaire with social work practice leads from all local authorities
- Up to 30 depth interviews with leads identified through the questionnaire as offering a comprehensive package of support

Findings from our scoping work

- A wide range of activities exist, ranging from two hour online training sessions involving a small number of staff to week long training for an entire team, leading to a complete service redesign

- Training is offered by a diverse range of organisations, clinical teams and individuals from highly varied backgrounds

- In some cases, it appears that the term trauma-informed care has been applied to practices that existed prior to trauma informed training, particularly when it comes to supervision and the integration of evidence based services.

High levels of staff turnover and stress

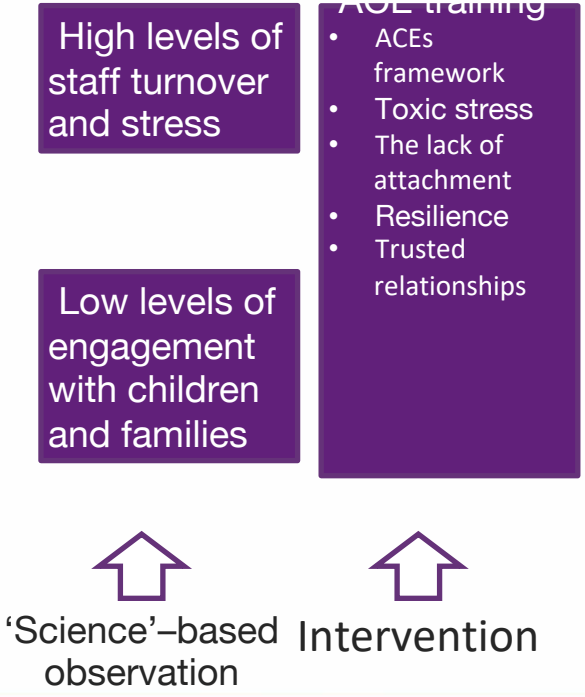
High levels of trauma experienced amongst the children they work with.

‘Science’–based observation

The language that they were using was . . . Yeah, yeah, this is really tough. And often, I dunno, what why I'm doing this work. or, even worse, I'm stressed, I want to get out, I don't like this work, I want to . . . I want to do a different job.

The young people who come into the service present with, you know, very high levels of developmental trauma, here are huge around I says numbers of, of childhood adverse experiences.

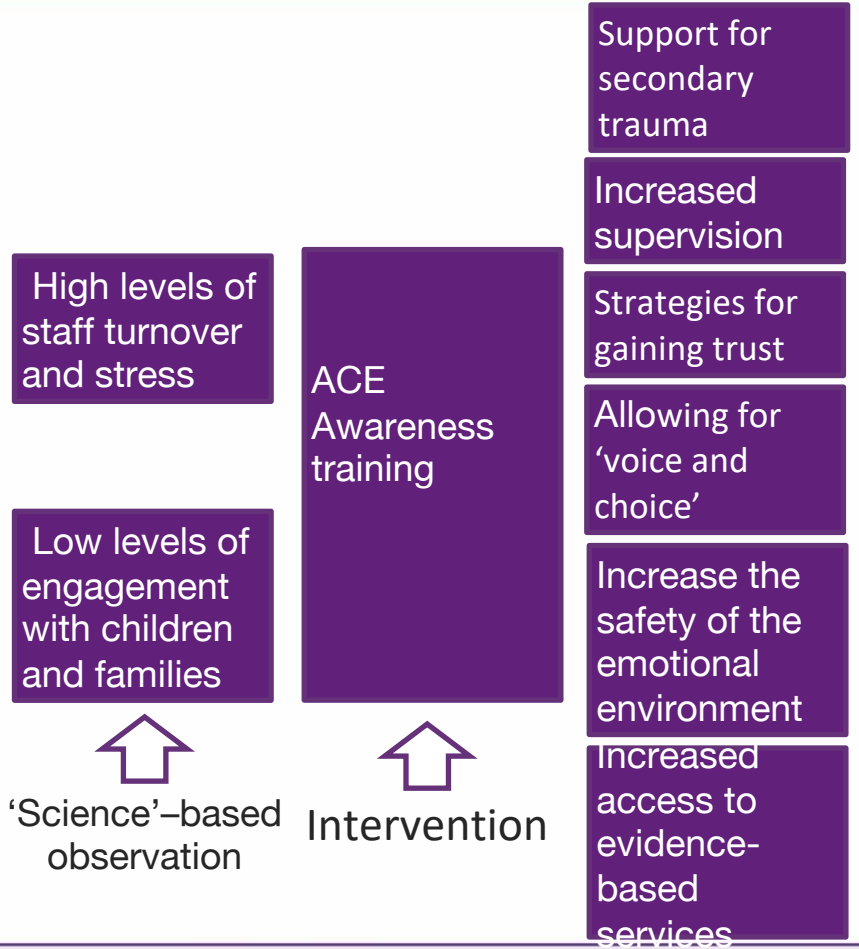
So we're talking about . . . A staff team that are now working with a very complex, high levels of risk and safeguarding group of young people and families, . . . they didn't really feel that the services they were in, were responding to the victimisation of the children, or their own --- impact of the work on themselves, the emotional impact in particular.



