Working together for the children of Edinburgh Conference 2024

Welcome to the Conference

Focussing on our children first not as a service

Amanda Hatton

Executive Director of Children, Education and Justice Services

Our agenda today

- 9.30am - Welcome and celebration – Amanda Hatton
- 9.35am - Celebration - Andrew Kerr and Cammy Day
- 9.45am – Keynote speaker - Claire Ryan Heatley
- 10.45am - Tea/coffee comfort break
- 11am - Spotlight presentations
- 11.45am - Panel Q&A
- 12noon - Workshops
- 12.55pm - Summing up - Andrew Kerr and Cammy Day
- 1pm - Event ends

https://youtu.be/1Evwgu369Jw


PEOPLE WILL FORGET
WHAT YOU SAID,
PEOPLE WILL FORGET
WHAT YOU DID,
BUT PEOPLE WILL NEVER FORGET
HOW YOU MADE
THEM FEEL.
- MAYA ANGELOU -

- Time to CONNECT
- Share your perspective
- Enjoy and empathise
- Just explore some of what we are facing
- Find joint and creative solutions

Andrew Kerr

Chief Executive

The City of Edinburgh Council

Cammy Day

Council Leader

Keynote topic
Trauma and resilience

Claire Ryan Heatley

Trauma Lead Officer/Lived Experience of Trauma

Invitation-As you listen, please capture questions , insights and connections regarding your individual or organisations experience of trauma and resilience, your strengths and emerging needs

What is trauma?

Trauma results from an event, a series of events or a set of circumstances, experienced by an individual as physically or emotionally harmful or threatening, that has lasting adverse effects on an individual's functioning, and physical, emotional, social or spiritual wellbeing.
SAMHSA 2013

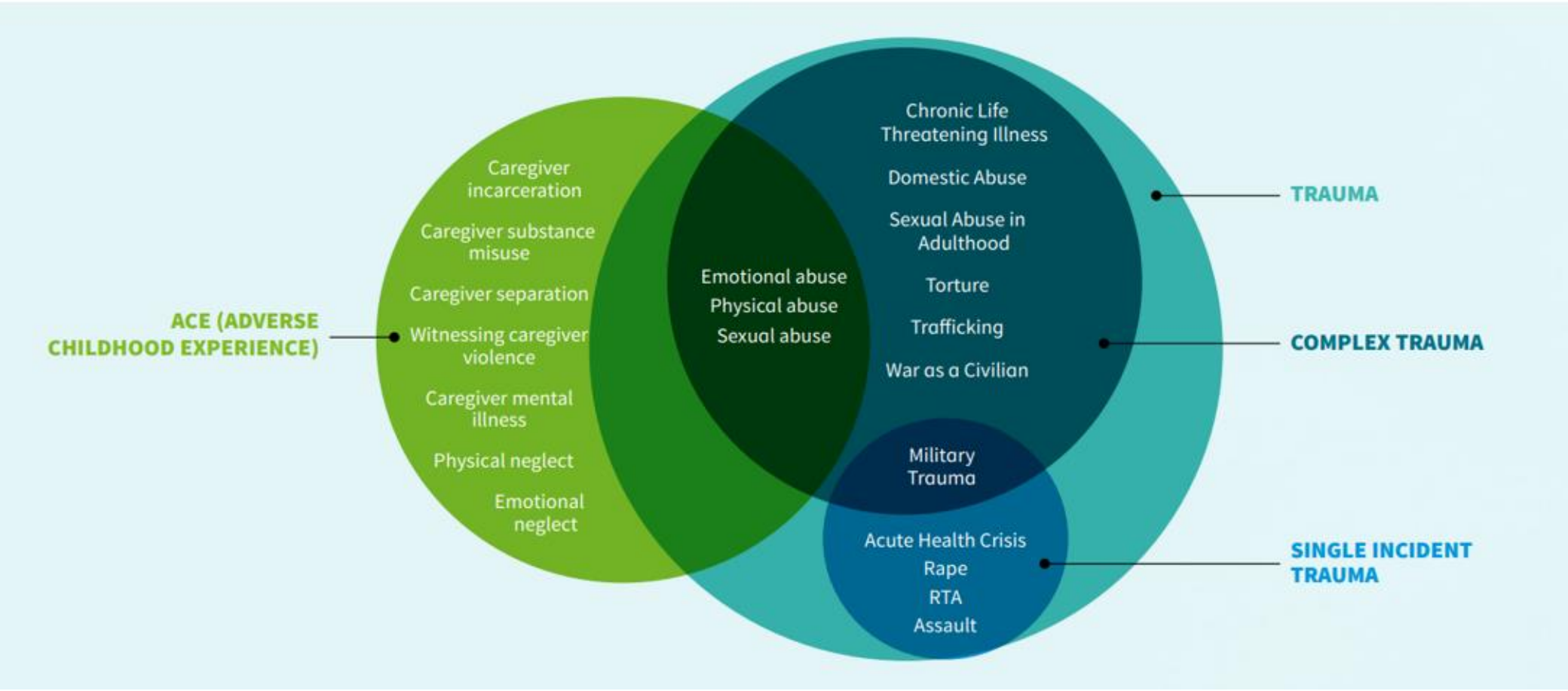
What % of the UK population is estimated to have been affected by trauma

A 10 to 20%
B 30 to 40%
C 50%
D 60 to 70%

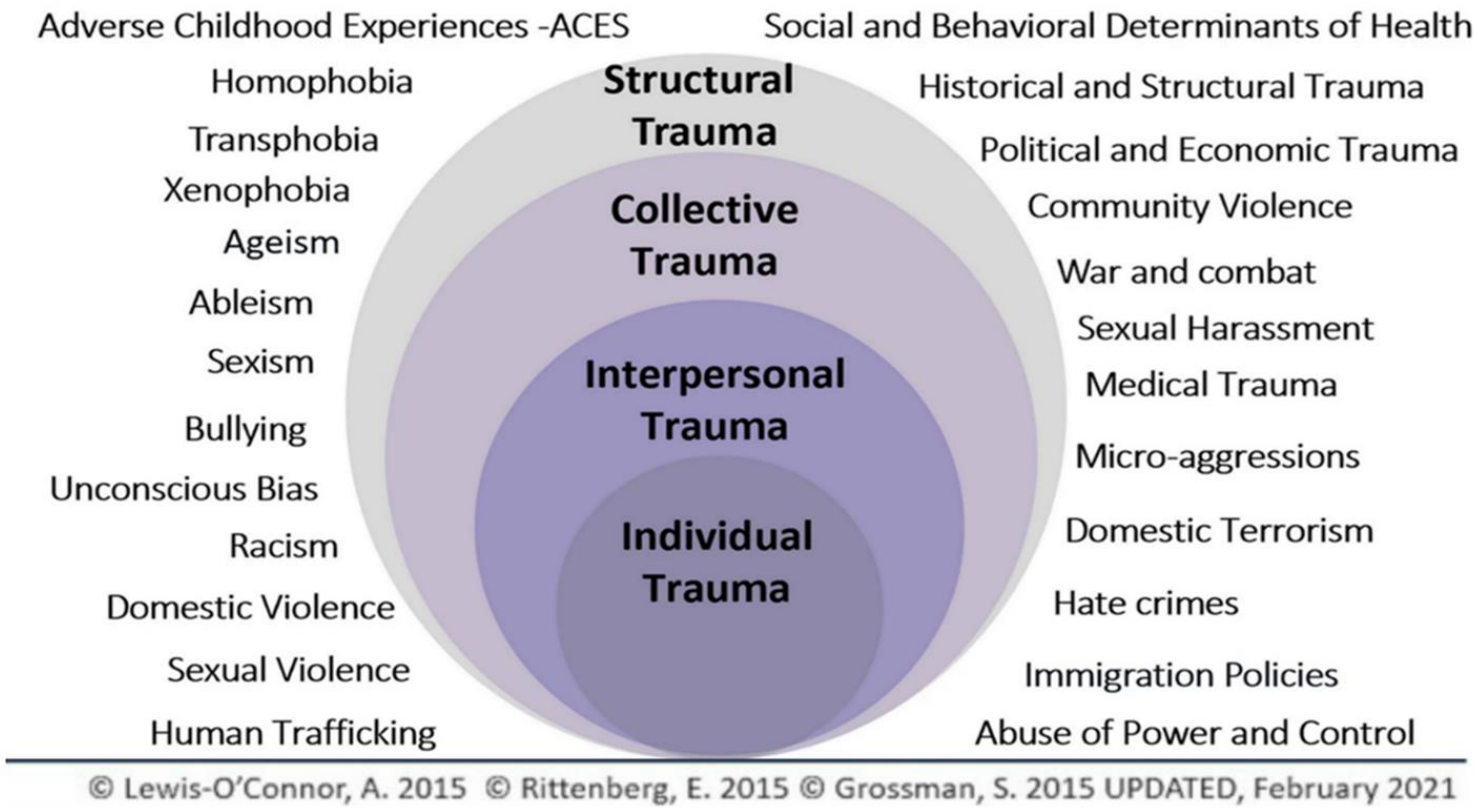
Trauma is not often recognised and under reported so this figure will in fact be higher.
Big T trauma and small t trauma

The language of trauma and adversity

Developmental trauma is the term used to describe the impact of early, repeated trauma, adversity and loss which happens within the child's important relationships, and early in their life.



Socio Economic Model of Trauma



About Trauma

An event is traumatic if it is extremely upsetting and at least **temporarily overwhelms** the individual's internal resources Briere and Scott (2006)

> The experience of trauma is simply not the rare exception we once considered it. It is **part and parcel of our social reality**
>
> Fallot and Harris, 2009

When we work with people**, no matter what service we offer**, we are likely to come in to contact with people who have experienced trauma NES 2022

Trauma in Context of our Services

Trauma is common, can occur at any time of life and can impact **how people behave and respond** to other people, **even if the trauma happened a long time ago.**

Trauma can impact on the experiences of **people who access the services** we deliver, **ourselves, and our colleagues**, because of past or current experiences, which may relate to personal or professional lives

The 'Hard Edges Scotland' study (2019) found that growing-up with experiences of trauma, underpins **severe and multiple disadvantage** experienced by adults in Scotland.

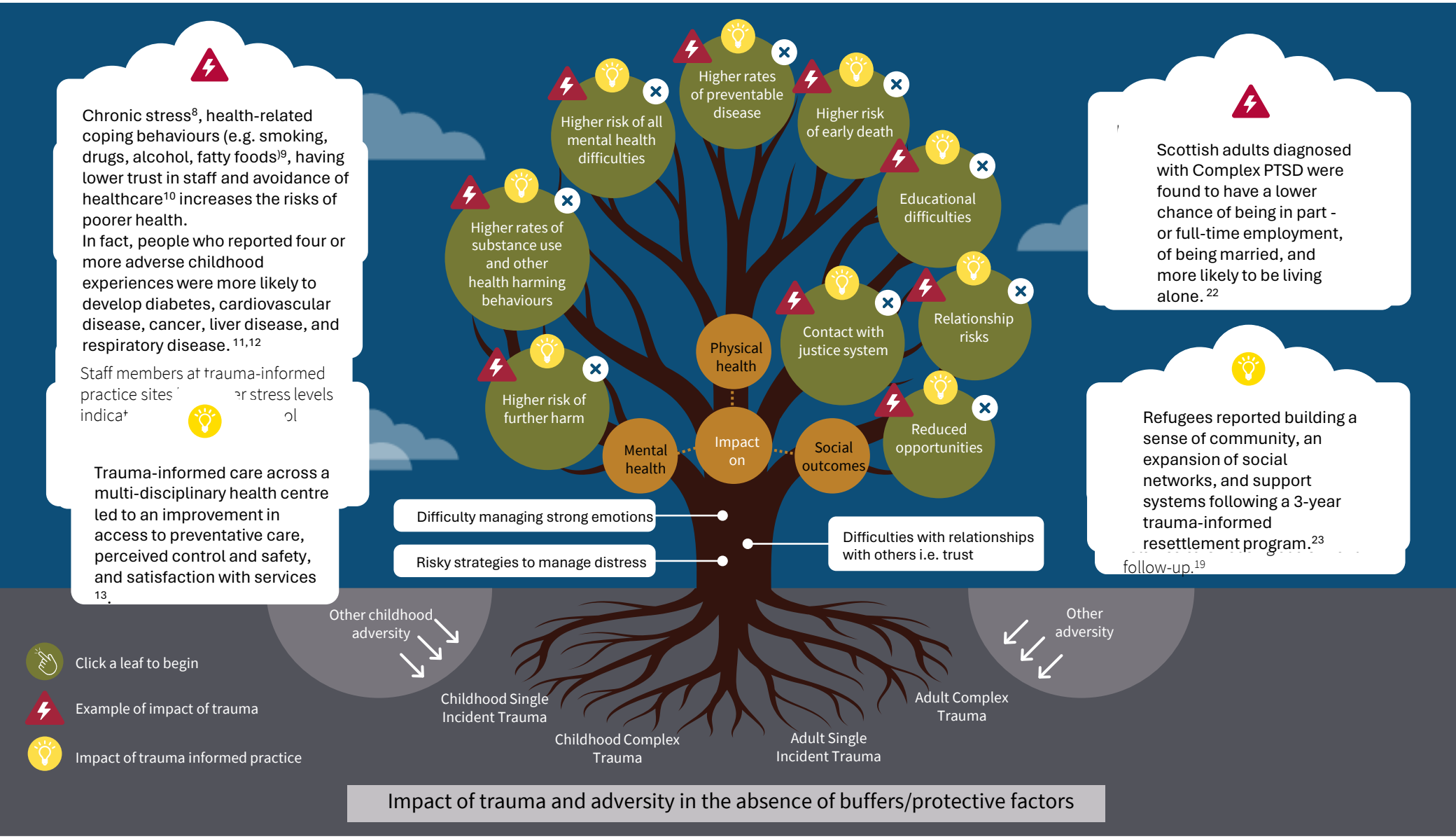
Their **needs have often not been met** by services and they can experience a range of challenges, which often **has roots in childhood trauma** and adversity including **addiction, mental health problems, and homelessness**, **offending, domestic abuse**, and **reduced opportunities in education and employment,** across the lifespan.

