West Yorkshire
Violence Reduction Unit
Tackling Violence Together

West Yorkshire
Health and Care Partnership

Adversity, Trauma and Resilience in West Yorkshire –

a review of life-course evidence, approaches and provision to support the transformation to a trauma informed health and care system by 2030

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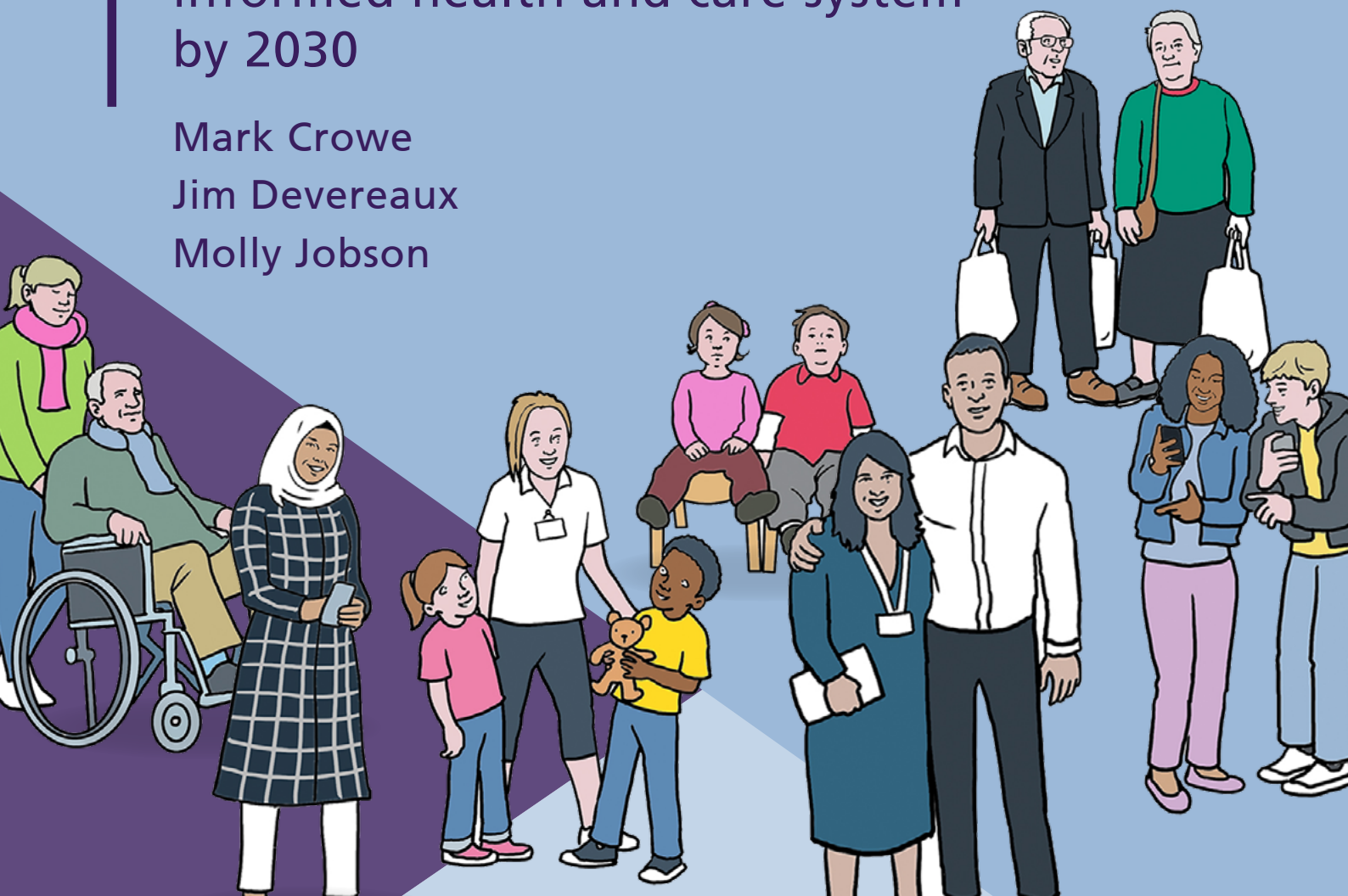

Image credit: Tom Bailey and West Yorkshire Finding Independence

Based on contributions by: members of the West Yorkshire Adversity, Trauma and Resilience Network, The West Yorkshire Multiple Disadvantage Consortium, people with lived experience of services (facilitated by the West Yorkshire Liaison and Diversion Service), West Yorkshire Violence Reduction Unit

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Structure of this report

This report is composed of data and evidence gathered from five main activities:

A rapid evidence review of around 200 pieces of research and grey literature discussing Adverse Childhood Experiences (ACEs), trauma, Trauma Informed (TI) approaches to service delivery and the socio-economic context for both the prevalence of needs and mitigation or prevention of those needs manifesting themselves.

Two mapping exercises of services offered to people who have experienced mental or emotional trauma or experience multiple disadvantage and exclusion at any point in their life. The definitions of mental or emotional trauma include all kinds of adverse childhood experiences, similar experiences as an adult that have gone unaddressed, exclusion or ineffective engagement with services. Separate questionnaires asked about services for adults and services for children, families and young people. However, both questionnaires asked about support specifically directed at 16-25 year olds as this is a period in the life-course when people switch service provision or stop receiving services.

Evidence gathered from approximately 50 people with lived experience of adverse childhood experiences, trauma, and multiple disadvantages and exclusions. This has largely been gathered from service users in the West Yorkshire Liaison and Diversion service. There was a particular focus on people under 25 years old as their subjective views are less frequently heard.

An equalities impact assessment looking not only at services in relation to protected characteristics but also a range of other vulnerabilities which can lead to people receiving less effective treatment from services.

An updating of estimates of future demand for services aimed adults experiencing multiple disadvantages and exclusion. This estimate is built on the numbers of children and young people identified as having had adverse childhood experiences or trauma, among other data sources.

These five evidence sources will be used to provide answers to the following questions:

- How do individuals make meaning out of trauma, how do they move beyond trauma, and what does a life after trauma look like?
- How do we identify and prevent adversity and trauma (in children and young people)?
- How do we prevent the re-traumatisation of people who are in services? What are the system changes and drivers we need to stimulate?
- What different things need to happen at place and systems levels?

These questions are not completely distinct from one another so the evidence will flow from one section into others as necessary.

The final section (fourth bullet point above) will be a vision for success, based on the work of the West Yorkshire and Harrogate Healthcare Partnership (WYHHCP) and the pledges made by the members of the Adversity, Trauma and Resilience Network, the Multiple Disadvantage Consortium and the ICS. Recommendations will be made to help the Partnership meet the outcomes necessary to achieve that vision.

Context

West Yorkshire and Harrogate Healthcare Partnership (WYHHCP, WY Integrated Care System or ICS)

West Yorkshire and Harrogate Health and Care Partnership is made up of organisations working closely together to plan health and care across the region. The Partnership focuses on the health and care needs of local people with key priorities / ambitions.

West Yorkshire and Harrogate Improving Population Health Programme (WYIPHP)

The Improving Population Health Programme aims to; improve the physical and mental health outcomes of people living in West Yorkshire and Harrogate; reduce health inequalities; understand the causes of ill health and wellbeing and identify the greatest opportunities to work together to tackle these at the right time in people's lives. This approach includes action to reduce the occurrence of ill-health and improve wellbeing, including addressing wider determinants of health.

West Yorkshire Violence Reduction Partnership (WY VRU or VRU)

The West Yorkshire Violence Reduction Unit (VRU) brings together specialists from health, law enforcement, local government, education, voluntary and community services and others to understand and tackle the root causes of violent crime.

It takes a fundamentally different approach to violence reduction – one where the public sector institutions and communities that make up West Yorkshire act together to help cut violence with early intervention, prevention, education and partnership working.

A number of people already have some of the tools they need to tackle violence and its root causes – but many need additional support to help put their time, expertise or skills to best use. The job of the VRU is to help unlock that potential by sharing information about what works in spotting the early signs of what might lead to criminal behaviour, and focusing attention and resources on what makes a difference.

West Yorkshire Consortium for Adults Facing Multiple Disadvantage (previously, West Yorkshire Finding Independence or WY-FI Core Partnership Management Board). Known as the WY Multiple Disadvantage Consortium)

The West Yorkshire Finding Independence (WY-FI) Core Partnership Management Board is an established partnership of statutory agencies, voluntary sector organisations and individuals with lived experience. Between 2014 and 2020 the Fulfilling Lives National Lottery Community Fund funded programme supported over 800 people experiencing multiple needs and exclusion across five local authority areas. The WY-FI Programme was externally evaluated by the Centre for Regional Economic and Social Research (Sheffield Hallam University) which found that that WY-FI works, by supporting people to:

- Live in a settled home
- Look after their health and wellbeing
- Access education, training and employment opportunities
- Have a positive outlook on the future

This was achieved by Navigators working with small caseloads who facilitated:

- Multi-agency working (through district level service providers)
- Flexible support
- Increased time on caseload (compared to other support workers)
- Peer mentor support

The WY Multiple Disadvantage Consortium's learning from delivering support and evidence about what works for adults experiencing multiple needs underpins the need for a co-ordinated approach to trauma and adversity across the life-course at the levels of both system and place.

Humankind

Humankind is the charity that led the WY-FI Partnership and developed the Multiple Disadvantage Consortium to continue the legacy of WY-FI. Humankind is committed to reducing deprivation and exclusion and to improving people's well-being. Humankind is a national charity with over 1,200 staff and around 100 volunteers providing services for over 76,000 people (2019-20). We have specialist services across England which include drug and alcohol, clinical, children, young people and families, health and well-being, employment, training and education, health and well-being, criminal justice and offender rehabilitation, gender specific and housing and housing support services. Humankind leads the substance use partnerships delivering services to adults and young people in Leeds and Calderdale, and delivers hostel accommodation and housing support in Bradford.

This report is a synthesis of data, evidence and learning that provides evidence and learning about need in order to embed sustainable transformation in the WYHHCP and its member agencies at system and operational levels in the following key aspects:

- To reduce trauma, adversity and build resilience for the population across West Yorkshire & Harrogate, in particular people who are vulnerable, facing multiple difficulties, complex needs, adversity and childhood trauma. It highlights the changes in demand to meet new and different needs in our population in relation to adversity, trauma and multiple disadvantages.
- Provide access to integrated support from a range of professionals across health, education, social care, youth justice, the police and the voluntary sector to ensure that their needs of the West Yorkshire & Harrogate population are met in a co-ordinated way. This

will reduce multiple disadvantages. It will also reduce the repeat demand on services and provide accessible services to better support and improve outcomes for people experiencing Multiple and Complex Needs.

- Influence a change in commissioning across the system (more integrated commissioning across health and social care). Support local and regional approaches to future commissioning of appropriate, effective and integrated multiple needs services. Support delivery plans at place, share learning and accelerate a replicate good practice across the system.
- Coordinated system approach to coproduction and engagement with people with lived experience.
- Enable system transformation and sustainability and increasing the capacity across West Yorkshire & Harrogate.

Introduction

There are several key concepts that it is worth outlining as an introduction to this report. They are central to the discussion about life-courses responses to adversity and trauma. They will be revisited from different perspectives in the course of the report and examined in terms of their value of system change.

Adverse Childhood Experiences

Adverse childhood experiences, or ACEs, can be defined/explained as potentially traumatic events that are experienced or witnessed by a child during the ages of 0-17. Examples of ACEs include: personally experiencing violence, abuse or neglect, witnessing violence at home or within the community or having a family member attempt or die as a result of suicide. A child's environment that can impact on their own sense of safety, stability and emotional bonding can also come within the scope of ACEs. Examples include where a child grows up in a household in which there are substance misuse problems, mental health problems or instability as a result of parental separation or household members being in prison (Siobhan Collingwood, 2018). This isn't a definitive list of ACEs and there are many other experiences of traumatic events that could come within the scope of ACEs. *We acknowledge that the use of the contractions "ACE" and "ACEs" are contested by some groups of people with lived experience of adversity and trauma. Whilst we concur with the view that experiences of adversity and trauma can't be described as "ace", for the purposes of this report we have used the current terminology in the literature and strive to find better language to use in future.* Trauma, resulting from an adverse childhood experience, can have an enduring negative impact on many aspects of a child's life as they grow up and transition into adulthood. It can impact on both physical and mental health, and life opportunities including education and career potential. ACEs can increase risks associated with many aspects of adult life including maternal health, the chances of developing chronic diseases and early death caused by cancer, diabetes, heart disease, and suicide. There is a clear link between the frequency/number of ACEs that a child experiences and the likely impact on that child's adult life.

Adults Experiencing Multiple Disadvantages and Exclusion

In 2013 the National Lottery Community Fund adopted a definition of multiple disadvantage in adults for the Fulfilling Lives Programme as experiencing two or more of the following: homelessness, addiction, risk of re-offending and mental ill-health (known as HARM). These definitions were used as an entry requirement for Fulfilling Lives programmes, including WY-FI. One aspect of these multiple needs was that some or all must be, at point of entry, "unmet" or the beneficiary was at risk of being excluded from services that could meet them, or had been repeatedly excluded from or had abandoned them (the so-called "revolving door").

Alongside the four HARM needs it was evident from initial research that a number of other issues compounded

and entrenched multiple disadvantage and exclusion. Poor physical health, life-limiting long-term conditions as well as other disabilities, being a victim of crime or racism, family breakdown (including being a victim or perpetrator of domestic violence and the loss of social networks), poverty or having "no recourse to public funds", learning difficulties and low levels of educational attainment were all factors contributing to the core disadvantages for beneficiaries. One of the unexpected findings was that around a quarter to a third of people experiencing multiple disadvantage are also responsible for or are in contact with children.

It was also clear from their age profiles that beneficiaries didn't acquire multiple disadvantages in adulthood. They were frequently known to children, young people and family services, precisely because they had been through adverse childhood experiences or they had been "looked after" by local children's services.

Multiple disadvantages and exclusions are also known as "Severe Multiple Disadvantage" (SMD), "Multiple and Complex Needs" (MCN) or complex needs.

Transitions (16-25 Year Olds)

There are significant administrative, legal and medical status of individuals changes between the ages of 16 and 25. Changes in medical or psychological treatment pathways, eligibility for support such as housing and benefits and consequences of arrest and conviction are triggered on assuming a certain age and not necessarily on the capacities and needs of the individual. Transition from children's services to adult services are often highlighted as being a disruption to treatment, in testimony from people with lived experience and in the literature. In some cases treatment ends because of that transition, not because the treatment is complete.

The analysis of WY-FI evidence showed a significant number of people known to Children, Young People and Family services (CYPF) services who had not had a smooth transition in to adult services finding themselves in very high levels of need before being able to access services as adults.

Adversity, Trauma and Resilience (ATR)

Section 1 of this report opens with a discussion of the concepts of adversity and trauma. Whilst they have everyday connotations, the technical differences between them are extremely illuminating when it comes to formulating system design. We refer to adversity, trauma and resilience as ATR throughout this report.

The language used in this area of work, however nuanced or precise it tries to be, is inherently complex. The language used is also extremely powerful because it sets up the culture and expectations of both the person speaking the words and the person hearing them.

Trauma Informed Practice

Trauma Informed Practice (TIP), also known as Trauma Informed Care (TIC) or Trauma Informed Approach (TIA), is an adaptable framework which is a version of the principles of the WY-FI Navigator model.

Trauma informed practice follows key principles which influence engagement and relationships with all stakeholders within a service, organisation or sector: service users; all staff (paid and unpaid); commissioners and other funders; partners; community and voluntary groups, etc. These principles are set out in the SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (SAMHSA, 2014, p.10) as:

- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment, Voice, Choice

Section 01

How do individuals make meaning out of trauma, how do they move beyond trauma, and what does a life after trauma look like?

How the key factors for recovery from trauma and sustaining that recovery are not clinical or interventions but are the components of a "good society" and are the same components as those required for good public health.

1.1 Summary of Post Traumatic Growth:

Definition: **a traumatic event refers to an experience that causes an intense psychological or physical stress reaction in an individual** (Quaile, 2020). **70% of the adult population having experienced some type of traumatic event at least once in their lives** (Benjet et al., 2016).

Traumatic stress results in the nervous system being constantly activated, resulting in acute and chronic changes in the brain architecture. This results in emotional and behavioural dysregulation, increasing the risk of unhealthy coping mechanisms such as substance misuse, risky sexual behaviours, and engaging in violence (Bremner, 2006; Delgado et al., 2021). The effect of trauma on the brain is especially detrimental in young people as their brain is still developing. **Those that experience trauma are more likely to experience poor life chances; with higher risk factors of poorer educational attainment, homelessness, addiction and incarceration** (Amor et al., 2018). **Trauma also affects physical health by triggering a detrimental inflammatory cascade resulting in toxic stress which increases the likelihood of developing obesity, diabetes, cardiovascular and respiratory diseases amongst others** (Amor et al., 2018).

Each person has a subjective experience of traumatic events, while trauma can contribute negative physical, mental and socio-economic consequences to one's life, **people who experience challenging circumstances can thrive when the right support measures are in place** (Quaile, 2020).

Post Traumatic Growth (PTG) is a theory developed by Richard Tedeschi, and Lawrence Calhoun in the 1990s. Their hypothesis is that many individuals who encounter traumatic events, can mediate the suffering and produce positive psychological change in their lives (Tedeschi and Calhoun, 2004). There are three main domains of growth: **changes of perception of self, change in**

relationship with others and changes of philosophy of life (Oodward and Joseph, 2003).