Trauma informed care is great in terms of giving us a theoretical structure, you know, a good understanding of what it is that motivates people to, you know, to to offend. . . . It also gives you a toolkit that immediately emphasises the importance of positive relationships, you know, safety, all of that which is really useful.

So whether, whether you met the chief executive or you went to the youth club, or you went to the school, they were all talking this language.

Transformational . . . you're moving from that place where we have a group of staff who felt deflated and demoralised and under-skilled to now having a sense of value and purpose



When we surveyed staff, they were talking about high levels of stress . . . and not just normal stress, they were moving from a place of feeling a bit stressed to feeling burnt out. And then beyond burnout, when actually, you're experiencing symptoms of PTSD.

People are now. . . able to talk about what their feelings in relation to their work … and accept weakness to be able to, you know, talk to each other openly about when how they take stock and be reflective . . .

It starts from a basis of, you know? Rather than ‘Why did you do that?’ . . . , but ‘What happened to you? What’s happened to you what’s led you to be here

It’s about people who are in trouble being able to heal through identifying new ways for dealing with conflict, their own struggles and conflict with others

It’s about choice, voice of the child, and collaboration leading to mutuality, and, and empowerment.

So with the idea that harm has been caused and if you can get them in a room together, and it's safe, so much magic can happen between those people. And in fact, it gives back the ownership of the problem to them.

FFT was happening alongside and at that point that it went well for us, and I was invested in it and was seeing it had a really good evidence base, and we wanted to do family therapy.

Potential theory of change involving the benefits of trauma informed care

High levels of staff turnover and stress

Low levels of engagement with children and families

Observation

ACE Awareness training

Intervention

Increased use of strength-based methods

Support for secondary trauma

Increased supervision

Increase the safety of the physical environment

Increased access to evidence-based services

Intervention

Staff feel better about themselves; their role and their clients

Short-term outcome

Children and families feel better about the service, are more likely to trust their practitioner

Short-term outcome

Child is more likely to engage with and respond to the service

Medium-term outcome

Trauma is reduced; children feel more secure; outcomes improve

Long-term outcome

It’s the capacity of the staff to be able to deal with and face the work that they're being asked to face. And the strength that they've gained through the training and the support that they get ,to enable, you know, really troubled young people to trust them. – ***Youth offending team leader***

Next steps

- We now need to verify whether this theory of change is the same for children's social care teams
- We also need to know the extent to which service outcomes are achieved
- We need to know what practices support these outcomes
- And most importantly, we need to understand how children and families benefit from trauma-informed care

Dr. Mina Fazel

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Children, trauma and the evidence: some reflections on clinical practive