Trauma in Context of Recent Events

- 20%of all employees lost sleep over money worries 75% of all staff are stressed ,47% of all staff always go into work when unwell

- 88% of businesses said that recruitment and retention was problematic, almost 45% of social care providers were not confident they would be able to continue to deliver services at the same level they currently provide over the next 12 months if recruitment remains a problem

- **42% of all staff consider their organisation's culture has a negative effect on their wellbeing, 59% are not confident in disclosing unmanageable stress or mental health issues to their employer,49.8% said that psychological wellbeing/trauma has been a feature in sickness absence**


Chronic stress[8], health-related coping behaviours (e.g. smoking, drugs, alcohol, fatty foods)[9], having lower trust in staff and avoidance of healthcare[10] increases the risks of poorer health.
In fact, people who reported four or more adverse childhood experiences were more likely to develop diabetes, cardiovascular disease, cancer, liver disease, and respiratory disease. [11,12]
Staff members at trauma-informed practice sites
indica
ol
Trauma-informed care across a multi-disciplinary health centre led to an improvement in access to preventative care, perceived control and safety, and satisfaction with services [13].
Higher rates of preventable disease
Higher risk of all mental health difficulties
Higher risk of early death
Higher rates of substance use and other health harming behaviours
Educational difficulties
Contact with justice system
Relationship risks
Higher risk of further harm
Reduced opportunities
Physical health
Mental health
Impact on
Social outcomes
Difficulty managing strong emotions
Risky strategies to manage distress
Difficulties with relationships with others i.e. trust
Scottish adults diagnosed with Complex PTSD were found to have a lower chance of being in part - or full-time employment, of being married, and more likely to be living alone. [22]
Refugees reported building a sense of community, an expansion of social networks, and support systems following a 3-year trauma-informed resettlement program.[23]
follow-up.[19]
Other childhood adversity
Other adversity
Childhood Single Incident Trauma
Childhood Complex Trauma
Adult Single Incident Trauma
Adult Complex Trauma
Click a leaf to begin
Example of impact of trauma
Impact of trauma informed practice
Impact of trauma and adversity in the absence of buffers/protective factors

Trauma Informed, Equity and Social Justice Intersections

This infographic illustrates the intersection of trauma-informed approaches and equity and social justice initiatives. It uses a modified ecological model to show examples of factors that perpetuate inequity, induce trauma, and create poor health outcomes or conversely promote equity, healing, and well being.

About a Trauma Informed and Responsive Approach

Being ‘trauma-informed and responsive’ means being able to **recognise** when someone may be affected by trauma, **collaboratively adjusting** how we work to take this into account and **responding in a way that supports recovery,** does no harm, and **recognises and supports people's resilience.** NHS Education for Scotland, 2017

Awareness of how a **person’s past or current trauma, race, ethnicity, gender, sexual orientation, religion,** or other facets of one’s identity might shape their experiences and **create disadvantage and inequity**.

A trauma-informed and responsive approach **strives to be equitable**. It takes a strengths-based approach that believes in a person’s or **organisation’s ability to contribute to healing and recovery**.

We will use the term Trauma Informed and Responsive Approach in Edinburgh (TIRA)

Story of Survival and Hope

Trauma and adversity is Not Destiny. Recovery is possible, people show extreme resilience in the face of overwhelming adversity.

How do we support recovery and resilience? From fear to safety, from control to empowerment, and from abuse of power to accountability and transparency. (Concetta 2018).

What helps?

- Safety
- Choice
- Collaboration
- Trust
- Empowerment

What hurts?

- Threat
- Control
- Coercion
- Betrayal
- Disempowerment

The 5 Principles and the 6Rs

Key concepts of taking a trauma informed and responsive approach

The 5 Principles

The 6 Rs

Recognise the prevalence of trauma in society

Realise where trauma is impacting on the person

Resist practises and systems which re-traumatise

Respond in a way which supports recovery

Relationships matter

Respect resilience

Getting Clear on Trauma and TIRA

What it is

A **universal strategy** for addressing trauma that ensures a **shared understanding** of trauma and its impact, and a **collective response** to align practices and policies **to support resilience and healing**.

Trust, **Safety**, **Choice**, **Collaboration**, and **Empowerment**

- ✓ It is **all about relationships**
- ✓ Demonstrating a ‘what happened to you, NOT ‘what’s wrong with you?’ approach?
- ✓ Providing the five universal principles to all, whether or not we know about their trauma

We don’t need to know about **people’s traumatic experience or be an expert,** we take universal precautions. Think BBV!

Prevalence:

Trauma is common among adults and children in social service systems.

98% of **female offenders** have **experienced trauma,** often interpersonal trauma and domestic violence

96% of **adolescent psychiatric inpatients** have histories of **exposure to trauma**

93% of **homeless mothers** have a **lifetime history** of **interpersonal trauma**

90% of **juvenile justice-involved youth** have experienced trauma, often **multiple traumas from an early age**

75% of **adults** in **substance abuse treatment** report histories of trauma

70% of **children** in **foster care** have experienced multiple traumas

Goal:

Trauma-Informed Systems

https://www.air.org/sites/default/files/trauma_infographic.pdf

Moving Beyond ACES

Adverse Childhood Experiences: Impact individual and interpersonal unintentional emotional neglect, medical crisis.

Adverse Community Experiences: Impact population conditions. Poverty, structural racism, community disinvestment, disconnected relationships, unemployment,

Adverse Climate Experiences: Impact community conditions. Examples include COVID 19, floods and pollution.

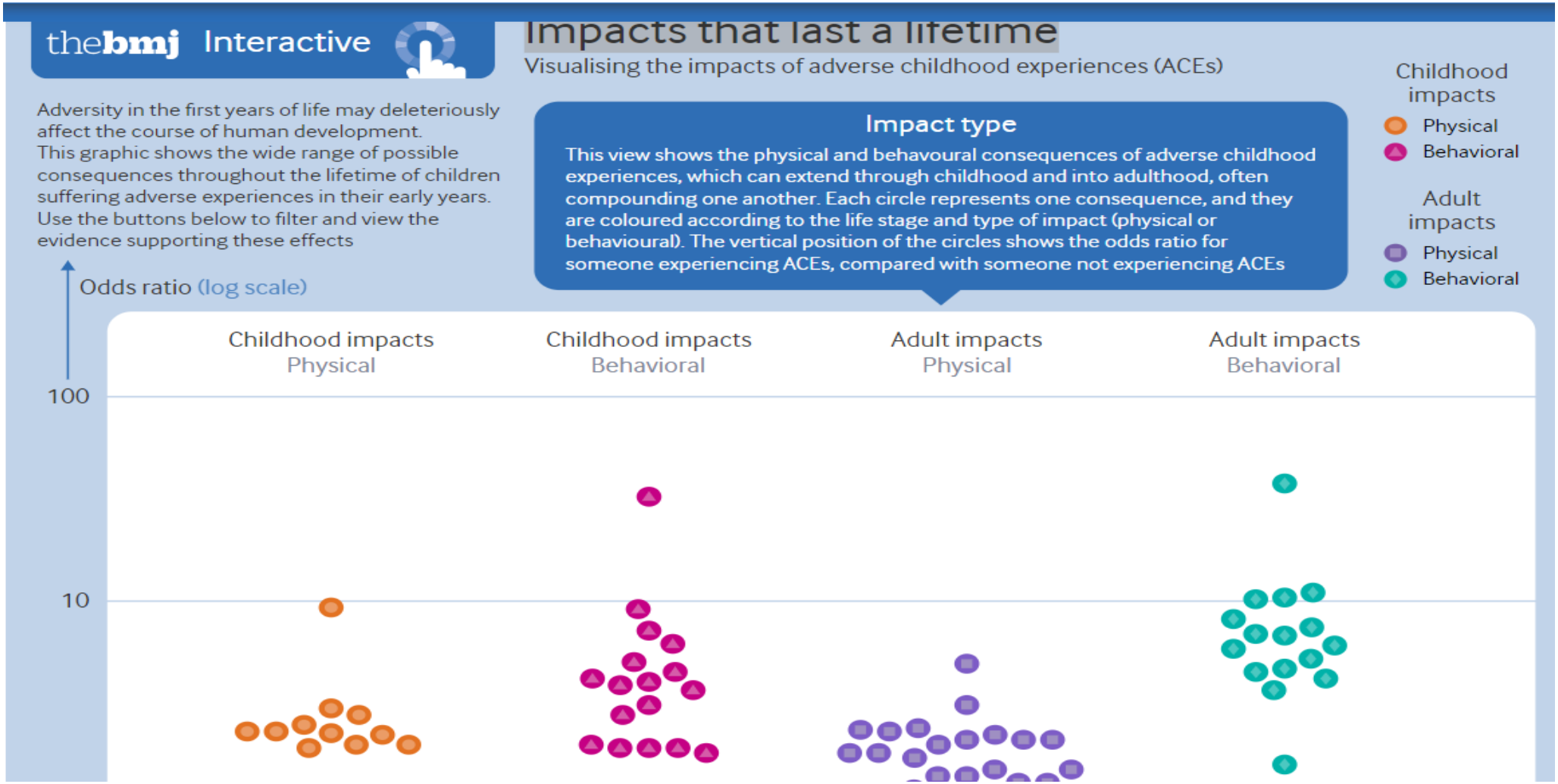
Atrocious Cultural Experiences: Impact macro and socio-historical conditions. Slavery, genocide, forced family separation, political and social mistrust.

Adverse Childhood Experiences - ACE's and Trauma

Consider ACE's in the context of the global pandemic, economic crisis, war, climate change, economic disparities and escalating violence in classrooms and support settings.

The biological and psychological toll is yet to be fully quantified .We are seeing it play out daily

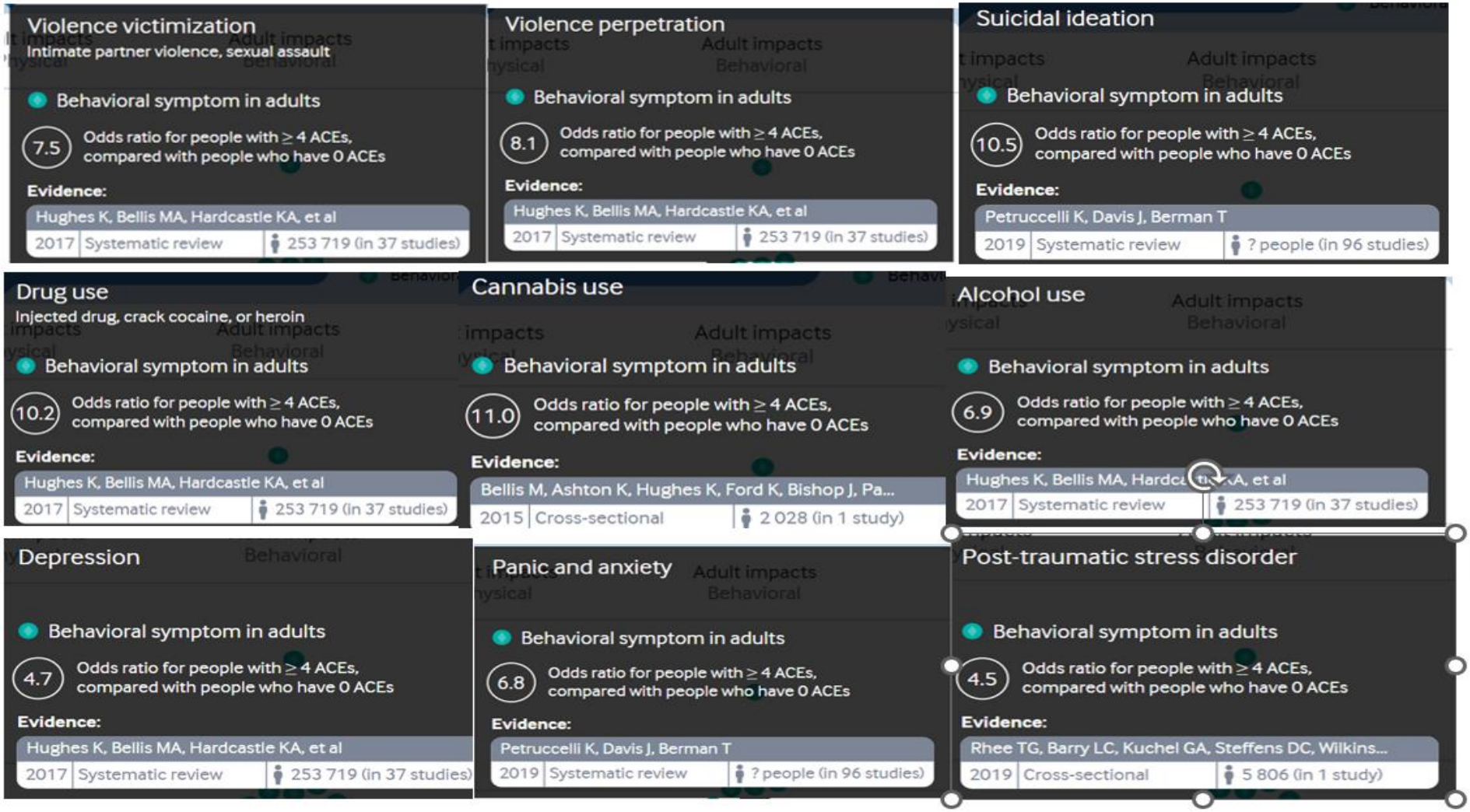
1 in 7 people in Scotland have experienced **four or more ACEs** before they turned 18**, 71%** had experienced at **least one ACE, that was before the collective trauma of the pandemic**


thebmj Interactive
Impacts that last a lifetime
Visualising the impacts of adverse childhood experiences (ACEs)
Adversity in the first years of life may deleteriously affect the course of human development. This graphic shows the wide range of possible consequences throughout the lifetime of children suffering adverse experiences in their early years. Use the buttons below to filter and view the evidence supporting these effects
Impact type
This view shows the physical and behavioural consequences of adverse childhood experiences, which can extend through childhood and into adulthood, often compounding one another. Each circle represents one consequence, and they are coloured according to the life stage and type of impact (physical or behavioural). The vertical position of the circles shows the odds ratio for someone experiencing ACEs, compared with someone not experiencing ACEs
Childhood impacts
Physical
Behavioral
Adult impacts
Physical
Behavioral
Odds ratio (log scale)
100
10
Childhood impacts
Physical
Childhood impacts
Behavioral
Adult impacts
Physical
Adult impacts
Behavioral

