Trauma informed, evidence based practice within the Wakefield Youth Justice Service

Embracing the Future

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Forward

This report looks to propose a new way of working within the Wakefield Youth Justice Service, which foundations are built upon a trauma informed, child first approach. A trauma informed approach encompasses a whole organisational shift, whereby all staff are aware of the prevalence of life adversity and the impact that this has upon an individual, their life chances and opportunities. Experiences of trauma can have a profound impact upon individuals, families and community life trajectory. Embodying the core principles of safety, trust, collaboration, choice and empowerment within our working practices with children, families and staff will strengthen relationships, support more positive short and long term outcomes and reduce re-traumatisation.

There is significant evidence around the all-pervasive impact that trauma can have upon a person's physical and emotional wellbeing, neurodevelopment and social capital. These issues can be the source and consequence of offending behaviour, leaving those involved vulnerable to the revolving door of the criminal justice system and poorer long term outcomes and higher risk of morbidity and mortality.

Through us as an organisation **realising** the impact that trauma can have on an individual/family/community, **recognising** the feelings and behaviours of someone who is traumatised, **responding** through a full organisational shift and **resisting re-traumtisation** in our practice, we will improve outcomes for the child, families and staff who are in contact with the Wakefield Youth Justice Service.

'…An alternative approach is therefore clearly needed: one that is rooted in an understanding of the relationships between impairment and behaviour, and engaged the young person accordingly; one that recognises the crucial importance of effective educational support; and one that supports families to provide effective care.' - Hughes & Chitsabesan (2015; p4)

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Introduction

Within this ever changing time there is a need for us as an organisation to grow and develop the way that we work, as to ensure that we continue to meet the needs of the children and families that we support and the staff we employ, in the most effective and compassionate way. We need to be malleable and utilise the best available evidence to mould our processes and interventions, to increase the likelihood of positive engagement and outcomes. A trauma informed place of work is one that fosters safety, trust, support, empowerment and acknowledges everyone's life experiences, not just children and families but also staffs' (SAMSHA, 2019). Around 50% of all adults living in the UK have experienced one form of adversity and 1 in 3 adult mental health conditions are known to directly link to trauma in childhood (Hughes et al, 2016; Kessler, 2010).

There is a significant amount of longitudinal evidence coming from across the globe which indicate the direct correlation between childhood trauma and poorer health, social and behavioural outcomes across a person's life course (Hughes et al, 2016; Bellis et al, 2015; Cronholm et al, 2015; McLaughlin, 2014; Bellis et al, 2014; Kelly-Irving et al, 2013; Felitti et al, 1998). Research consistently shows a strong association between adversity in childhood and crime (Scottish Government, 2018). Bellis et al (2015) found that people with 4+ adversities in childhood (compared to someone with 0) were 15x more likely to be a perpetrator of violence in the last year and 20x more like to be incarcerated. Although trauma informed practice has been gaining momentum for several years now, the UK unfortunately seem to be behind Wales and Scotland, who have now started integrating this approach across their Government agenda and policy. Young Minds (2018) emphasised the need for commissioners, providers and practitioners to embody adversity and trauma informed care within their practice. The Youth Justice Board (YJB, 2019;2020) have voiced their commitment to prioritising trauma informed practice in their business plan for the past 2 years and are looking to develop a strategy of how to embed this in practice. HMIP (2017) inspection, recommended '*all YOTs should be able to identify and respond effectively to emotional trauma and other adverse events in young people's lives,*

and apply the strategies available for tailoring services to take account of trauma'. The West Yorkshire and Harrogate Care Partnership are proposing that organisations across West Yorkshire are to be trauma informed and responsive by 2030.

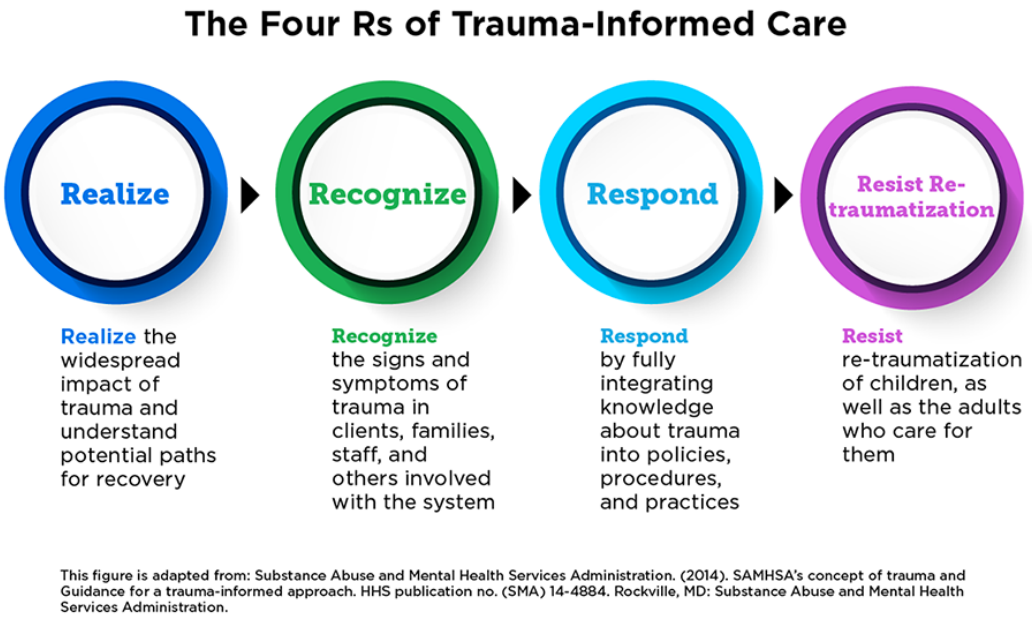
This report looks to highlight the evidence that supports implementing a trauma informed approach within our organisation. It also seeks to propose some changes as a means of improving assessments, planning and interventions based upon this approach, prioritising the ethos of 'child first, offender second' . With all this taken into consideration, it is felt by the writer of this report that a fresh perspective needs to be taken on ways to 'reduce re-offending,' that is more awakened to the primary causes of criminogenic factors, seeing crime as a maladaptive coping strategy and takes a whole child and family focused approach. It will also give a strong evidence base to our practice, which is coveted by the YJB (2005,2019,2020). Ensuring that our work as an organisation is grounded in the evidence ensures transparency in performance management and increases the probability that interventions will be effective, the outcomes are more likely to be positive, sustained and will cause no harm (Chapman & Hough, 1998; YJB, 2019;2020).

This report is split in two sections; one, which looks at the supporting evidence and the other which considers how we can change and integrate recommendations and interventions into practice.

Background

What is trauma informed practice?

*'The key goal of trauma informed practice is to raise awareness amongst all staff about the wide impact of trauma and to prevent the re-traumatisation of clients in service setting that are meant to support and assist healing…' (*The National Association for People Abused in Childhood (NAPAC), 2020).



SAMHSA (2014) offer 4 key assumptions to a trauma informed approach;

The response is multi-faceted, considering the needs of children, families and staff. It requires multiple levels of organisational growth and development. It is not being

proposed that we 'treat' the children and families trauma, however, now more than ever we have a duty of care to use the rich evidence available to us to better serve the people we work with. We must be mindful that the criminal justice system is a setting which can '*ease or exacerbate an individual's capacity to cope with traumatic experiences'* (SAMHSA, 2014. pg 3). Becoming a trauma informed organisation means that everyone from administration, to senior leadership, from volunteers, to students are trained to realise, recognise and respond to trauma and that children, families and staff feel safe, secure and are not re-traumatised by practice. It means that we are accessible, predictable, empowering and deeply embody the belief that people's reactions and responses are their adaptation; their best attempt to survive and make meaning of their experiences (Young Minds, 2019). This report is going to focus primarily on operations of the service, please see Appendix 1 for plan outline.

<u>What does the literature tell us about trauma?</u>

It cannot be disputed that more often than not, deeply rooted systemic factors such as abuse, neglect, domestic abuse, parental substance misuse, parental mental health, poverty, low socioeconomic status, intergenerational adversity, interfamilial criminality, bereavement, social isolation, discrimination and bullying are the foundational experiences of a large proportion of those involved in the criminal justice system (Ford et al, 2019; Scottish Government, 2018; McLaughlin, 2016; 2017; William, 2015). The impact that these experiences have cannot be underestimated, affecting victims on a biological, genetic, neurological, cognitive, psychological, behavioural, emotional and social level. Adverse Childhood Experiences (ACE's) studies (Hughes et al, 2016; Bellis et al, 2015; Cronholm et al, 2015; McLaughlin, 2014; Bellis et al, 2014; Kelly-Irving et al, 2013; Felitti et al, 1998) have highlighted a direct correlation between adversity in childhood and poorer physical and emotional health, social outcomes and higher rate of morbidity and mortality (see Appendix 2). Statistically, victims are more likely to experience difficulties in their ability and capacity to learn, communicate, form relationships, regulate emotions, tolerate distress, manage impulsivity, relate and empathise with others and develop a positive sense of self and where they 'fit' into the world (Balbernie, 2001; Creeden, 2009; UK Trauma Council, 2020). Adversity and trauma in childhood are associated with many criminogenic factors which include substance misuse, poor educational

attainment/unemployment, deprivation and mental health problems (Centre for Disease Control and Prevention, 2019; Williams, 2015).