Recovery from trauma is a journey – either a return to the "pre-traumatic self" (a form of self-resilience) or growth towards a "post-traumatic self". Tedeschi and Calhoun devised The Post Traumatic Growth Index (PTGI) to assess the positive outcomes in individuals that experienced trauma (Tedeschi and Calhoun, 1996) on the journey to a "post-traumatic-self". The index measured 21 items over five domains of PTG: relating to others, new possibilities, personal strength, spiritual change and appreciation of life (Tedeschi and Calhoun, 1996, Figure Two). The PTGI does not assess negative emotions or outcomes of trauma; only the absence/presence of growth (Tedeschi and Calhoun, 2004). There is also a revised PTGI (PTGI-C-R) for assessing children which makes the domains more 'child friendly' and simplistic in language (Kilmer et al., 2009). The components of that journey are described in the Figure 1 below.

PTG is not a linear concept, **if and how much PTG an individual will experience is affected by a wide range of factors.** There are two traits that make some individuals more likely to experience PTG- openness to experience and extraversion (Tedeschi and Calhoun, 1996; Karanci et al., 2012; Garnefski et al., 2008). This is because individuals who are more open are more likely to reconsider their belief systems, and extroverts are more likely to be more active in their response to trauma and seek support (Jia et al., 2015; Tedeschi and Calhoun, 1996). **Supportive social networks increase the chance of growth** (Collier, 2016). Age is a factor, as **children under 8 are less likely to have the cognitive capacity to experience PTG**, while **those in late adolescence and early adulthood, who are cultivating their own identity and values, are more open to the type of change that such growth reflects** (Collier, 2016).

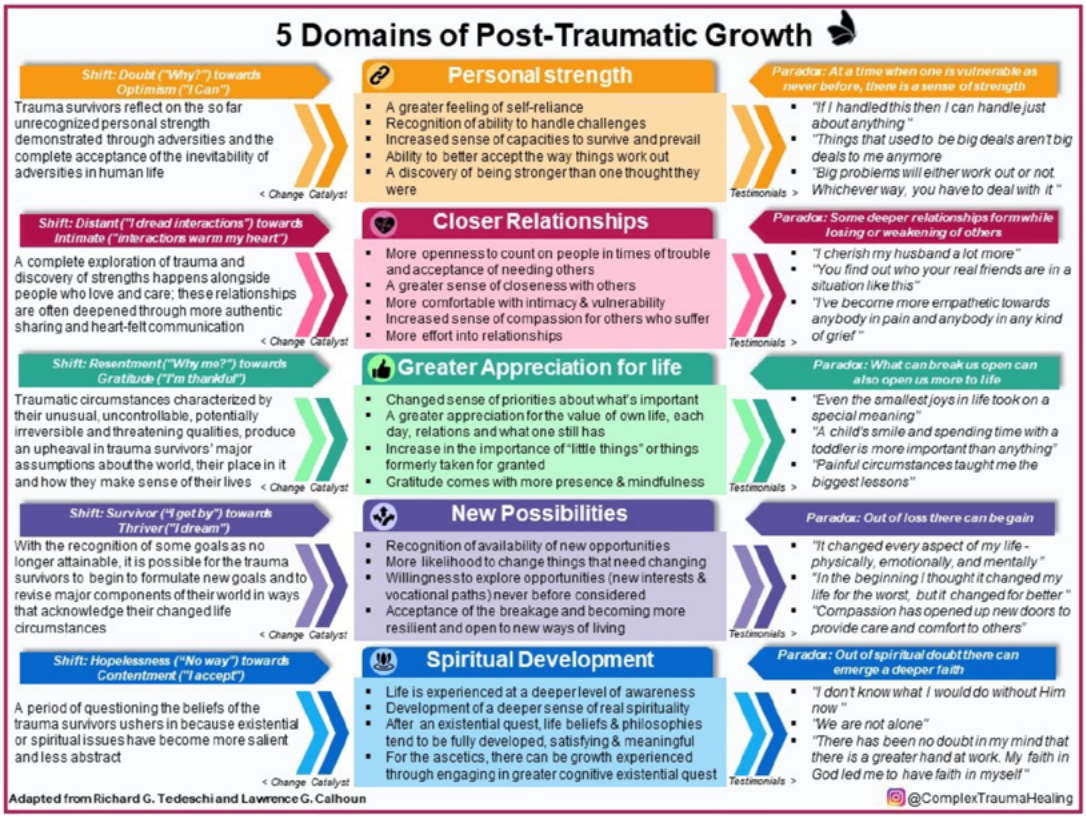


Figure 1: The 5 Domains of Post Traumatic Growth

Resilience is another factor that impacts if, and the amount of PTG that occurs. It is important to understand that resilience and PTG are different concepts; research suggests that the concepts are related but the specific mechanisms are still invasive (Ogińska-Bulik and Kobylarczyk, 2016). Resilience is the personal attribute or ability to bounce back (Collier, 2016). PTG, on the other hand, refers to what can happen when someone who has difficulty bouncing back experiences a traumatic event that challenges his or her core beliefs, endures psychological struggle and then ultimately finds a sense of personal growth (Collier, 2016; Tedeschi and Calhoun, 2004). Those that are already highly resilient, will not experience PTG as they have the cognitive functions to deal with the traumatic event and the emotions that accompany it, due to their ability to 'bounce back' as a result of their protective beliefs system (Tedeschi and Calhoun, 2004). This is because PTG is not a direct result of the trauma itself, but is a result of rumination of the trauma which leads to a cognitive and emotional struggle which leads growth of the individual to a higher functioning than before the trauma (Kutza and Cornell, 2021). It is thought that experiencing PTG can foster resilience, meaning when an individual experiences trauma in the future, they can cope with the outfall more effectively (Tedeschi and Calhoun, 2004).

A study into PTG in the prison population in South Africa suggests that a strong, trustworthy relationship with their therapist increases the chances of PTG occurring (Mapham and Hefferon, 2012). In a 2011 study Tedeschi conducted in combat veterans to see what factors facilitate PTG, he found that understanding the body and mind's response to trauma, emotional regulation (such as anxiety reduction techniques), constructive self-disclosure (including to friends and family, not just health professional), creating a trauma based narrative, and developing constructive life principles are all qualities that enhance PTG (Tedeschi and McNally, 2011).

There are some limitations to the theory of PTG. For example, Tedeschi and Calhoun define trauma as a single event which is out of the ordinary and unexpected for the individual. However, there have been studies showing the prevalence of PTG in individuals that experience mental illness and addiction (Ogilvie and Carson, 2021; Slade et al., 2019). Another limitation is that most research on PTG assesses positive retrospective changes following adversity using the self-reporting PTGI as opposed to assessing affective, cognitive, and behavioural changes through the use of multiple assessment methods (Jayawickreme and Infurna, 2021). What appears to be PTG in some cases may not be real growth of character but instead unhealthy coping strategies that enable the moving on from trauma (Jayawickreme and Infurna, 2021). Most research into PTG only assesses individuals at one time, whereas to determine PTG accurately, it should be assessed longitudinally.

1.2 ACEs and Complex Trauma:

There are two types of trauma an individual can experience: 'single incident' trauma which refers to a single, unexpected, random event such as an assault or natural disaster, or 'complex trauma' which is cumulative, repetitive and interlinked (Center for Substance Abuse Treatment (US), 2014). Complex trauma is the product of overwhelming stress which is interpersonally generated including intimal and familial abuse, and community violence like racism, poverty and war (Bowen and Murshid, 2016). Complex trauma, unlike single incident trauma, penetrates every aspect of an individual's being - it shapes and defines their life narrative (Kezelman and Stavropoulos, 2019). A way to understand the difference is this: individuals that experience single incident trauma often express 'wanting their life before trauma back', meanwhile individuals that experience complex trauma never express this - they don't have a pre-traumatic life.

Despite complex trauma being far more intrusive to an individual, it has been studied less in comparison, with Complex-PTSD only being recognised by the WHO in 2019. Adverse Childhood Experiences (ACEs) can be the source of complex trauma. ACEs are a set of 10, highly stressful childhood events that fall into three categories: abuse, neglect or household dysfunction and that are known to impact healthy development and cause poor mental and physical health (Finkelhor, 2020). **In England, approximately 50% of the population has experienced one ACE, with 9% of the population having experienced 4 ACEs or more (Couper and Mackie, 2016). ACEs are disproportionately experienced by marginalised communities** - studies have shown an increased prevalence of ACEs in deprived and BAME communities (Lewer et al., 2019; Goldstein et al., 2020).

ACEs and trauma are often discussed interchangeably (Amor et al., 2018). However, an adverse experience doesn't always mean a traumatic experience. **Adversity describes the situation and experience that a person has**, whereas **trauma refers to the impact it has on their mental health** (Brennan et al., 2019). Thus, experiencing a single ACE in childhood could be considered an adverse experience or single incident trauma, depending on the effect of the individual, whereas an accumulation of ACEs is synonymous with complex trauma.

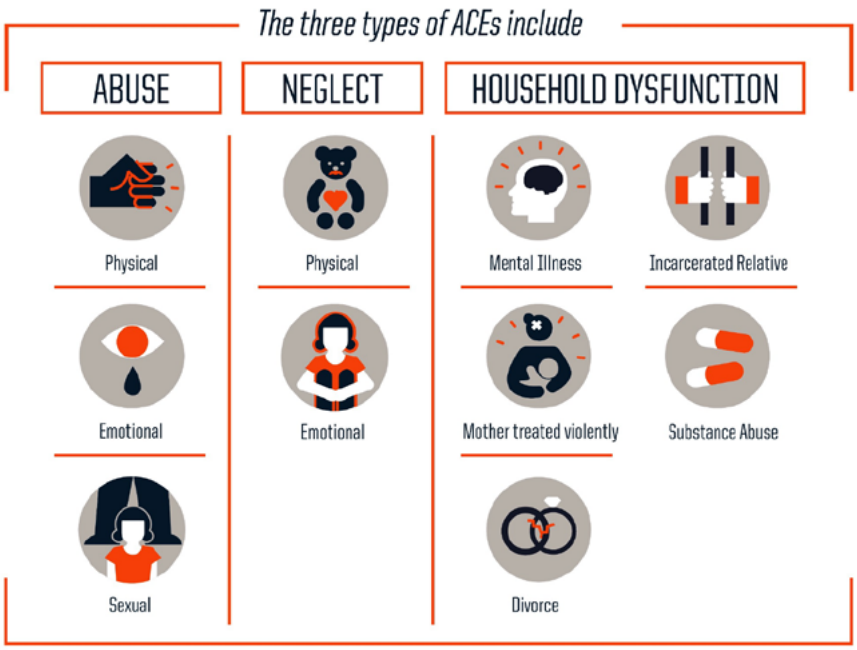


Figure 2: Diagram showing the 10 ACEs categorised into Abuse, Neglect and Household Dysfunction.

1.3 How Trauma Affects the Individual

Childhood trauma is complex trauma at its most insidious (Kezelman and Stavropoulos, 2019). It disrupts a child's normal progression **and has wide-ranging impacts across the life-course** or until the trauma is resolved (Kezelman and Stavropoulos, 2019). Childhood is when the brain is the most malleable - the first stage of neuronal growth and proliferation that the brain is most neuroplastic (Kolb and Gibb, 2011). Thus, **childhood trauma can lead to numerous differences in the structure and physiology of the brain that would affect multiple human functions and behaviours** (De Bellis and Zisk, 2014).

Children who have adverse experiences are under a great deal of stress (Nelson et al., 2020). In children that experience cumulative trauma their flight or fight response is constantly activated as **they are always perceiving a threat** (Nelson et al., 2020). Children that experience a series of ACEs **typically don't have access to the buffering factors** such as empathetic caregiver relationships (Franke, 2014). These children experience toxic stress - prolonged activation of the fight or flight response **leading to disruption of the development of the brain's architecture and mechanism**, as well as other organ systems (Nelson et al., 2020). This cascade of events represents a common pathway to the development of behavioural, social and health issues (Anda et al., 2006).

One of the primary consequences of toxic stress is **hypothalamic–pituitary–adrenal (HPA) dysregulation**, as the developing neuroendocrine system is constantly activated (Anda et al., 2006). Dysregulation of the HPA axis is associated with emotional dysregulation (Kinlein, Wilson and Karatsoreos, 2015) or the impaired ability to regulate emotional states (Dvir et al., 2014). Those that experience emotional dysregulation are unable to self sooth, because of this the individual is more likely to engage in risky coping mechanisms like unsafe sex, substance misuse, gambling and violence (Center for Substance Abuse Treatment (US), 2014). As the individual is emotionally volatile, they struggle with forming interpersonal relationships (Poole, Dobson and Pusch, 2018). Stable, supportive interpersonal relationships are known to be a mediating factor for trauma (Poole, Dobson and Pusch, 2018).

Attachment theory can also be used to explain how ACEs can have long-term consequences on the individual. Attachment theory hypothesises that children develop particular beliefs, values and behaviours based on the relationship they have with their primary caregiver (Bowlby, 1979). Through the initial relationship with the caregiver, children form an attachment (Bowlby, 1979). The optimal form of attachment for development is a secure attachment - this is when the caregiver is empathic, organised and responsive to the child's needs (Bowlby, 1979). A child that experiences a multitude of ACEs is significantly more likely to form an insecure attachment (Grady, Levenson and Bolder, 2017). Childhood insecure attachments can be categorised within three subcategories: **anxious, avoidant, and disorganized**. Children develop **attachment insecurity** in the context of **unresponsive, inconsistent, abusive, controlling, or neglectful caregiving**. Children that develop insecure attachments are more likely to demonstrate **maladaptive emotional and cognitive behaviours and insecure imitate relationships** (Grady, Levenson and Bolder, 2017). Insecure attachment also **increases the likelihood of mental health concerns, including anxiety and depressive disorders, psychotic and personality disorders and substance abuse** (Grady, Levenson and Bolder, 2017).

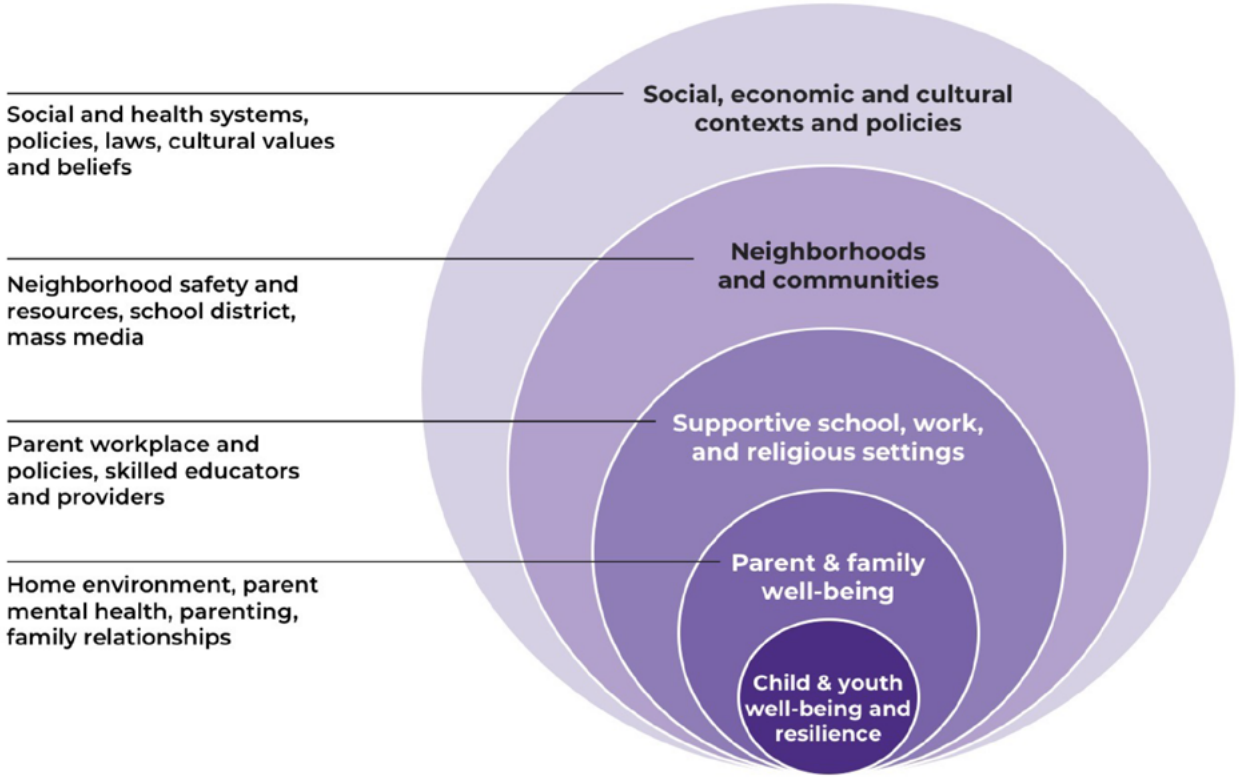
1.4 Resilience and Mediating the Effects of Complex Trauma

People who experience complex trauma are not broken or beyond repair. There is a growing body of literature that discusses **the mediating effect of resilience when it comes to complex trauma**. Studies have found that people with high levels of resilience that have experienced ACEs were more likely to have grown into well-adjusted and emotionally stable adults (Hughes et al., 2018). Resilience can counterbalance the effects of ACEs (ACEs, Trauma and Resilience (ATR) steering group, 2021).