One year after a school-wide trauma informed implementation, disciplinary referrals decreased by 32%, and by 87% at 5 years post implementation

Just one year after implementation, a trauma-informed child welfare system reported a 15% reduction in substantiated reports of maltreatment

Staff members at trauma-informed practice sites had lower stress levels


Violence victimization
Intimate partner violence, sexual assault
Behavioral symptom in adults
7.5
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Hughes K, Bellis MA, Hardcastle KA, et al
2017 | Systematic review | 253 719 (in 37 studies)
Violence perpetration
Behavioral symptom in adults
8.1
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Hughes K, Bellis MA, Hardcastle KA, et al
2017 | Systematic review | 253 719 (in 37 studies)
Suicidal ideation
Behavioral symptom in adults
10.5
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Petruccelli K, Davis J, Berman T
2019 | Systematic review | ? people (in 96 studies)
Drug use
Injected drug, crack cocaine, or heroin
Behavioral symptom in adults
10.2
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Hughes K, Bellis MA, Hardcastle KA, et al
2017 | Systematic review | 253 719 (in 37 studies)
Cannabis use
Behavioral symptom in adults
11.0
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Bellis M, Ashton K, Hughes K, Ford K, Bishop J, Pa...
2015 | Cross-sectional | 2 028 (in 1 study)
Alcohol use
Behavioral symptom in adults
6.9
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Hughes K, Bellis MA, Hardcastle KA, et al
2017 | Systematic review | 253 719 (in 37 studies)
Depression
Behavioral symptom in adults
4.7
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Hughes K, Bellis MA, Hardcastle KA, et al
2017 | Systematic review | 253 719 (in 37 studies)
Panic and anxiety
Behavioral symptom in adults
6.8
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Petruccelli K, Davis J, Berman T
2019 | Systematic review | ? people (in 96 studies)
Post-traumatic stress disorder
Behavioral symptom in adults
4.5
Odds ratio for people with ≥ 4 ACEs, compared with people who have 0 ACEs
Evidence:
Rhee TG, Barry LC, Kuchel GA, Steffens DC, Wilkins...
2019 | Cross-sectional | 5 806 (in 1 study)

Role of TIRA in building resilience and supporting positive outcomes

We are talking about crisis, in relation to Mental Health, Substance use, increased Aggression and Violence ,Suicide, Housing- **Common denominator here is TRAUMA**

If we are to effectively address the problem and look to foster resilience, we need to look to **solution the real problem**.

Important we recognise social trauma and the intersectionality of multiple traumas and establish **links between trauma and presenting** challenge/distress.

Policy Context

Our ambition is for a trauma informed workforce and services across Scotland, supported by our National Trauma Training Programme.

This ambition is framed within the **context** of:

- Reducing the gap in health outcomes between our most and least deprived communities (1)
- Preventing and Mitigating the Impact of Adverse Childhood Experiences (2)
- Getting It Right For Every Child (GIRFEC) (3)

It is underpinned by our **six public health priorities** for Scotland (4):

- A Scotland where we live in vibrant, healthy, and safe places and communities
- A Scotland where we flourish in our early years
- A Scotland where we have good mental wellbeing
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
- A Scotland where we eat well, have a healthy weight and are physically active

It will be reinforced by current and forthcoming **legislation**, including:

- The Human Rights Act 1998 and provisions in the Scotland Act 1998 (5)
- The United Nations Convention on the Rights of the Child (UNCRC) (Incorporation) (Scotland) Bill (6)

It is supported by a number of long term **strategies and action plans** to help tackle inequalities and improve outcomes for all, including:

- Tackling Child Poverty Delivery Plan (7)
- The Independent Care Review and The Promise (8)
- Mental Health Strategy (2017-2027) (9)
- Ending Homelessness Together Action Plan (10)
- Public Service Reform (11)
- Equally Safe (12)
- Health and Work Strategy (13)
- National Strategy for Community Justice (14)

It is reinforced within a range of national **policy and practice guidance**, including:

- The Charter of Patient Rights and Responsibilities (15)
- Children's Services Planning Guidance (16)
- National Standards for Secure Care (17)
- National Guidance for Child Protection (18)
- Standards for Weight Management Services (19)

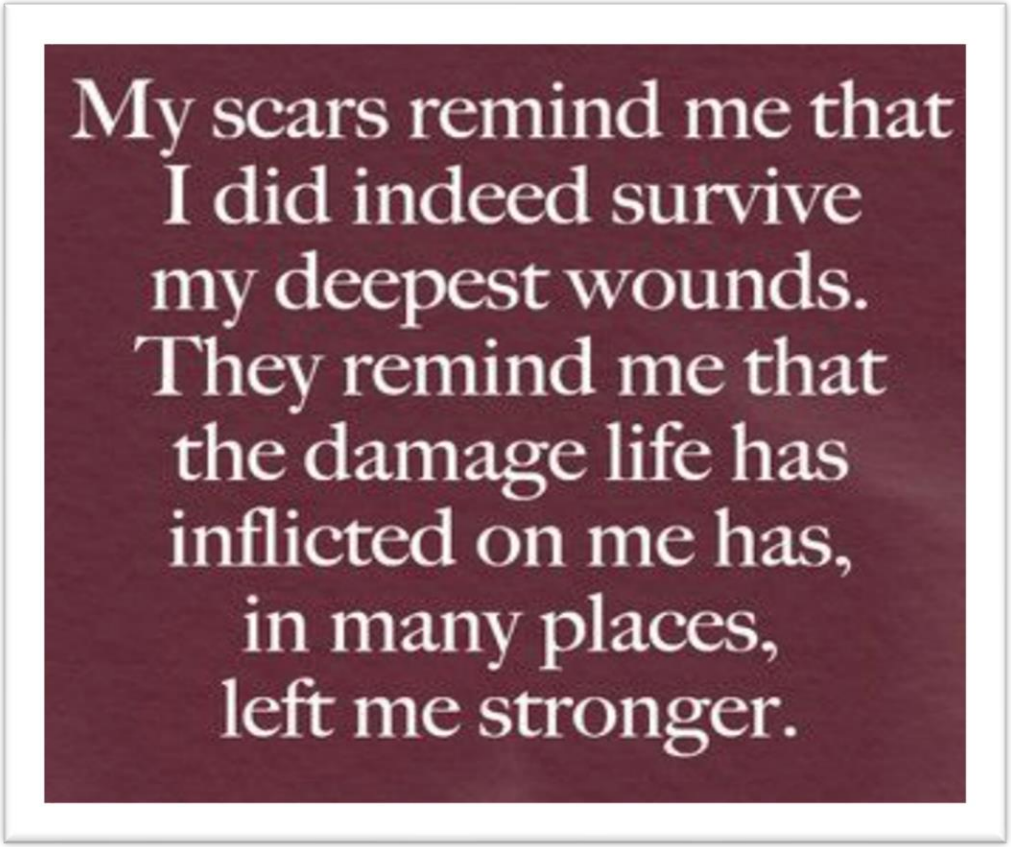
It supports our shared, long term response to **recovery from COVID-19**, as highlighted in:

- Mental Health Transition and Recovery Plan (20)
- COSLA Blueprint for Local Government (21)

The impact on **outcomes** will be monitored in line with our National Performance Framework (22), and in particular:

- We grow up loved, safe and respected so that we realise our full potential
- We respect, protect and fulfil human rights and live free from discrimination
- We live in communities that are inclusive, empowered, resilient and safe
- We are healthy and active

Resilience in action



Resilience is built through some of our most painful moments. It's when the worst of life doesn't take over the best of life

Charles Hunt -Resilience Expert

Resilience exerts a buffering role in the relationship between traumatic experiences and adverse psychological outcomes after trauma

Pinquart 2009

Strength based v deficit based approach

Resilience Matrix - Example

Wellbeing & Nurture Team
Denny High School

Resilience

These are the characteristics of the young person or child that helps them cope with adversity and vulnerability.

- *Social temperament*
- *Able to reach out for help*
- *Sense of humour*
- *Assertiveness*
- *Cognitive skills*
- *Problem solving skills*
- *A language for feelings*
- *Healthy assertion and self efficacy*
- *Emotional self regulation*

Example: Winning personality, able to get on with adults, intelligent.

Protective Factors

These are aspects of the young person's life which may act as a buffer against the negative effects of adverse experiences.

- *Relationships with adults*
- *Relationships with siblings or friends*
- *Club memberships*
- *School attendance*
- *Positive relationships with adults in the school*

Example: Positive attachment to grandparents, good relationship with teachers, Mum trusts health visitor and teacher, Dad consistent in concern and contact, History of good care and positive parental attachments.

Vulnerability

The characteristics of the young person, their family, the wider community and the functioning of professionals which may threaten the young person's healthy development or safety.

- *Illness*
- *Disability*
- *Temperament*
- *Past experiences - bullying etc.*
- *Aggressive behaviour*
- *Parents expectations of behaviour*
- *Self esteem*
- *Parenting*

Example: Anxious about mum. Anxiety enhanced by mums depression and emotional withdrawal.

Adversity

This covers life events, circumstances and relationships the child or young person is currently experiencing which may challenge or threaten their healthy development or lead to harm.

- *Poor housing*
- *Recent loss or separation*
- *Racism*
- *Domestic Violence*
- *Illness*
- *Neglectful parenting*
- *Insecure attachments*

Example: Mum and Dad are separated. Has a parental role looking after mum & siblings. Mum is currently depressed. Loss of nurturing routines.

Two sides of the same coin

- The absence of positive things may be more harmful than the presence of the negative (ACEs).
- Providing the opposite experience can neutralise the negative impact
- Benevolent Childhood Experiences- and Positive Childhood Experiences lower trauma-related symptoms
- Post Traumatic Growth- The meaning they give to their suffering and their motivation for wanting to live
- Decrease trauma and adverse childhood experiences and increase their positive experiences
- Trauma happens in relationships. Recovery happens in relationships
- Never underestimate the role you play .Intentionally try to build positive relationships

Protective Factors to build resilience

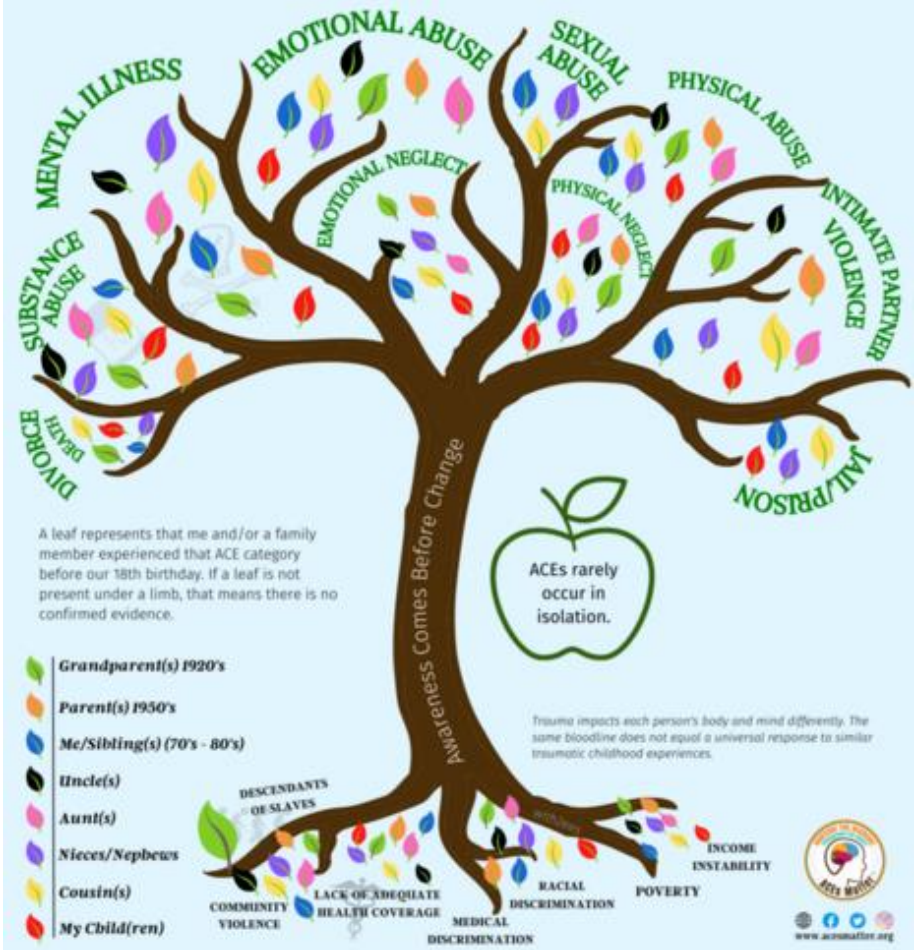
Benevolent Childhood Experiences- BCE's

1. At least one caregiver with whom you felt safe?
2. At least one good friend?
3. Beliefs that brought comfort?
4. Enjoy school?
5. At least one teacher who cared about you?
6. Good neighbours?
7. An adult ,not a parent or caregiver who could provide you with support and advice?
8. Opportunities to have a good time?
9. Like yourself or feel comfortable with yourself?
10. Have a predictable routine, like regular meals and regular bedtime

My ACEs Tree | Genealogy

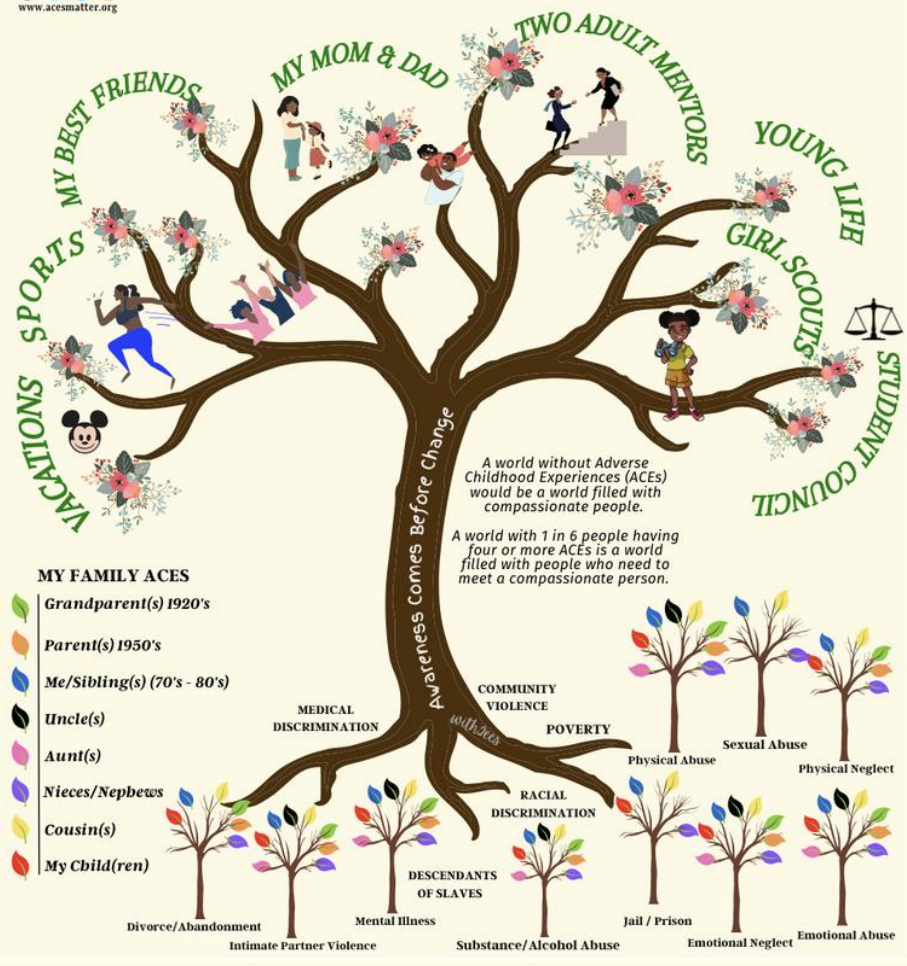
A world without ACEs would be a world filled with compassionate people.