'Trauma compromises our ability to engage with others by replacing patterns of connection with patterns of protection' – Steven Porges

How does this impact upon us as a Youth Justice Service?

Brennan (Young Minds, 2018) argues that often practitioners become so focused upon a child's risky or challenging behaviour that we forget that they have adapted and adjusted to keep themselves safe and make sense of their experiences. '*Many of the deep rooted issues can be both the source and consequence of some of the patterns of offending and re-offending behaviour'* (NHS England, 2016, p.5). Skuse & Matthew (2014) (See Appendix 3), emphasise that many of the interventions completed within the youth justice system are behaviour focused rather than targeting the underlying causes of the behaviour. Wigzell (2021) expresses how input from the youth justice system has been focused around criminogenic behaviour and risk management, rather than adopting a more holistic, child lead approach. This creates a multitude of issues when considering that there appears to be a relationship between trauma, welfare needs and factors which increase vulnerability to criminogenic factors (McLaughlin, 2016; Ministry of Justice, 2012; 2011; Foy, Furrow & McManus, 2011; Kessler & McLaughlin, 2010; Finkelhor, 2008; Showyra & Cocozza, 2006; Hussey, Chang, & Kotch, 2006; Yoder, 2005; Smith, Ireland & Thornberry, 2005; Dong et al., 2004; Vermeiren, 2003; Widom & Maxfield, 2001; Scarpa, 2001; Erwin et al 2000; McGruder-Johnson et al 2000; Weeks & Widom, 1998; Widom, 1989; Steiner, Garcia & Matthews, 1997; Maxfield & Widom, 1996; Dziuba-Leatherman & Finkelhor, 1994; Burton et al, 1994).

By adopting a trauma informed way of working we reframe the way that we view the behaviour children and families as adaptive, not 'difficult' or 'damaged', which then paves the way for more empathic, warm, holistic support that meets their individual needs (Young Minds, 2018; UK Trauma Council, 2020). Fostering a shared belief that everyone has the capacity to change and that everyone wants to be the best that they can be, will

keep us focused on the children and families when devising shared plans and interventions.

So why change?

We have an obligation to reduce recidivism and when we consider these principles on a more basic, humanistic level it means that children should be leaving our service feeling safe, valued, supported and with embedded skills. This will improve their long term outcomes, ultimately improving the outlook for future generations. We need to play a bigger role in trying to break the intergenerational cycle of abuse and deprivation. Bellis et al (2014) suggests that if we prevent adversity in childhood, incarceration and violence perpetration could be halved. West Yorkshire – Finding Independence (WY-FI,2020), highlight that *'Traumatic events for children and young adults lead to multiple exclusions in later life. Effective early intervention for children and families of beneficiaries is crucial.'* (pg.3). It is clear that those who experience multiple disadvantage have worse outcomes and are more likely to become entrenched in the criminal justice system (MEAM, 2020). We cannot change the past, however we do have the opportunity to guide discovery, educate, show compassion and reduce re-traumatisation. With the right support and intervention people can go on to live the lives they want and deserve (SAMHSA, 2014).

'*Child First, Offender Second'* – Haines & Case (2015)

1) **The Evidence**

This section of the report is going to briefly explore the all-pervasive impact that trauma can have upon a person's brain development and how this may impact upon their perceptions, experiences and behaviours. Understanding these concepts will support us when considering how we interpret behaviour, communicate with others and undertake assessments and interventions in a way that is not only going to not re-traumatise, but can also shape the work that is done to reduce re-offending and improve future outcomes for the child and their family.

'…G*iven the prevalence of trauma for these young people, there is a strong case for all YOTs to adopt what is known as trauma-informed practice'* (HMIP, 2017, p.4)

Neurodevelopment & trauma

It is now well known that the first 1001 days of life are critical in providing a solid foundation for the rest of a person's life (Parent Infant Foundation, 2021). Neurodevelopment and attachment begins whilst we are in-utero and continues throughout our life. However, the period between conception to 2 years old is critical as there is prolific growth of neural pathways within the brain. This occurs through warm, attuned, repetitive and consistent experiences and interactions with primary care givers (Balbernie, 2000). Babies and children are evolved in a way to adapt to their environment, namely their primary care giver, to ensure their survival (Siegal, 2006). Chronic and acute experiences of trauma impact the brain and the body – although these experiences may not be explicitly remembered, the brain and body don't forget (Beacon House, 2019; Van der Kolk, 2014). If a baby or child feels under threat regularly and does not have a secure base to help them regulate they can get stuck in 'survival mode'. If a child is spending much of their time in 'survival mode' they do not get the opportunity to build strong brain connections with the higher functioning part of the brain (Cortex), where rationalisation, problem solving, empathy, emotional regulation and a general wider understanding of situations occur. What this means is that their brains have adapted in a way that is prioritised with safety and therefore even small, seemingly 'insignificant' experiences can trigger the body quickly into 'fight, flight, freeze, fawn' response. This makes it difficult for them to think, feel or behave in any other way than in a way that makes them feel safe, which may look like aggressive, avoidant or disassociated behaviour. Whilst in this state, biologically we are unable to think logically, process or remember information effectively and our ability to communicate effectively is limited.

Brain adaptations occur due to many interplaying factors such as '*genetics, pre-birth or birth trauma, traumatic brain injury, infection or illness in childhood or extreme nutritional, education or emotional deprivation*' (Hughes & Chitsabesan, 2015, p3). Neuro-imaging has shown structural changes in the brain of a victim of trauma including under modulated and over pruned areas in the Cortex (higher cognitive functioning part of the brain), a larger amygdala (threat system alarm), a smaller hippocampus (associated with memory storage), smaller corpus callosum and less left right hemispheric integration which impact on verbal skills, understanding others and being able to learn from past experiences, especially from more emotionally charged or traumatic experiences

(Creeden, 2009). This means that a victim of trauma may have more difficulties in accessing higher cortical skills, which may present as executive functioning difficulties, speech language and communication difficulties and emotional and mental health issues. These difficulties may be misunderstood by others and labelled as 'behavioural problems'; adultifying children and potentially leading to school exclusions, social isolation and social thinning (UK Trauma Council, 2020). Not recognising these behaviours as a means of communication can re-traumatise and embed feelings of rejection, leading to higher subsequent risk and therefore involvement with the criminal justice system (Hughes & Chitsabesan, 2015).

Executive functioning

Executive functions are our higher cortical skills which include working memory, flexible thinking, and self-control - we need these skills to filter distractions, be flexible, prioritise, organise, multi-task, achieve goals, regulate emotions and control our impulses. '*We are not born with these skills, we are born with the potential to develop them'* (Harvard University, 2021). Genetics play a role in brain architecture, however adversity in childhood can disrupt neurodevelopment, impairing the development of executive functioning skills. Self-regulation problems have consistently been found to be related to offending risk (Andrews & Bonta, 1998; Friendship & Thornton, 2001; Grann & Wedin, 2002). Morgan & Lilinienfield (2000) and Ogilvie et al (2011), found in their meta-analysis's that there was a strong association between anti-social behaviour and poorer executive functioning. Challenges in accessing these skills can impair day to day functioning, relationships, thoughts, feelings and behaviours (Florida State University, 2014). However, it must also be acknowledged that there is strong evidence to suggest that we do not fully develop executive functioning skills until we are at least 20 years old (Lamb & Sim, 2013), which further highlights the difficulties that children within the criminal justice system may experience due to professionals expectations.

Speech, language and communication difficulties

The national evidence suggests that within youth justice, children with speech, language and communication needs (SLCN) are over represented (Royal College of Speech and Language Therapists, 2017). In Wakefield we have recently collated our own data and

found that 78% of children who were on statutory court orders (Oct 2019-March 20) had moderate to severe needs. This can present as difficulties in understanding and processing information, learning and using new vocabulary, difficulties staying on topic, understanding non-verbal communication and difficulties with emotional literacy. The implications of SLCN can be profound, impacting upon educational attainment, employability, social interaction, emotional and behavioural difficulties (NICE, 2016). Around 40% of children in the criminal justice system find the strong verbal context in which interventions are delivered difficult to access or are unable to benefit from them at all (Bryan, 2004; Bryan et al, 2007).

Trauma victims can overinterpret/misinterpret mildly difficult or innocuous social cues as being significantly threatening and may find understanding other people's perspectives difficult (UK Trauma Council, 2020; Snow & Powell, 2011; Brownlie et al, 2004). Social communication difficulties can impact upon peer relationships and although the adolescent brain is already primed to value peer experiences above all else, for those who have SLCN, it can lead to an even more heightened need for peer acceptance leaving them vulnerable to peer pressure/exploitation (Baldry et al, 2011; Botting & Conti-Ramsden, 2000).

Neurodiversity & Learning Disabilities

'Neurodiversity - The range of differences in individual brain function and behavioural traits, regarded as part of normal variation in the human population' - Oxford Languages 2021.