Resilience refers to a complex and dynamic developmental process which comprises biological, psychological, and social factors which help to buffer the impact of stress associated with ACEs (Masten and Barnes, 2018). Meins (2017) comments **that resilience isn't an individual trait but rather a process involving multiple systems – child attributes, family functioning, social relationships, and the surrounding environment**.

Thus, systems that foster resilience are essential for mediation of ACEs. Bronfenbrenner's Bioecological Model of Childhood Development shows a complex system, with 5 levels of environments that interact with each other that influence the development of the child (Ashiabi and O'Neal, 2015). **Resilience must be fostered at every level of the system - trauma is felt in individuals, families, and communities and must be counteracted in each level as well** (ACEs, Trauma and Resilience (ATR) steering group, 2021)

Figure 3: Bronfenbrenner's Bioecological Model of Childhood Development: systems the five environmental systems that interact with each other to influence childhood development.



Positive relationships, particularly in childhood, are essential for development of individual resilience (Masten and Barnes, 2018). Positive and fulfilling connections with others are consistently associated with increased levels of happiness and self-esteem and crucially, have been shown to buffer the effects of stress (Poole, Dobson and Pusch, 2018). In children, the literature shows that stable, supportive relationships with an adult may reduce the harmful effects of early toxic stress by providing them with emotional support and safety (Franke, 2014). Every individual within the system should be aware of the positive effects that building supportive relationships with those that have experienced trauma can have, and should strive to implement that in every aspect of their work.

Other factors that can enhance resilience in childhood include:

- Developing the child's social and emotional skills
- Peer support
- Playing an active part in the community
- Participating in activities outside of education - such as a sport (ACEs, Trauma and Resilience (ATR) steering group, 2021).

Factors that can enhance resilience in adults include:

- Experiencing financial security
- Stable support systems
- Feeling connected with one's culture
- Participating in the community e.g. religious groups, charity, clubs etc (ACEs, Trauma and Resilience (ATR) steering group, 2021).

1.5 The Determinants of Resilience

Resilience is not shared equally. **Some people can cope with adverse experiences and their consequences better than others** (Amor et al., 2018). Resilience is a dynamic process that is influenced by the surrounding environment (Chmitorz et al., 2018). Bronfenbrenner's Bioecological Model suggests how environmental systems of various scope influences the development of a child, and thus the development of resilience (Ashiabi and O'Neal, 2015).

Poverty is known to cause toxic stress; disrupting cognitive development by altering the brain's structure and mechanisms in the same way as other traumatic events (Francis et al., 2018). This leads to a cascade of physiological, behavioural and emotional dysfunction, increasing the prevalence of mental and physical health concerns, poor educational attainment, addiction, violence, domestic abuse, incarceration, and crime (Gupta, de Wit and McKeown, 2007; Smith and Barron, 2020; Fell and Hewstone, 2015; Francis et al., 2018). This means individuals living in poverty are more likely to have an unstable life-course (Sheehy-Skeffington and Rea, 2015). Stability is a key trait for the process of resilience, and a trait which is lacking in many people experiencing poverty.

Poverty has a severe negative impact on one's agency and self-esteem (Doi et al., 2019; Fell and Hewstone, 2015). Individuals living in poverty feel embarrassment, stigma and shame due to their circumstances - a feeling which is exaggerated by the neoliberal take on the 'undeserving poor', - a view which has become more prominent in society during the last 10 years of Austerity (Purdam, Garratt and Esmail, 2016; Patrick, 2016; Garthwaite, 2016; Fell and Hewstone, 2015). Individuals feel inadequate or lesser compared to their peers due to lack of resources and a lower social standing. This is reflected in studies where children in poverty are more likely to report feeling 'useless' and 'worthless' than more affluent children (Fell and Hewstone, 2015).

Poverty also affects one's decision making; resource scarcity and increased exposure to threat makes those experiencing poverty more likely to seek short-term gratification leading to risky behaviours like unsafe sex, gambling, substance misuse, crime and violence (Liu et al., 2012; Sheehy-Skeffington and Rea, 2015; Fell and Hewstone, 2015). These behaviours reward the individual temporarily, but are likely to add to long lasting determinants further along in the life-course (Liu et al., 2012; Sheehy-Skeffington and Rea, 2015). Poverty also increases the likelihood of experiencing trauma, and increases the stress and uncertainty of the everyday (Collins et al., 2010). Individuals that experience these precarious settings are less equipped to deal with stressors due the dysregulation poverty causes (Collins et al., 2010). Thus, poverty **creates the perfect conditions for trauma to fester in and vice-versa, while also creating conditions that prevent the growth of traits that facilitate resilience**.

Living under harsh, **traumatic conditions erodes the normal functionality of the familial unit**, affecting the structure, relationships and coping mechanisms (Collins et al., 2010). **Families living in poverty are more likely to suffer adverse experiences like domestic abuse, fatalities, incarceration, financial instability and homelessness**. Thus, families experiencing poverty often suffer ongoing, cumulative, and multi-generational patterns of stress (Collins et al., 2010; McEwen and McEwen, 2017). This stress affects the functioning of the individuals, which in turn affects the functioning of the entire family subsystem (Banovcinova, Levicka and Veres, 2014).

Chronic stress causes the family to become disorganised, meaning the navigation of daily life is difficult (Wadsworth and Rienks, 2012). Parent-child relationships are greatly affected - the experiences of **chronic stressors associated with poverty have been associated with decreased parental effectiveness, less warmth, low understanding of child development and needs, increased use of corporal punishment and harsh discipline, increased prevalence of emotional, and physical neglect, and an overall strategy of emotionally reactive parenting** (Collins et al., 2010). Thus, children growing up in poverty are less likely to have stable, supportive relationships with their caregivers, with their physical, social and emotional needs less likely to be properly met (Wray and Ed., 2015). **A supportive, empathetic relationship with a caring adult is the trait highly associated with higher levels of resilience in children** - as adults can buffer the most serious outcomes of adversities and can nurture traits that can mediate the impact of the issue (Masten and Barnes, 2018; Gartland et al., 2019; Hill et al., 2007).

Communities are an important factor in producing resilience; suitable environments are ones with plentiful resources such as **employment and education opportunities, physical safety, green spaces, clean air, and proficient care services** that promote community (Hobfoll, 2012). Poorer communities typically have less access to these resources than more affluent communities (Pearce et al., 2006). Poorer communities typically also have higher rates of crime and antisocial behaviour, leading to **lower social cohesion** (Batty, Cole and Green, 2011); higher social cohesion within the community is known to promote resilience (Vinson, 2004). Factors that promote resilience in children in deprived communities include supportive relationships with adults in school - which can offset the absence of a fulfilling caregiver relationship (Turliuc, Măirean and Danila, 2013). Additionally, spirituality was associated with resilience in a study of children living in a high crime, high poverty area in Texas (Gartland et al., 2019).

Poverty influences how resilience is fostered on an individual, a family and a community level (Turliuc, Măirean and Danila, 2013). Poverty is often intergenerational, and low levels of resilience are often passed from one generation into the next (Hill et al., 2007). The important thing to remember is that **resilience isn't fixed - it's malleable, and can be grown through supportive, empathetic social relationships, improved mental health, connecting with the community and a stable home environment**. Individuals experiencing chronic trauma need support from the system, to help grow their resilience so they are more capable to navigate life and stressors with less distress.

1.6 What does good look like?

In order to see what 'good looks like' in individuals who have experienced adversity and trauma, staff and volunteers in the West Yorkshire Liaison and Diversion Service interviewed 49 service users who have experienced some form of disadvantage as a child or young adult, which has had some bearing on their need to use services as an adult. Several themes featured repeatedly which strongly echo the literature reviewed in the previous section. The themes that emerged from the interviews are discussed below.

1.6.1 Getting the right type of support - the earlier the better.

An overriding theme throughout the interviews is that good equates to accessing empathetic, non-judgemental support that lets them explore and process their trauma.

"I feel the most important thing is that someone is willing to listen and understand and not make judgement."

"Being offered support early and being able to talk about past"

Service users also believe that the timing of the support is key, with earlier intervention being advocated. A group of service users felt that if early invention occurred when they were experiencing trauma, then their overall situation would be resoundingly more positive and that the disadvantage they have experienced would have been significantly reduced.

"Good would have been making sure that these things that did not happen in the first place. People asking me if I was okay and if I needed support. People tell me now that I'm clever and brave and that I could get a job helping others, I just wish someone had told me that 30 years ago".

"Get me whilst I was young so I had a good chance. Bad experiences through life have impacted me all the way through"

"Quicker access to the right support, took me over 40 years. More and quicker access and longer therapy support."

"I think support is getting better but there needs to be more safety nets for children from a young age – not just the delinquent children because sometimes others are struggling just as much but don't always have the ability of confidence to speak up."

Service users also said that good support should be more accessible, with shorter waiting times. Some service users felt like they didn't know who to reach out to and when they did, the demand on the service was so high there were long waiting lists. Not being able to access support can make individuals who experience multiple disadvantage feel rejected (a version of re-traumatisation), and can prevent further interaction with the services.

"Make support services easier to find. I did not know who to speak to in order to ask for support"

"[This service user] stated he would benefit from getting long term mental health support in a timely manner rather than having to wait such a long time due to the long waiting list."

Service users also mentioned that a more holistic approach between different agencies working together would be an improvement, as it would prevent vulnerable children like themselves from slipping through the cracks.

"More help from the GP originally. Some coordination with school. They knew I had problems in school but nothing was shared. More coordination and more information. More of a holistic approach."

1.6.2 Positive intimate relationships

Service users overwhelmingly mentioned that having good, healthy relationships with their partners, friends and family fits into their picture of what good looks like. Positive, supportive relationships are known to mediate the effects of trauma and disadvantage by fostering resilience and support.

"Strong relationship with family and friends"

"This individual sees himself as a family person. He would love to see his kids more. He would like to receive less hassle from his ex- partner, and meet someone he gets along with and has a laugh with "

"Better relationship with mum"

"Being with his new child and having a healthy relationship"

"She would have her children back in her care but understands that she can't due to previous DV and trauma."

1.6.3 Mental and physical wellbeing

Having a good degree of mental and physical health is a basic need for human wellbeing. Experiencing disadvantage increases the risk of developing mental and physical disorders, as well as a decreased life expectancy. Throughout the interviews, the service users felt that having good mental and physical wellbeing was key to what good looks like.

"[This service user] states good to her would mean every day she felt happy and stop the battle with mental health that she faces each day"

"To be drug and alcohol free."

A number of respondents mentioned that good would look like being able to control their anger. Trauma disrupts the normal development and functioning of the brain, leading to behavioural and emotional dysregulation which can result in problematic, unjustified anger.

"Be able to walk away from confrontation"

"Good would be not kicking off"

"Being able to manage emotions and control anger"

1.6.4 Financial stability

We have shown that poverty and adversity are inherently linked. Poverty increases the chances of suffering from abuse and maltreatment as a child. Poverty also increases the likelihood of addiction, crime and poor mental health. Poverty lowers self-esteem and agency. Many of the respondents commented that good would look like a world in which they could afford the basic necessities and don't have the all-encompassing stress of living on the breadline.

"Money behind him. Doesn't have to panic about how he will pay his next bill or food shop etc. House to call home and not worry about being evicted."

"To have savings behind you"

"House - nothing fancy, somewhere clean in a friendly neighbourhood. Savings - not rich but comfortable for spontaneous trips. Food- always full. There is never no issues"

1.6.5 Employment/educational/ volunteering opportunities

Many of the respondents mentioned that good would look like having a job or getting into volunteering or education. Many of the respondents would have had their education disrupted as a child due to adversity, which would have impacted their future job opportunities. Having a job, or getting involved in education or volunteering, gives individuals a sense of purpose and achievement, increasing agency and self-esteem.

"Give back to the community and help others"

"Able to go to college and do Maths and English. To have part employment or volunteering"

"[Having a] good job to save money"

1.7 Case Study Example: Adverse Childhood Experiences - how to intervene and start to build towards "what good looks like"

Although we cannot change what has happened in a person's past, we can change how the past affects people. We do not necessarily need to target the trauma itself, but instead address the problems most evident: ability to control emotions, poor self-worth and difficulty in relationships. Examples of how to effect change include: promoting resilience, intervening to change behaviour and how trauma can effect responses and psychological treatment of traumatic memories and how that person processes them. A flexible person-centred approach is important which is consistent with giving people a sense of control.

Resilience and protective factors can be maximised through practical approaches such as these described for use in a custodial setting, but the principles are widely transferable:

Intervention	Resilience building
Support worker works with service user to identify current coping strategies in response to trauma	Allows an individual to identify their positive and negative strategies to build on the positives and find alternatives to the negatives
Support worker works with service user to identify positive supportive relationships	Use existing supportive relationships to develop a support network
Recognise an individual's own strengths and resources and incorporate these into support plans	Develop confidence in own ability to deal with adversity
Develop interpersonal skills	To help develop positive relationships
Develop parenting skills	To develop resilience in future generations
Mindfulness and relaxation exercises	To develop positive skills to help remain within the window of tolerance

Table 1: A background trauma framework in male custodial settings

The goal here is to use both existing resources and new skills in order to improve the ability to deal with adversity. It will not address their previous trauma, though this may be recognised, but will potentially deal with some of the consequences. "Resilience shouldn't be viewed as an individual trait; rather, it embodies a process involving multiple systems – child attributes, family functioning, social relationships, the broader environmental context – at particular points in time" (Cicchetti 1989, Rutter, 1990). It does not even require acknowledgement of background trauma; not everyone will wish or be able to disclose issues in their past and acknowledging that choice is a significant step in not re-traumatising the individual.

1.8 Recommendations

People's capacity to respond to trauma is individual, some can return to their life before the trauma but more often people need to be supported to go beyond the trauma. However in many aspects the assets that have been shown to be effective in being resilient to trauma, and also in the growth beyond trauma, are not individual but rely on the collective or the communal.

Response to trauma requires not only the integration of support along the life-course but also pathways of person-centred support across the services and agencies that are the anchors in communities. The consequences of trauma and adversity impact on all the public institutions and agencies in West Yorkshire, more to the point the impact is disproportionate to the number of people who are substantially and persistently affected by trauma and adversity.

Using the evidence laid out above we can clearly identify the places/ communities most likely to be affected by the consequences of trauma and it is there that movement to a whole system approach to trauma and adversity should be focussed. This includes:

- Provision of trauma informed interventions to address individual trauma and reduce the use of crisis services, including:
  - Additional psychological services (CAMHS, IAPT, counselling, well-being, community-based self-help, street-based services, education-based services)
  - Drug and Alcohol treatment pathways that support multiple disadvantage
  - Physical Health services (walk-in services, street-based services, extended GP services/ Alternative Medical Practice models, community midwifery and neo-natal/ paediatric services)
- Co-ordination of services to a) identify individuals/ families who have experienced / are experiencing / are at risk of trauma; and b) co-ordinating the delivery of packages of support to individuals, including:
  - Widening out the membership of WY-FI Multi-Agency Review Boards to include Children's and Family Services, Supporting Families Programme and Education services in particular
  - Developing and using a common referral and initial assessment protocol including the use of assessment tools – no wrong door approach
  - Robust referral pathways to ensure timely access to specialist services and wraparound support
  - Take a "risk and vulnerability" management approach to ensure that people who need services are not excluded
- Co-ordinate community services that support resilience and connection along the life-course, including:
  - Youth services, detached youth work, youth clubs, young people's in community-based assets and inter-generational activities such as museums, galleries, art projects, radio stations, festivals, music, environmental action, action research projects
  - Utilise (and invest in) community assets such as venues, libraries to host in-reach services into communities
  - Connect with non-commissioned services and groups that are close to communities of place and communities of interest –e.g. faith groups, foodbanks, community advocacy centres, CABx/ Law Centres,

Section 02

How do we identify and prevent adversity and trauma (in children and young people)?

2.1 Early Identification

The early identification of adversity in childhood will not only enable preventative action and tailored intervention to be taken at an initial stage and likely to result in better future outcomes for that child but it can also have the effect of reducing or even preventing future costs of health and social care treatment.

A distinction can be made between identifying adversity targeted at/ directly impacting on a child such as abuse and neglect, and situations affecting the health and/or behaviours of parents/ caregivers which result in ACEs in children. Examples of this could be domestic violence or substance misuse by parents witnessed by children.

In the last year WY-FI has published three substantial reports reflecting different sub-populations of people who experience multiple disadvantages and exclusions in West Yorkshire: women, offenders and young people. All three of these reports comment on the impact trauma and adversity have through the life-course. Although WY-FI worked specifically with adults we were surprised at the proportion of them that were responsible for children. All that we knew from the literature and previous experience was confirmed by the analyses of data and testimony from adults who experienced complex needs and exclusion for support services:

- That the adults had history of personal trauma and adversity going back to childhood.
- Initial presentation of trauma was unaddressed by services, leading to an accumulation and "hardening" of the issues these young people faced.
- Removal from the family in terms of children's safety or as sanction i.e. being "looked after", removal from mainstream school (into pupil referral units, suspension or exclusion), removal from the community into custody, is too late a stage to start to address trauma in young people. Removal as a solution has the consequences of multiplying and entrenching trauma in the psyche of the individual.
- These interventions take place when the point of trauma has long since passed and the accumulative consequences of that trauma have already begun to take hold.
- That children who had experienced trauma and accessed services had not had a "seamless transition" into adult services to continue treatment.