A world with 1 in 6 people having four or more ACEs is a world filled with people who need to meet a compassionate person.



My Positive Childhood Experiences | Tree

www.acesmatter.org



Difference categories of resilience

Emotional resilience is the way through which we empower ourselves to perceive adversities as ‘temporary’ and keep evolving through the pain and sufferings.

Family resilience the “characteristics, dimensions, and properties of families which help families to be resistant to disruption in the face of change and adaptive in the face of crisis situations. Whole family approach- build resilience of family. Need to be mindful of trauma adversity of parents-Intergenerational trauma. Healing needs compassion and support not shaming and blaming.

Community Resilience: Growing research on resilience at the community level. the importance of social relationship. We all exist in communities, in the places we live and, in our workforce.

Organisational Resilience: Organisational resilience goes beyond building inner strength as an individual, a team or a leader. It means building an environment that enables people to maintain transformational growth in the face of change.

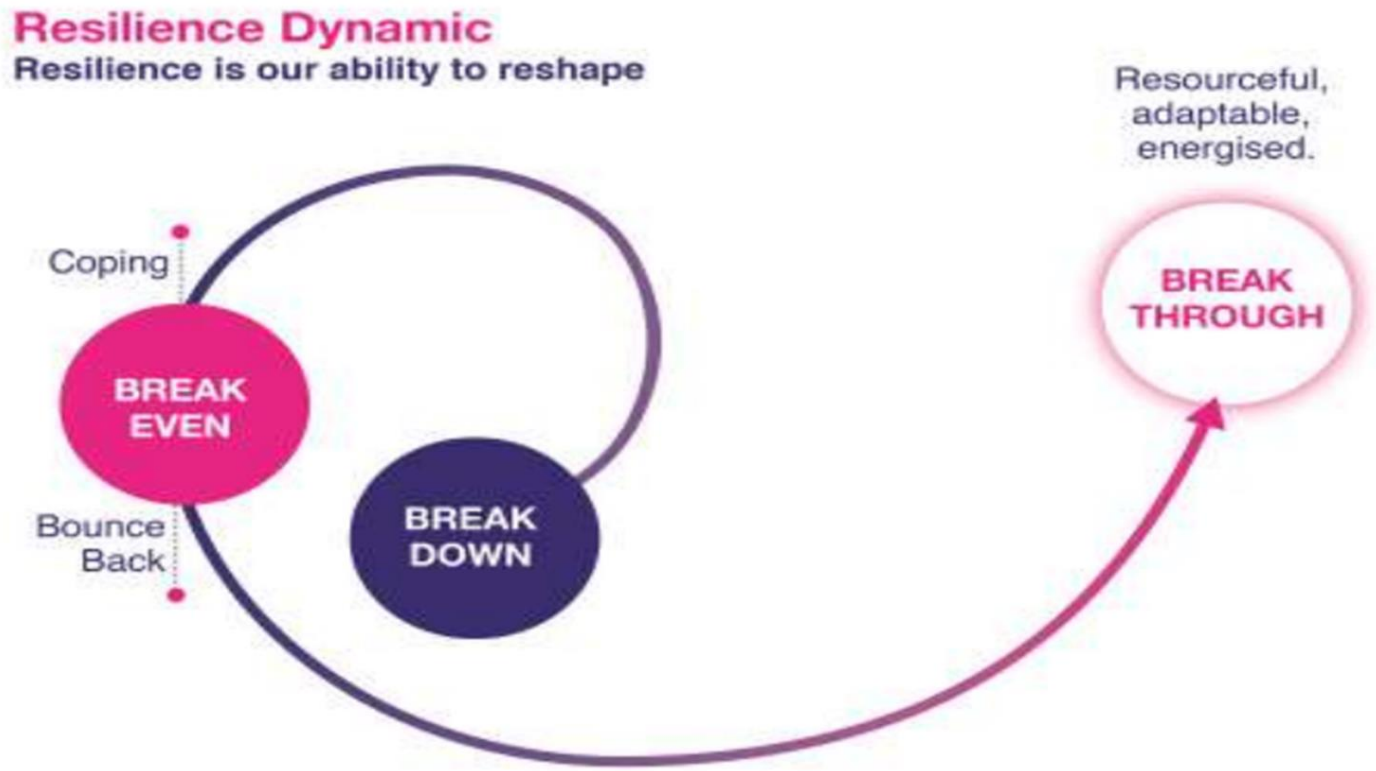
https://youtu.be/SxV72Zph9U0

Pause and reflect, what one message will you take away from from John?

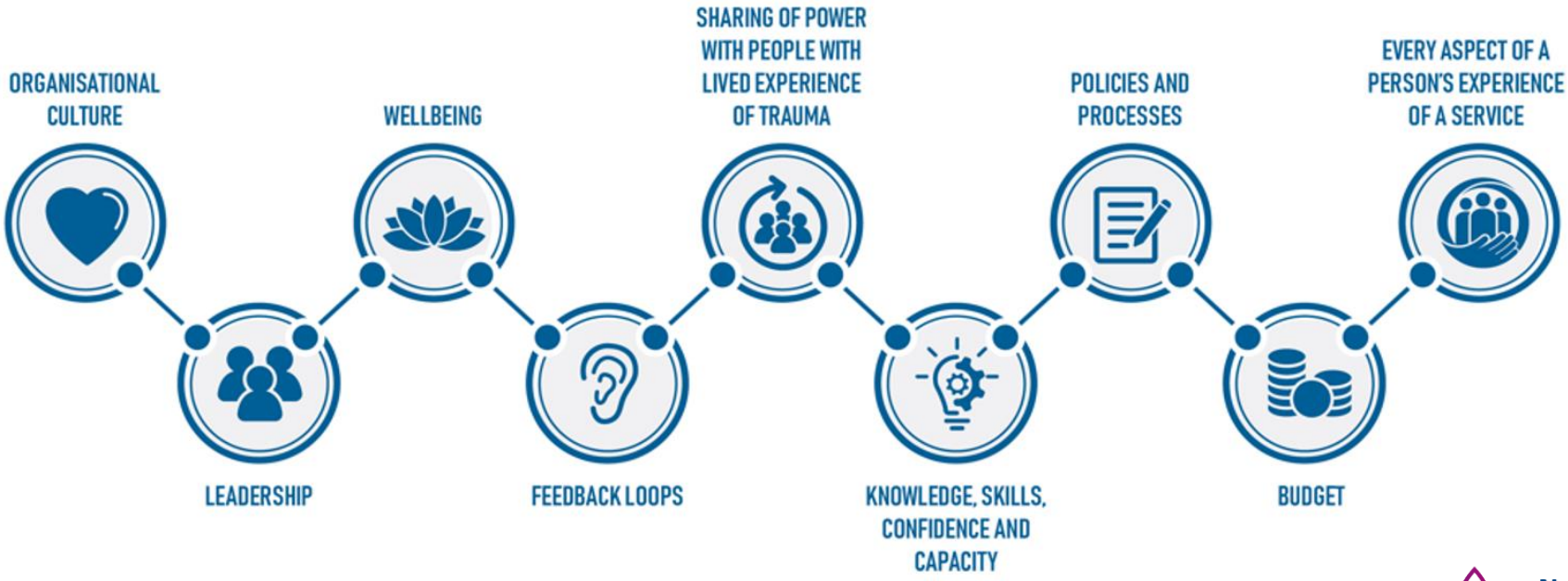
Why Organisational Resilience Matters

Organisational resilience goes beyond building inner strength as an individual, a team or a leader. It means building an environment that enables people to maintain transformational growth in the face of change.

Organisational Resilience and the Resilience Dynamic



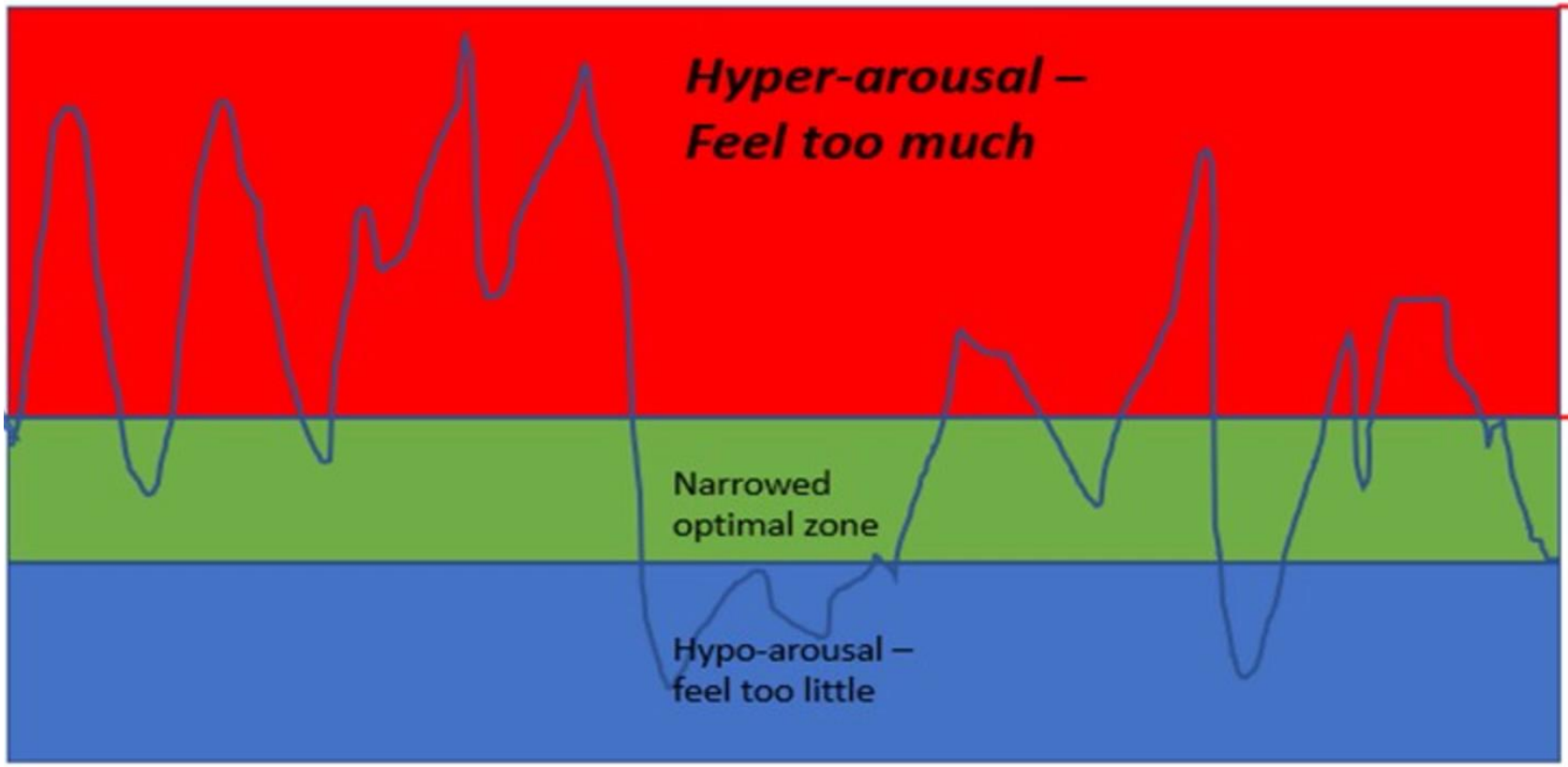
What do trauma-informed and responsive organisations, systems and workforces look and feel like?