Neurodiversity includes learning disabilities, specific learning difficulties, communication difficulties, attention deficit hyperactivity disorder (ADHD), autistic spectrum condition (ASC) and fetal alcohol spectrum disorder (FASD) (Patel et al, 2011; American Psychiatric Association, 2013). Underdiagnosis of neurodiversity in children who enter the criminal justice system is common place, often due to missed opportunities (Achievement for All, 2016). Hughes et al (2012) found that a significant amount of children within the custodial setting to have one or more neurodevelopmental difficulties and that many children experience sub-clinical levels meaning numbers are even further underestimated. Hughes & Chitsabesan (2015) suggests that for children who are criminalised, often the youth

justice system becomes their primary service provider. It could be argued that their offending behaviour is an attempt to make sense of their experiences and navigate the world (Young Minds, 2018).

ADHD is primarily an executive functioning disorder, which can present as difficulties in managing impulsivity, higher emotional reactivity and inattentive behaviours. Symptoms can look very similar to that of trauma and can overlap or exacerbate it (Szymanski, Sapanski & Conway, 2011). It has been said that ADHD increases susceptibility to trauma and vice versa (Heckman, 2020). There is significant evidence to suggest that ADHD is inherited and there has also been links to preterm birth or low birth weight (which are linked to parental adversity), brain injury and exposure to substances in-utero - which are interestingly all experiences of trauma (The National Child Traumatic Stress Network, 2016). Hughes et al (2012) found that 12% of children in the custodial setting had a diagnosis of ADHD compared to 1.7-9% in the general population.

A learning disability is defined as having IQ measures of 70 or below. 23-32% of children within the secure estate were found to have a learning disability (compared to 2-4% of the general population) (Hughes et al 2012; Louks, 2006). Louks (2006) highlighted that there is high proportion of people within the criminal justice system who have learning disabilities. This not only impacts upon their ability to cope within the criminal justice system but also increases their risk of re-offending, due to their needs not being identified and therefore interventions and support not being inclusive or even implemented.

Mental health & trauma

'*Maltreatment in childhood is associated with a significantly increased likelihood of psychiatric disorder that ensures across the life span.'* (McCrory & Viding, 2015 p. 493).

Research consistently shows a correlation between offending in childhood and mental health, particularly between those who persistently offend (Carswell et al, 2004; Harrington et al, 2005; Mitchell et al, 2011). More often than not, children involved in the criminal justice system experience missed opportunities for early identification and support in regards to their needs, furthermore they may often have more than one mental health issues combined with their life experiences. What makes this even more challenging is that they do not always fit into a clear diagnostic category, which makes

them further vulnerable to slipping through the net and not getting the right support (Twitchett & Sylvester, 2018).

Two out of five children on community orders have emotional and mental health needs, the same amount have experienced abuse, neglect or homelessness and half had been a victim of crime themselves (Young Minds, 2018). Chitsabesan et al (2018) found in their study that one in ten children involved in the criminal justice system (community and secure estate) had anxiety or Post-traumatic Stress Disorder and one in five had significant depressive symptoms.

The UK Trauma Council (2020) highlight how trauma in childhood increases latent vulnerability. Latent vulnerability '*…captures the degree to which an ostensibly health individual previously exposed to maltreatment is at future risk of developing a psychiatric disorder.*' (McCrory & Viding, 2015 p.494). This theory acknowledges how the brain and body systems adapt to trauma which can lead to a heightened risk of developing psychiatric disorders, especially when someone has low protective factors, high stressors and genotype risk (see Appendix 4).

2) **What does this mean in practice?**

With great knowledge, comes great responsibility. In knowing this information we have a duty of care to ensure that everything that we do as an youth justice service considers the impact that trauma has upon a person's neurodevelopment, mental health and behaviour and how ultimately these adaptations can lead to further abuse, discrimination and isolation, entrenching them further into criminal justice system and leading to poorer outcomes (WY-FI, 2020). The YJB (2020[2]) wrote '*not enough systematic consideration has been given to matching the type of intervention and method of delivery with the developmental level of the individual child or their cognitive functioning and ability to engage in the interventions on offer*' (p. 4). We now have an opportunity to re-evaluate our position and re-consider how we engage, assess and support the children and families we work with in a way that targets these underlying causes of offending behaviour, builds protective factors and reduces re-traumatisation (YJB, 2020[3]). There has been concerted efforts made over the years within the Wakefield Youth Justice Service to increase the

mental health and speech and language provision, as well as the significant input from the ETE team, but what is being proposed is that these ideas are expanded and become the undercurrent of all work that is undertaken within our youth justice service, not only to reduce re-offending but to improve long term outcomes.

Recidivism, long term outcomes & trauma informed approach

Andrews, Bonta & Wormith (2006) identified 8 central risk factors for recidivism

1) Established criminal history
2) Anti-social cognition (attitudes, values & thinking styles supportive of crime e.g. misinterpreting what others are saying/behaviour and requiring instant gratification)
3) Anti-social personality patterns (stimulation seeking, low self-control and anger)
4) Anti-social associates
5) Substance misuse
6) School/work problems
7) Family problems
8) Low engagement in prosocial leisure pursuits

The above indicate not only a static risk but a changeable need (SAMSHA, 2019). Evidence suggests that responding to three or more of these risks reduces recidivism (French & Gendreau, 2006). Chapman & Hough (1998) stipulate that *'programmes which target needs related to offending (criminogenic needs) are likely to be more effective (the need principle)'* (p.12). Not only this, but they highlight that much of the research indicates that structured, multi-modal, skills-orientated, community based, employment/education related interventions with underpinning theory from cognitive behavioural therapy and regular monitoring and evaluation have the strongest impact.

'So what does this mean?' It means, interventions need to address as many of the above risk factors as possible in structured and goal orientated way that acknowledges the children and family's strengths and struggles and works with them in the best way to suit

their needs. We must continue to be flexible in our mode of delivery and emphasis needs to be placed on ETE but also learning, developing & scaffolding skills around speech, language and communication, executive functioning, emotional health, general wellbeing, prosocial and life skills. It is felt that devising individual plans and interventions that seek to reduce the above criminogenic factors is going to be the key in devising effective plans and interventions to ultimately reduce re-offending and improve the child's quality of life and their future prospects.

The YJB have identified how trauma informed practice aligns with their principles (see Appendix 5) and recommends that '*the right intervention is delivered at the right time at the right level of developmental need, with emphasis on minimising contact with the criminal justice system or further involvement in it. The approach removes the focus from the symptoms of offending, to what happened to them, reducing the need for offence specific interventions.'* (YJB, 2020[2], p.12). This highlights the need for our interventions to focus more upon the complex factors which lead to the child offending in the first place.

Despite there being limited evidence base around specific interventions practitioners can use to improve outcomes for those in the youth justice system (Newburn & Souhami, 2005; Prior, 2005), this should not deter us. If we view the children who we work with in an intersectional way, as victims of trauma and discrimination, who have poor educational attainment, who may have emotional health needs, who struggle with speech and language and executive functioning rather than 'criminals' - '*really seeing'* why they have offended, then we can work with them and their families in a more meaningful way, targeting the core of the issues, utilising wider health and social care evidence base. In the YJC's business plan 2020-2021, there is a running theme of prioritising the need for strengthening and building an evidence base to inform our operations. The Youth Justice Institute was created in 2019 as a means of bringing together Youth Justice organisations and academia to disseminate the most up-to-date evidence base and to offer courses for practice development including self-evaluation. The YJB have devised a workforce development strategy which outlines the training staff and volunteers should undertake to be sufficiently prepared to work within the Youth Criminal Justice System, creating quality, consistency and replicability across the service.

Things for us to consider

The recommendations made in this section have been devised based upon the evidence around trauma, recidivism and longer term outcome. It is being proposed that they become the underlying 'thread' of the work that we undertake as an organisation. This is the long term goal and it must be acknowledged that additional training and resources will be required for staff across the organisation. Staff have highlighted that they would need refreshing on training and supporting in implementing practice from training. Some suggestions are made but it will be critical that these recommendations and considerations will be discussed in the working group.

- *Enhanced Case Management & Formulation*

In Wales, the Youth Justice Board has been piloting an Enhanced Case Management (ECM) approach (YJB, 2020[2]) which was in response to caseloads reducing in number but increasing in complexity. The theory is rooted in psychology, considering the impact of child development and how traumatic childhood experiences influence's a child's behaviour including offending (YJB, 2020[3]). It is theoretically underpinned by the Trauma Recovery Model (Skuse & Matthews, 2015 - see Appendix 2) which grew from Maslow's hierarchy of needs, clinical experience within the youth secure estate and the evidence base surrounding the impact of maltreatment on child development. Staff undertook a three day training programme around trauma and how to implement the Trauma Recovery Model within practice. This pilot was seen as successful, with improvements noted in relationships between children and YOT staff, it was generally compatible with existing case recording approaches and children and psychology staff and YOT staff agreed that

the children's lives had improved after the pilot. All stakeholders involved believed that the ECM approach should be rolled out (Welsh Government, 2020). The YJB continue to evaluate this pilot programme as part of their 2020/21 Business Plan.

