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## Pathways and Planning:

## Creating a Safe Base: Level 1 Trauma Recovery Model

Assessments completed with children who have experienced trauma, often highlight the absence of stable living arrangements and positive personal relationships as factors which contribute to negative or challenging behaviours. Trying to address these factors, where family relationships are irreparable, can seem like a difficult task.

A secure base is usually experienced through a child's attachments to responsive caregivers who meet the child's needs and who they can turn to as a safe haven, when upset or anxious. Where consistency, predictability and reliability are absent in a child's life, this framework can be provided by the practitioner or the agency. Offering consistency, predictability and reliability is a way for the case manager and other practitioners involved in the child's care to communicate and behave in a way to make the child feel safe (Skuse and Matthew, 2015).

Children who are referred to the YOT are often anxious about what will be expected of them, this fear is often heightened for children who have experienced trauma and where their developmental functioning is not age consistent. They may be embarrassed about not being able to comprehend what is being asked of them or feel uncomfortable about potentially having to discuss experiences that were deeply traumatic. This anxiety may present as defensiveness, hostility, avoidance, or other challenging behaviour.

For children assessed at Level 1 of the Trauma Recovery Model (Skuse and Matthew 2015) creating a safe base may be the main or only focus of the intervention. Creating a safe base is a prerequisite to the success of other interventions and therefore this should be the main focus of initial sessions (where this is not established); to provide a building block on which to deliver other interventions (Skuse and Matthew, Trauma Recovery Model, 2015).

### Boundaries

Children who have experienced trauma can find it difficult to navigate new relationships, and numerous workers can be overwhelming and counterproductive to creating a sense of safety. Therefore, it is preferable to keep the number of professionals involved with a child to a minimum, so that interventions are delivered through key consistent professionals. Where introducing a new worker is unavoidable it is recommended the worker is introduced in a phased gradual manner via a worker with whom the child has already established trusted relationship.

The brain develops from the back to the front and from inside to out. When emotionally dys-regulated it is the brain stem and limbic areas which are activated. This results in the deactivation of the frontal cortex, which is responsible for executive functions, including attention and impulse control. Any intervention and support you offer therefore needs to be targeted at safety and connection (brain stem and limbic system) and not at a cognitive, language-based level (Government of Jersey and Psychology Wellbeing Service, 2020). Boundaries, requirements, rules and consequences need to be set and help to provide a safe framework in which to deliver other interventions and help the child feel contained. It is important that boundaries and consequences are outlined when the child is in a calm state and not when angry/agitated or stressed or have just breached/broken a boundary.

When behaviours need to be addressed, descriptive feedback should be given that relates to the specific behaviour (not the child) and should be balanced with positive feedback so the child receives a blend of positive and negative feedback.

For example,

> "I don't want you to swear at me, swearing is against the rules of the order. I can see you are frustrated about having to get up early. Your reparation officer informed me you worked really hard in last week's afternoon reparation session. Perhaps we can arrange all of your sessions later in the day?"

Expectations need to be set but practitioners can be flexible with their approach, offer alternatives and tell children what they can do rather than what they can't.

For example,

> "You have to attend an appointment this week but if Wednesday is not a good day, I could re-arrange your appointment for Thursday?".

It is also useful for practitioners where possible to own the statement of correction.

For example,

> "I don't want you to kick that chair. Can you come outside with me?"

The interventions themselves should not be built around consequences at this stage. Children who have experienced trauma may not have developed the skills for such strategies to be effective.

For example,

- The child's experience of negative consequences to date may mean they have learned how to numb themselves out so they don't feel consequences or may not be able to show professionals the level of vulnerability expected.

- The child may not think they deserve the rewards that compliance brings, or results in anything better than not complying. They have learned adult response to behaviours which are not followed through or consistent.

- They may not have confidence in their own ability to do whatever it is you are asking (it's easier to not try at all than it is to fail) (Jen Taylor, 2015)

Practitioners should always seek to ensure as much consistency, predictability and reliability (CPR) (Skuse and Matthew, TRM, 2015) as possible in interactions with the child by:

- Offering appointments at the same time each week
- Being on time
- Planning activities in advance
- Keeping the structure of the appointment the same e.g. check in, do an activity, talk about activity, arrange the next appointment (beginning, middle, end).