National Trauma Transformation Programme
Responding to Psychological Trauma in Scotland

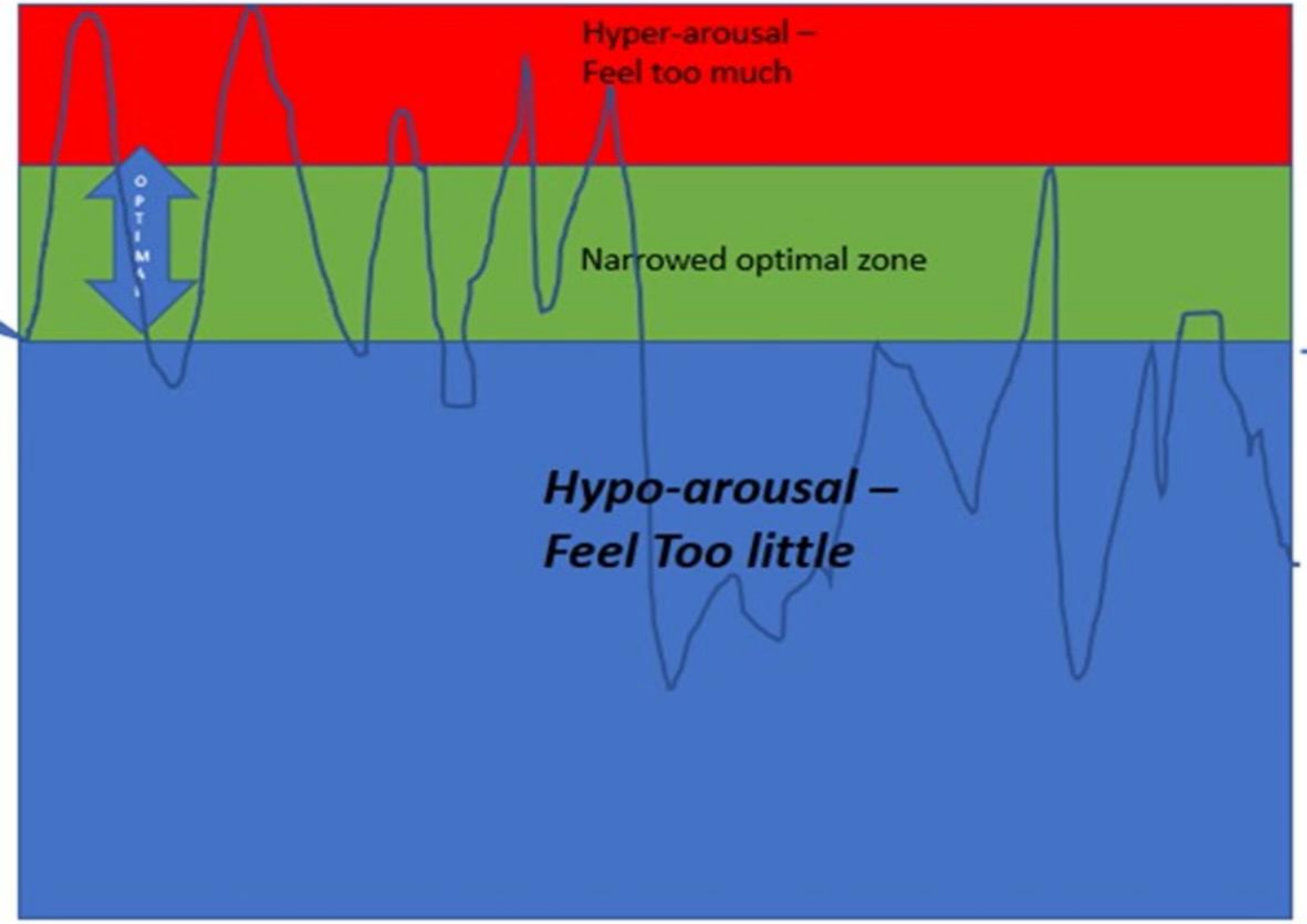
Organisational Resilience and the Window of Tolerance

In The Green Zone



- Fight/Flight reactions e.g.
- Anger
- Panic
- Distress
- Intensity
- Overwhelm
- Sensitivity +++
- Loss of control
- Can't think 'straight' / focus
- Can't problem solve
- Agitated / Restlessness
- Startle response
- impulsive
- Body arousal – heart rate increases, sweat, shake, dry mouth, breathe faster/ shallower

In The Red Zone

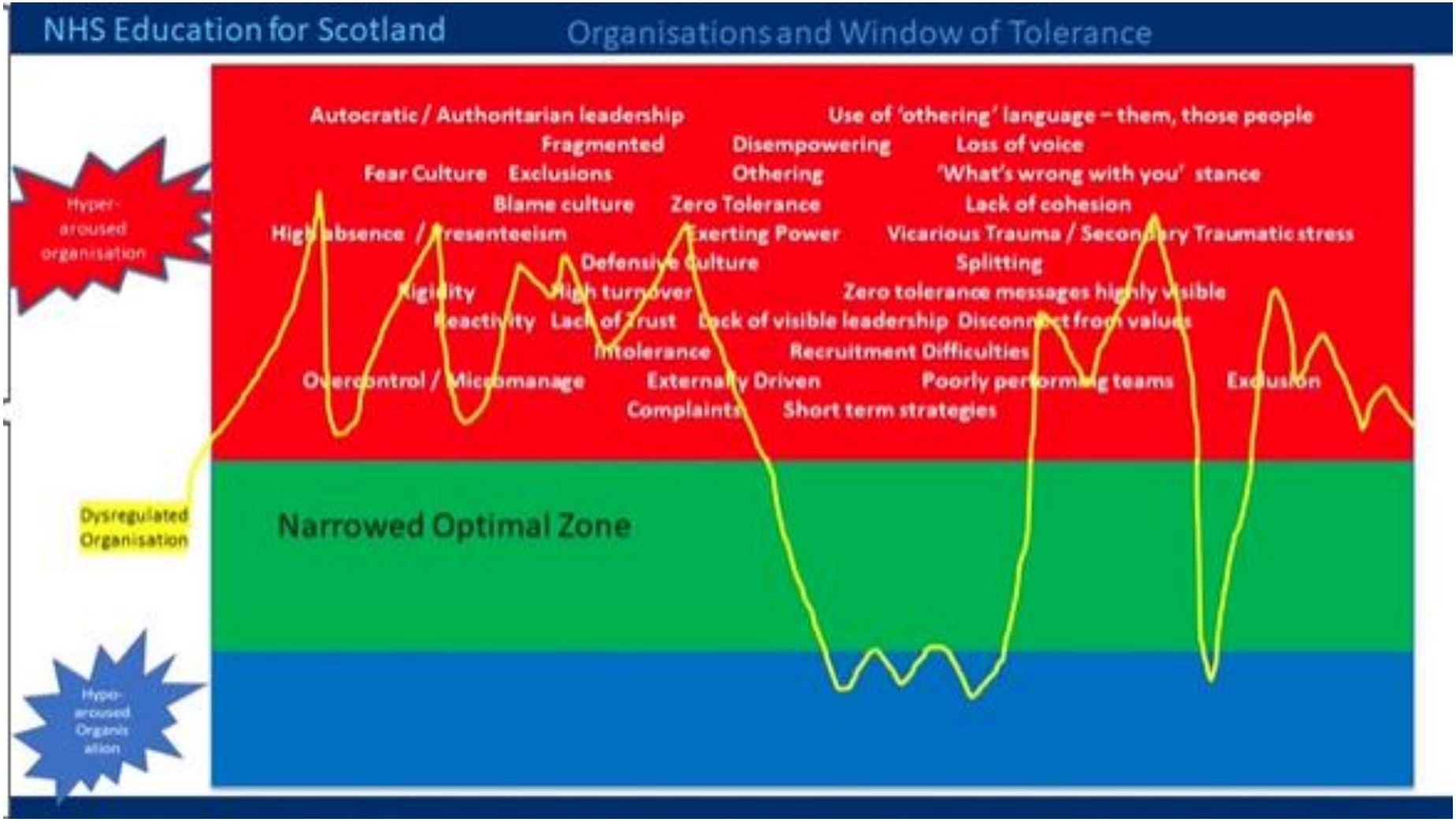


- Freeze / Flop responses
- Disconnected
- Zoned 'out'
- Shut down/shut out
- Sensitivity ---
- Numbing
- Less responsive
- Lack of expression
- No longer present
- Appears bored, tired, disinterested
- Unavailable
- Lack of emotion

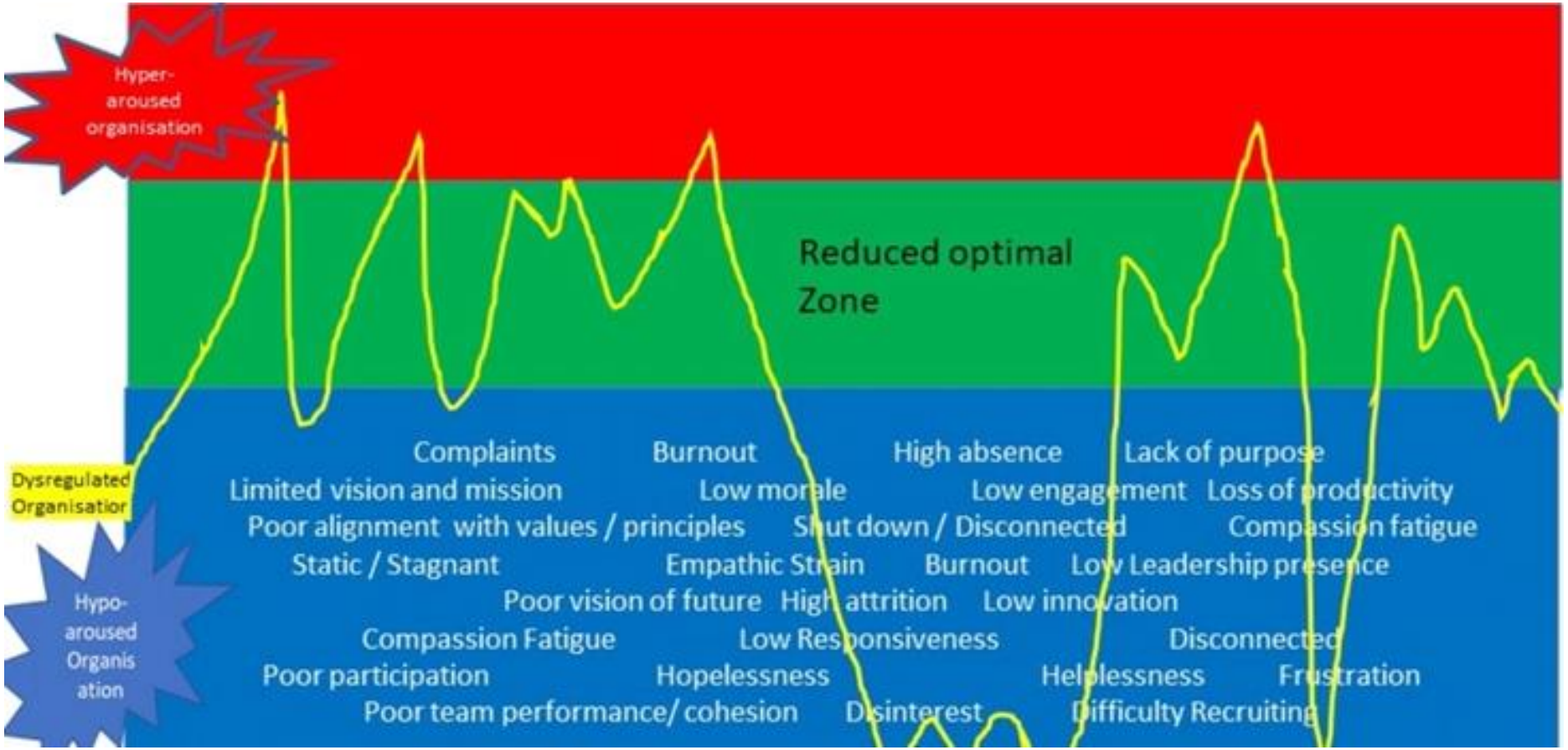
In The Blue Zone

Organisational Window of Tolerance

In The Green Zone



In The Red Zone



In The Blue Zone

Complex Interplay of resilience and TIRA

- ✓ A need for awareness raising with the general public about trauma to enable a **community asset-based approache**s –focusing on safe interactions“ not interventions”.
- ✓ **Success** needs to be **defined collaboratively** and consider what would have the biggest impact for the person, the staff and the service.
- ✓ TIRA as the potential to lead to a **fundamental shift in how services are organised and delivered**, so they are better able to meet the needs of all key players.
- ✓ A cultural shift not just a behavioural one– a change in the way front-line staff, managers and leaders **understand the impact of trauma, which in turn informs strategic decisions policy and influences practic**e.

Consider at a service level

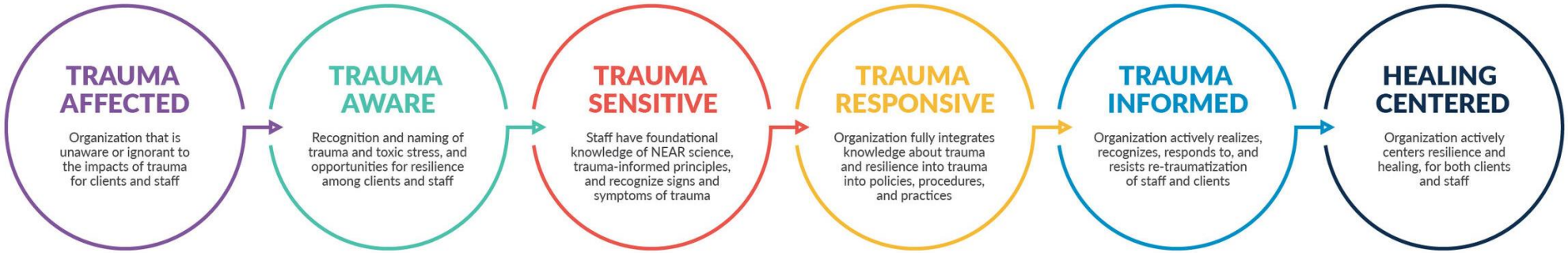
- ✓ People who have experienced trauma will interact with a range of services throughout their lives- Adopting TIRA that embodies the 5Ps/6Rs- **set people up for success not failure**. Applies to **workforce and our "citizens**.
- ✓ **Feeling unsafe** in a trauma un-informed system can cause our citizens and people accessing our services to **become aggressive**.
- ✓ This can, in turn, make staff feel unsafe. Need to raise awareness, e**ducate, support capacity and confidence** throughout our organisations.
- ✓ Culture change- **Curiosity and safety**, not judging , shaming, blaming.