Staff in Wakefield had training in formulation practices from FCAMHS in 2020. This training highlighted how formulation can be helpful in practitioners understanding and analysing the presenting, predisposing, precipitating, perpetuating and protective factors and then developing a plan to best suit those individual needs. The ECM evaluation (YJB, 2020[2]) highlighted how critical staff found the multi-agency formulation meetings as it improved information sharing and offered richer insight into the child's life, in a more time effective manner for Asset assessments. It also was found to improve coordination of support, limiting the amount of professionals working with the child and family. It was also found to give staff a deeper understanding of where the child was at developmentally (social, emotional and cognitive) meaning interventions were more suitable to that child's individual needs and this was acknowledged by children involved and made them feel 'better' and 'happier'. This highlights what a valuable tool formulation could be, it is also worth considering how formulation can help with accountability, transparency, creating SMART goals and plans, which will therefore prevent drift and improve outcomes. See Appendix 6 for considerations around process.

- *Psychological and behavioural approach (CBT/DBT/Emotion coaching/Motivational Interviewing)*

McCrory &Viding (2015) propose that a preventative approach needs to be adopted for *'offsetting risk trajectories before psychiatric disorders emerge'* (p.493). NHS England (2016) highlight the need for a strong focus on mental health provision within the criminal justice system. We already have a strong psychological input within Wakefield Youth Justice Service and many of our practitioners are trained in elements of the above. DBT in particular offers learning opportunities around emotional regulation, distress tolerance, communication and problem solving, which would support the development/growth of executive functioning and speech language and communication skills. Adopting SMART goals and goal based outcomes have many benefits including being able to align our

work with the children and families expectations and aspirations - improving engagement, supporting a growth mindset, teaching organisation and planning skills and increasing motivation, accountability, self-efficacy and a sense of achievement.

As stated above there are many children within the criminal justice system who hit 'sub-clinical' thresholds for diagnosis of emotional health needs and some may not be ready to access 'pure' CBT. However, we can utilise guided discovery, socratic questioning and targeted psychologically based interventions as part of our everyday practice. The above techniques have a strong evidence base and the outcomes would support the development of skills which can reduce recidivism.

- *Making every contact count & honouring the importance of the therapeutic relationship*

Bruce Perry (2017) highlights the importance of relationships and connection in aiding healing from trauma and that every contact is an opportunity to aid growth and healing. Young Minds (2019) suggest that professional curiosity, listening, reflecting on what presenting behaviours really mean and avoiding making assumptions and offering solutions are all vitally important to embody as part of trauma informed practice. Making every contact count is a behavioural approach which is endorsed by the NHS where professionals utilise every interaction as an opportunity to promote them making positive changes to their health and lifestyle.

- *Resiliency Framework*

The Resiliency Framework is a library of resources available to practitioners who work in the Wakefield district. 'T*he purpose of the framework is to reduce risk and to build resilience, and in doing-so will improve health, educational and social outcomes for children and young people' .* This is a resource available to us all with no additional cost

and offers us the opportunity to assess the strengths and difficulties that the child faces and then gives recommendations as to interventions which develop and build resiliency.

- *Trauma Enquiry*

There has been recommendations made that routine trauma enquiry should be adopted as part of standard practice. The evidence suggests that asking about experiences of trauma can reduce distress, impacting positively on recovery, improve a person's view of themselves and strengthen resiliency (Frattaroli, 2006). Dr Warren Larkin developed the REACh model which offers a clear framework for training and developing staff's confidence in asking openly about trauma experiences. His research into the programme has highlighted that routine enquiry helped clients make links between their past and present situation which supported them in being able to decide what support would best meet their needs (Real Life Research, 2015). However, what is not being proposed is 'ACE scoring' as this potentially offers another label for the child, the enquiry would be to offer a safe space to talk about experiences and consider what, if any support the child wants moving forward.

- *Developing skills in speech, language, communication and executive functioning*

The Communicate Programme is something that we offer to all the children who are assessed as having under 'average' SLCN and this is currently working incredibly well. Another programme has been devised by Lucy Wilkinson which looks at learning skills around time. What is being proposed is that more staff are trained in delivering this programme due to the significant impact that SLCN can have upon recidivism.

DBT offers another opportunity for us to impart speech, language and communication skills as well as executive functioning skills and this can be delivered in a purer or more ad hoc form.

- *Developing life and pro-social skills*

As we know peer relationships are incredibly important in developing a positive sense of identity and resilience. We need to consider how we can grow more group work interventions and sport/outdoor pursuits now that we are coming out of lockdown. We could also consider how we can encourage and engage past service users in the development and implementation of interventions and/or a peer mentoring service.

Communicate and DBT interventions can also support the development of life and prosocial skills.

- *Youth Justice Centre*

The Youth Justice Centre could be a great opportunity to offer group work-shops that takes a public health approach. We could offer a menu of choices that could be offered as part of their Asset plan - sleep, healthy lifestyles, smoking, sexual & reproductive health, consent, healthy relationships, problem solving skills, becoming parents, psychoeducation, & emotional literacy, self-esteem and body confidence, communication and problem solving, life skills e.g. writing a letter, managing money, shopping, paying bills. We could consider how we can get volunteers/previous service users involved in this process.

These groups could be open to children who are working with Liaison and Diversion as well as those who are at risk of becoming involved in the criminal justice system as a way if prevention/early intervention.

- *Creating a sense of safety*

Creating a sense of safety and predictability is critical when adopting a trauma informed way of working. We could think about our how our building looks, where we meet children, our induction pack, use of timetables and how we prepare children and families for court – these were all considerations staff had during the team meeting.

- *Supervision, team meeting & peer supervision*

For staff to be able to change how they work they will need to be supported in being able to do this. When adopting a trauma informed approach, staffs wellbeing also needs to be considered as well as their clinical practice - adoption of a clinical supervision model could aid in this approach. This was something the staff highlighted by staff in the team meeting.

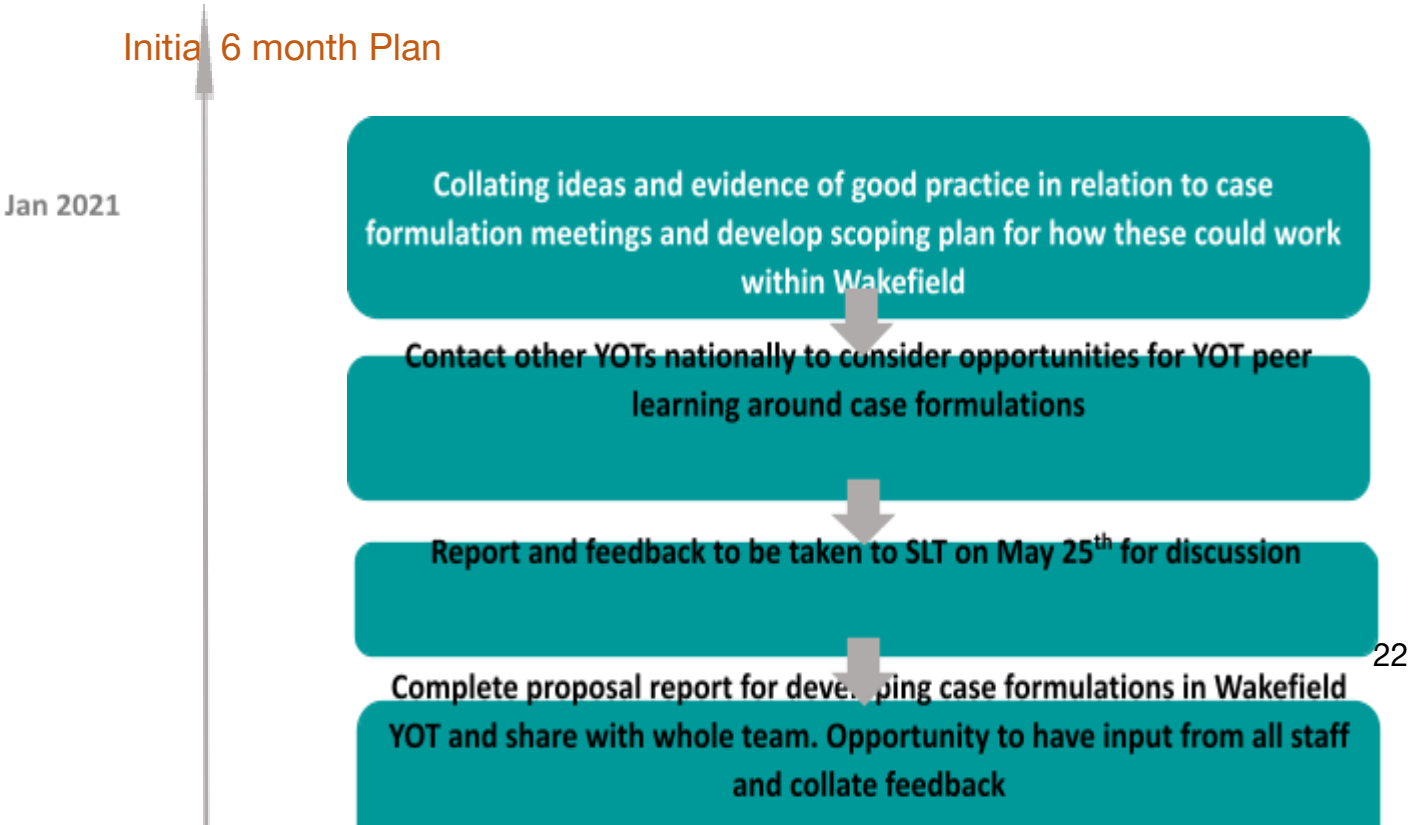
We have already started to consider how the team meeting could grow and become more effective. We also need to think about how we ensure this is a forum that considers trauma informed principles.