This ensures that when safety is not present or achievable with the child's living arrangements or personal relationships, this unmet need is provided by the practitioner and the agency.

For example,

The child's assessment may identify instability in living arrangements as a factor against desistance. This unmet need is targeted by providing stability (consistency, predictability and reliability) with the practitioner.

**Engagement**

Research indicates that the most challenging and difficult to engage children are often the children who have experienced trauma and are most in need our support (Youth Justice Board/Ministry of Justice, 2020). Children should not be prevented from receiving a service because they are finding it difficult to engage with a direct intervention.

Children may find face to face contacts intensive/intimidating and may not have reached the developmental stage that enables them to engage with this process. Practitioners can consider less intensive ways to initiate contact where necessary, e.g. texts, notes, social media messages or offering to transport the child. Other multi-agency support/advocacy can still be valuable to the child where they are struggling to engage with face to face contacts. For example, a child may consent to you liaising with the school on their behalf or advocating to the police that they are not criminalised. A child may eventually be more likely to accept support from a professional who they perceive to be supporting/advocating for them. It is recommended that practitioners continue to present for the weekly appointment even if the child is not engaging, to convey a message that you want to see the child and will persist/return. Practitioners should be conscious to avoid conveying a message that the contact is conditional/time limited or process driven, e.g. "if you don't attend next week, I will close the case or send you a warning". The rules of the order will have already been set out but overly

focusing on demands and consequences for children at this developmental stage is unlikely to be an effective strategy and is not helpful in relationship building.

**The PACE (Playfulness, Acceptance, Curiosity and Empathy) model**

The PACE model (Dan Hughes 2021) is another way of communicating and behaving in a way to make the child feel safe. It's based on how parents/carers connect with very young infants. The approach is a useful tool to engage any child but is a particularly useful strategy when you are seeking to engage a child who has experienced trauma. It may be particularly helpful for children who present at the lower levels of the Trauma Recovery Model (Skuse and Matthew 2015) as the model can be used even when a child is not actively engaging, may still have a hostile attitude towards practitioners, may not be will/able to answer questions/respond or be anxious/withdrawn.

**Playfulness**

This is about creating a relaxed and safe atmosphere. A playful stance can help diffuse a tense situation. The child is less likely to react defensively when the practitioner has a touch of playfulness in their approach. Children who have experienced trauma may struggle to regulate their emotions and even feelings of excitement and joy can trigger anxiety or challenging behaviour. A playful stance assists practitioners to deliver an intervention that is tailored to the child's level of functioning (developmental mapping) as it replicates what adults unconsciously do with much younger children (e.g. a playful tone, a sing song voice, repetitive language, exaggerated expressions or gasps). For example, if you are transporting a child to an appointment and they have overslept you might say once on the way (in the car as this is less intensive/threatening) in a playful tone,

> "Oh no, oh no, we are late again, I hope Mr ------- is in a good mood or we will be in trouble."

The practitioner has made point but is not expecting a response or explanation as to why the child has overslept.

This is different to requesting an explanation and outlining consequences whilst still in the child's house,

> "Why didn't you set you alarm? Mr -------may now close your case as this is the second time you have been late."

This approach may escalate the situation and result in the child refusing to attend the appointment at all.

Of course, there may be a consequence of the child turning up late, which may or may not be within our control. Here the onus would be on the professional to advocate with other workers/partnership agencies that the child's behaviour (in this case turning up

late) may be related to the adversity they have experienced, evidenced by the developmental mapping exercise and Trauma Recovery Model (Skuse and Matthew 2015) assessment.

**Acceptance**

Unconditional acceptance is crucial to a child's sense of safety. Practitioners should always seek to communicate the message that they accept the wishes, feelings and urges that underlies the child's behaviour, without judgement or evaluation. Practitioners can still seek to stop the behaviour whilst accepting the motivation behind it. A message should be conveyed that it is the behaviour being criticised rather than the child themselves.

For example, when discussing an incident where the child had been found in possession of a knife in his local community. The worker says to the child,

> "I'm really worried you took out a knife, you must have been feeling very scared to have decided to do this."

**Curiosity**

Curiosity seeks to help a child make sense of why they behave in a certain way which helps with acceptance. Often children understand that their behaviour was inappropriate but do not know why they behaved in this manner (due to the impact trauma may have had upon neurodevelopment) or are reluctant to tell us why or do not have the necessary verbal skills to articulate the problem.