Consider at a service level

- ✓ Roles based on **trust, collaboration, choice, empowerment, safety**
- ✓ **Emotional and physical safety** for those we support and provider. Reframe symptoms as c**oping adaptations**
- ✓ Working in **partnership with** trauma survivors, e.g. to design, deliver and evaluate services
- ✓ Adopting strengths-based approaches that enhance **resilience** and success as defined by the person
- ✓ **Collaborative relationships -** away from power over dynamic. Win-Win approach.
- ✓ We are **already doing it**. Whole Family Wellbeing, TYLA, 3 Conversations, Family Group Decision Making, Systemic Family Therapy, Trauma Project Willow

Roadmap to set people up for success

This graphic illustrates the spectrum of organisation types when considering the level of trauma-informed and healing centred approached they currently implement.



Some ideas re: next steps

- Invitation to **align strategic thinking, planning and decision making with a TIRA** . Consider adding Trauma to our IIA and adopting a TIRA in Edinburgh.
- Invitation for leaders to attend the **Scottish Trauma Informed Leaders Training (STILT**), a half day workshop for strategic and operational leaders and managers with ongoing coaching and peer leadership support opportunities..
- Invitation for **Elected Members** attend event-online event 'Trauma Is Everybody's Business' on Monday, 19th February, 10am-12pm.
- Staff **trained to the right degree for their role**, and have the knowledge, skills and confidence to apply this in their role. Leaderships commitment to support learning and development across all teams within the CEC & HSCP.
- Resilient services **requires resilient staff** -supported to be resourced, with space to pause to invite curiosity in what's working, how can we support successful outcomes- for all.

Appreciations and Commitments

Before we finish, what is one thing that you appreciated from today, and what is one thing that you would like to commit to?

How can we support each other to keep this going? Can we use this evidence base to inform key decisions, policy and practice and funding allocation?

Further Information https://www.traumatransformation.scot

Thank you for your time, Questions?

Small group work

1. How well do we build resilience together?
2. How do we know this ? (we want tangible evidence here)
3. What can we do the be even better ? (we want measurable actions here)

TIME FOR A BREAK…

Spotlight presentations

Developing Life Story Practice

Elspeth Russell

Team Leader (Fostering), Family Based Care

Hannah Baillie

Senior Practitioner (Adoption), Family Based Care

Life Stories and Recording – Why is it important for our care experienced community?

- For most of us, our memories are scaffolded by our families and other people that we have enduring relationships with. If children and young people have experienced fractured relationships, these memories are easily lost.

- Most children and young people who are looked after away from their family have experienced loss, trauma and multiple changes in adult carers. Life story work can help them understand and integrate their past, make sense of their present and develop a clear sense of identity for their future. It is an invaluable tool in helping them make sense of what has happened and is happening to them.

Life Story Group – Our Aim

All children and young people who are looked after away from their families - past, present and future - should

- be able to explain why they could not remain with their first family and understand their life journey without gaps or inaccuracies.
- have life records which represent an honest and personal account of their family, identity and their journey through care. This should include photos, achievements and anecdotes.
- should have access to a visual narrative that focuses on their life experience in a chronological, age-appropriate way.
- be given the message regularly that they can ask difficult questions of their carers, and social workers, and that these adults will be the agents in seeking information for them.
- be able to identify relationships that are or have been important to them. Children and young people should be supported to rebuild or continue these relationships where it is safe to do so.

All care experienced children, young people and adults are entitled to have a clear, visual narrative of their journey through care, that is accessible to them for the duration of their lives.

Stage 1 - Current care experienced children and young people

- After consultation with practice team workers, residential workers, foster carers and Family Based Care workers, we began providing 1:1 consultations to address the gap in life story discussions and work being done with children. This seemed to stem from lack of training opportunities, lack of confidence and lack of time.

- The one-hour consultation provides the basis for a visual, chronological narrative for children and young people.

- The consultation with the PTSW and foster carer is important to gauge:

  - the child's current knowledge and level of understanding,
  - the age, developmental age and cognitive ability,
  - the complexity of care experience so far, complexity of family relationships and knowledge of direct relations,
  - how much information the has child had so far, questions asked, gaps, 'dangerous fantasies' etc.

Stage 1 (cont.)

- A narrative is created and provided to the child and their adult carer. The child is given a notebook to note down any questions that might stem from the narrative, taking the pressure off foster carers or social workers from having to answer complex questions on the spot. It shows the child that their questions are valued. The PTSW, FBCSW or residential worker should act as an agent on behalf of the child, in being able to fill any gaps or seek further information.

- When the child begins to ask more 'but, why?' questions, further detail can be added to the narrative. The narrative should be reviewed and updated every six months.

- Any children who require to be referred to the more intensive Therapeutic Life Story Work service to be identified via these consultations.

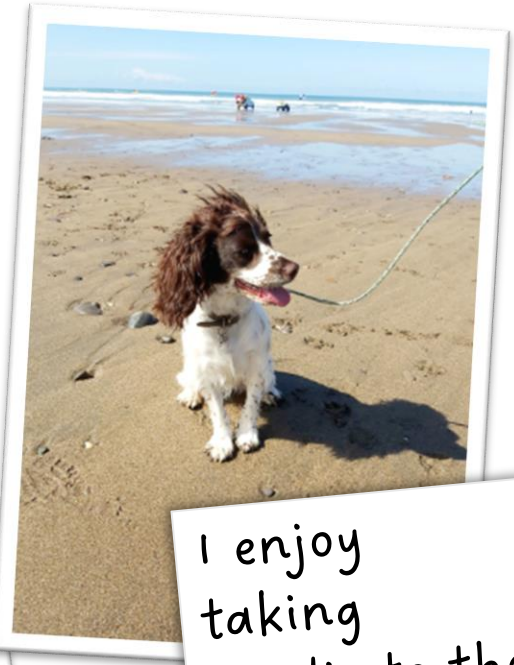
Example Visual Narrative

"My name is Ryan, and this book is all about me and my family."

We also live with Andrew, who is 16. We have a dog called Brodie.

Andrew

Brodie



I enjoy taking Brodie to the beach

"My name is Ryan. I am 15 years old and I live in Buckhaven with my foster carer, Karen."

Buckhaven is about one hour drive from Edinburgh.

Karen

Our house

I go to Abercorn Academy, and I am in my fourth year. My favourite thing at school is art. I enjoy drawing animals, which is not easy to do!

My school

My drawing of Brodie

My friend is called Seth

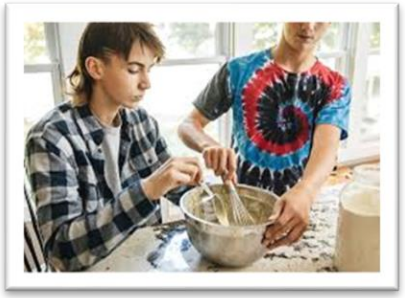
My favourite things:

My phone!

Playing football. I play for my school team.

Dogs!

Prime!



Baking. Sometimes we bake with Karen.

Listening to music.

Until March 2023, I used to stay with my brother Kyle. He is 14. He stays with Cally and Paul in Dunfermline.

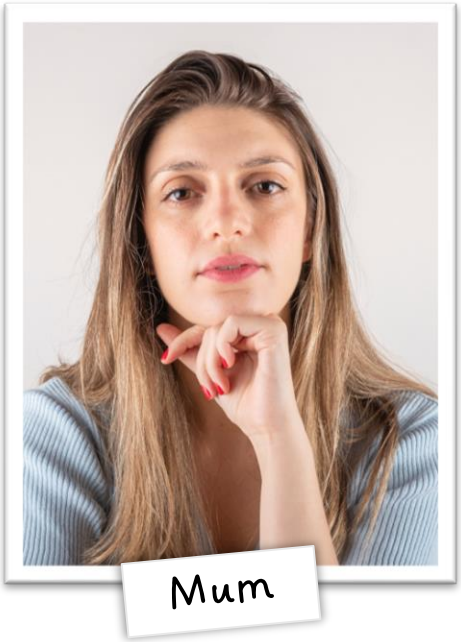
Kyle

Cally and Paul

Cally and Paul's house

Kyle and I have had lots different social workers and lots of different foster carers. This is a lot given that we are only 14 and 15.

Kyle and I didn't always live with our foster carers. We used to stay with our mum (Kayleigh) and our dad (Ryan).



Mum

Dad

Here is my story...

I was born on 27 May 2008 at the Royal Infirmary in Edinburgh. I was born at 7.36pm in the evening on a Saturday!

My dad Ryan was with my mum when I was born. My mum chose my name because it was the same as my dad's.

I weighed 8lb 3oz, which is about the same as an Xbox!

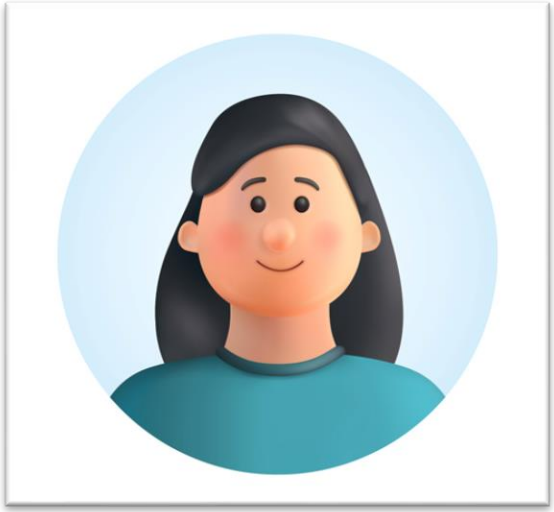
When my mum was pregnant with me, social workers, nurses and doctors were worried. My mum was not looking after herself - she was drinking alcohol, using drugs and did not have a house. A lot of different meetings were held as people were worried about me living at home with my mum after I was born. Social workers tried to help my mum to get a house and get ready for me arriving, but she could not manage to do this.

Our mum and dad were not looked after properly when they were little, so they did not understand how to look after babies and children. Because grown-ups had not cared for them properly, they did not know how to do this.

My mum couldn't get help from her family, as they were not safe people to look after a baby either. Their homes were very, very unclean, covered in old food and dog dirt and very smoky. Our mum had not told people she was pregnant for a long time, so hadn't let nurses or doctors make sure that she and her baby (me) was ok.

Babies need a lot of looking after. Social workers and nurses knew that my mum and dad found it hard to look after themselves and keep their home a safe place. Babies need clean nappies, cream, milk, baths, cuddles, sleep, a quiet and clean house. They also need to be taken to different medical appointments to check that they are growing healthily.

I stayed in hospital with my mum and dad for three days.



A social worker called Liz Graham came to collect me and spoke to my mum and dad, and my gran (Diane), who had come to visit.

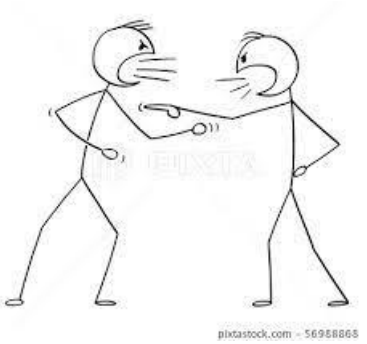
My mum was going to come in the car to drop me off to my foster carer, but she found this too sad, so Liz took me in the car herself.

My mum and dad weren't looked after properly when they were little. They was not given enough food to eat, not kept safe and they were often hurt and scared. As they grew up, they felt very sad inside and thought that taking drugs might make them feel better. But it didn't, it made them feel worse and worse, but they found it hard to stop taking them.




Taking drugs stopped my mum and dad from looking after themselves and looking after Kyle and I. It stopped them from getting jobs and having money to buy food and clothes.

Drugs made my mum and dad sleepy. They were not good at making sure we were safe, fed, got enough sleep, and went to nursery.



They were friends with other people who used drugs, who could be quite loud, sleepy or scary to children.

On 3 March 2011, two months before my 3rd birthday, police visited our mum and home. They phoned social workers to tell them that our house was very dirty and that there were lots of things that were unsafe for us. We had very bad nappy rash as our nappies had not been changed enough.

My mum would often invite other grown-ups round to their house for parties and it would be noisy and loud. She also used to take me to peoples' houses for parties and I would have to sleep on the floor. Children should sleep safely in a cosy bed or a cot in a nice quiet house, like I do at Karen's.

Kyle and I were taken to stay with Alice and Rachel, foster carers in Lasswade. We were able to take our Christmas presents with us. We stayed with them until 22 March 2013. They took good care of us.

Alice and Rachel

Where I lived in Lasswade

We had safe, cosy beds to sleep in and they made sure we were clean and had nice food to eat. Our mum sent us our toys, comfort blanket, scooters and clothes with our social worker. We missed our mum, and I was worried that she would be crying without us.

This is what our foster carers wrote about us on 29 December 2012 :

"Ryan and Kyle settled in well had a good nights sleep on Friday night they both fell asleep watching the bedtime story. Both boys slept until just after 8am they were very tired after the previous night.

Ryan has eaten very well, and Kyle has also tried very hard. Ryan has become quite chatty and enjoyed playing at cafes taking orders and making up lists, he also enjoyed a bit grocery shopping with Rachel. Ryan has been encouraging Kyle to join in when he has been playing, at present he has no particular favourite toy or game and is happy floating between things but can use his imagination. Ryan enjoys hugs and will ask to be lifted up and likes to be carried through to bed.

Kyle is quieter but takes everything in he has a good understanding of what is being said, he is able to make himself understood when he needs to and will repeat words if it is to get what he wants. Kyle enjoys watching adults do household chores especially cooking.

"Ryan does not ask for his mum but did ask on Friday when she was coming to collect him, when we phoned Mum on Saturday he started to cry quietly and would not speak, he cuddled in whilst I told her what he had up to. Kyle made noises when mum spoke to him and tends to ask for her when he is sleepy. Kyle did have a short cry late morning asking for her. Ryan has had some reflective moments since we called Mum and we asked him before tea if he wanted to speak to Mum since he had not managed earlier and he shook his head. Both boys appear to be missing mum and would probably benefit from a contact sooner rather than later.

"Spoke to mum on Saturday prior to letting the boys call. We let her know that they were doing well. She was very appreciative and although clearly upset she did manage to hold it together when she spoke to the boys.

Saturday night boys settled in bed by 7.30pm they are a pleasure to care for."