Peer supervision can be a positive way for staff to be able to have a safe space to be able to reflect and expand their knowledge, skills and experiences, through discussions with their peers. A peer supervision group has been developed for the DBT work and offers practitioners the opportunity to be able to discuss the work they have been doing, reflect and make plans for future sessions.

- *Child First*

Achievement for all are devising a standard a Child First quality mark for Youth Justice organisations to work towards. Megan Watson is going to be a part of the steering group for this.

Appendix 1 – Case Formulation and Trauma Informed Practice Development- Initial 6 month Plan



May 2021

Appendix 2 – ACE pyramid: a conceptual framework

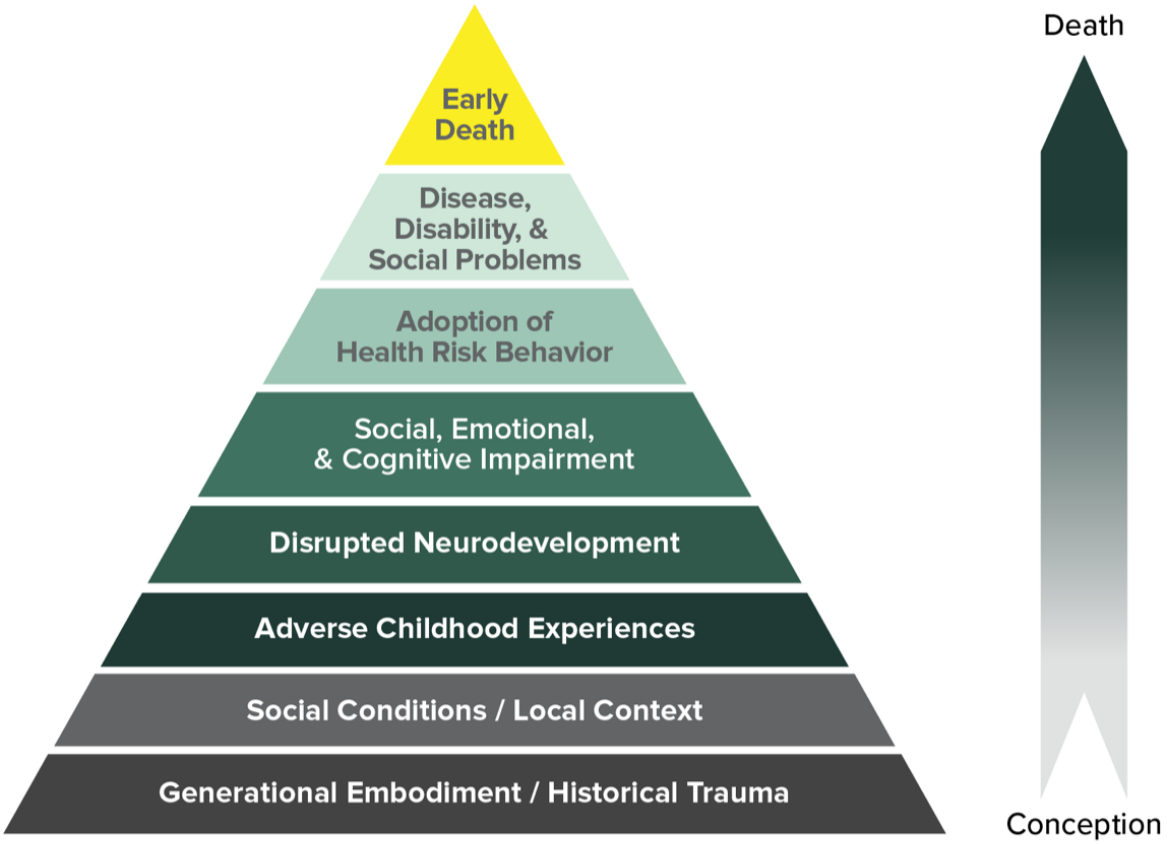
June 2021

July 2021

July/August2021

September 2021

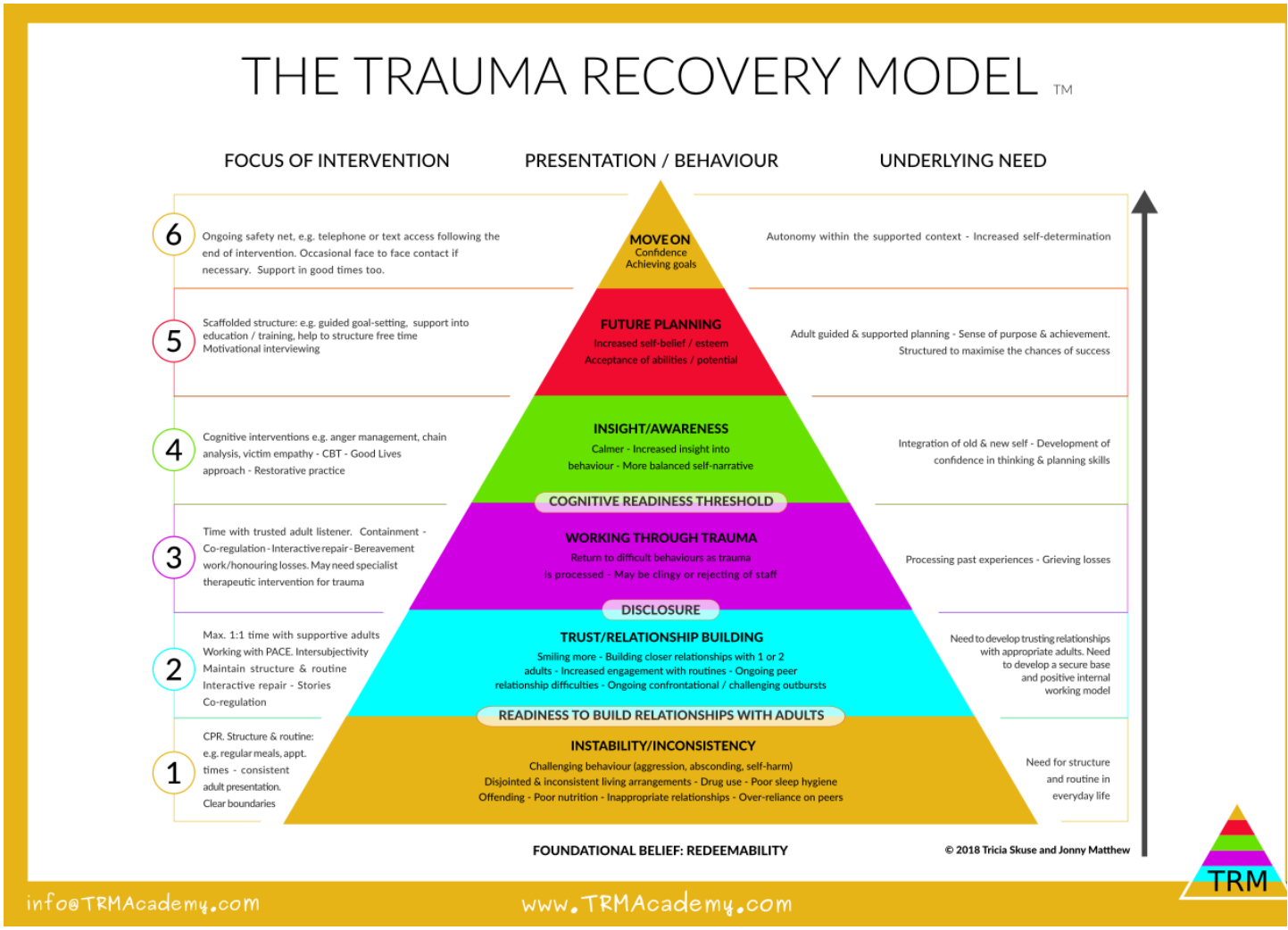
October 2021



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

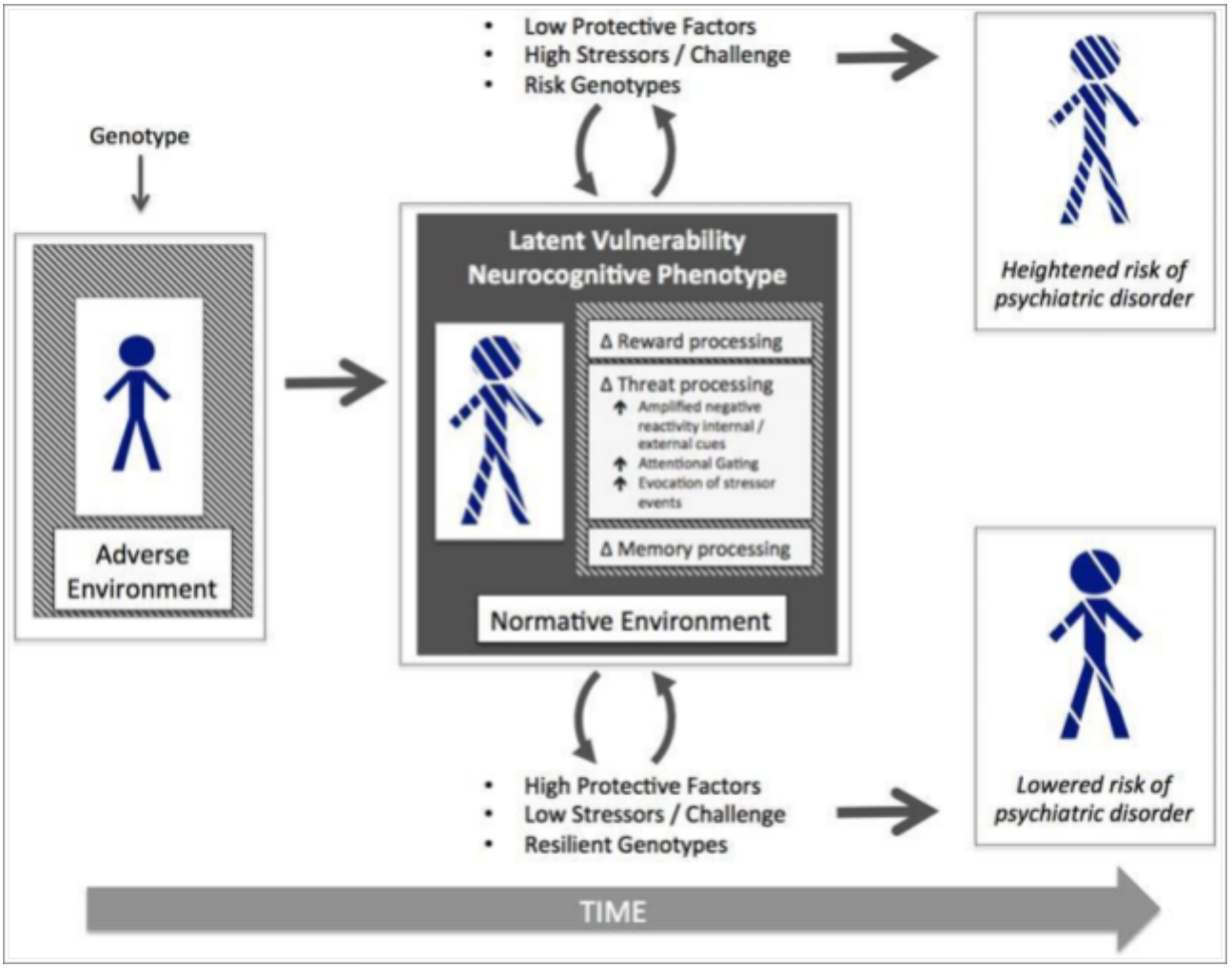
Image retrieved from About the CDC-Kaiser ACE Study |Violence Prevention|Injury Center|CDC

Appendix 3 – The Trauma Recovery model



Accessed from [TRM Academy - Trauma Informed Practice]

Appendix 4 - Latent Vulnerability



Accessed from: McCrory, EJ., & Viding, E. (2015). The theory of latent vulnerability: Reconceptualizing the link between childhood maltreatment and psychiatric disorder. *Development and Psychopathology (27)* p. 493-505.

Appendix 5 - YJB Principles & Trauma Informed Practice

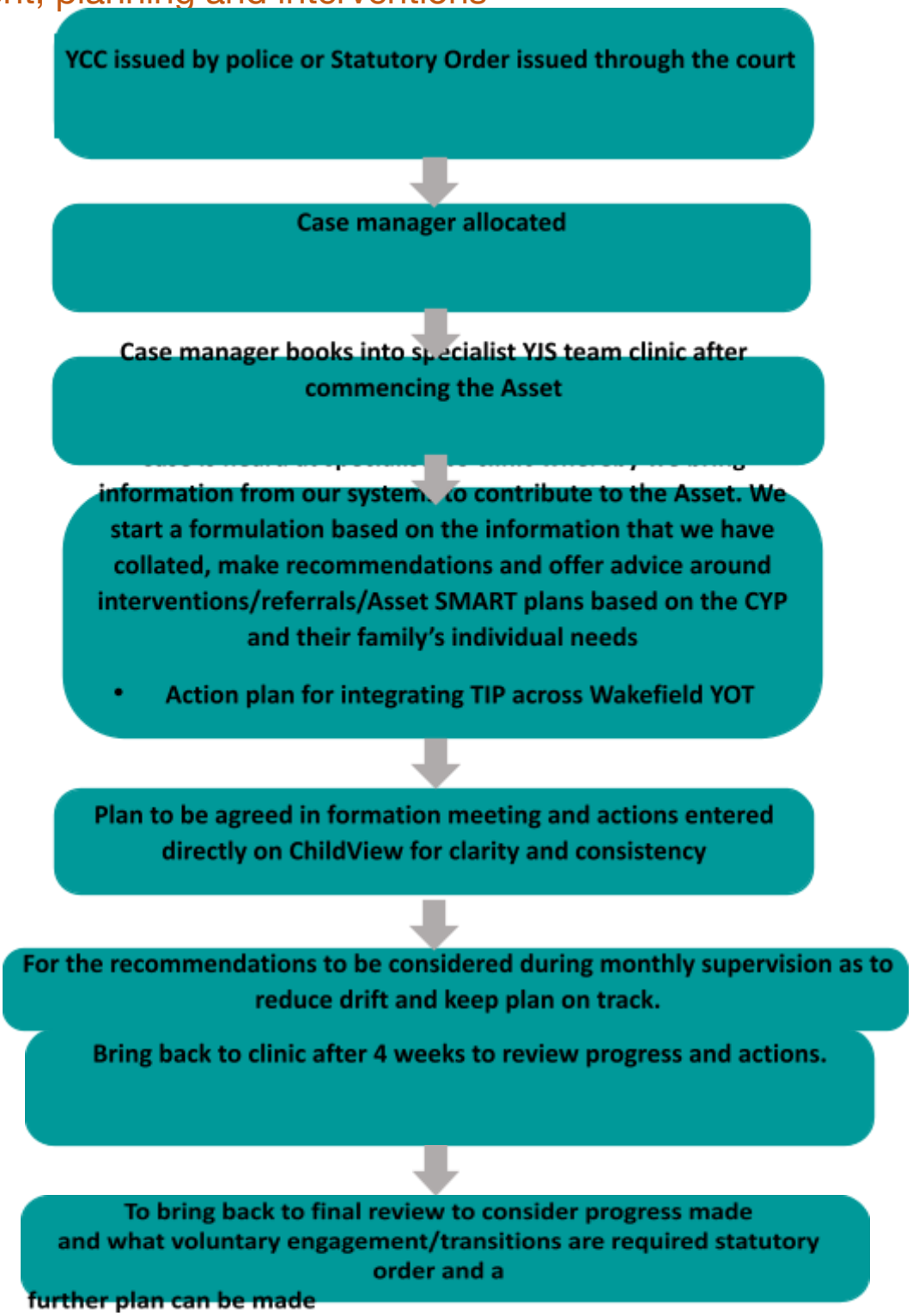
YJB Principle	How trauma-informed practice achieves this
Prioritise the best interests of children, recognising their particular needs, capacities, rights and potential. All work is child-focused and developmentally informed.	• Children are not defined by their behaviour and have the capacity to thrive with the right help and support. • The reasons for offending are explored by understanding what a child has experienced, that their functioning may be rooted in the adversities they have experienced and they require assistance, patience and empathy to overcome the difficulties they are experiencing. • Presenting issues can be changed over time through sensitive, developmentally focused and sequenced interventions, which consider each child's physical, cognitive, emotional and social ability,