2.2 How can we identify ACEs?

2.2.1 Training and Awareness

The most conventional route for the identification of ACEs by early help services is through referrals received from services that have frequent contact with families and children such as the police, health services and education professionals. In order for these referrals to be appropriate and effective **it is crucial that referrers have attained a good level of awareness, knowledge and understanding of ACEs and trauma**. Evaluation of ACE trauma-informed multi-agency (ACE TIME) training provided for the police, has shown that ensuring potential referrers have quality/accredited, comprehensive training on ACEs and **being trauma-informed will enhance the understanding of and response to vulnerability**. This training has also demonstrated the importance of multi-agency working in responding to ACEs and has had a beneficial effect on the generational succession of ACEs Newbury, A., n.d.).

The ATR Service Mapping recently undertaken in West Yorkshire shows most early identification activity being undertaken by public sector agencies in pursuance of their statutory duties towards vulnerable children and families. These services tend to operate their screening/ early assessment on a "single service" basis and still often as a reaction to an event or situation the young person finds themselves in. The challenge will remain in balancing the resource requirement of "pre-emptive" identification and assessment and being able to respond quickly enough to support children who have experienced trauma and adversity.

2.2.2 Screening and Routine Enquiry

Screening is an established method of identifying ACEs used within US health care services, however, there is not universal agreement on when and how to screen adults and children for ACEs and what to do with the results or information obtained. Key considerations have been identified that should be taken account of before screening including:

- Screening should be guided by the treatment setting and patient population. For example, universal screening may be appropriate in some paediatric settings but in other clinical settings it may be appropriate for the provider and patient to have established a relationship prior to screening taking place.
- The screening should benefit the patient in that the provider carrying out the screening must have clear plans in place to support the patient if required
- Rescreening should be avoided to avoid the potential of re-traumatisation of patients (Maul, 2019)

In 'Responding to Adverse Childhood Experiences', Di Lemma (2019) highlights established tools in the UK for identifying and therefore potentially taking early action against health harming behaviours including alcohol misuse (AUDIT or Alcohol Use Disorders Identification Test) and with domestic violence (The Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model). Identification and early intervention to mitigate against may prevent the development of ACEs among children witnessing these situations. (Di Lemma L.C.G., 2019).

The Safe Environment for Every Kid (SEEK) model cited in Ford (2016) Is a targeted intervention which provides support and access to programmes of treatment and community resources for at risk families after screening during primary care check-ups for children up to 5 years old. The SEEK model uses a screening tool to identify risk factors associated with child maltreatment including questions about maternal depression, substance misuse, domestic violence and parental stress. This helps health professionals to identify possible problems and refer onto for support (Ford K, 2016).

Routine enquiry based on the REACh (Routine Enquiry into Adversity in Childhood) model is an established method of identifying potential ACEs by service providers routinely asking about childhood adverse experiences in the course of undertaking assessments. In asking these questions practitioners are in a more informed position to understand what their clients' needs are and help them appropriately (Bellis, 2018).

The REACh Model has 5 key staged elements. The first stage is readying an organisation to **engage in routine enquiry via a co-produced audit and evaluation**. This leads into the second stage of **assessing an organisation's systems and processes necessary to support the effective and safe delivery of REACh**. The third stage is **training**, adapted to the needs of the organisation this is **followed by staff consultation and supervision** to help effective implementation and the final stage is **evaluation to assess the impact on the service provided and clients**. (Warren Larkin Associates, 2021)

The REACh programme was used in Blackpool by Health Visitors who were asked to discuss ACEs with every woman visited. The concept of ACEs was introduced and explained and responses to the ACE questionnaire with potential impact on the woman's mental health, pregnancy and becoming a parent were discussed. Many of the women involved responded positively to the discussion of ACEs and even when they had no direct personal experience or trauma associated with their own childhood they felt it was important for these issues to be raised. In some instances the ACE enquiry encouraged self-reflection on personal childhood experiences and how they would parent their own children differently. (Centre for Early Child Development - Blackpool Better Start Partnership, 2020)

2.3 How do we prevent adversity and trauma?

Prevention of adversity and trauma is intrinsically linked to early identification. The Early Action Together programme in Wales, is a police-led initiative which has adopted a multi-agency approach to identifying and supporting people with ACEs. **Successful early help services depend on collaborative working across statutory and third sector partner agencies** to provide support to children and families. Also they work closely with child protection services where there is a need for specific support on cases or, if required, escalation. This initiative identified that the police play a key role in early intervention and prevention of ACEs. Following ACE TIME training the quality of referrals received from the police were reported as improving significantly (Newbury, A. n.d.).

Training was also provided to some police forces on the submission of Public Protection Notifications (PPNs), incident reports of police interaction with vulnerable people. References to ACEs within a PPN and obtaining consent for the sharing of information enabled the Early Intervention Project to offer early support and advice to families (Royal Society for Public Health, 2021).

In order to prevent ACEs and for children to achieve their complete health and life potential there needs to be a focus on developing relationships and environments that are safe, stable and nurturing for all children and their families.

The report No Child Left Behind (Public Health England, 2020) highlights the importance of a public health informed approach to preventing adversity and trauma by improving health and wellbeing outcomes for the whole family, preventing occurrences of ACEs, intervening early and mitigating the negative impact of ACEs through the whole life-course. **It is not an inevitability that ACEs result in poorer outcomes and opportunities for children. In family and other care settings the promotion of a safe and secure environment is vital so that even when a child is at risk of poorer outcomes they are more resilient and therefore the risk of negative outcomes is mitigated against**. The report also stresses the importance of the role of community where the right conditions are in place to support and help children to thrive. (Public Health England, 2020)

Research suggests that **ACEs and the harms caused by ACEs are clearly preventable by use of practical measures and adoption/ implementation of strategies**. The Centers for Disease Control and Prevention (CDC) in Atlanta, USA highlight a **range of prevention strategies with emphasis on: strengthening economic support for families, promoting social norms that protect against violence and adversity, making sure children have a strong start in life to enable them to achieve their full potential and connecting young people to 'caring adults and activities'**. They also stress the importance of giving parents and young people the skills to 'handle stress, manage emotions and tackle everyday challenges.' Also important are the **interventions and treatment from primary care and victim centred services to reduce the harm caused by ACEs and prevent future problems such as with substance misuse and involvement with violence**.

Preventing ACEs	
Strategy	**Approach**
Strengthen economic supports to families	• Strengthened household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality child care • Preschoolenrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long-term habits	• Enhanced primary care • Victim-centred services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behaviour and future involvement in violence • Family-centred treatment for substance use disorders

Figure 4: National Center for Injury Prevention and Control, 2019

The strategies highlighted in Figure 4 focus on **changing norms, environments, and behaviours in ways that can prevent ACEs from happening**. The final strategy focuses on mitigating the immediate and long-term physical, mental, and behavioural results of ACEs. By addressing the situations that enable ACEs and, at the same time, address the needs of children and parents, **these strategies take a multi-generation approach to prevent ACEs** and ensure safe, stable, nurturing relationships and environments. To be effective these strategies shouldn't be adopted in isolation but combined together to achieve the best impact (National Center for Injury Prevention and Control, 2019).

The recent ATR Mapping of Children's Services in West Yorkshire indicates that these kinds of interventions were generally not recognised as being interventions related to children's adversity, trauma and resilience and therefore not included by respondents. The weight of responses given by service providers was in favour of "remedial interventions" after an event had already occurred or adversity identified. This approach to solving problems that have occurred will continue to focus resources on dealing with the consequences of those problems rather than taking a step back and seeing if they can be prevented. The implicit message in the provision of "remedial" services is one of deficit, or worse, sanction. By taking

an intergenerational, long-term view it is possible to use approaches across the life-course to reduce the consequences of adversity and trauma for children, young people and adults, now - and to minimise their re-emergence in the future by promoting resilience in communities and by having a system which is in itself a healthy system. In other words a system that is responsive to indiviual and collective needs as they change, which is connected to its constituent parts and which leads implementation and delivery at the level of place.

2.4 Case study: Example of data sharing and analysis in practice for early intervention - One Reading Prevention and Early Intervention Partnership Model

The Reading-wide 'Joining the Dots' (JtD) project brings people together from public sector, business, and charity/voluntary organisations for weekly, and larger monthly, problem-solving meetings based on a distributed leadership model. JtD was established by the police with early and active participation by Reading Borough Council and the Royal Berkshire Hospital. Early scanning sessions identified assets within organisations and our communities whereupon a 'value' market emerged and groups were able to identify opportunities to link together across systems and exchange effort, space, information, and other resources for the common good. An important focus of the Reading Model is that it focuses on 'family' interventions.

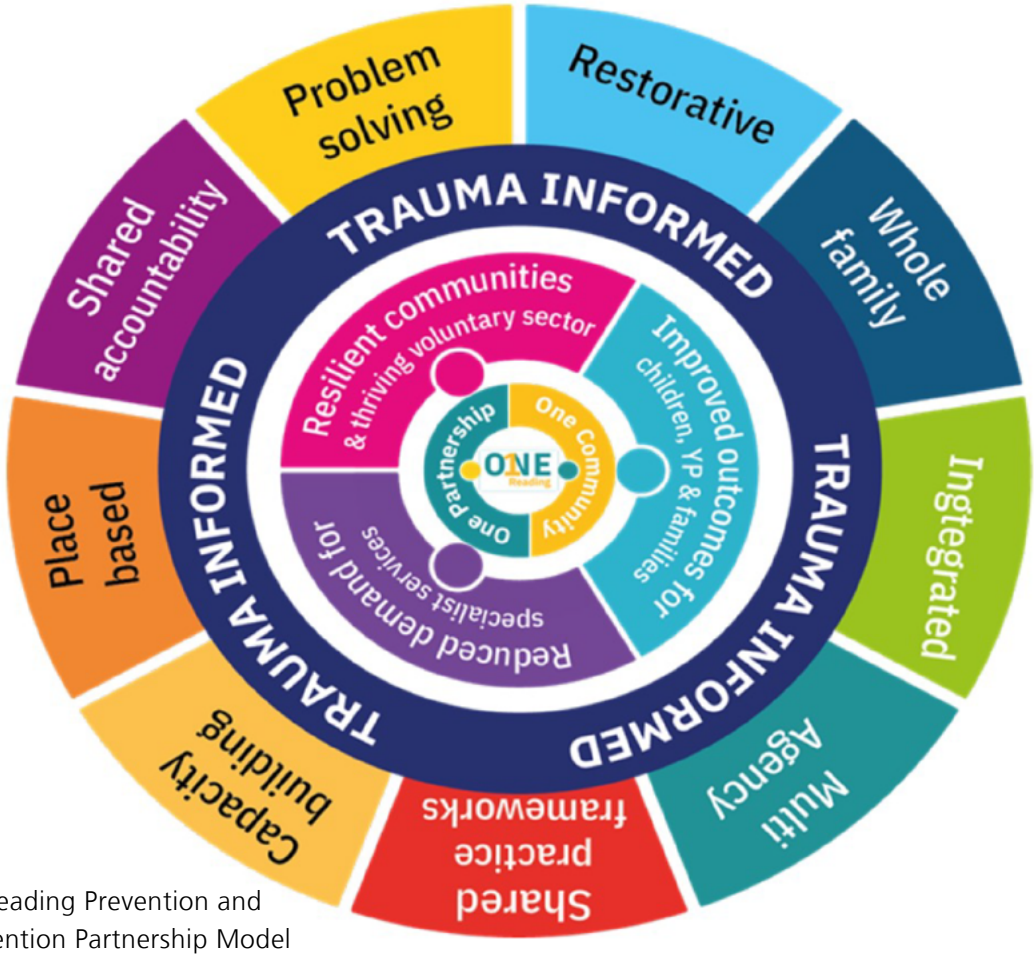


Figure 5: Reading Prevention and Early Intervention Partnership Model

Objectives:

To reduce offending and re-offending by children in Reading by:

- reducing the threat, harm, and vulnerability of children and young people in Reading from exploitation by criminals
- ensuring that children and young people in Reading were not being criminalised through exploitation
- embedding a trauma informed and public health approach to policing these issues

Scanning: Scanning of information systems towards the end of 2017 revealed a small and sudden rise in antisocial behaviour, including street violence among children and young people in Reading.

Analysis: Analysis identified an emergence of social media representations of gang culture and the exploitation of young people by 'county lines' drug dealers. A link was identified between 'missing from home' reports and involvement in crime.

Response:

- **Improve the data picture:** Create a strategic management group (SMG) of cross-sector partners to drive an operational group with a focus on sharing information, knowledge, and data in order to identify vulnerability and opportunity. Wide use of data sharing agreements, with a whole family approach to understanding the issues. Capture emerging data from interventions to understand the needs and issues of those most affected, linking with the Reading Troubled Families Programme and the local youth offending service.
- **Improve leadership and engagement:** Identify leadership of thematic areas to increase engagement with organisations and communities. The Multi-Agency Support Team (MAST) was created to generate collective impact. Engagement officers established (including for schools, antisocial behaviour, mental health, youth engagement, and enforcement) and neighbourhood policing teams restructured to provide more focus on building community resources (e.g. safer neighbourhood forums and police/community groups such as MiniPolice) and increased social media presence via dedicated Facebook, Twitter and Instagram accounts.
- **Improve organisational capacity and capability:** Use the outputs from the scanning and analysis exercises to identify areas of need and make improvements to knowledge, practice, and resources e.g. bringing youth workers into the MAST and restructuring some partnership meetings such as missing from home risk meetings. Briefings on resilience and trauma informed practice for all agencies and community members.

Outcomes: Although there has been a general rise in recorded violent crime across Thames Valley, Reading Local Policing Area is bucking the trend with lower increases and vastly improved outcomes. Missing from home episodes for the most vulnerable children and young people are down 80% and involvement in crime is trending towards zero. Work is ongoing to develop a return on investment model to support further investment across organisations on early intervention.

For a more detailed review of practice see: **https://cleph.com.au/application/files/6815/3249/4877/Reading_PPH_July_2018_Stan_Gilmour.pdf**

2.5 Recommendations

The 2018 Annual Report of the Director of Public Health in NHS Highland emphasises the extent of system change required to effectively understand and respond to adversity. There needs to be a whole system change in awareness and practice from statutory services, including police, health, education and this change needs to happen with children, young people, families and communities. The report states that adversity may shape people but that it shouldn't define them and that there is a need to shift focus from the vulnerability of individuals who have experienced adversity to the strengths of individuals and their communities.

A public health perspective to understanding preventative approaches to adversity across the population needs to be based on a **common data framework across health, social care, criminal justice, and in local authorities, housing and education services**. The ad hoc development of a number of different systems within each of these services mitigates against the straightforward analysis at the system level. Furthermore, changing data regulations leaves people with the option to "opt-out" of various levels of data usage and collection. **Adopting a preventative approach to ACEs can have the impact of reducing health, education, social care and policing costs in dealing with the consequences of ACEs**. (Director of Public Health - NHS Highland, 2018).

The excerpts from the report to the right cover much of the recommendations we would make from a West Yorkshire perspective:

Overall, we have identified a number of cost-effective, evidence-based interventions to prevent ACEs and support those affected by ACEs (Chapter 3). Most of the identified interventions were considered to be aligned to a single, or small number of ACEs, yet it is recognised that ACEs are strongly correlated (e.g. individuals exposed to adversity are often exposed to more than one type; Hughes et al., 2017). Thus, ***complex adversity requires a response which extends across sectors (e.g. health, social care, policing, education etc.) and the life-course.***

This review identified four common approaches across interventions: ***supporting parenting*** *(Section 3.1),* ***building relationships and resilience*** *(Section 3.2), early identification of adversity (Section 3.3) and* ***responding to trauma and specific ACEs*** *(Section 3.4). Interventions largely support the protective effects of a trusted adult relationship in a child's development (focused on improving parental practices, overall child's development and parent-child relationships, such as parenting interventions: IY, NFP, SEEK model, Triple P [EIF, 2017]; Section 3.1), and building resilience to protect against the impact of ACEs (Section 3.2).* ***The mitigation of ACE-related harms focuses on the provision of tailored clinical support for individuals that have experienced trauma (Section 3.4), alongside specialist interventions. Increased awareness about the impact of ACEs, and appropriate ACE prevention and response amongst non-specialist professional groups and across sectors, could help to support a universal approach to ACEs.***

A gap in the evidence was identified for adversities related to parental separation and incarceration, and interventions across non-health sectors, such as housing *(Appendix 3). Research is urgently required to test which interventions can be implemented successfully across different sectors to support progress towards achieving an ACE-informed society. In Wales, such an approach is currently being introduced and evaluated within housing, education and criminal justice sectors, and early results are positive (Barton et al., 2018; Ford et al., 2017; Grey and Woodfine, 2018).*

The findings of NHS Highland's report mirror the findings of the work of WY-FI in addressing multiple disadvantage and exclusions in adults discussed in the next section-Prevention of Re-Traumatisation. There is a strong case to be made for a common approach to services addressing the needs of people who have experienced trauma which can be accessed and re-accessed at any point in the life-course. This common approach across the life-course would smooth out some of the issues that exist in the transition between services, between institutional care and the community and the transition from being a child to an adult.

The core values of this approach to the users would be based on the principles of trauma informed practice. It would put those into practice by being:

- Person-centred – meeting needs as appropriate depending on changing circumstances,
- Holistic support matching "interventions" with social development and community engagement,
- Open to rapid engagement/ access, of flexible duration, and focussing on inclusion and the possibility of re-engagement,
- Outcome and impact focussed,
- Co-produced and co-delivered with people who have lived experience.