Regards Alice and Rachel

On 12 October 2015, when I was 7, a Permanence Panel was held, where lots of different workers that knew us (our social worker, health visitor, visits supervisor, nursery workers) attended to recommend where Kyle and I should live until we were grown up. It was decided that we should live with our foster carer Angie.

On 29 October 2016, a Sheriff at Edinburgh Sheriff Court granted Permanence Orders for us. This meant that the City of Edinburgh Council now had parental rights for us, instead of our mum and dad, and that they should decide where we should live, who should look after us, where we should go to school. Our mum had a lawyer who helped her to argue against this, but the Sheriff read all about us and felt that this would be best for us.

Since I have been living with Karen, we have done lots of fun things. We have been on holiday to France, been bowling, I have started guitar lessons and I have been chosen for the school football team.

I see my brother Kyle every 2 weeks and we WhatsApp quite a lot. I think it is better that we don't live together anymore, as it is quieter without Kyle and I can concentrate more.

I see my mum Kayleigh every month.

My name is Ryan, and this is the story of me and my family.

All families are different, and all families are special.

My hopes for the future...

I would like to keep seeing Kyle and Mum.

I would like to stay living with Kathy until I am old enough to find a flat of my own.

I would like to go on another holiday to France!

When I am older, I would like a dog of my own!

Stage 2 - Future Children and Young People

The hope is for future children and young people to have a better understanding of the reasons they are unable to live with their first family. This will involve:

- A basic visual narrative of their story from early on in their care journey, with their memories, achievements and experiences being captured from the outset.
- “Checking-in conversations” twice a year, which will hopefully prevent gaps and fantasies from forming.
- The creation of a digital storage vault to capture memories, anecdotes, achievements and voice recordings relevant to their life. This will be accessible to them throughout their childhood and for the duration of their lives. They will be able to contribute to it themselves, should they wish to do so.

Stage 3 – Care Experienced young people and adults

The aim is for **ALL** care experienced adults to be better supported to understand their own care experience, the ideal model including:

- a narrative written by a social worker/social work assistant based on their historical files and documents.
- support from a social worker or social work assistant to read through and process their historical records, with acknowledgements of poor practice where appropriate.
- the adult to have the opportunity to add their voice to their historical records as it is likely that this will not be recorded.
- to identify a resource who could provide ongoing support to the adult to process their life story once the narrative has been provided.

lifestories@edinburgh.gov.uk

Chris Adams

Strategy Manager

The impacts of child poverty

Starts before birth

Can extend through a lifetime

Going to school or bed hungry

Being ill more often

Living in cold damp home

Missing out / Being left out

Growing up too quickly

Seeing / experiencing crime

Doing less well at school

Seeing parents struggle

Edinburgh Poverty Commission

By 2030 Edinburgh should aim to be a city where:

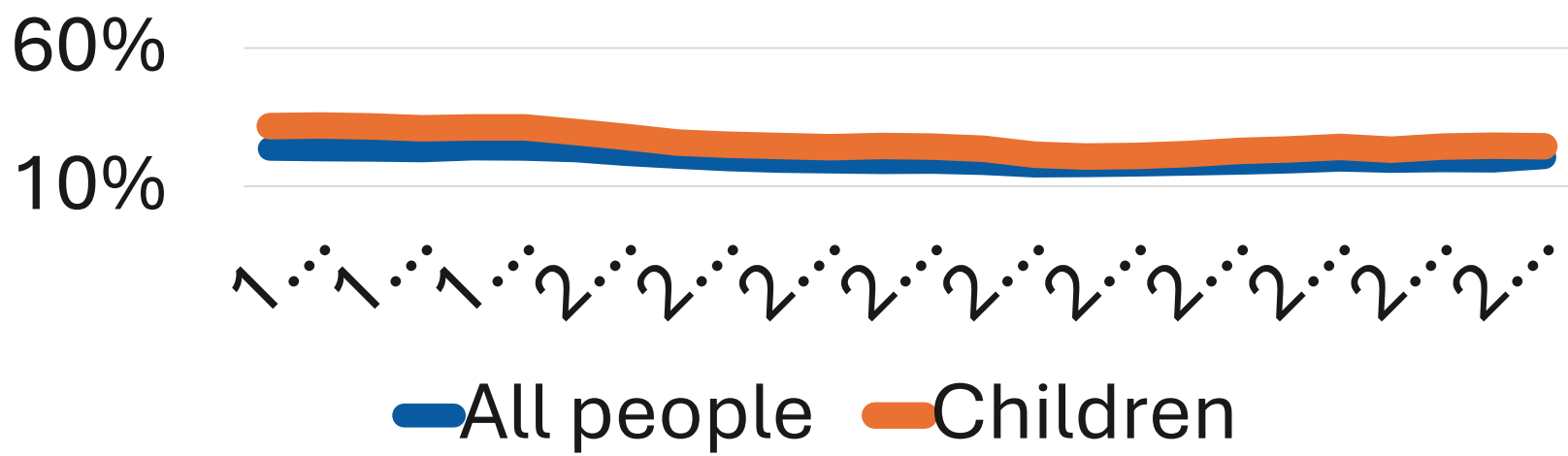
Fewer than 1 in 10 children and adults live in poverty at any given time

No-one is trapped in long term persistent poverty

No one has to go without the basic essentials they need to eat, keep clean and safe, and stay warm and dry

No one feels stigmatised, abandoned, or treated with less respect by the city when seeking or needing support

Poverty in Scotland
(After Housing Costs)
1994-2022



Child Poverty in Edinburgh, After Housing Costs)

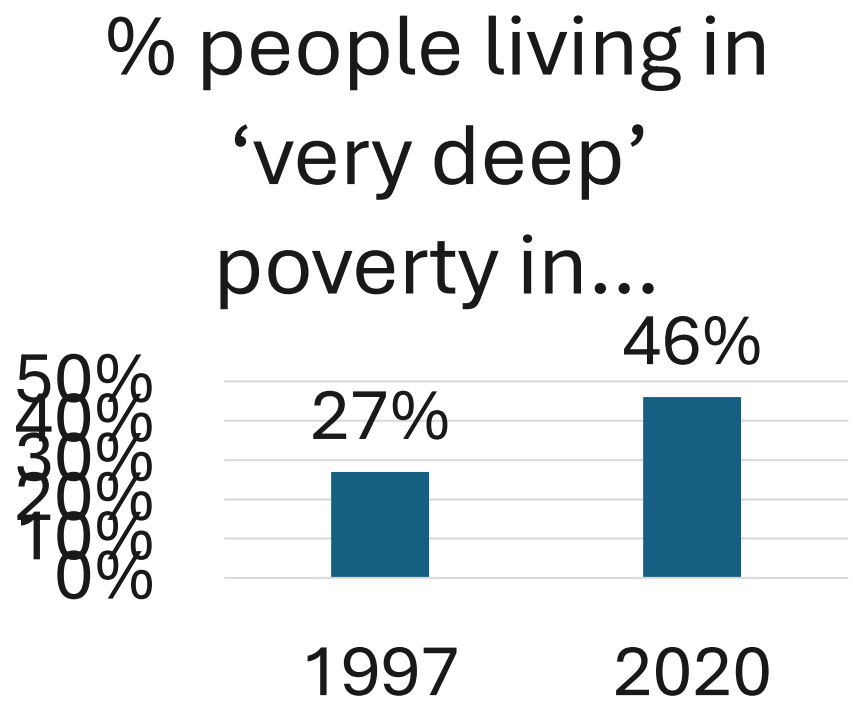
Poverty is deepening

Poverty Threshold for a couple with 2 children

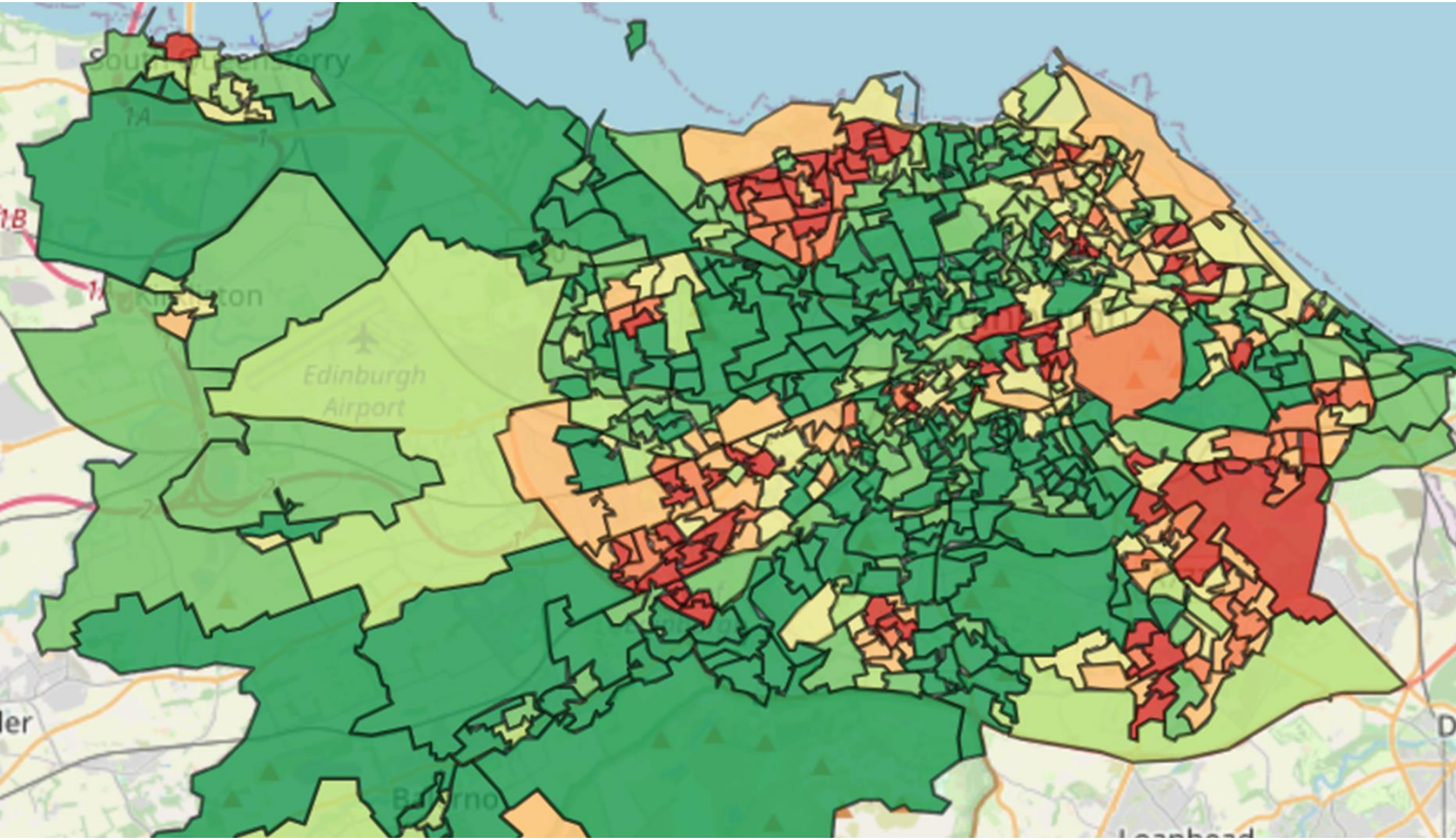
- £27,000 after tax pa

"Very deep" poverty threshold

- £18,000 after tax pa



Black or Asian household	49%	Single Parent	38%
Household with disabled child	28%	Youngest child under 1	34%
Household with disabled adult	25%	3 or more children	34%
Council/RSL tenant	46%	Mother under 25	55%
Private sector tenant	34%	Noone in paid work	60%
SIMD 1+2	30%+	Part time work only	47%
SIMD 9+10	11%	Couple, 1 in FT work	32%


Edinburgh
Airport

Actions to End Poverty in Edinburgh

Increase income from work and opportunity to progress

- Promote fair work that provides dignity and security
- Help people to access and progress in work
- Improve attainment, achievement, and positive destinations for young people who grow up in poverty

Maximise support from social safety nets

- Maximise uptake of benefits entitlements and other support
- Deliver well targeted cash first and local crisis support programmes
- Help prevent homelessness

Reduce the cost of living

- Deliver decent homes that people can afford to live in
- Provide targeted support for rising energy costs
- Improve access to affordable childcare
- Improve digital inclusion and access to affordable transport

Make it easier to find help

- Deliver integrated, ‘no wrong door’ approaches to service delivery and prevention of poverty
- Provide the support people need, in the places they live and work
- Deliver poverty awareness training programmes that address stigma

Actions to End Poverty in Edinburgh

- 700 Living Wage Accredited employers
- 4,000 people helped into work and learning
- A narrowing of the poverty related attainment gap

Increase income from work and opportunity to progress

Maximise support from social safety nets

- £20m in financial gain for advice clients
- £2m in crisis grant payments
- 300 households prevented from homelessness

- 450 new social rented homes
- Energy Advice services saved households £200k
- Subsidised childcare places in deprived areas
- Delivered 44,000 digital devices to learners

Reduce the cost of living

Make it easier to find help

- Integrated Front Door programme
- Teams around the learning community
- Lifting Neighbourhoods Together
- Poverty Prevention Training

Actions to End Poverty in Edinburgh

- 28k workers still earn below rLW
- 13k people in work, but claiming UC
- Attendance rates challenge

Increase income from work and opportunity to progress

Maximise support from social safety nets

- Benefits uptake still low among key groups
- Crisis schemes and budgets under pressure
- c4,500 households in temporary accommodation

- Housing emergency
- CPI above target until 2026
- Affordable childcare needs

Reduce the cost of living

Make it easier to find help

- Public Sector Reform

Edinburgh Poverty Commission

"To end poverty in the city, the pre-condition and the single biggest transformation Edinburgh could achieve would be to **make the experience of seeking help less painful and confusing, more humane and more compassionate"**

Rose Howley

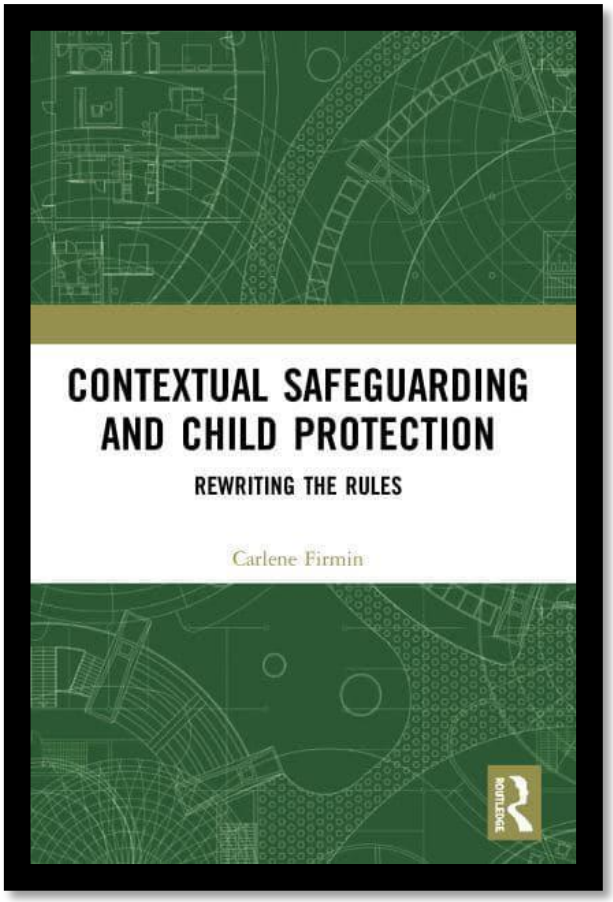
Service Director Performance and Improvement and Chief Social Worker

David Orr, Team Leader Young People's Service
Marnie Coull, involved with Action for Children's SideStep Service
Leigh-Ann Parker, Senior Practitioner at Young people's service

Edinburgh Contextual Safeguarding Pilot 2022-23

- What is Contextual Safeguarding?
- Why did we test it in Edinburgh?
- The Pilot
- Evaluation & Learning
- Next Steps
- Q & A

Contextual Safeguarding: Re-writing the rules of child protection (Carlene Firmin)



[Ted-Talk - Contextual Safeguarding: Re-writing the rules of child protection]

What is Contextual Safeguarding?