Promote children's individual strengths and capacities as a means of developing their pro-social identity for sustainable desistance, leading to safer communities and fewer victims. All work is constructive and future-focused, built on supportive relationships that empower children to fulfil their potential and make positive contributions to society.	• Practice focuses on developing a sense of safety and security, is collaborative, participatory, empowering and helps children to make good choices and develop their own goals. • Relational working and the development of a trusting relationship is a key intervention. As children recover from trauma, there is a shift to targeting support in assisting them to focus on future goals. • Children are empowered to feel they can succeed and are supported to build resilience and recognise their strengths. • Children are helped to feel safe, as it is recognised that those who have experienced trauma often feel unsafe and insecure and are likely to have experienced abuse of power in significant relationships. • A greater sense of safety coupled with enhanced resilience and awareness of personal strengths and abilities enables children to develop pro-social identities and to view the future with hope and optimism.

YJB Principle	How trauma-informed practice achieves this
Encourage children's active participation, engagement and wider social inclusion. All work promotes desistence through co-creation with children.	• Children are helped to learn about themselves, rather than simply focusing on what they have done • Children are helped to make informed choices about what they can do and how they can achieve their goals. • Opportunities are provided to engage with activities, to build positive networks of support and to exercise choice and control.
Promote a childhood removed from the justice system, using pre-emptive prevention, diversion and minimal intervention. All work minimises criminogenic stigma from contact with the system.	• The right intervention is delivered at the right time at the right level of developmental need, with emphasis on minimising contact with the criminal justice system or further involvement in it. The approach removes the focus from the symptoms of offending, to what happened to them, reducing the need for offence specific interventions. • Recognising and addressing past trauma enables children to feel heard and valued, offers them the coping skills to move forward positively in their lives, to reduce the likelihood of contact with the youth justice system and to lessen the likelihood of offending. • Being trauma-informed enables practitioners to explain and contextualise children's needs and behaviours in settings where adverse decisions could be made about them e.g. in sentencing or in relation to breach. • Trauma-informed practice is non-stigmatising and seeks to understand and not to judge, blame or shame.