Section 03

How do we prevent the re-traumatisation of people who are in services? What are the system changes and drivers we need to stimulate?

3.1 Prevention of Re-Traumatisation

3.1.1 How does re-traumatisation occur?

The narratives of people who have received support from services focus to a great extent on the multiplicity of services they are obliged to access simultaneously; or the sequence of services they have been through chronologically to get the support they need. Whilst there are many pathways within services, it appears there are relatively few that have been designed with each other in mind either simultaneously or sequentially. This leads to re-traumatisation of individuals by the system in the following ways (not an exhaustive list):

- Rejection by services – approaching the "wrong" service, not meeting the threshold for access (either too high or too low), services not having the capacity to help, not meeting other criteria (wrong place, wrong age, etc.). Having an unplanned or unsuccessful exit from support. The testimonies of people with lived experience are littered with examples. Those mentioned frequently, include school exclusion and not being able to access mental health treatment because of concurrent substance use.
- Having to re-live trauma without proper support, to no particular end if a service is not forthcoming, on trying to access services. This also occurs when there is a change of worker. This is known as having to re-tell one's story. "… a barrier was a worker was on leave all the time and had to tell my stuff to different workers who were covering all the time" "…Having to talk to a 20 years old man about domestic violence with only textbook experience was hard too" – Huddersfield (WY-FI, 2020).
- Repressing or internalising trauma whilst similar situations repeat themselves or the fear of being put into similar situations. Examples include being housed with controlling or coercive individuals, being housed with people using substances after being discharged "clean" from prison, miscarriage or having children taken into care.
- Being told to "move on" or having concerns about being re-traumatised or being exposed to "triggers" dismissed. Sometimes this occurs when there is only one course of action presented. Examples might be having to go back to

live in a place that trauma occurred or repeating a treatment option that was traumatic.

- Being subject to multiple compliances (e.g. probation, DWP/ benefits, rules in supported housing or hostel) where failure in one area leads to a rapid unravelling of other support

As we have seen in the first two sections, response to unresolved trauma is at a neuro-biological level. This reduces the body's physical and chemical capacity to regulate responses to trauma. The consequences are behaviours based on the "fight or flight" response. Neither of these responses fit with effective engagement in services. Services therefore have to adopt a trauma informed approach that as a bare minimum reduces, minimises and ultimately, prevents re-traumatisation.

The ATR mapping exercise undertaken alongside this report indicates some sequential pathways and some joint working. It also points to the provision of a number Navigator-type support offers which connect and co-ordinate care for those experiencing the kinds of multiple disadvantages which make them vulnerable to re-traumatisation. This lessens the impact of potential re-traumatisation by acting as an advocate for the individual in accessing services. These Navigators are able to share information about the individual's history and advise on techniques for effective engagement. In particular they are able to prepare transitions from one service to another and make exiting a service a positive experience.

The core elements of the narratives of people with lived experience we heard through the interviews conducted by the West Yorkshire Liaison and Diversion Team support the idea that engagement with services is a mirror of Bowlby's attachment theory. Common in the narratives that people shared were the ideas that when they disclosed trauma as children or adults they wanted to be believed, they needed a basis of trust to disclose and they wanted to feel cared for as a result of disclosing, not to be further judged or stigmatised.

3.1.2 Pregnancy and parenthood as both a traumatising and a re-traumatising experience

Given, again, what we have shown from the literature in sections 1 and 2 that we know trauma frequently leads to complex or accumulated trauma we can also assume that there will be a number of triggers to re-traumatisation as well as a corresponding reduced capacity to manage it. For family members being part of this trauma (directly or as witnesses) and this possibility needs to be taken into account by service providers when engaging with clients. An example of this (taken from Sperlich, M, 2017) is how adverse childhood experiences can impact on adverse pregnancy outcomes such as low birth weight and pre-term birth and also post-birth mental health issues and negatively impact on bonding with the baby as a form of both re-traumatisation and trauma transmission. Trauma informed care in health care can improve both maternal and infant health and intergenerational ACEs could be treated during the pregnancy stage.

One in 5 women worldwide has experienced ACEs such as physical, sexual and emotional abuse. Many of these women who have experienced ACEs have recovered from their experiences prior to childbirth but it is estimated that a third of these women continue to be affected by trauma during pregnancy. It is important to understand how maternity care providers can support these women more effectively, which could include:

- Adapting trauma-informed care used in other health and mental health settings for maternity care could help to mitigate the impact of ACEs on pregnancy outcomes.
- Trauma-informed care for maternity care practice could be centred on types of relationship that have already been applied to practice such as attachment, dyadic regulation and holding environment.
- Trauma-informed care could be adapted to meet common pregnancy needs including: 'need for control, difficulties with disclosure, struggling with dissociation, hoping for healing, coping with remembering, and the discomfort that comes with vulnerability.'

3.1.3 The Criminal Justice System and Re-Traumatisation

The criminal justice system has a significant role to play in the reduction of re-traumatisation. As we have seen in Section 2, having a family member sent to prison or involved in criminal activity is one of the 10 ACEs; early contact with the police is a strong predictor of becoming an adult with multiple disadvantages. The consequences of contact with the criminal justice system are not just about crime and punishment (to coin a phrase) but also about stigma and reduced options.

3.1.3.1 Liaison and Diversion Led Approaches

3.1.3.2 Case study: Building resilient communities to take action on ACEs in Gloucestershire

In 2017, Gloucestershire's health and wellbeing board formed an ACEs panel, bringing together representatives from local voluntary sector organisations, elected members and statutory agencies to develop an ACEs strategy for Gloucestershire.

Figure 6: Building resilient communities to take action on ACEs in Gloucestershire

The ACEs strategy sets out a vision for a resilient Gloucestershire where communities and organisations are aware of, able to talk about and take action on ACEs. It gives a message of hope; that the potential negative effects of ACEs can be overcome by building resilience, and that ACEs can be prevented in future generations. It encourages people to change the question from 'what's wrong with you' to 'what's happened to you'. It gives people a common language for talking about adversity and resilience. The full strategy (along with other resources) is available on their website www.actionaces.org.

Examples from the strategy that are most relevant to reducing offending and re-offending in young people are as follows:

The Aston Project: The Aston Project is a police-led project working with children by utilising a work for reward ethos. Children take part in constructive activities for which they earn credits, such as volunteering at community events. The referral form includes ACEs questions which helps to inform the staff working with the children from the start, with staff then briefed to be ACE aware in all of their interactions with the children.

This gives them the opportunity to build positive peer connections, connect with the wider community in a positive way, work alongside PCSOs and volunteers who act as trusted adults and positive role models, and to feel a strong sense of inclusion – or in other words to build resilience. They then get the opportunity to spend their credits and enjoy a reward activity of their choice. Further information can be found at www.astonproject.co.uk.

Children First: Children First is a diversion scheme that aims to divert children away from the formal criminal justice system. Its objectives are early intervention, practical and effective partnership working, information sharing, and the progressive replacement of criminalising sanctions with restorative practice approaches in child offender cases.

A joint decision-making panel (JDP) consisting of police sergeants, youth support team managers and NHS mental health colleagues accesses information from across the partnership, in order to make informed decisions on sentencing options. The vast majority of cases are dealt with through a Youth Restorative Intervention (YRI) although the JDP are also able to recommend youth cautions or charging where appropriate.

The YRI does not attract a criminal record. In the first year of the scheme, the JDP has considered a total of 331 cases, with 243 YRIs being given as a direct alternative to a formal criminal sanction.

3.1.3.3 Women in the Criminal Justice System – some evidence from WY-FI

WY-FI evidence about the impact of repeated short sentences on female offenders shows that they are neither effective in protecting the public to any significant degree nor are they meaningfully rehabilitative for the women themselves. Frequently returned to custody for breaches of licences or minor offences the cost to the public purse is not only in the cost to the criminal justice system, it is in the crisis use of A&E, ambulances, failed tenancies and evictions, the tense relationships with parents and children and the consequences of them going back into controlling and coercive relationships, drug and alcohol use, and sex work. The personal cost of being re-traumatised is incalculable.

WY-FI conducted an in-depth analysis of 21 women who had been among the first starters on the programme in June 2014, known as TWP21. Of these, just over half (12) had unplanned exits.

The common core of factors in these "unplanned exit" cases were:

- Childhood trauma and early use of alcohol and drugs, which in some cases leads to dependency
- Being in violent, controlling or coercive relationships that revolved around sex working and substance use
- Untreated mental ill-health and low self-esteem
- Sexual assault, financial abuse (in and out of the home) and domestic abuse
- Uncontrolled drinking leading to public order and other offences (by and large not serious)
- Breach of orders and subsequent recall to prison
- Frantic attempts to secure accommodation either on release from prison or as a result of "anti-social behaviour" or rent arrears
- A sense that these women were in a permanent state of vulnerability – in terms of finances, housing, contact with children and families, breaching orders, losing their freedom, being sanctioned, falling into gaps in the benefits system, or failing breath tests and/or blood and urine tests. In short they felt they were always on the verge of not complying with the "system" or being haunted by past failures.

Five women had planned exits from WY-FI, mostly with "external networks in place", two women with planned exits had journeys of 20 months and 4 ½ years respectively and showed sustained progress throughout. And whilst both these women had many of the core characteristics of the TWP21 group of women, they had support from family and/ or a partner which led to them being sustainably housed.

In addition, they engaged positively with addiction and mental health services and in their last two years on the WY-FI caseload, didn't record any reoffending behaviour. The woman on the 4 ½ year journey had three prison sentences, a hospital stay of three months, and reduced from opiate use to a script, before achieving complete abstinence. At the end of her journey with WY-FI she was healthy and in a secure property. In addition, she was pregnant and looking forward to having a baby with her partner.

Looking at the four longest journeys made by TWP21 women, one thing common to them all is the consistent involvement of a small number of core workers. From reading the case notes, these workers have shown an almost superhuman commitment to their work, operating as a "multiagency unit" to pool knowledge, resources and opportunities in an attempt to stabilise their beneficiary's life. This may not be surprising though, as a good number of the TWP21 women were well known to services for many years and workers may well have had previous contact with them.

3.1.3.4 Case Study – Calderdale 1325 Group

Project 1325 works with 13-25 year old disadvantaged women and girls throughout Calderdale and Kirklees. Women and girls who were referred to the project have various needs that were not being met by the traditional services, meaning they were at risk of transitioning to adulthood with various levels of disadvantage.

The women and girls varied immensely in the types of needs, the types of support they required and the sorts of changes they set out to achieve as a result of the support. Typical needs included poor mental health, problems in education and employment, poor relationships with family and peers, emotional and sexual abuse, domestic violence, low confidence and self-esteem, risk taking behaviours, self-harm, and bullying. On average the majority of the girls presented with 4-6 needs. It was reported that the majority of girls didn't seek support because of specific needs but for overarching negative thoughts and feelings that were overwhelming and immobilising.

Project 1325 utilised trauma informed and women centred care. The support given was in depth, specific and holistic to the girl's needs. The central aim was to empower the girls to reclaim their own narrative and to develop agency, resilience and self-esteem so they could live more inherently positive lives. The ethos of the project is that support is built around trust, listening, and empowerment, where the support is nurturing, and empathic. A real strong point of the project was the non-judgemental relationships built between the girls and the caseworker - "I don't feel analysed and judged here. I don't feel like a patient".

The project resulted in positive outcomes for the majority of service users. Over 90% of the girls experienced a positive impact on their mental health, with large proportions of girls also reporting healthier relationships, emotional stability and increased confidence and resilience. Overall, the girls expressed having more control over their lives and expressed that they were more able to 'bounce back' from negative emotions and experiences.

An evaluation of Project 1325 revealed positive traits and improvements that could be applied to other services:

- **Specific to the target population needs.** Project 1325 works with a women-centred approach, specific to each young woman's individual need. This perspective underscores the need for services to adapt for different target groups rather than devising new ways of working. An example of this is how Project 1325 operates differently in Calderdale and Kirklees - two different areas with different populations and needs. The success of the project lay with its flexibility and working across two districts according to geographical needs and assets.
- **Focus on transition points.** Young women's struggles with transition points were evident in the project. These points were moving from primary to high school (broadly age 11 to 12) and moving from adolescence into adulthood (broadly age 17 to 19). Many girls stated that their troubles began or intensified at these periods.
- **Collective Work.** Project 1235 offered collective work where the women worked and supported each other in group settings. This was important to show the girls that experiences were shared, to foster agency and empowerment, and to build social connections.
- **Plan for Demand.** Exponential increase in demand meant caseworkers found it difficult to meet needs without compromising the integrity of the Project (frequent, flexible, paced and responsive one-to-one support).

3.1.3.5 The Criminal Justice System – Risk and Vulnerability

WY-FI worked with colleagues in the Fulfilling Lives Programmes in Nottingham and Newcastle/ Gateshead to look at the data relating to beneficiaries involved in the criminal justice system in 2019. Out of 215 individuals, 148 were men and 67 were women. What is striking is that over 30% (21) of the women were also victims of crime, as opposed to 12% (18) of the men. The WY-FI report into the experience of multiple needs from women's perspectives "Keeping a Face to the World", found that:

> Offences committed by women were mainly breach of orders (30 cases). These were breaches of licences, failure to attend court and restraining orders. Almost all these cases resulted in arrest and around a third led to an immediate recall to prison. The next largest category were offences against a person/ public order of varying degrees.
>
> Intoxication was a factor in a quarter of these and five or six were potentially life-threatening (stabbing, arson, brandishing a bladed weapon in public, possession of a firearm). In addition, 10 offences were acquisitive and four were drug-related.
>
> Conversely, over half the crimes committed against these women were of immediate and serious personal violence: four assaults; four rapes/ sexual assaults; two domestic abuse cases; and two women were victims of breaches of restraining orders. Others received threats or were subject to aggressive behaviour and there were five victims of theft/ burglary. In six cases, victims did not go to the police (one was a case of sexual assault and one was domestic abuse).
>
> The criminal justice system in particular is designed to distinguish between two mutually exclusive categories (innocent and guilty; victim and perpetrator) and it does not handle the complexity of multiple disadvantage well or easily. Almost a quarter of women who offended whilst on their Fulfilling Lives journey were recalled and a further quarter were given a custodial sentence for some (or the remainder) of their journey with the programme. Given the cost, as well as the poor outcomes of prison sentences on Fulfilling Lives journeys, there should be increased investment into diversion and non-custodial sentences to improve outcomes for service users and the public sector alike. (Headley, E. and Crowe, M., 2020)

Agencies within the CJS have made strides towards better prevention activities – West Yorkshire has a recently established Liaison and Diversion Team, already working with over 500 clients. The West Yorkshire Violence Reduction Unit has produced evidence of understanding the complex links between serious violent crime and vulnerable people in the West Yorkshire context, particularly among young people where the links between exclusion, trauma and criminal exploitation have become well documented. The preventative activities funded by the VRU (and also the West Yorkshire Fire and Rescue Service) represent some of the few genuinely pan West Yorkshire service offers.

3.1.4 Lived Experience Research into ATR – Service Use, Need and the Prevention of Re-Traumatisation

Survey Templates were distributed through Liaison and Diversion team members working in each of the 5 local authority districts in West Yorkshire. The Liaison and Diversion Team was selected as they had clients who were likely to have experienced adversity and trauma and were likely to have clients across the life-course from early teens, with a diverse demographic base.

By the deadline almost 50 responses were received. The geographic distribution of these responses was weighted towards the urban districts of Leeds and Bradford. There were some logistical issues in getting interviewers and subjects together in the smaller districts that could have been overcome with more time.

The distribution of responses was as follows:

District	Respondents
Bradford	14
Calderdale	4
Kirklees	4
Leeds	22
Wakefield	3

Age Range	Number of Respondents	%
Under 18	6	13%
18-25	6	13%
26-35	17	35%
36-45	8	17%
46-55	4	8%
56-65	5	10%
Over 65	0	0%

The questionnaire was developed with input from the WY-FI Co-production Team. This was in two sections. The first asked about the services that were actually used and those that were needed on a "yes/no" basis. The second section asked open questions about the individual's experiences and reflections on those experiences through the life-course and into the future.

3.1.4.1 Service Use

The **most frequently used services** (by more than 40% of respondents) were those where there is universal provision – **health services, Job Centres, housing services, opportunities for education, training and employment** and, somewhat surprisingly given the level of disinvestment over the years, youth services.