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Overview

- Trauma
  - Intergenerational transmission
  - Avoidance
- Working with young people who are refugees
  - Use of evidence in mental health research
  - Narrative exposure therapy (NET)
- Current focus
  - Schools-based therapies
  - Trauma-informed care
  - C19

Trauma and its psychological sequelae

- Range of psychological responses
  - Acute and longer term implications
  - Associations with anxiety disorders, depression, substance misuse, adjustment problems
- Post-traumatic stress disorder (PTSD)
  - Reaction to a life-threatening disorder
  - Encompasses an increasing range of events and human reactions across different cultures
  - ?cross-cultural medicalisation of normal human emotions

PTSD – diagnosis DSM 5

Stressor

Intrusive memories (re-experiencing)

Negative alterations in cognitions and mood

Avoidance of stimuli that might arouse recollection of the trauma- *effortful avoidance*

Alterations in arousal and reactivity

Intergenerational effects

- Studies across disciplines
- Parenting
  - Clusters of adversities cascade across generations
  - Disruption to parenting role
  - Parental mental illness
  - Aggression in families

Instagram

humansofny

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humansofny (1/2) "My childhood was dominated by her stories: living in the ghetto for two years, surviving off potato peels, running like an animal from the Nazis. She was the only one who survived. I have no grandparents. No aunts or uncles. Her entire family was killed. We rose up from the ashes. And my mother became a monster. She deprived us like she was deprived. My brother and I were always made to feel like a burden. Like we were leeching from her. There were no special occasions. No birthdays. No cake. Everything was counted. Everything was calculated. Whenever I asked for something, I was made to feel responsible for World War II. She'd say: 'I didn't survive Hitler to get you a bag of potato chips.' She never let me feel like we were in America. I felt like I was the one wearing stripes. I've dreamed about Hitler since I was child. He tells me I'm a mistake. And that I should have been killed. I remember when I grew older and started visiting the houses of friends. I saw how their parents treated them. How they were given gifts. And how they were loved. It felt like I was crawling out of the sewer, after the war, and learning that this entire time-- some people had been living normal lives."

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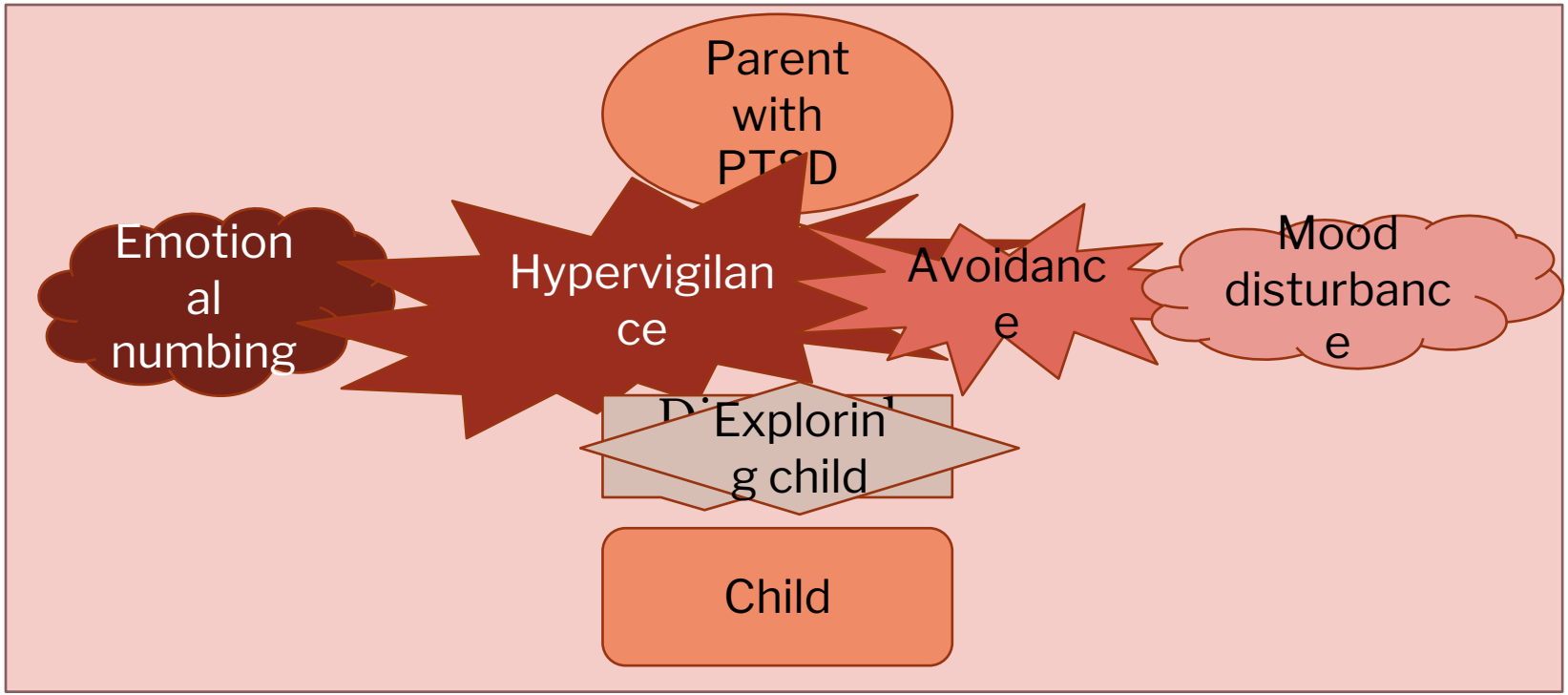
Parental PTSD: Mechanisms of intergenerational transmission