Accessed from;

https://yjresourcehub.uk/trauma-and-wellbeing/item/807-enhanced-case-management-and-child-first-principles-september-2020.html

Appendix 6 - Flow chart for entry into the youth justice system, assessment, planning and interventions



References

Achievement for all. (2016). *Youth Justice SEND.* https://afaeducation.org/coaching-programmes/youth-justice-send/youth-justice-send/

American Psychiatric Association (2013), *Diagnostic and statistical manual of mental disorders* (5th ed.), Washington DC: American Psychiatric Association.

Andrews, DA., & Bonta, J. (1998). *The psychology of criminal conduct.* Cincinnati, OH: Anderson Publishing.

Andrews, D. A., Bonta, J., & Wormith, S. J. (2006). *The recent past and near future of risk and/or need assessment. Crime & Delinquency,* 52, 7–27. doi:10.1177/0011128705281756

Ardino, V. (2011). Post-traumatic stress in antisocial youth: A multifaceted reality. In V. Ardino (Ed.), *Post-traumatic syndromes in children and adolescents* (pp. 211229). Chichester, UK: Wiley/Blackwell Publishers.

Ardino, V. (2012). Offending Behaviour: the role of trauma and PTSD*. European Journal of Psychotraumatology, 3*(1), 18968, DOI: 10.3402/ejpt.v3i0.18968

Balbernie, R. (2001). Circuits and circumstances: the neurobiological consequences of early relationship experiences and how they shape later behaviour*. JOURNAL OF CHILD PSYCHOTHERAPY 27*(3); 237–255. Circuits and circumstances: the neurobiological consequences of early relationship experiences and how they shape later behaviour (allanschore.com)

Beacon House. (2019). Developmental-Trauma-Close-Up-Revised-Jan-2020.pdf (beaconhouse.org.uk)

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C. and Lowey, H. (2014) 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England' *BMC Medicine*: https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-72 3

Bellis, M. A., Ashtoni, K., Hughes, K., Fordii, K., Bishopi, J. and Paranjothyi, S. (2015) *Welsh Adverse Childhood Experiences (ACE) Study: Adverse Childhood Experiences and their impact on*

health-harming behaviours in the Welsh adult population: http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf

Baldry, E., Dowse, L. and Clarence, M. (2011), *People with mental and cognitive disabilities: pathways into prison,* National Legal Aid Conference: Darwin.

Botting, N. and Conti-Ramsden, G. (2000), *'Social and behavioural difficulties in children with language impairment', Child Language Teaching and Therapy, 16*(2), pp. 105-120

Brownlie, E., Beitchman, J., Escobar, M., Young, A., Atkinson, L., Johnson, C., Wilson, B. and Douglas, L. (2004), 'Early language impairment and young adult delinquent and aggressive behavior', *Journal of Abnormal Child Psychology, 32*, pp. 453-467.

Bryan, K. (2004). Prevalence of speech and language difficulties in young offenders. *International Journal of Language and Communication Disorders, 39*, 391-400.

Bryan,K., Freer, J. & Furlong, C. (2007). Language and COmmunication DIffculties in Juvenile Offenders. *International Journal of Language and Communication Disorders, 42*(5), 505-520.

Burton, D., Foy, D. W., Bwanausi, C., & Johnson, J. (1994). The relationship between traumatic exposure, family dysfunction, and post-traumatic stress symptoms in male juvenile offenders. *Journal of Traumatic Stress, 7*(1), 8393.

Carswell K, Maughan B, Davis H, et al. (2004) The psychosocial needs of young offenders and adolescents from an inner city area. *Journal of adolescence, 27*(4), p.415–28.

Centre for Disease Control and Prevention. (2019). *Preventing Adverse Childhood Experiences (ACEs) to improve U.S. health.* Preventing Adverse Childhood Experiences (ACEs) to improve U.S. health | CDC Online Newsroom | CDC

Chapman, T., & Hough, M. (1998). Evidence Based Pracice. A Guide to Effective Practice. PublicationsEVIDENCE_BASED_PRACTICE.pdf [Accessed 29.12.20]

Chisabesan, P., Kroll, L., Bailey, S., Kenning, C.,Sneider, S., MacDonald, W., & Theodosiou, L. (2018). Mental health needs of young offenders in custody and in the community. *Cambridge University Press (188)*6. p. 534-540

Creeden, K. (2009). How trauma and attachment can impact neurodevelopment: Informing our understanding and treatment of sexual behaviour problems. *Journal of Seuxal Aggression, 15*(3), 261-273. doi:10.1080/13552600903335844 (arfamiliesfirst.com)

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M., Pachter, L. M. and Fein, J. A. (2015) 'Adverse Childhood Experiences: Expanding the concept of adversity' *American Journal of Preventive Medicine 49*(3): 354-361.

Dong, M. Anda, RF., Felitti, VJ., Dube, SR., Williamson, DF., Thompson, TJ., Giles, WH. (2004) The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 28*, 771784.

Dziuba-Leatherman, J., & Finkelhor, D. (1994). How does receiving information about sexual abuse influence boys' perceptions of their risk? *Child Abuse & Neglect, 18*(7), 557568

Erwin, B. A., Newman, E., McMackin, R. A., Morrissey, C., & Kaloupek, D. G. (2000). PTSD, malevolent environment, and criminality among criminally involved male adolescents. *Criminal Justice and Behavior, 27*, 196215.

Felitti V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P. and Marks, J. S. (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.' *American Journal of Preventative Medicine 14*(4): 245-258: http://www.ncbi.nlm.nih.gov/ pubmed/9635069/

Finkelhor, D. (2008*). Childhood victimisation. Violence, crime and abuse in the lives of young people*. Oxford, UK: Oxford University Press.

Ford, K., Barton, ER., Newbury, A., Hughes,K., Bezeczky, Z., Roderick, J., Bellis, MA. (2019). Understanding the prevalence of adverse childhood experiences (ACEs) in a male offender population in Wales. The Prisoner ACE survey. https://phw.nhs.wales/files/aces/the-prisoner-ace-survey/

Foy, D. W., Furrow, J. & McManus, S. (2011). Exposure to violence, post-traumatic symptomatology, and criminal behaviors. In V. Ardino (Ed.), *Post-traumatic syndromes in children and adolescents.* (pp. 199210). Chichester, UK: Wiley/Blackwell Publishers.

Frattaroli, J. (2006) 'Experimental disclosure and its moderators: a meta-analysis'. *Psychological Bulletin 132*(6): 823.

French, SA. & Gendreau, P. (2006). Reducing prison misconducts: What works!. *Criminal Justice and Behaviour 33*(20), 185-218

Friendship, C., & Thornton, D. (2001). Sexual reconviction for sexual offenders released from prison in England and Wales. *British Journal of Criminology, 41*, 285292.

Grann, M., & Wedin, I. (2002). Risk factors for recidivism among spousal assault and spousal homicide offenders, Psychology. *Crime & Law, 8*(1), 523.

Harrington R, Bailey S, Chitsabesan P, et al. (2005) *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community.* Youth Justice Board.

Harvard University. (2021). *Executive Function & Self Regulation*. https://developingchild.harvard.edu/science/key-concepts/executive-function/

Heckman, KJ. (2020). *ADHD and Trauma; Untangling Causes, Symptoms & Treatments.* https://www.additudemag.com/adhd-trauma-somatic-therapy/

Hughes, N., Williams, H., Chitsabesan, P., Davies, R. and Mounce, L. (2012), *Nobody Made the Connection: The prevalence of neurodisability in young people who offend,* London: Office of the Children's Commissioner for England

Hughes, K., Lowey, H., Quigg, Z. and Bellis, M. A. (2016) 'Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey' *BMC Public Health 16*:222.

Hussey, J. M., Chang, J. J., & Kotch, J. B. (2006). Child Maltreatment in the United States: Prevalence, risk factors, and adolescent. *Health Consequences Pediatrics, 118*(3), 933942.

Kelly-Irving, M., Lepage, B., Dedieu, D., Bartley, M., Blane, D., Grosclaude, P., Lang, T., Delpierre, C. (2013). Adverse childhood experiences and premature all-cause mortality. *Eur J Epidemiol (28)*721–34.

Kessler, R. C. and McLaughlin, K. A. (2010) 'Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys' *British Journal of Psychiatry 197*(5): 378–385.

Lamb, ME. & Sim, MPY. (2013). Developmental Factors Affecting Children in Legal Contexts. *Youth Justice, 13*(2), p.131-144

Loucks, N. (2006) *No One Knows: Offenders with Learning Difficulties and Learning Disabilities. Review of prevalence and associated needs.* London: Prison Reform Trust.

Making Every Adult Matter. (2020). *The sentencing white paper: impacts on people facing multiple disadvantage.* MEAM-sentencing-white-paper-final-in-template.pdf [Accessed 29.12.20]

Maxfield, G. M., & Widom, C. (1996). The cycle of violence revisited 6 years later. *Archives of Pediatric & Adolescent Medicine, 150*(4), 390395.

McCrory, EJ., & Viding, E. (2015). The theory of latent vulnerability: Reconceptualizing the link between childhood maltreatment and psychiatric disorder. *Development and Psychopathology (27)* p. 493-505.