The following services had been used by 20% - 40% of respondents:

- Counselling, Mental Health or other emotional help/support
- Benefits or Help Managing Money
- Physical Health
- Probation Services (including YOT)
- Services for your Children
- Mental Health Services (CAMHS)
- Meaningful Activities
- Extra Help in School (either education or welfare support)
- Help with somewhere to live long term
- Managing Myself – Healthy Eating, Exercise, Time Management
- Confidence and Motivation

3.1 4.2 Service Need

The areas of service provision where there is most need identified is not simply the inverse of the services used. A number of the services for which there is most need are in the "second tier" of services used. This indicates that although there is provision, there may be challenges in accessing those services. This assertion is supported by the narrative responses in section 2 of the questionnaire that identifies support at school, mental health support and self-esteem/ self-management support as needs that were historically or currently unmet. The most frequently mentioned (by 20%-30% of respondents) as unmet service needs were:

- Extra Help in School (either education or welfare support)
- Counselling, Mental Health or other emotional help/support
- Confidence and Motivation
- Physical Health
- Meaningful Activities
- Mental Health Services (CAMHS)
- Managing Myself – Healthy Eating, Exercise, Time Management
- Reconnection to family/managing relationships

3.1.4.3 Extending Services

This is a slightly different category of service development. In the questionnaire there was scope for people to say that had used a given service and that they had a need for the same service. In the narrative responses to section 2 of the questionnaire it was clear that some respondents needed more support than some services could provide and that they were discharged from, or stuck in, services without those needs being met. Examples include obtaining immediate or temporary housing but not being supported into accommodation that was more suitable in the long term. Similarly access to counselling through a GP might be for 6 or 8 sessions which may be helpful as far as it goes but there was no referral pathway for more work to be done. Other potential barriers were waiting times (cited in relation to mental health services), obtaining a diagnosis (physical and behavioural health) and being "too complex" or "too high risk" for a service. The most frequently mentioned services (by more than 10% of respondents) were:

- Housing Services (Council housing, Supported housing, Homelessness)
- Extra Help in School (either education or welfare support)
- Counselling, Mental Health or other emotional help/support
- Benefits or Help Managing Money
- Health Services (Seeing a GP or Dentist)

3.1.4.4 Overall Priorities

By combining the levels of use and need for each category we can see the priorities for service use among this cohort of service users. The top service priorities (identified by more than 50% of respondents) are:

- Health Services (Seeing a GP or Dentist)
- Housing Services (Council housing, Supported housing, Homelessness)
- Counselling, Mental Health or other emotional help/support
- Opportunities for Education, Training and Employment
- Physical Health
- Confidence and Motivation
- Extra Help in School (either education or welfare support)
- Youth Service (Youth Clubs/Detached Youth Work Service)
- Job Centre Plus/DWP

The needs of this cohort reflect the priorities borne out of the research into the WY-FI cohort of adults experiencing multiple disadvantages and exclusions. What we have been able to inquire about more closely in this survey has been the specifics about the early part of people's experiences, particularly in relation to school, family and early contact with the criminal justice system. Interestingly, the criminal justice system doesn't figure on that list. The Liaison and Diversion Service, even though it takes referrals from the police and courts, does not seem to be seen as part of the CJS by its service users. The challenge with the criminal justice system is that once involved with it, a person is labelled and that has a significant impact on the perceptions of other services and what they feel able to offer, in some instances over a long period of time. It is clear from some testimonies that although the individual had committed an offence, their criminal behaviour was a response to trauma or the lack of direction as a child. This "doubles down" on the original trauma and may require a difficult acknowledgement on the part of services of subsequent re-traumatisation.

3.1.5 Recommendations

Out of the list above, services can be grouped together by the nature of their provision and where they fit in to a trauma informed approach to systematic service delivery.

3.1.5.1 Statutory services: Health, Housing/ Homelessness and DWP/ Job Centre

These are frequently accessed in part because it is a requirement for people to access them. However these services are subdivided and people's contact with them is episodic, the **sub-services accessed are not sufficiently inter-linked to support people with multiple or complex disadvantages through a whole journey**. Presenting as homeless to a local authority might get some initial support but it doesn't necessarily lead to a "forever home", particularly if there are other complications. The ATR Lived Experience survey conducted for this report showed that a number of people linked their current experience of multiple disadvantage and exclusion to frequent house moves, temporary accommodation and frequent moves as looked after children. **A trauma informed approach would centre on the person's whole needs and look at supporting them through a sequence of support interventions which would build on each other to restore the individual**. A trauma informed approach would flex access to services and sustain them to point of efficacy not to the limit of what can be provided under contract. These three areas of service are notable for their explicit and/ or implicit use of conditionality to sustain access to them. The research undertaken in WY-FI points to the precariousness individuals feel when subject to multiple forms of conditionality and how, for this cohort, it is ultimately self-defeating because it is simply unsustainable for service users.

3.1.5.2 Informal Health and Wellbeing Support: Counselling, Physical Health, Confidence and Motivation

The **provision of these services is generally through the gateway of another service which is frequently either community-based** whether a community of interest (e.g. women's service) or a community of place (e.g. a neighbourhood community centre). Health of mind and body is an essential part of restoring and individual from trauma and these informal services also **provide opportunities for re-socialising people who have become used to rejection and isolation** not just socially but also by the "system" of services. Strongly associated with this group of services are the group of services which attracted responses of 40% to 50% of respondents such as Meaningful Activities and Relationships/Reconnecting with Family. These are the **activities that sustain recovery and restoration from trauma and the consequences of trauma such as addiction and crime**. In the qualitative element of the questionnaire respondents repeatedly tell us that **their future includes the ability to restore or sustain family and social relationships**. These are generally not costly nor do they have prescribed "interventions" or predictable outcomes. To some extent they are based on **mutual trust** of the participants rather than the "authority" of experts. As a result they tend to be on the margins of attention in the "system" of services yet in terms of the transition from dependence on services to independence they are critical and should not be simply left to the vagaries of short term funding or the drive and will of a few individuals.

3.1.5.3 Early Identification and Childhood Support

The preceding sections deal with services that are largely accessed by adults, or adults on behalf of children. **Extra Help in School and Youth Services were services used and needed by over 50% of respondents**. Schools have a very powerful role to play in the identification and mitigation of adversity and trauma. The provision of extra help either academically or emotionally was sometimes mentioned as helpful in the narrative responses (particularly among younger people). However, the responses around school were generally divided between those who were able to conform and those who were not. For those who were not able to conform, there were missed opportunities to pick up on **learning difficulties (dyslexia, ADHD, literacy) and situations at home (presenting as malnourishment, extreme tiredness)**. The latter can be characterised by paraphrasing one respondent: **I couldn't understand why school didn't see what was happening to me**.

Rule infractions at school seem to have had a disproportionate impact on young people who were already emotionally damaged by trauma and adversity. Trauma was typified by family breakdown, bereavement and the challenges adjusting to new "blended" families. These **infractions were often violent as the result of provocation** and in a couple of cases, sexual assault. Sometimes this provocation was from one group of pupils against another (bullying). Sometimes it was unintentionally endorsed by the institution itself for example by lumping together children from a children's home as a group and referring to them as such and treating them differently.

Sanctions used by schools as a "first response" to infractions are not reported by this group to have had any beneficial effects. Pupil referral units, suspension and exclusions simply seem to have put young people more at risk. School-based **counselling support and learning support units were identified as more supportive environments** for those facing adversity and trauma. Despite a number of respondents either making disclosures or wanting to make disclosures to schools some were not believed or, perhaps worse still, feared that they would not be believed. Some of these disclosures made by both older and younger respondents related to sexual abuse in the family or in care homes and in these instances applied to male and female children.

3.1.5.4 School Exclusion

Exclusion from school is a sanction of last resort in terms of a pupil's behaviour. However the data suggests that it is pupils who are already experiencing adversity who are most likely to be excluded. Data for West Yorkshire shows that in 2018-19 while children with SEN provision constitute only 15% of the pupil headcount they represent 47% of permanent exclusions and 42% of fixed-term exclusions. Similar proportions of children eligible for free school meals (18% of headcount) account for permanent exclusions (53%) and fixed-term exclusions (43%). The benefits of staying in school are more than simply educational.

3.1.5.4.1 How to keep exclusion rates low – evidence from research:

- A strong pastoral support system
- Counselling and peer support programmes are effective in managing negative behaviour among pupils
- Universal programmes including teaching social-emotional skills achieve more effective results. But this is largely based on US studies
- Vocational training can be a significant protective factor against exclusions
- Nurture groups of small groups of 'at risk' children and teachers with an emphasis on developing secure attachments has been shown to improve social, emotional and behavioural outcomes and children's enjoyment of school. But there is little evidence of positive results in secondary schools
- Family- based interventions focused on strengthening the skills and resilience of families have been successful but the actual impact on exclusions in difficult to pinpoint.

3.1.5.4.2 Good practice in an ACEs aware and trauma-informed educational settings:

- Safe, secure, flexible and caring environment with a strong focus on positive relationships
- Social and emotional learning, wellbeing and development of resilience
- A school-wide awareness to include staff and parents of ACEs and trauma and impact
- Assessment and focus based on what has happened to a pupil as opposed to what is wrong with them
- A whole school approach by senior leadership team and practitioners that is reflective and supportive and that promotes wellbeing together with targeted support that meets the needs of all pupils. (Education Scotland, 2021)

3.1.5.4.3 Examples of ACEs awareness and trauma-informed practice in schools

Beacon Academy in Cleethorpes, Lincolnshire, an area that has relatively high levels of deprivation, has taken a completely different approach to behaviour management in school. Instead of 'zero tolerance' or 'no excuses' discipline policies it uses a trauma-informed approach with excellent results and great feedback from parents, reflected in the fact that it is over-subscribed.

Trauma Informed Schools UK, has worked with over 3500 schools in the UK including all schools in Cornwall providing training to teachers. Return to school online training after lockdown was attended by over 20,000 teachers.

The Difference (https://www.the-difference.com/) provides specialist mental health and trauma-informed practice training for senior leadership teams. As well as working with individual schools the organisation has now started working with local authorities and multi-academy trusts and is carrying out research on best practice in responding to the impact of Covid-19 in schools. (Guardian article: https://www.theguardian.com/education/2020/oct/10/is-the-tide-turning-against-zero-tolerance-in-uk-schools)

At Carr Manor Community School in Leeds there is a strong emphasis on relationships to promote inclusion. In the 2019 Year 11 group, 53% were pupil premium including significant numbers of looked after children and with special educational needs and disabilities. The focus on building an interconnectedness between staff and pupils has meant conflict and other difficulties in relationships can be managed effectively creating an even greater bond. In the last 15 years there has been no permanent exclusions from the school.

There is an emphasis on getting to know children and their families using 'coaching circles' which are led by staff three times a week with pupils from all year groups. Monday and Friday check ins/out are held with all pupils as well as a mid-week session focusing on subjects such as careers, well-being, health and citizenship. All sessions encourage the building resilience and independence for pupils. (https://www.tes.com/news/you-want-cut-exclusions-and-maintain-staff-morale)

There are similar approaches being taken in schools in Kirklees and in Kirklees College which are whole organisation approaches to becoming trauma informed.

3.1.5.4.4 Case Study Kirklees College – A Trauma Informed College

Kirklees College is a further education centre, which is amongst the largest in the country. The college has seven campuses across Huddersfield and Dewsbury - both areas with relative high levels of deprivation. The college offers 16-18 years old education, higher education, adult education and apprenticeships. Kirklees College was observing high rates of problematic behaviour, disruption and truancy before it was decided that the whole system needed an overhaul to properly support and nurture its students.

Kirklees College is on a journey to becoming a 'Trauma-Aware College". The key emphasis staff say is on the word 'journey'. Being a trauma-aware service does not happen overnight, and requires every member of staff to be aware, understand and appreciate the impact of trauma has on a student's well-being and behaviour. A trauma-aware service understands that everyone walking through its doors will have experienced some form of trauma - with many people experiencing complex, entrenched trauma. A college is not just an educational facility but a service that is responsible for the wellbeing of its students. To get the best out of its students, a holistic approach must be undertaken - the whole person and their experiences must be considered as this determines their behaviour.

This understanding was established when Kirklees College facilitated restorative practice - restorative practice is a method of building healthy and repairing relationships. From this, it was understood that incidences of bad behaviour stemmed from trauma and adversity - be that abuse, mental ill health, illness, discrimination or family dysfunction. Once staff understood the trauma, they understood the behaviour and they understood how to work together with students in order for them to heal and grow.

Kirklees College therefore has produced a 90 minute module regarding trauma, its impact on an individual, and how to communicate effectively with students that are undergoing hardship. Every single member of staff - from the Principal to cleaners, will engage with this module. There is a specialised team with trauma informed practices qualifications that specialise in liaising with students. Punitive punishment isn't used - bad behaviour doesn't result in punishments or anger, which can isolate or re-traumatise students. Emphasis is placed on compassion and empathy which fosters trust - forming positive relationships and allowing growth. It only takes 7 minutes of an empathetic conversation for new brain pathways to form in the teenage brain, highlighting the importance of kindness and understanding in dealing with trauma.

The outcomes have been overwhelmingly positive. Not only have bad behaviour, disciplinary cases and sanctions dramatically reduced but students report feeling happier and more engaged with their studies. Staff have noticed a difference too - at the start, some staff questioned the usefulness of trauma awareness. However, they have observed real change in the student population and have even learnt about their own traumatic experiences and behaviours. When you become trauma aware in one aspect of your life, it transfers into others - improving the community all round.

3.1.5.5 Children leaving care

The removal of children from their families shows that unsupported children in foster care or local authority care can have a torrid time, which in turn increases the chances of frequent moves. To paraphrase another respondent in the ATR Lived Experience Survey: **I wish I could have just stayed with one good foster family instead of getting moved all the time.** One person reported a good experience of local authority care and remained in contact with his Leaving Care Team as a young adult. Others were less fortunate, low aspirations from life in care homes and the influence of other residents on leaving led to a downward spiral of drug use and sex work for one female respondent.

3.1.5.5.1 Case Study Wakefield Council Leaving Care Team

Transitions are difficult times of life for any person. The transition for children leaving the care system into adult services is particularly daunting. The Wakefield Leaving Care Team assists young people within the care system with preparing for and facilitating independent living. Wakefield's Leaving Care Team identified that the current system is failing its young people - and are starting to make amendments to change that. The overwhelming failure is that these young people are not engaging with services that would help with their current situation, leading to further disadvantage. The service is not classed as trauma informed, however it makes a real effort to view the young people holistically and to listen and adapt to their individual needs.

The leaving care team identified that the service that young people were disengaged with the most was mental health services. This was especially concerning as many of the young people had experienced traumatic experiences which had affected their mental health. The young people didn't want to attend, primarily due to the negative stigma surrounding mental health. Additionally, some found issues with the staff or didn't like the building as it was 'too restrictive'.

In order to mitigate this problem the Emotional Well-Being team set up a once a week drop in service - where the young people were allowed to come along as and when they saw fit. The Emotional Wellbeing team also acted like a first-line reception, signposting the young people to other services when it was appropriate. The Leaving Care team is also in the process of recruiting Care Navigators - members of staff that will triage young people along with the Health and Emotional Wellbeing Teams in order to work out a satisfactory plan to meet the needs of the young people. The team is planning to start the transition period earlier - so the young person works with both the adults and child services for a longer time, allowing them to form relationships and build trust.

While it is early days, with the changes all being implemented within the last 6 months, the young people that used the service have spoken positively about the changes that have commenced. They have told staff that they particularly like the informal drop in as it is flexible and informal, allowing them to build empathic and trustworthy relationships with staff.

3.1.5.6 Youth Services

Youth services seem to have been the other side of the coin, particularly for older respondents. They **represented a child centred environment with an opportunity to build relationships with adults**. Obviously they focus on the relational and social development for children and young people but they also provided significant opportunities for some of those activities – particular physical exercise, trips out etc. Older respondents reported a significant loss when those clubs were closed and there wasn't any replacement. Younger respondents weren't always aware that what they described as "a need" had previously existed.

3.2 Evidence about the numbers of service users in West Yorkshire and the future Demand for Services in West Yorkshire.

3.2.1 Adverse Childhood Effects (ACEs)

Adverse Childhood Effects (ACEs) are a prominent Public Health Concern in West Yorkshire. ACEs are a set of 10, highly stressful childhood events that fall into three categories: abuse, neglect or household dysfunction and that are known to impact healthy childhood development, and later life course progression (Finkelhor, 2020).

In England, approximately 50% of the population has experienced one ACEs, with 9% of the population has experienced 4 ACEs or more (Couper and Mackie, 2016). Individuals with 4+ ACEs are significantly more likely to suffer from poor physical health, poor mental health, problematic drug and alcohol use, incarnation, and interpersonal and self-directed violence (Hughes et al., 2017). These factors all contribute to an all-round more difficult, disjointed, and unstable life trajectory. Individuals who experience cumulative ACEs are more likely to experience multiple needs and disadvantages, meaning they need help from various types of services - like mental health support, housing support and drug and alcohol services.

Adverse Childhood Experience		Prevalence Nationally
Child Maltreatment	Verbal Abuse	17.3%
	Physical Abuse	14.3%
	Sexual Abuse	6.2%
Childhood household included	Parental Separation	22.6%
	Domestic Violence	12.1%
	Mental Illness	12.1%
	Alcohol Abuse	9.1%
	Drug Use	3.9%
	Incarceration	4.1%

The ACE Index's ecological regression showed that child poverty and higher population density are both strongly associated with a higher rank on the ACE Index (Lewer et al., 2019). Nationwide, 120,000 more children were plunged into child poverty as a result of the Covid-19 Pandemic, suggesting that the prevalence of ACEs is only going to increase in West Yorkshire in the forthcoming years.

How many people are affected by multiple disadvantage in West Yorkshire?