Avoidance 1

- For the individual
  - Many effective treatments are exposure based
  - Comorbid psychological and physical disorders, especially if untreated
- For their carers
  - Buffering role of parents
  - Impaired interpersonal relationships
  - Parenting style less encouraging of independence
  - Family social withdrawal: avoidance in dealing with child's distress
  - Emotional regulation and harsher parenting styles

Avoidance 2

- Therapeutic
  - Training and supervision
  - Case load
- Intervention research
  - Treatment of family systems
- Broader societal responsibilities
  - Social fabric
  - Supportive environments

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Recent Systematic Review of prevalence of mental illness in refugee children

8 studies in 5 countries of 779 child refugees

Ahmad – Sweden; Daud – Sweden; Gosnell – Malaysia; Jakobsen – Norway; Nasiroglu – Turkey; Ruf –Germany; Sapmaz – Turkey; Soykoek – Germany

Prevalence:

PTSD 22% (95% CI 29-41)

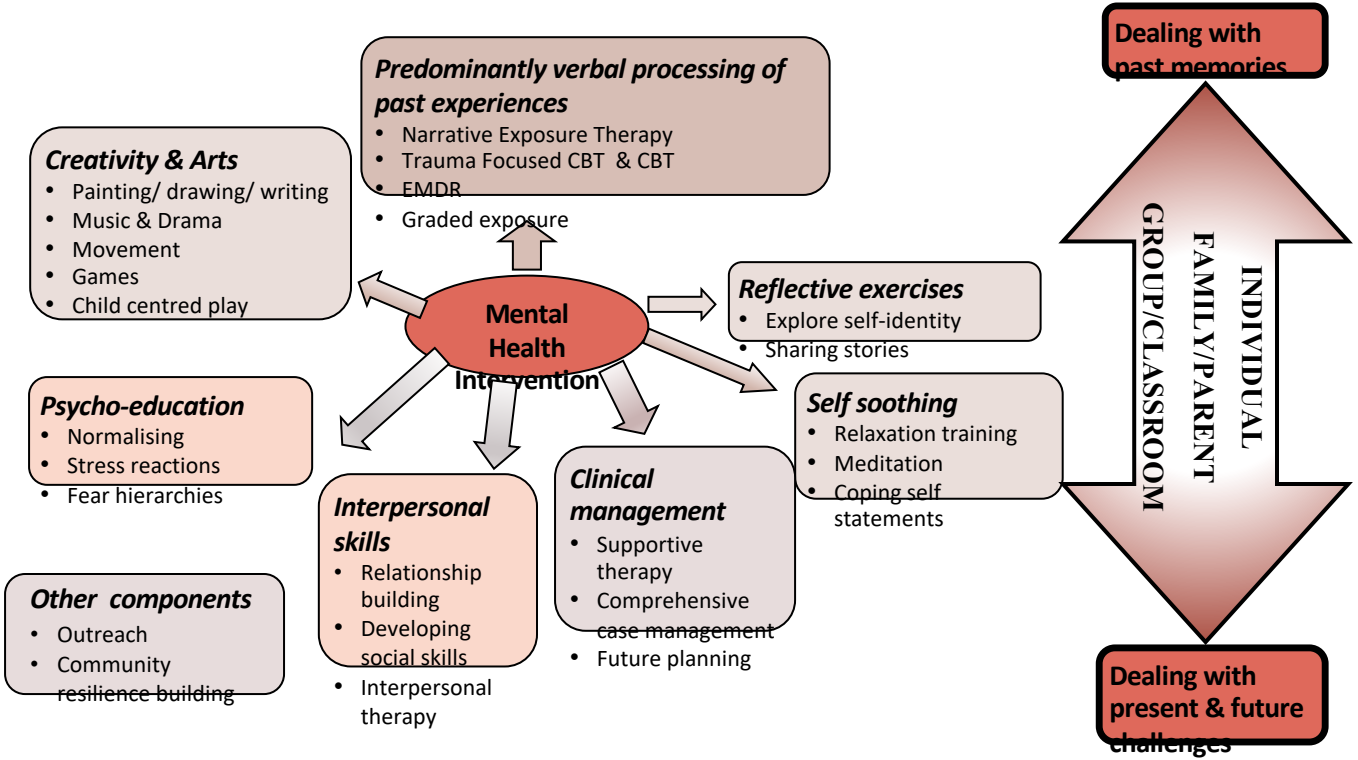
Depression 14% (9.9-18.5)

Anxiety disorders 15% (14.9-24.6)

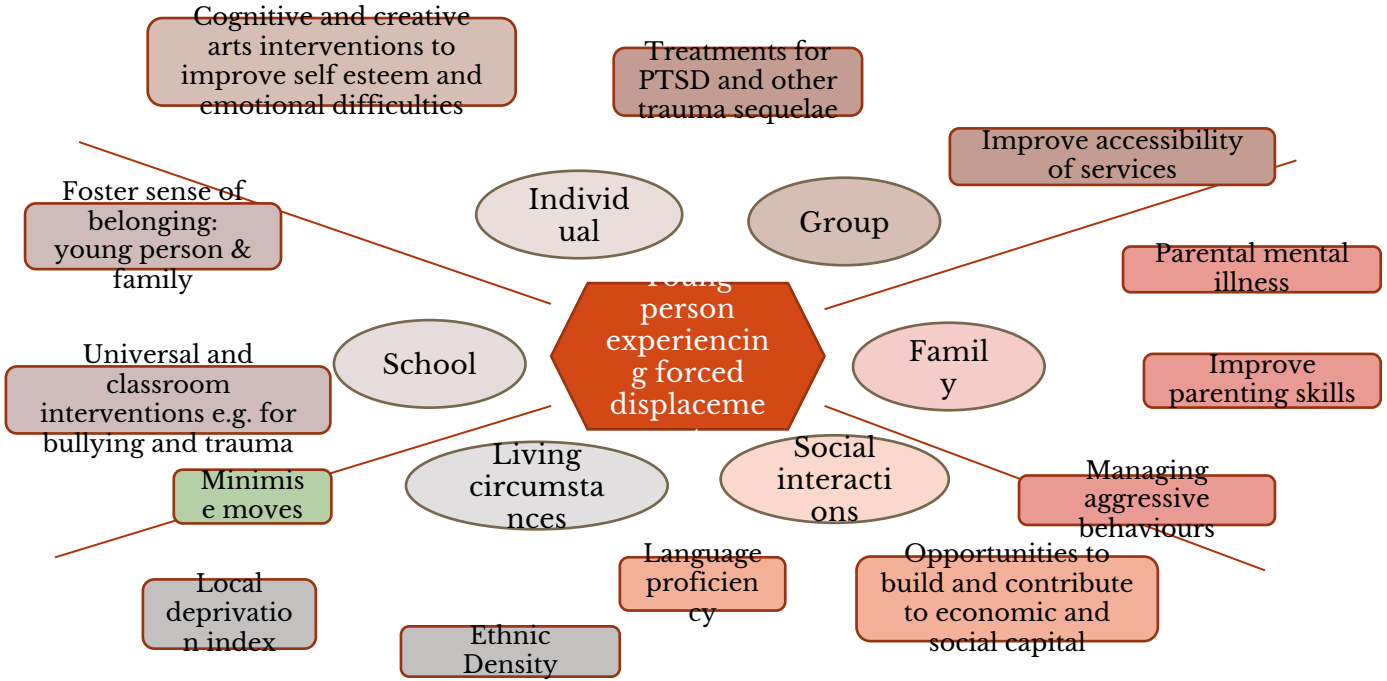
ADHD 8.6% (1.8-11)