McLaughlin, K. A. (2016) 'Future Directions in Childhood Adversity and Youth Psychopathology' *Journal of Clinical Child and Adolescent Psychology 45*(3): 361-382.

McLaughlin, K. A. (2017) 'The long shadow of adverse childhood experiences' *Psychological Science Agenda*: http://www.apa.org/science/about/psa/2017/04/adverse-childhood.aspx

McGruder-Johnson, A. K., Gleaves, D. H., Stock, W., & Finch, J. F. (2000). Interpersonal violence and posttraumatic symptomatology*. Journal of Interpersonal Violence, 15*, 205221.

Morgan, A. and Lilienfeld, S. (2000), 'A meta-analytic review of the relation between antisocial behavior and neuropsychological measures of executive function', C*linical Psychology Review,*

20, pp. 113-156.

Ministry of Justice. (2012). *Prisoners' childhood and family backgrounds Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners.* Prisoners' childhood and family backgrounds (publishing.service.gov.uk) [Accessed 29.12.20]

Mitchell P, Smedley K, Kenning C, et al. (2011) Cognitive behaviour therapy for adolescent offenders with mental health problems in custody. *Journal of adolescence, 34*(3), p.433–43.

National Institute of Clinical Excellence (NICE). (2016). Early years: promoting health and wellbeing in under 5s: Quality standard number 2: speech and language. https://www.nice.org.uk/guidance/qs128/chapter/Quality-statement-2-Speech-and-language

Newburn, T. and Shiner, M. (2006) 'Young people, mentoring and social inclusion', *Youth Justice, 6*(1), pp.23–41.

NHS England. (2016). *Strategic Direction for Health Services in the Justice System: 2016-2020.* https://www.england.nhs.uk/wp-content/uploads/2016/10/hlth-justice-directions-v11.pdf

Ogilvie, J., Stewart, A., Chan, R. and Shum, D. (2011), 'Neuropsychological measures of executive function and antisocial behavior: A meta-analysis', *Criminology, 49(*4), pp. 1063-1107.

Parent Infant Foundation. (2021). First 1001 Days Movement. 1001 Days - Parent-Infant Foundation

Patel, D., Greydanus, D., Omar, H. and Merrick, J. (eds.) (2011), N*eurodevelopemntal Disabilities: Clinical Care for Children and Young Adults.* New York: Springer

Perry, B. with Szalavitz, M. (2017) The Boy Who Was Raised as a Dog: and other stories from a child psychiatrist's notebook (3rd Revised Edition). New York: Basic Books.

Prior, D. (2005) 'Evaluating the new youth justice: what can practitioners learn from research?', *Practice, 17*(2), pp.103–112.

Real Life Research.(2015). *An Evaluation of REACh: Routine enquiry into adversity in childhood. Blackburn with Darwen: Independent evaluation of work commissioned by Blackburn local authority Public Health team*

Royal College of Speech and Language Therapists. (2017). Justice Evidence Base Consolidation: 2017. https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/justice-evidence-base2017-1.pdf

Roy, P., & Chiat, S. (2013). Teasing apart disadvantage from disorder: The case of poor language In: Marshall, CR (Ed.) *Current issues in developmental disorders* (p. 125-150). Hove, UK: Psychology Press

Scarpa, A. (2001). Community violence exposure in a young adult sample: Lifetime prevalence and socioemotional effects*. Journal of Interpersonal Violence, 16*(1), 3653.

Scottish Government. (2018). *Understanding childhood adversity, resilience and crime.* Understanding childhood adversity, resilience and crime - gov.scot (www.gov.scot)

Seigal, D. (2006). Early childhood and the developing brain - All In The Mind - ABC Radio National

Shelemy, L. & Knightsmith, P. Building resilience in the face of adversity In: *Young Minds – Addressing Adversity.* ym-addressing-adversity-book-web-2.pdf (youngminds.org.uk)

Skowyra, K. R., & Cocozza, J. J. (2006). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system.* Delmar, NY: National Center for Mental Health and Juvenile Justice and Policy Research Associates.

Skuse, T., & Matthew, J. (2014). The Trauma Recovery Model: Sequencing Youth Justice Interventions for Young People with Complex Needs. *Prison Service Journal, 220*, 16-25

Smith, C. A., Ireland, T. O., & Thornberry, T. P. (2005). Adolescent maltreatment and its impact on young adult antisocial behavior. *Child Abuse and Neglect, 29*(10), 10991119.

Snow, P. and Powell, M. (2011), 'Oral language competence in incarcerated young offenders: Links with offending severity', *International Journal of Speech-Language Pathology, 13*(6), pp. 480-489.

Steiner, H., Garcia, I. G., & Matthews, Z. (1997). Posttraumatic stress disorder in incarcerated juvenile delinquents. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(3), 357365.

Substance Abuse and Mental Health Services Administration (SAMSHA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach | Youth.gov

Substance Abuse and Mental Health Services Administration (SAMSHA). (2019). *Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide.* HHS Publication No. SMA19-5097. Rockville, MD: Office of Policy, Planning, and Innovation. Substance Abuse and Mental Health Services Administration.

Sweeny, A. & Clement, S. & Filson, B. & Kennedy, A. (2016). Creating trauma-informed mental healthcare in the UK. In: Young Minds. (2018). *Addressing Adversity.* ym-addressing-adversity-book-web-2.pdf (youngminds.org.uk)

Szymanski, K., Sapanski, L., & Conway, F. (2011). Trauma and ADHD — Association or diagnostic confusion? A clinical perspective. *Journal of Infant, Child & Adolescent Psychotherapy, 10*(1), 51–59. https://doi.org/10.1080/15289168.2011.575704

The National Association for People Abused in Childhood (NAPAC). (2020). *Trauma-informed practice: what it is and why NAPAC supports it.* https://napac.org.uk/trauma-informed-practice-what-it-is-and-why-napac-supports-it/. [Accessed on 17.9.20.]

The National Child Traumatic Stress Network. (2016). Is it ADHD or Child Traumatic Stress? https://www.nctsn.org/sites/default/files/resources/is_it_adhd_or_child_traumatic_stress.pdf

Twichett, C. & Sylvester, S. (2018). Trauma informed care for children with complex needs in the criminal justice system. In: Young Minds. (2018). *Addressing Adversity.* ym-addressing-adversity-book-web-2.pdf (youngminds.org.uk)

UK Trauma Council. (2020). *The guidebook to childhood trauma and the brain*. Accessed from: https://uktraumacouncil.org/wp-content/uploads/2020/09/CHILDHOOD-TRAUMA-AND-THE-BRAIN-SinglePages.pdf [Accessed on 17.9.20]

Van der Kolk, B. (2014). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*.

Vermeiren, R. (2003). Psychopathology and delinquency in adolescents: A descriptive and developmental perspective. *Clinical Psychology Review, 23*(2), 277318.

Weeks, R., & Widom, C. S. (1998). Self-reports of early childhood victimization among incarcerated adult male felons. *Journal of Interpersonal Violence, 13*, 346361.

Welsh Government. (2017). *Evaluation of the Enhanced Case Management Approach. https://www.cordisbright.co.uk/admin/resources/170328-evaluation-enhanced-case-management-approach-en.pdf*

West Yorkshire – Finding Independence (WY-FI). *Surviving the Revolving Door: A study of the evidence about offending in WY-FI. Executive Summary.* surviving_in_a_revolving_door_executive_summary_final.pdf (westyorkshire-pcc.gov.uk) [Accessed on 29.12.20)

Widom, C. S. (1989). Child abuse, neglect, and adult behavior: Research design and findings on criminality, violence, and child abuse*. American Journal of Orthopsychiatry, 59*(3), 355367.

Widom, C. S., & Maxfield, M. G. (2001). *An update on the ‘‘cycle of violence’’*. (NCJ 184894). Washington, DC: National Institute of Justice, 200 pp.

Williams, K. (2015). *Needs and characteristics of young adults in custody: Results from the Surveying Prisoner Crime Reduction (SPCR) survey.* Analytical Summary 2015 - Needs and characteristics of young adults in custody: Results from the Surveying Prisoner Crime Reduction (SPCR) survey (publishing.service.gov.uk)

Yoder, C. (2005). *The little book of trauma healing: When violence strikes and community security is threatened.* Intercourse, PA: Good Books.

Young Minds. (2018). *Addressing Adversity.* ym-addressing-adversity-book-web-2.pdf (youngminds.org.uk)

Young Minds. (2019)*. Adversity and Trauma Informed Practice. A short guide for professionals working on the front line.*

https://youngminds.org.uk/media/3091/adversity-and-trauma-informed-practice-guide-for-professionals.pdf

Youth Justice Board for England & Wales. (2005). *Managing Risk in the Community*. London: Youth Justice Board.

Youth Justice Board for England & Wales. (2019). *Youth Justice Board for England and Wales. Business plan 2019-2020*.

Youth Justice Board for England & Wales. (2020). *Youth Justice Board for England and Wales. Business plan 2020-2021*.

Youth Justice Board for England & Wales. (2020[2]) *Why Enhanced Case Management is 'Child First'.*

Youth Justice Board for England & Wales. (2020[3]). *Enhanced Case Management. Implementing the Approach.*