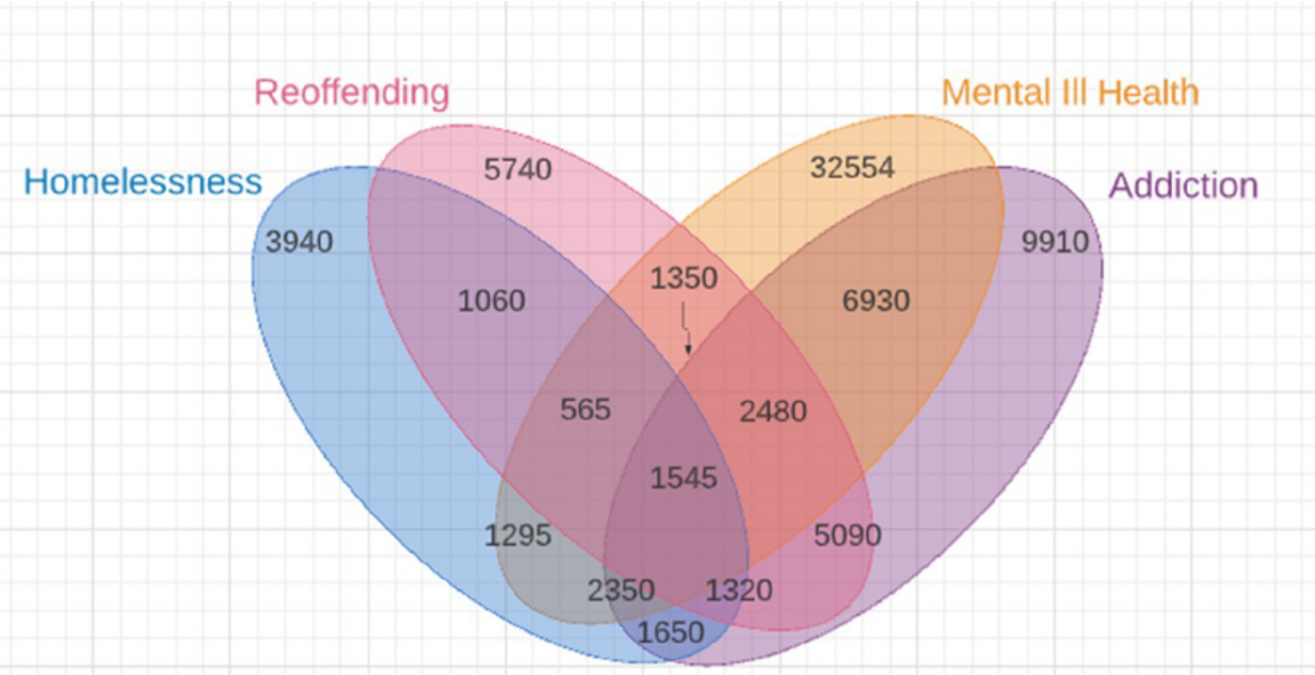


Figure 7: Venn diagram showing the numbers of people in each area of service use and each individual area of multiple service use across West Yorkshire

Nationally the key data on Severe and Multiple Disadvantage is set out in the Lankelly Chase Foundation's report, Hard Edges, which estimates that over a quarter of a million people in England each year access at least two of the three types of services that they measured – homelessness, criminal justice and substance misuse. The report estimates 58,000 people nationally have contact with all three types of services. In addition the report identifies "poverty as an almost universal, and mental ill-health a common, complicating factor".

In West Yorkshire, the WY-FI Project has developed current estimates of the total number of people accessing homelessness, addiction, re-offending and mental health services using the methods established in Hard Edges. The total number of individuals using these services is almost 52,000 across West Yorkshire. Of these, almost 7,000 individuals will access 3 or 4 services which equates to 1,400 people per West Yorkshire local authority on average (see diagram Figure 7).

WY-FI has been able to build in estimates for people accessing mental health services (omitted from Hard Edges). WY-FI estimates 1 in 32 people in the adult population receive some type of treatment for mental health conditions. In the context of this work, which ultimately looks at people who are excluded from treatment, this seems to be a more appropriate figure to use than the widely accepted 1 in 4 adults who experience some sort of mental ill-health issue.

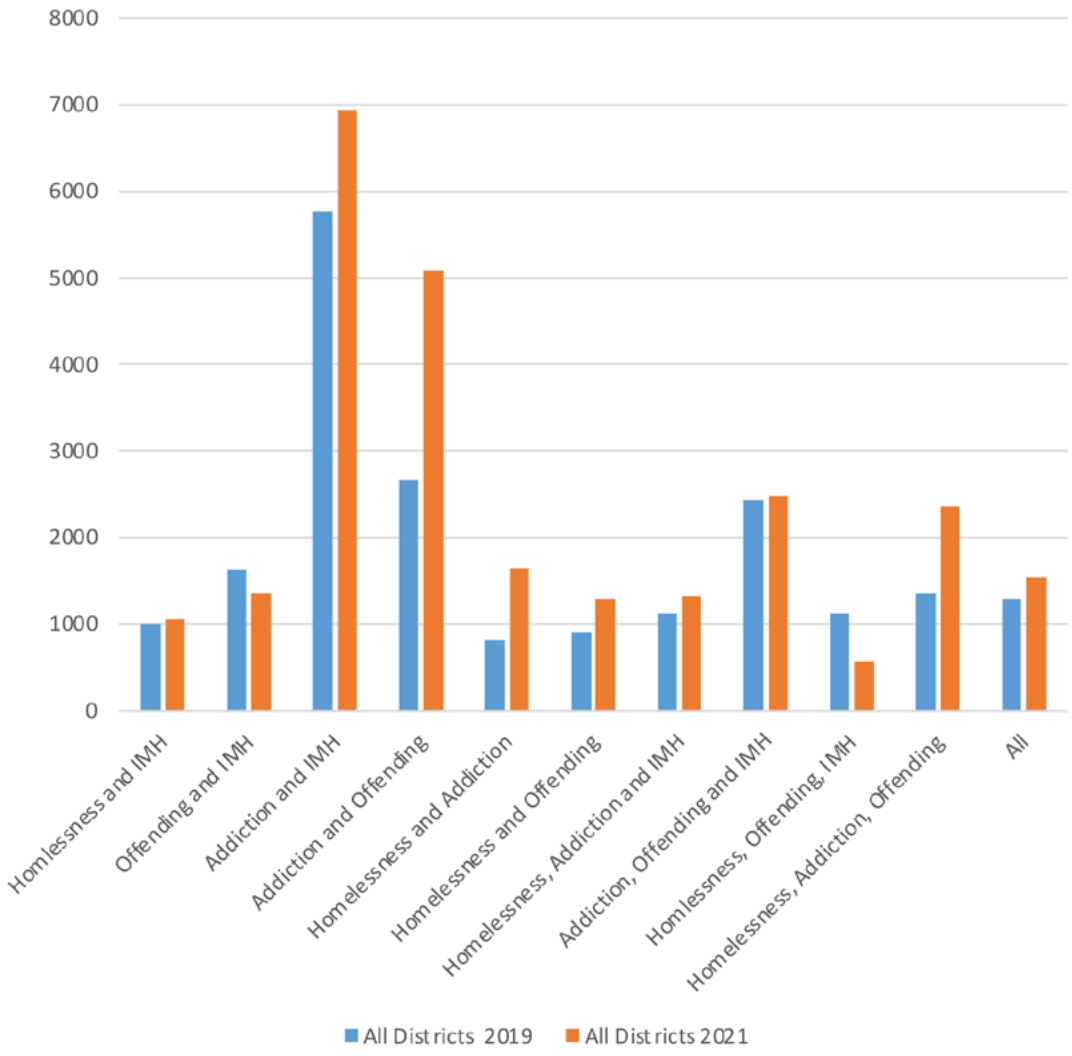


Figure 8: Changes in Multiple Needs among Adults in West Yorkshire 2019/ 2021

Based on the four themes of homelessness, addiction, reducing re-offending and mental ill-health changes in the estimated numbers of adults experiencing multiple needs is shown in the diagram above. Overall an increase of 20% in the number of people experiencing all four of those needs is shown.

3.2.2 Housing Insecurity and Inadequate Housing

Housing insecurity is a reality for thousands of families and children. The number of families with dependent children living in temporary accommodation has risen steeply in recent years. In 2015 a total of 106,240 children were living in temporary accommodation and by 2019 that figure had risen to 127,370 children (The Children's Society, 2020).

More than 1 in 5 houses in Yorkshire and Humber have failed to meet the decent home standard (Marmot et al., 2020). In deprived wards, damp and overcrowding is common, leading to health concerns such as Covid-19 and other respiratory illnesses. Children in overcrowded accommodation may not have had a suitable study space for home-schooling during the Covid-19 pandemic, leading to a widening educational attainment gap between the most deprived children and the most affluent.

3.2.3 Ill health

WY-FI data shows that around 40% of all cases present with a disability/long-term illness, which is a significant complicating factor in terms of accessing services in addition to poverty. This contributes significantly to the exclusion from services experienced by people with multiple needs.

3.2.4 Offending

Hard Edges gives us strong statistical indications about the experiences of children and young people that are common to adults who experience multiple needs and exclusion. Just under a third of adults with multiple needs were convicted as children, a fifth had their first contact with the police under the age of 14 years.

Locality	Rank (1 worst locality – 152 best locality in England & Wales)	Rate of proven offences per 10,000 of general 10-17 population	Rate of children sentenced per 10,000 of general 10-17 population	Rate of cautions and court sentences per 10,000 of general 10-17 population
Bradford	24	148.5	59.2	82.3
Calderdale	47	129.3	51.6	80.1
Kirklees	48	95.7	46.1	62.4
Leeds	71	103.2	38.8	48.1
Wakefield	87	108.3	43.5	52.9

3.2.5 Violence and Domestic Abuse

People who experience disadvantage are significantly more likely to commit violence and have violence committed against them. Deprivation, low educational attainment, mental health concerns, substance misuse, being a looked-after child and being BAME are all risk factors for experiencing and committing violence.

Crimes of Violence against the Person are more severe in West Yorkshire than the rest of England and Wales - with the crime severity score for West Yorkshire in the year ending 2020 at 5.6, compared to the England and Wales average of 3.9 (West Yorkshire Violent Reduction Unit, 2021).

West Yorkshire has one of the highest domestic abuse rates in England and Wales, with 40 incidents per 1,000 people compared to the national average of 22 (West Yorkshire Violent Reduction Unit, 2021). Domestic abuse is more prevalent than any other kind of violent crime. Leeds accounts for 33% of all offences, with Bradford accounting for 26%, Kirklees accounting for 17% and Wakefield and Calderdale lower on 15% and 9% respectively (West Yorkshire Violent Reduction Unit, 2021).

Domestic violence rates in West Yorkshire increased by 3.8% during the pandemic (West Yorkshire Violent Reduction Unit, 2021). Another notable factor is that the more children were present at domestic abuse incidents than they were pre-pandemic. 44% of Domestic Abuse incidents that occurred with a child present were repeat offenders (West Yorkshire Violent Reduction Unit, 2021).

The estimated cost of Violence in West Yorkshire is over £874 million a year (West Yorkshire Violent Reduction Unit, 2021). To reduce that figure early intervention is key; to identify those that exhibit the risk factors that predispose the occurrence of violent crime. That way the intergenerational cycle of violence can be halted in the most vulnerable and deprived communities.

3.2.6 Childhood vulnerability to victimisation

Statistics on childhood vulnerability to victimisation in England and Wales estimated that during the period March 2017 – March 2019, 751,000 (19.3%) of children between the ages of 10 to 15 lived in households with an adult who had experienced mental ill-health, domestic abuse or substance misuse in the previous 12 month period.

Children aged 10-15 years old who lived in households with mental ill-health and/or domestic abuse were twice as likely to experience violent crime as those living in households where mental ill-health or domestic wasn't reported.

3.2.7 Childhood mental health and education

West Yorkshire has high rates of children with social, emotional and mental health needs, as well as higher than average rates of children with learning difficulties. There are estimated to be significant numbers of children experiencing mental health disorders in West Yorkshire. Data from NHS Digital indicates that in Leeds there are nearly 14,000 children with a mental health disorder, with Bradford following closely at over 12,000 (NHS Digital, 2020).

Four out of the five districts have a fifth or more of pupils with a statement of Special Educational Needs (SEN), and that the same four authorities are ranked in the bottom third in England for the proportion of pupils with a social, emotional and mental health need. Over time the number of pupils with a SEN statement had dropped but is now showing a marked rise. Likewise the proportion of those children receiving additional classroom support for behaviour or learning without a statement has stopped falling and, in some cases, has begun to increase.

3.2.8 Loneliness and social isolation

The Department for Culture, Media and Sport's Community Life Survey 2017-18 reveals that the two age bands that report the highest proportions of loneliness are 16-24 year olds and people aged 25 to 34 (Department for Digital, Culture, Media and Sport, 2018). People living in the most disadvantaged areas are twice as likely as those living in the least disadvantaged places to report that they feel lonely. Factors impacting on loneliness are broadly speaking the same as those impacting on ACEs and multiple disadvantage and exclusion.

3.2.9 Poor education and unemployment

Performance at school impacts directly on participation in further/higher education and employment opportunities. Hard Edges identifies that almost 50% of adults experiencing multiple needs have no educational qualifications. For over 10% lack of literacy is an ongoing challenge and numeracy is a problem faced by around 15%.

West Yorkshire as a whole has a lower percentage of children achieving 5 GCSEs at grades A* to C (including English and Maths) than the English Average (West Yorkshire Violent Reduction Unit, 2021). However, this average figure for West Yorkshire masks some differences within the county, with Bradford (45.8%) and Leeds (51.9%) achieving a significantly lower score than the national average whereas Wakefield (57.1%), Calderdale (58.2%) and Kirklees (56.3%) return figures above the national average (West Yorkshire Violent Reduction Unit, 2021).

The latest NEET figures from 2020 in West Yorkshire are promising. The percentage of 16-17 year olds recognised as NEET is 4.7%, lower than the English Average of 5.5% (Anon). Four out of five Local Authorities recorded a significant decrease in the proportion of 16-18 years old that are NEET - the exception being Wakefield, where the figure stayed static (Anon).

The rate of exclusions in West Yorkshire is increasing slightly but still below the national average (West Yorkshire Violent Reduction Unit, 2021). There is a clear trend that children who are either BAME, entitled to free school meals or SEN are disproportionately affected by exclusion. Exclusion is a risk factor for becoming NEET, committing violence crimes and substance misuse.

3.2.10 The next generation

The Hard Edges evidence around adults with multiple needs being in contact with children came too late to influence the main data collection in WY-FI. What we can say from the data WY-FI collects is that one quarter of beneficiaries are in receipt of child tax credit – i.e. over 200 people have a primary responsibility for one or more children. Findings from the WY-FI Beneficiary Insight Survey show that 21 (17%) beneficiaries in the sample (123) had attempted to access children's services – only four of whom had a good experience without a Navigator.

3.3 Covid and Emerging Risks and Needs in Relation to Trauma and Adversity amongst Young People

3.3.1 Findings from the literature

3.3.1.1 Effects of school closure

- Schools and play areas closed – exams cancelled and loved ones separated (UNICEF 2020)
- In excess of 700 million education days lost in 2020 (UNICEF 2020)
- The Childhood Trust highlighted the impact that lockdown has had on children confined to home with no opportunity to 'take refuge at school and clubs/organisations' with adults/ teachers/coaches trained to pick up evidence of abuse' (The Childhood Trust, 2020)
- Remote learning has impacted disadvantaged children more – restricted access to technology and shared study spaces at home with siblings – lack of supervision – attainment gap with less disadvantaged children will increase. All this exacerbated by children experiencing homelessness and/or temporary housing – overcrowded/ cramped spaces (Childhood Trust 2020)
- The briefing also highlights a widening gap of learning time per day between the richest and poorest children which has grown by a third from 45 minutes to 1 hour per day (Andrews et al, 2020).
- Young carers haven't had the break that school attendance allowed – limited access to support groups and friends/ family and key workers due to shielding/ lack of home visits.
- Teachers have had to revise and adapt established methods of assessment very quickly and provide online teaching where it is difficult to measure the effects.
- Children and young people are not only worried about current situation but about future education/careers prospects (UNICEF 2020)

3.3.1.2 Poverty

- Children facing food insecurity as unemployment impacts on family finances – children have less access to health care
- Action for Children highlighted the fears of families, across UK 30% of children living in poverty before crisis – families were very worried about paying for food, electricity and gas then rent. There were 4.1 million children (30% of all children) were living in poverty in the UK in 2017/18. These children were living in households with a relative low income (after housing costs (Action for Children, 2020)
- The Evidence Based Practice Unit's research bulletin issued in April 2021 (Jeffery, 2020) states that the Institute for Public Policy Research (IPPR) estimates that 1.1 million more people could be left below the pre-Covid poverty line. This would include an additional 200,000 children. (McNeil, 2020)
- Families with pre-existing financial problems have been overly affected by the pandemic including 57% not being able to access essential household items and 47% not able to afford food (Buttle, 2020) again cited by Hagell
- Families without recourse to public funds – no access to furlough scheme or benefits – risk falling into 'severe poverty and increased risk of exploitation – limited or no access to traditional sources of support e.g. church groups/ local charities and/or community groups.

3.3.1.3 Abuse/neglect

- Children are at greater risk of abuse in their homes and online (UNICEF 2020)
- The NSPCC reported that the number of counselling sessions for some services concerning child abuse within families has tripled following the lockdown. (NSPCC, 2020).
- The online mental health service, Kooth, recorded that issues of child abuse, sexual exploitation and neglect had risen by 37% by June 2020 as compared to the previous year. (Kooth, 2020)

3.3.1.4 Impact on maternity

- Impact on maternity care – especially new mothers rely on friends/family to provide support and advice – professional support services limited during pandemic – rate of breastfeeding may drop hugely – potential future health issues for children
- Loss of choice and stress of giving birth during Covid will increase risk of postnatal depression – mothers giving birth in hospital with limited support from partners/friends etc.