ODD 1.7% (0.8–4.2)

Diagram to show the range of mental health interventions studied for refugee children



Multicomponent interventions



How to prevent mental illness in refugees?

Autobiographic memory

Knowledge about lifetime periods

Knowledge about general events

Knowledge about specific events

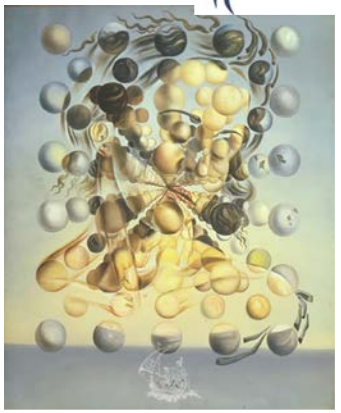
Cold Memory

Event specific emotional-sensory network

Hot Memo

NARRATI ON

Trauma narratives



- no chronological order
- fragmented memories
- difficulties putting the experiences into words

Symptoms of PTSD are based on a pathological representation of traumatic experiences

Development of NET

Brief intervention for PTSD symptoms in conflict areas:
- simple and effective
- can be provided by local people following short training
- culturally applicable
- bears witness to human rights violations

M Fazel, H Stratford, C Chen, H Griffiths, E Rowsell, K Robjant. Five applications of Narrative Exposure Therapy for children and adolescents presenting with post-traumatic stress disorders. *Frontiers in Psychiatry* 2020; **11**:19

Lifeline

Rope as symbol for Life

Flowers as symbols for good events

Stones as symbols for bad events

Lifeline as therapy map

1. Autism Spectrum Disorder and Psychosis

- ASD and intellectual disability; poor expressive and receptive language
- Past physical and sexual abuse

Reflections

- Psychotic features
  - PTSD main driver
  - Poorly encoded memories
- NET's suitability
  - Lower cognitive load as has focus on description rather than meaning
  - Predictable questions
- NET's delivery

2. Childhood Sexual Abuse

CSA in context of other traumatic exposures and abuse

Significant self-harm

Foster care, difficult to trust adults and peers

Chose NET as wanted to talk through all her experiences

- Has some evidence of inter and intra-personal difficulties

NET delivery

- Included key adults in her system in psychoeducation and treatment plan
- Was able to share lifeline with adults caring for her; school had better understanding; foster carer join at end of each session