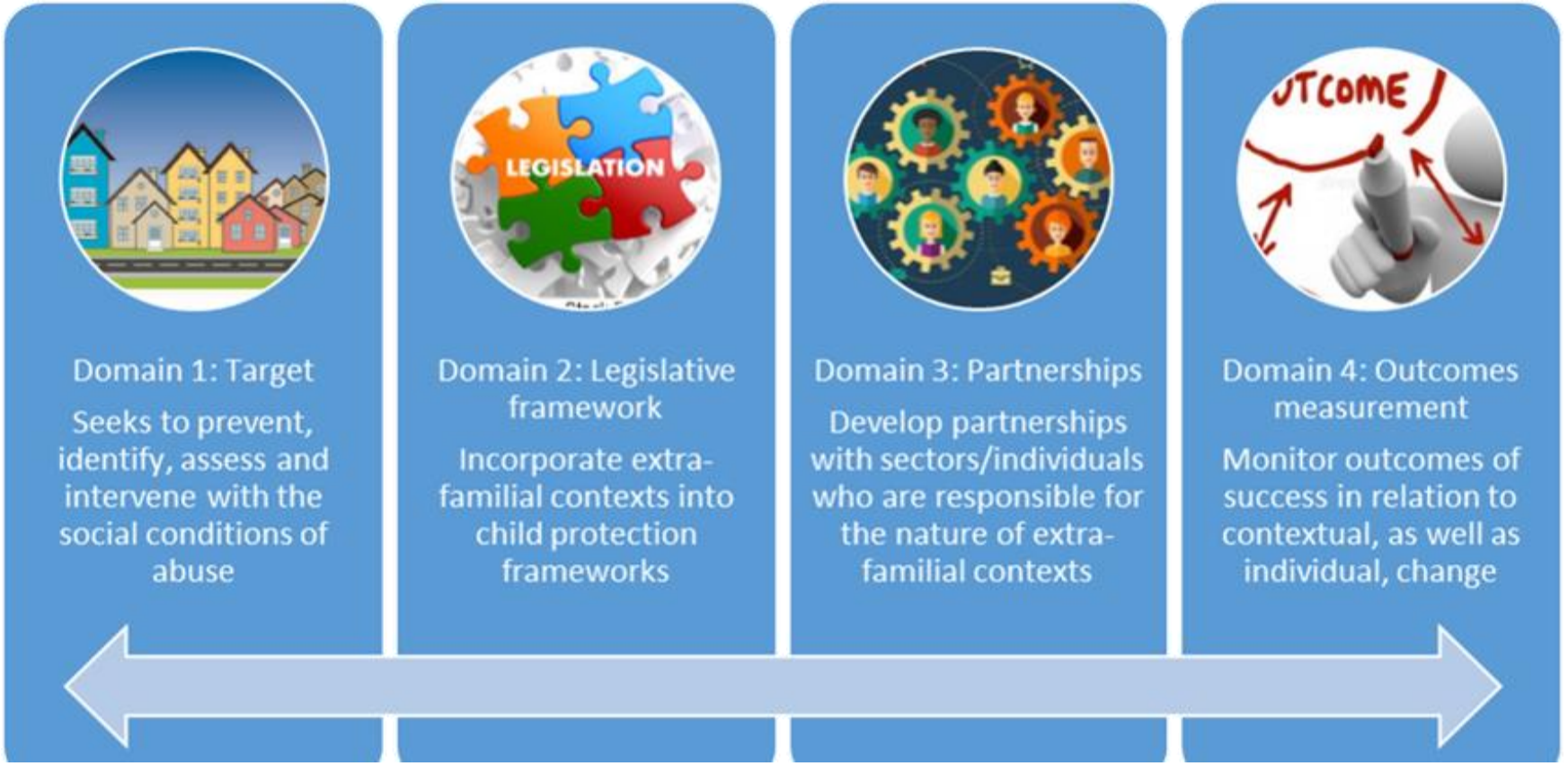
- Contextual Safeguarding is an approach to protecting young people who are at risk of extra familial risks and harms. It supports a shift in practice in which child protection professionals and partners actively take steps to make the contexts in which young people have experienced abuse, safer.

  Such places include peer groups, parks, transport hubs, schools and on-line. It also supports agencies to develop systems and structures for identifying, assessing and intervening in the places and groups in which young people are at risk of **significant** harm.

Extra familial risk and Harms (EFRH)

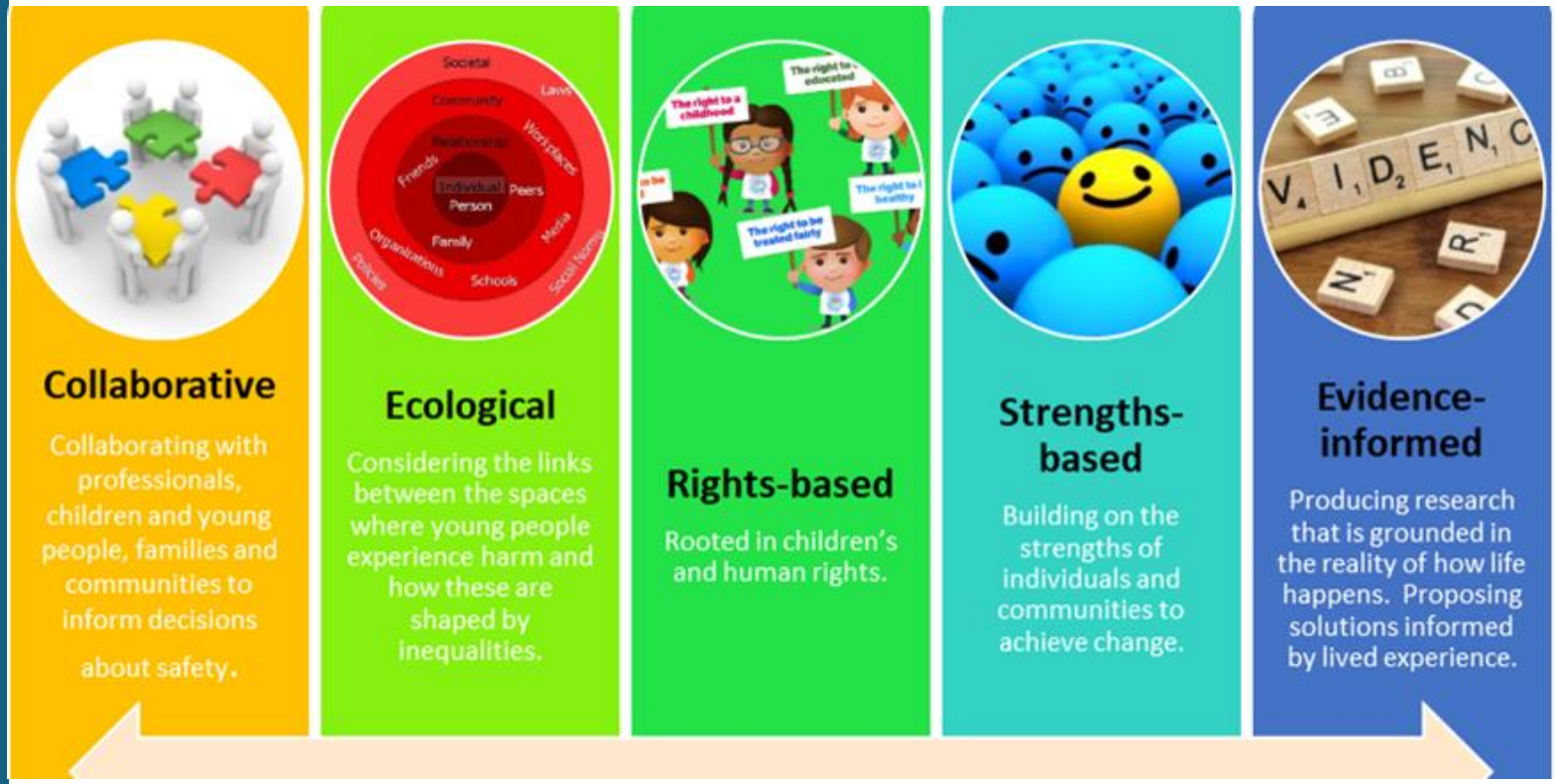
- Child Sexual Exploitation (CSE)
- Child Criminal Exploitation (CCE)/Exploitation by criminal gangs
- Peer-on-Peer abuse
- Human Trafficking and Exploitation
- Extremism leading to radicalisation
- Online/digital abuse
- Other forms of abuse

Four key domains in targeting harm outside the family home



(Firmin 2020)

The core principles



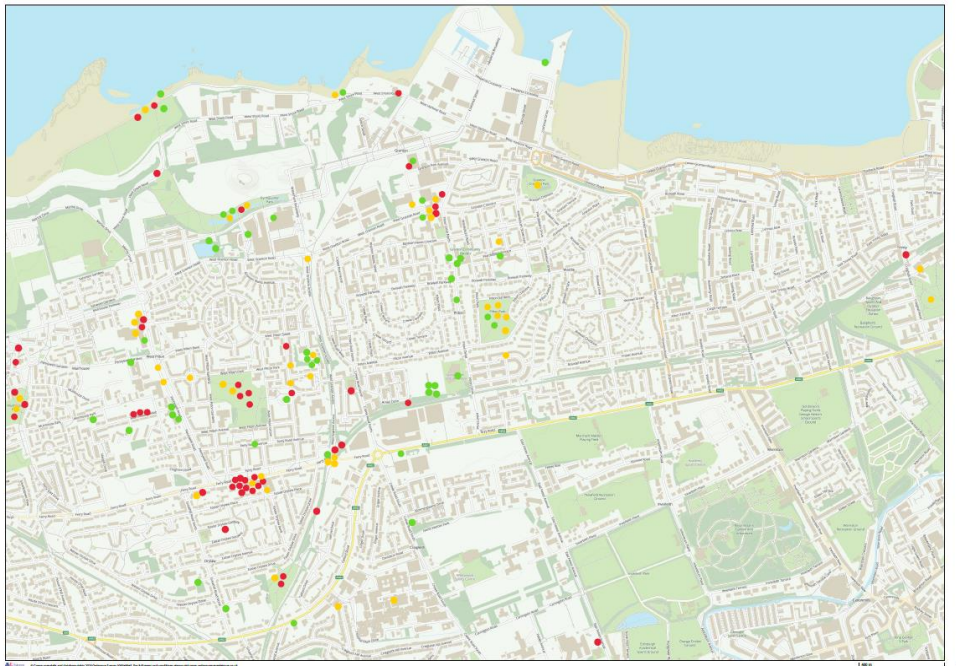
(**Firmin *2020***)

Underpinning principles aligned with policies and practice guidance in Scotland

The Promise	**UNCRC**	**GIRFEC**	**National Guidance to Child Protection in Scotland 2021**	**Youth Justice Strategy**	**National Crime Agency Guidance**

The Pilot- The Promise: A Good Childhood

- Identify contexts, places and spaces of safety and risk
- Community Participation and Guardianship
- Develop Systems. Guidance and Policies
- Specific input within schools, youth centres and other education provisions
- Training/awareness raising
- Scaling up and rolling out across the city.



Evaluation and Learning

- Raising Awareness and Training
- Language Document and Toolkit
- Steering Group and Relationship Building
- Education
- Information Sharing

Edinburgh- Next Steps for Contextual Safeguarding

- Strategic Steering Group - what we can do now and longer term
- Public Protection away day
- Maximising opportunities and thinking creatively about resource
- Opportunities for training
- Respect the voices, experiences and expertise of children
- Being strengths based and relationship-based
- Recognise and respond to trauma
- Looking for those reachable moments

Q&A Panel

Hosted by Andrew Kerr Panel members:

- Amanda Hatton
- Claire Ryan Heatley
- Hannah Baillie
- Elspeth Russell
- Chris Adams
- Rose Howley
- David Orr
- Marnie Coull
- Leigh-Ann Parker

Workshops

1. How well are we doing this at the moment?
2. Where are the examples of great practice we can share and learn from? be specific we will come back to you
3. What do we need to do together to get even better?
4. How will we know when we have achieved this?

Let’s reflect…

THANK YOU