When adopting a PACE approach, you would seek to help the child with understanding by exploring the reasons underlying the behaviour. You should avoid displaying any annoyance about the behaviour or focusing purely on the consequences of the behaviour. This is about getting to know the child rather than gathering facts. In the above example the worker conveys their acceptance of the reasons underlying the child's behaviour (being in possession of a knife) by making a guess out loud that the child may have felt scared. The worker may go on to say,

> "I wonder why you took a knife out last night, maybe that fight you told me about made you feel a bit anxious!"

The worker is almost having a conversation with themselves, with the child in the room, they are not expecting a response from the child. This is different to saying,

> "Do you know that the starting point for a second knife crime offence is a detention and training order?"

The worker makes a deliberate decision not to outline the legal consequences of knife crime at this stage/point in conversation. I am not suggesting the child should not be made aware of the facts relevant to their behavior: the practitioner may choose to do

this following panel/court/at the start of the intervention. However, it is important to highlight that whilst this consequences should be outlined and remains in place, an intervention based on consequence/punishment (by saying *if (this) then (that)*) won't be as effective for children at lower stages of the Trauma Recovery Model.

**Empathy**

The objective here is for the practitioner to show the child empathy. Practitioners should not try to persuade the child out of the feelings they are having or try and persuade them to consider the feelings of others. You cannot teach a child empathy as it is learned through experience. Research shows that when trusted adults respond to children with empathy and help them to understand their feelings, outcomes are improved. When using this approach, the practitioner would seek to demonstrate to the child that they understand how difficult an experience it is for the child by affirmation, understanding and recognising the feeling the child is having. Using language and a tone that conveys empathy. In the above example the practitioner might say;

> "I understand why you might feel scared at night, when you know other people are carrying knives and you saw that fight last week. I think I would be nervous to go out too."

This is the opposite of saying,

> "You don't need to be scared as if there is any trouble you can call the police/care home staff."

Practitioners who use the principles of PACE can successfully reduce the level of conflict, defensiveness and withdrawal that tends to present when working with children who have experienced trauma. This improves the level of engagement and strengthens the relationship between the child and the practitioner. Through the improved relationship the child is enabled to reflect on thoughts and feelings that lie underneath their more negative and challenging behaviour and build the skills they need for a better future.

More information can be found at https://ddpnetwork.org/about-ddp/meant-pace/

**Practice Example**

*The YOT practitioner arrived for her weekly appointment with Harry at his care home; he was smashing up his bedroom. The care home staff informed him unless he cleaned up the mess he would lose his free time. This had escalated Harry's temper further and he continued to smash up items in his room. The YOT practitioner sat outside his doorway ensuring her body language was non-threatening and said, "I can see today is a bad day, you are really angry as you have smashed up your wardrobe". Harry continued to punch his walls/furniture and to shout abuse about staff members in his care home. The practitioner deliberately repeated what he had said (without*

*agreeing) to show he had been heard, "So you are cross as you think Sarah is a xxxx and you also think Tony is a xxxx as they won't let you smoke your vape pipe".*

*The practitioner was deliberately validating Harry's emotions, showing he had been heard and allowing time for him to calm down.*

*The practitioner made a deliberate decision not to outline any consequences of Harry's behaviour or make any commands. The practitioner then sat quietly with Harry until he returned to a calm state. She subsequently ascertained that he was upset as he was not allowed to smoke his vape pipe in his new placement but had been allowed to in his previous placement. It was something the practitioner was able to address with the new placement.*

*The practitioner visited the following week and used PACE (Dan Hughes 2021) strategies, to revisit the previous weeks incidents now Harry was in a calm state by saying;*

- *You seemed upset last week when you were smashing up your room.*
- *It must have been frustrating moving to a new house with new rules.*
- *Do you feel happier now we have been able to speak to staff about the rules?*
- *Wow, you did cause a lot of damage, I am so pleased the staff didn't call the police.*
- *The staff seemed really concerned when they saw you were angry and didn't understand why.*

*The practitioner didn't necessarily expect an answer from Harry, her main focus was naming and labelling a range of emotions.*