3. Repeated medical investigations

Multiple cardiac surgeries

Increasingly anxious about medical procedures

Well known to clin psych

Stones identified not those anticipated

Location challenges

- Trauma related to hospital incidents
- Distressed children in earshot

4. Engagement with treatment

- Physical trauma, father in prison for abusing sibling
- Initially treated for depression and anxiety but by 3rd month evidence comorbid PTSD
- Liked idea of a lifeline
  - Only agreed to do this initially
  - Needed longer to trust an adult when coming to trauma experiences vs talking about depression
  - Lifeline in itself made some of the experiences clearer
  - Non-threatening and simple
  - Cathartic
  - Took some months before decided to start the narration

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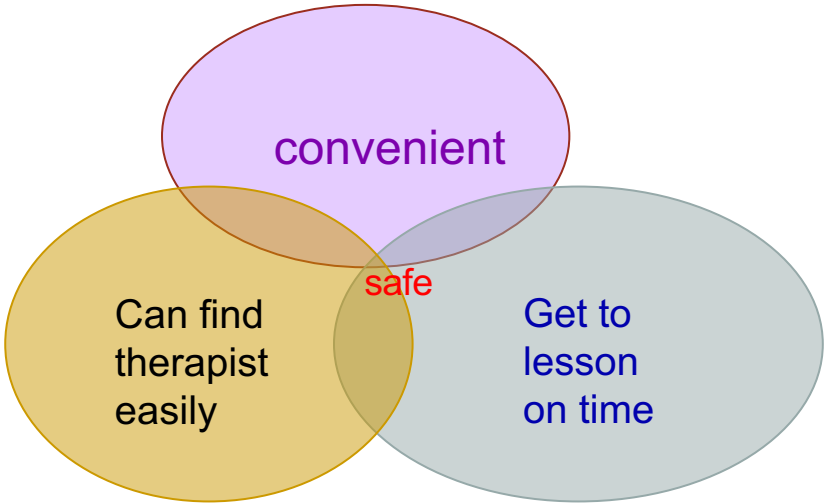
Working in schools

What we learned with refugees: ISOLATION

1. High rates and poor access
2. Family needs
3. Benefit of peer interactions
4. Isolation extreme

School location: Advantages for refugee sample

72% preferred to be seen in the school location



Good to have it in school, if come to hospital it is scary, I don't know if I would go if it was in a hospital ...no one likes hospital

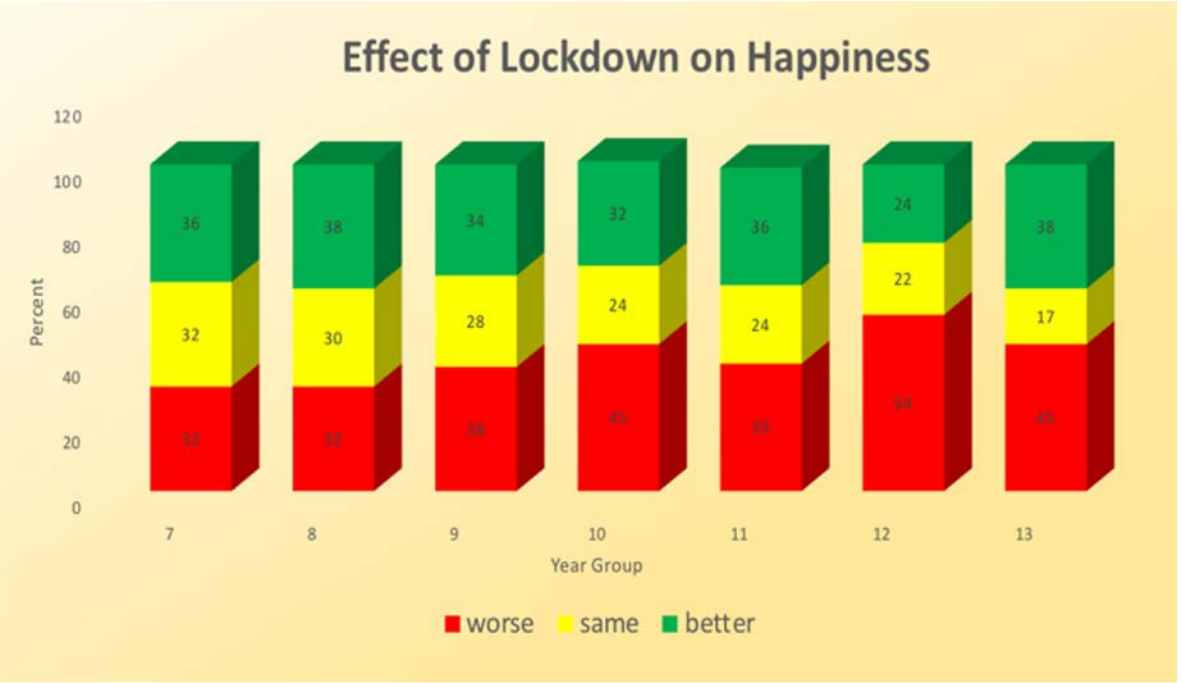
How do I look after myself?

The OxWell School

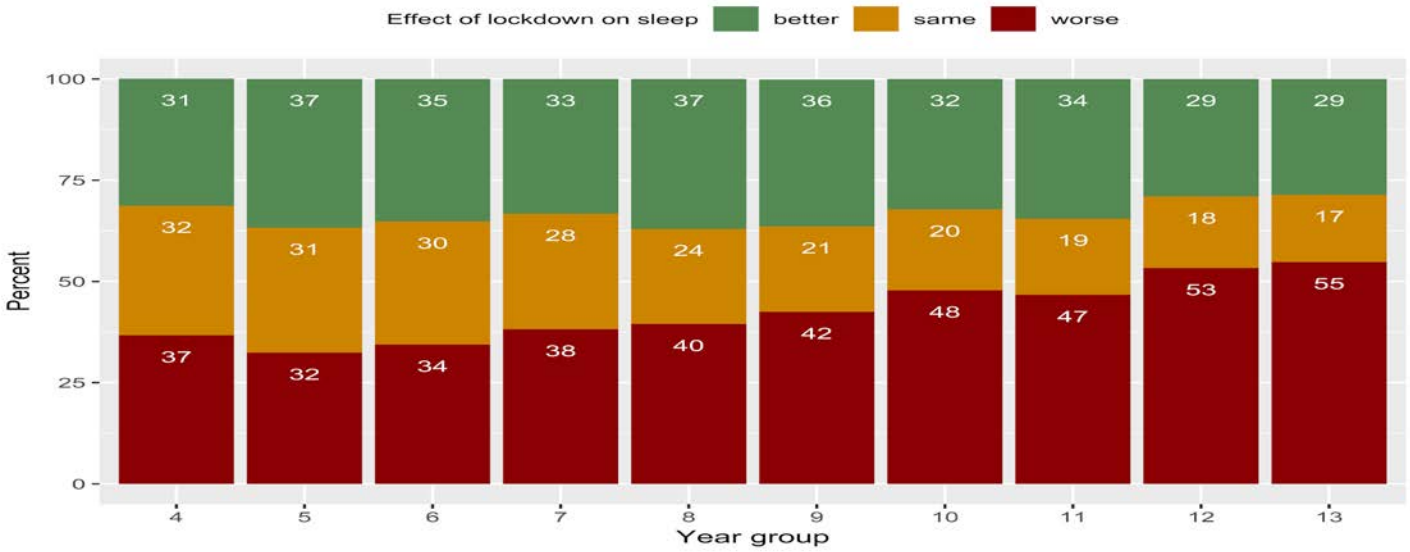
survey

2020

- 19,000 responses
- 237 schools, 6 counties
- All reports to schools & access to data portal
- Youth-led student dissemination
- June- July 2020



Effect of lockdown on SLEEP



Conclusions

Barriers to accessing care

Schools important role

Evidence base!

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QUESTIONS
AND
DISCUSSION

What Works for Children's Social Care

Thank you

@whatworksCSC