**Window of Tolerance**

The Window of Tolerance (Dan Siegal cited in the Government of Jersey of Psychology and Wellbeing Service, 2020) describes the best state of 'arousal' or stimulation in which children are able to function and thrive in everyday life. When children exist within this window, they are able to learn effectively, play, and relate to others. However, children who have experienced trauma will have a smaller window of tolerance and are more likely to move outside of their window. They can become hyper-aroused or hypo aroused. Hyper-arousal results from the fight or flight response and is characterised by excessive activation/energy. It can present as difficulties in concentrating, irritability, anger and angry outbursts, panic, constant anxiety, being easily scared or startled and self-destructive behaviour. Hypo-arousal results from the freeze / flop drop response where there is a sense of shutting down or disassociating. This can present as exhaustion, depression, flat affect (emotionless), numbness and disconnection. Some children can swing between one extreme to the other but struggle to remain within the window of tolerance.

Practitioners in the longer term should seek to help children develop self-awareness of their position in terms of their window of tolerance and what triggers them into a state of feeling overwhelmed or unable to regulate their emotions well, helping children to expand the window of tolerance, stay calm and focused and develop their self-awareness. However, for children at Level 1 of the Trauma Recovery Model, 'Compensation Interventions' need to be put in place by practitioners, e.g. adapting the environment (e.g. sensory accommodations); building in predictability (e.g. visual timetables, structure, routines); and providing 1:1 support with trusted adults. Whilst further interventions will be introduced to assist the child develop internal resources, at this stage we try to improve stability/safety by increasing the external controls/support systems to prevent the child falling out of the window of tolerance.

When a child emotionally dysregulates, practitioners should focus on validation; self-soothing or self-regulating behaviours before trying to help the child make sense of a situation. A child needs to feel safe, understood and accepted (have emotional resonance).

**Environment**

YOTs will have their own local procedures about where appointments take place, but careful consideration should be given to how this may impact upon the child's feelings of safety and the child's capacity to engage with what is expected. Often children who have experienced trauma are those who have less support surrounding them which will impact significantly on their ability to attend venues outside of their home.

Such considerations may be:

- The child may not have the advance finances for transport.
- They do not have the experience, capacity or confidence to navigate public transport.
- The child may not have an adult who will transport them or who may agree to transport them but be 'angry' about having to do this.
- The child may not be able to tell the time or understand the passage of time.
- The child may have a poor working memory.
- Children who have experienced trauma and abuse in their early years having repeatedly had their alarm systems triggered (fight or flight mode), which can lead them to being locked in a permanent state of higher alert/hypervigilance. Children's whose systems are 'locked' into a higher state of alertness are unable to differentiate between a safe venue and one that poses a threat.
- The child may not know where the venue is, or be able to find out or be able to recall instructions you have provided.
- They may not be able to articulate the problems listed above or feel shame in discussing them.

- Abuse is surrounded by secrecy. The child may be concerned about who can overhear what they say when talking in their home or the community.
- The child maybe fearful of upsetting others who can hear what they say.

**Practice Example**

*Kian had established a relationship with his worker and had been very good at keeping his appointments with the YOT. On the day in question his worker was running late and called Kian to explain he would be ten minutes late. Upon arrival at the home address there was no answer from Kian, he did not answer his phone and missed the scheduled activity. When the reason for missing the appointment was explored, it transpired that Kian had got undressed and gone back to bed as he thought the worker would be 'ages'. Whilst this type of behaviour could have resulted in a 'warning', the trauma informed lens enabled the worker to recognise that Kian did not understand the passage of time. The period of ten minutes had no meaning to him. Following this his worker was able to deliberately label the passage of time to assist Kian to develop this skill.*

*For example*

- *This journey just took us ten minutes, that wasn't long.*
- *Last time I came to see you was two days ago.*
- *I am coming in ten minutes that is just enough time to put your shoes and coat on.*
- *I am coming again on Thursday, that's two sleeps/days time.*
- *I will make you a cup of tea it will take two minutes*

Here is a further example with reference to Kian:

*The practitioner working with Kian was aware that he would be quite withdrawn during sessions that took place in the family home, possibly as Kian's father had a quite punitive approach and would often reprimand him for not meeting his high expectations. On the day in question Kian's worker made the decision to complete the session in a quiet café in the local supermarket. Her intention was to discuss the activity planned for the following week. She collected Kian from his home and transported him to the local café, he was relaxed and chatty in the car. Once in the café the worker noticed that Kian was looking over her head into the cars in the car park. At one-point Kian remarked about a woman parked ten rows back who had left her shopping on the roof. When the practitioner returned Kian home and said, "see you on Monday". Kian replied, "What is happening Monday?", despite the practitioner having discussed this at length during a fifty-minute session, A trauma informed lens allowed the practitioner to recognise (in hindsight) that Kian was 'hypervigilant' and in the supermarket was preoccupied with looking for threats in the wider environment*

*(the car park) and therefore could not focus on what the practitioner was saying. He was in survival brain not learning brain (Ham, J, 2017).*

Children who have experienced trauma can appear as if they find it difficult to concentrate and pay attention. In reality, they are probably very good at paying attention to things that could be potential threats, e.g. Kian was able to note things in the car park that his worker did not, but this was at the expense of paying attention to things that do not pose an obvious threat. Children may avoid attending venues that trigger their fight/flight response but would not be able to articulate this problem. The issue may not be obviously apparent to a practitioner who is able to comprehend that the venue poses no threat. There will of course be trial and error in ascertaining the right environment for the individual child. The point to highlight is that these children should not be apprehended/warned for avoidance behaviours that may link directly to the adversity they may have experienced. It's vital we take the time to understand what might lie beneath the behaviour.

Where contacts are taking place outside of the child's home safety tours can be helpful. Providing the child with a tour of the building, showing security, alarms, locks windows, toilets, CCTV and who is in the building. It can also be useful, particularly in an education, training or employment environment to explore ways the child can communicate they need a safe place, e.g. red cards/traffic light cards (Triesman, K, 2009).

**Multi Agency Planning/External Controls**

Children at Level 1 of the Trauma Recover Model may present with harmful behaviours. Safety and practical considerations (keeping the child, others and staff safe) should be prioritised over consequential thinking. Problem solving and de-briefing should happen once the child has down regulated. Whilst the practitioner focus is on creating stability for the child there may need to be an increase in external controls built into the interventions (e.g. through a multi-agency plan).

For example,

> Arson was identified as a 'Future Behaviour' for Eden. Eden was not at the cognitive stage where he would engage with the 'Fire Safe' programme (a cognitive programme based on consequence (saying if *(this)* then (*that)).* Therefore, external controls were increased to ensure he did not have access to fire-starting material, similarly to how we would manage behaviours for a young child. The YOT practitioner worked in partnership with his care provider and education placement via multi agency forums to ensure these controls (e.g. room searches, supervised leisure time/school breaks) and increased support, supervision and monitoring from trusted adults were put in place.

Sometimes the identified harm related future behaviours requires a multi-agency response, e.g. when a child dysregulates in a residential home and other children are present. Trauma informed multi-agency planning can be important in these circumstances to predict behaviours and co-ordinate a multi-agency response, e.g. the police may intervene but it's agreed that a (trauma informed) intervention will be undertaken by the YOT or social worker rather than criminalising the child. Where the

child is subject to a statutory order, multi-agency forums with management oversight can be used to consider the context of the child's behaviour and use discretion (in YJB *Standards for Children in Youth Justice*) to consider whether enforcement action is appropriate. The developmental mapping exercise and Trauma Recovery Model (Skuse and Matthew, 2015) assessment can assist to inform this decision-making process and what external controls are developmentally appropriate.

**Targets associated with progression/recovery**

Practitioners may focus on the interventions above until the child is willing to meet with one key worker on a regular basis. The practitioner may need to be flexible with appointments, e.g. if the child forgets the scheduled appointments re-arranging it for a different date the same day each week. The targets would be for the child to be keeping most of the appointments (if offered on a flexible basis) and perhaps responding to text/calls when they miss appointments. The child's behaviour is likely to continue to be challenging, defensive, hostile or withdrawn but there will be some willingness to at least present/attend/allow you to visit/open the door/answer the phone. At this stage practitioners can shift the focus of the intervention to Level 2 Trauma Recovery Model interventions whilst ensuring the fundamental interventions explained above (the safe base, CPR) remain in place.

NOTE: Practice examples have been anonymised and the nature of the significant events have been amended to protect the identity of the children.

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