3.3.1.5 Mental health

- Mental health of children and young people – getting the virus, passing it to family and losing loved ones.
- Restricted access to support services and friends
- Reporting of higher instances of anxiety and depression and loneliness
- The Children's Society report, 'Life on Hold: Children's Well-being and Covid', cite studies which indicated that there has been increases in levels of anxiety, emotional and behavioural difficulties of children aged 4 to 10 years and young people's anxiety (aged 13-24) (Levita, 2020).
- According to research by Young Minds (2020) a quarter of young people surveyed with a history of mental health needs did not have access to mental health support due to the pandemic. Recommendations for the Government include 'comprehensive measurement of children's subjective well-being' 'funded prevention and early intervention strategy to promote positive well-being – supporting financial security of low-income families. The Children's Society has called for more comprehensive approach to getting data on children's collective well-being
- Impacts vary for some groups of young people including young carers (Carers Trust, 2020) LGBT young people (Sachs and Rigby, 2020; Anderson, 2020) and some people from BAME backgrounds (Kooth, 2020c) as cited by Hagel (2021) in a briefing for the Association for Young People's Health on the impact of Covid-19 on young people.
- Shum, (2020) reports Parents from single adult households, low income families and those with children with Special Educational Needs/ Neuro Diversity (SEN/ ND) have reported increased levels of anxiety and depression (Shum et al, 2020).
- It is also evident that young people in low income families and areas have seen increases in mental health problems and do not have the same level of access to technology as their school mates inhibiting communication with school and friends. (Andrews et al, 2020; Buttle, 2020; Public Health England, 2020)

3.3.1.6 Social isolation

- Across the board, the voices of children and young people have been absent from decisions about their lives' (UNICEF 2020)
- In the future physical wellbeing and ability to exercise/play is crucial for health of children need investment in communities/youth centres – impact on sports clubs (The Childhood Trust, 2020).
- A wider range of preventative activity is also needed – access to sport, art, music and play clubs – massive reduction in early years spending in recent years Las struggle to keep up with statutory duties for vulnerable young people (The Childen's Society, 2020)

3.3.2 COVID-19 Impact on Social Care

As the country entered lockdown referrals to children's social care fell significantly as school and health staff prioritised critical 'frontline responses' meaning that many more children were likely to be living with abuse over an extended period of time. The lockdown and resulting confinement exacerbated family tensions and meant that it was for more difficult for people to leave abusive situations. The domestic violence charity Refuge recorded a ten-fold rise in visits to the National Domestic Abuse Helpline website. (The Association of Directors of Children's Services (ADCS) Ltd, 2020).

As lockdown eased referrals to children's social care began to rise swiftly including a group of newly vulnerable families that social services had not worked with previously – issues include domestic abuse, neglect and financial hardship. For young men. Homelessness and harmful behaviours have risen significantly and it is evident that children have spent a lot more time online in 'digital world' to forestall isolation and family tensions - - likely to lead to more incidents of 'grooming, online bullying and exploitation' (The Association of Directors of Children's Services Ltd, 2020).

ADCS stressed the *vital importance* of public health and early intervention have been highlighted during the Covid crisis – has also started a public debate about health 'inequalities, deprivation and ethnicity' (The Association of Directors of Children's Services Ltd, 2020).

Criminal activity in communities is more visible – able to identify children involved in county lines.

Pandemic has disrupted professionals' relationships with children and families – the longer term impact on charities/ voluntary sector organisations who work with statutory agencies is unknown.

Quick conversion to online and new ways of communication has impacted families where there isn't a quiet place to talk also where there isn't access to new technology – also causes issues where initial contact is made without face-face meeting – less impactful and reduces progress.

Impact on staff/professionals – increased risk of experiencing trauma particularly NHS staff and those working in adult social care – BAME staff and those with underlying health conditions – higher risk of burnout given extended period of crisis. Staff are reported as not taking annual leave as per normal – leaders are having to absorbing a lot of emotional stress from staff – dealing with complex and competing priorities – home working not.

There have been some aspects of the Covid-19 pandemic that have brought some benefits – families enjoying quality time together - vulnerable children and those of key workers will have benefitted from smaller class sizes and increased levels of support associated with this – 'a greater openness and willingness to talk about mental health – death and grief and loss is emerging'

3.3.3 COVID-19 Young People and Violence

Covid-19 will undoubtedly have a social and economic impact on young people at risk of violence – identified psychological effect of isolation during lockdown – spending time online and risk of exploitation – also disruption to education/ employment/support services.

The attainment gap will have increased – job sectors young people work in have been severely impacted leading to more young people living in poverty - , **the pandemic has exacerbated the risk factors for involvement in serious violence**, at the same time as **stripping away key protective factors**.

Children very rarely become seriously ill after contracting Covid but have suffered disproportionately as a result of the 'secondary risks' their rights and needs have been ignored – restaurants, non-essential shops and pubs were open at a time when schools were closed – vulnerable children in care, custody and with SEND have had 'rights actively downgraded' when protections should have been increased. Before pandemic 2.2 million children in households affected by combinations of domestic abuse, substance misuse and severe parental mental health issues.

Stripping back of 'key support services' – likely economic recession – Covid crisis has shown how limited resources are available to families in time of crisis – (proliferation of demand on food banks) – although children can be resilient and adaptable some of their coping strategies may be unhealthy if left unchecked over a period of time.

The challenge is twofold – adapting response to Covid-19 so reducing the impact on most vulnerable children and secondly addressing the underlying issues that made 'these children and families so susceptible to adversity in the first place.' The call to 'build back better' needs to be put into action.

Families want to be able to support children and it is the state's role to ensure that this can happen – especially important with Government's 'levelling up' agenda. The aftermath of Covid has the potential to 'impact families' to a far greater extent than the virus – potential to become and 'intergenerational crisis with the impact of the economic fall out on parents determining the future prospects of their children'

Call for much greater investment in early help services for families so that they can access help and support in their communities before they reach crisis point. In education, as much as in other areas of the public sector, funding needs to be targeted at vulnerable and disadvantaged children who have lost out the most, not ensuring 40 schools can teach Latin (Children's Commissioner for England, 2020).

3.3.4 Summarising what we know so far about the impact of Covid-19 on young people

In the recent AYPH (Association for Young People's Health) report on the impact of Covid-19 on young people an emphasis is placed on the disproportionate effect on children and young people and particularly how the average effect can be misleading. Children living in poverty, with a disability or with difficult family situations are likely to be hit hardest by the pandemic, especially by medium to long term effects on education and health inequalities. The report states that there is no quick fix but the following mitigating actions should begin as soon as possible:

- Focus on youth voice, leadership and co-production
- Create a national inequalities strategy for education
- Extend placement of NHS counsellors in schools
- Catch up tuition should begin in more deprived areas
- Eradicate digital inequality
- Increase support for youth activities and clubs
- Use impact assessments to monitor the impact of polices on young people and collect evidence on the impact of the Covid-19 crisis by different age groups.
- Use targeted policies and services for vulnerable youth groups (Hagell, 2021)

MIchael Mamort's Covid-19 Review: Building Back Fairer (2020) has shown that The Covid-19 pandemic has disproportionately affected the health of the country's most deprived areas with the consequences outlined above. Marmot highlights the mechanisms by which this virus, specifically has a disproportionate impact on disadvantaged areas. Those that live in deprived areas are more likely to be key workers - meaning that they cannot work from work and thus are exposed to a greater number of people. People in deprived areas are also less likely to self-isolate when experiencing Covid or have been in contact with a positive case, as they cannot afford to take unpaid time off work. More deprived areas are more likely to have lower quality housing, including damp - this increases the prevalence of respiratory diseases in the population, leading to more severe Covid. Overcrowding leads to a higher viral load. It is not surprising then, that the Covid-19 Pandemic has further emphasised and expanded the massive gulf in health between the rich and the poor in the UK.

Section 04

Why doing nothing is not an option

4.1 Cost Effectiveness of Intervention Models

4.1.1 The Cost of Adverse Childhood Experiences on the Individual and Society from the Literature

There is a clear link between ACEs and negative life outcomes. A recent systematic review analysing ACEs study conducted over the past 20 years found that 4 or more ACEs is associated with:

- A weak (less than two-fold) increase in the odds of developing obesity, physical inactivity or diabetes.
- A moderate (between two and three-fold) increase in the odds of smoking, general poor-health, cancer, stroke, heart or respiratory disease.
- A strong (between three and six-fold) increase in odds of sexual risk-taking, poor mental health and problematic alcohol use.
- A very strong (greater than seven-fold) increases in odds of problematic drug use and interpersonal and self-directed violence, and suicide (Hughes et al., 2017; Asmussen et al., 2020; ACEs, Trauma and Resilience (ATR) steering group, 2021).

It is important to note that even a relatively weak increase of odds of an individual developing a condition can have a significant impact on the health of the overall population (Asmussen et al., 2020).

Thus, ACEs place great economic strain on the health and social care system. A study analysing primary data on ACEs and 13 health outcomes from five general population ACE surveys estimated the financial burden of ACEs in England and Wales at £42.8 billion (Hughes et al., 2020). This figure is equivalent to 2.6% of the total GVA (Gross Added Value) in England and Wales or £1,800 per household per annum (Hughes et al., 2020). Of course, this study had limitations - not all 13 health outcomes are available from each study (i.e. mental illness was only measured in the Welsh study) and the data used was self-reported, like in the majority of ACEs studies (Hughes et al., 2020). Hughes et al., (2020) considered this figure to be a conservative estimate, as not all outcomes as a result of ACEs (unsafe sex, crime etc.) could be reviewed.

Research has found the lifetime cost of non-fatal child neglect or abuse in the UK to be £89,000 per victim. This cost includes the financial costs of maltreatment in

terms of impact on health and social care, education and the criminal justices system, as well as the costs to the wider economy in lost productivity (Gabriella Conti, 2017)

The Early Intervention Foundation estimates that the cost of providing late intervention across England and Wales amount to £17bn per year (2016) (Chowdry H, 2016).

It is vital to invest in early intervention and prevention to allay the impact of exposure to abuse and violence for children and young people during the lockdown. The exponential costs of ACEs and violence rise across the life-course, with late intervention increasing the expenditure. Acting early can significantly improve outcomes for children and young people and, at the same time, reduce the costs on services. (Annemarie Newbury, 2020).

4.1.2 The WY-FI model: the financial impact on services working with adults experiencing multiple disadvantage

4.1.2.1 Early findings from WY-FI

Early in the WY-FI Programme we wanted to understand the costs that were incurred by an individual and to which type of agencies these accrued. The result were a number of detailed case studies that culminated in graphical representations of an example service user journey, which of the four HARM needs the costs related to and whether they were rehabilitative (positive costs or greater than zero) or remedial/ unplanned costs (negative costs represented as less than zero).

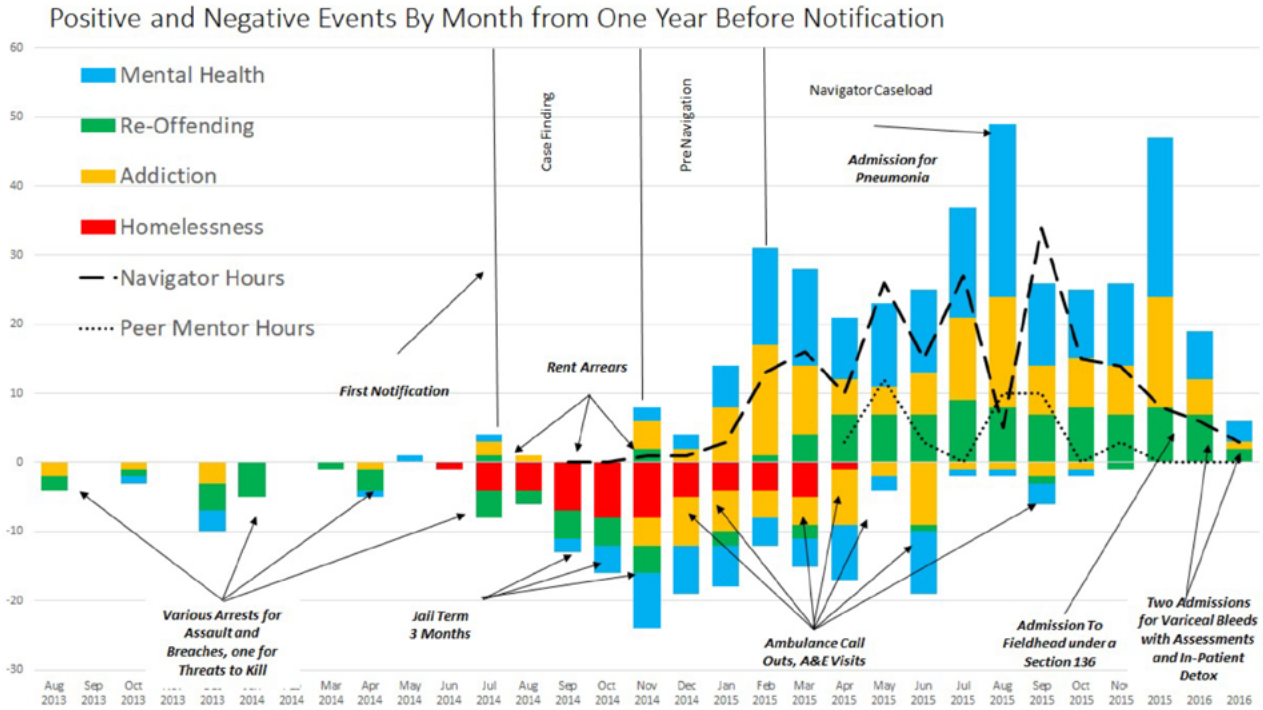


Figure 9: Positive and Negative Events from One Year Before Notification (Referral) to WY-FI

This graph illustrates a number of key facts about service use by adults who experience multiple disadvantage and exclusion (and by extension the resultant spending). The measure on the vertical axis is the number of incidences of service use in each month, in each category of HARM.

The first is that, without support from a WY-FI Navigator all the expenditure was in terms of addressing crisis. Second is that with support from a WY-FI Navigator and the Multi-Agency Review Board, initially a variety of services are involved, and broadly speaking the more involvement from a

navigator the greater the engagement with services. The third point is that there is a shift in the type of services used, and this is made much clearer in the pie charts below, where we can see that a relatively small number of contacts with the criminal justice system cost the public purse as much as hospital stays to address long term health needs and inappropriate ambulance call-outs, managing addiction and having contact with the criminal justice system that reduces re-offending. Finally the course of this spending from referral is for a period of 18 months. There isn't necessarily a smooth transition from negative to positive access to services, from unplanned to planned service use, but the trend is there.

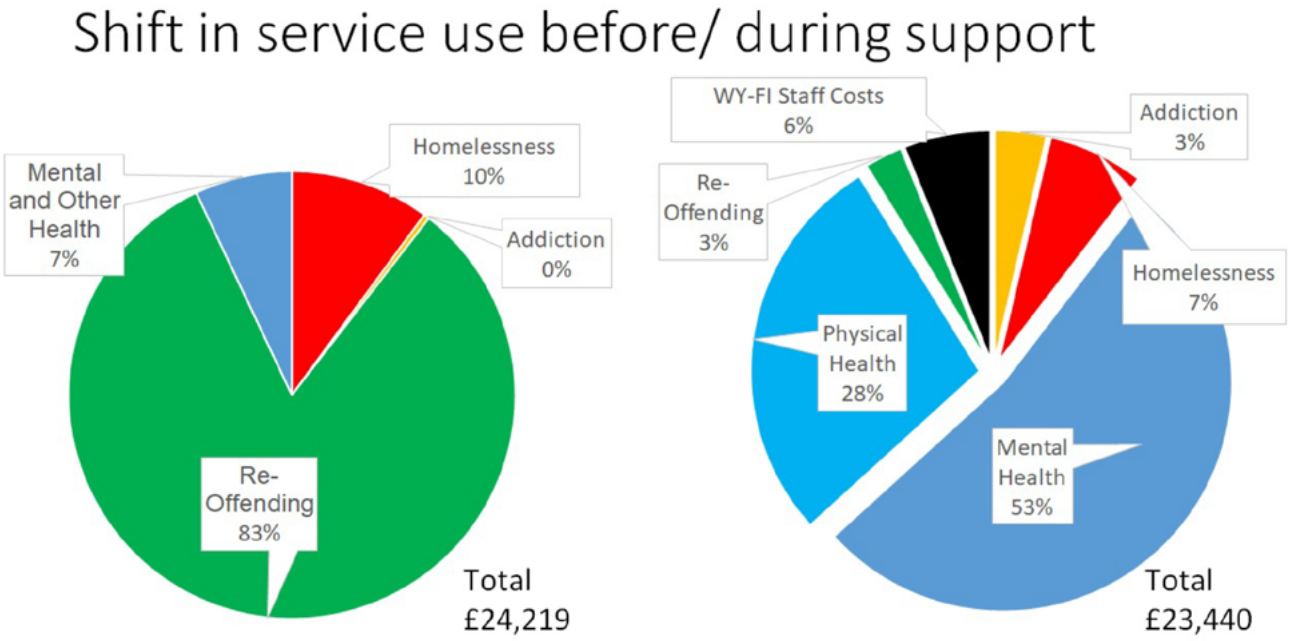


Figure 10: Shift in Service Use Before/After WY-FI Support Started

Following this exercise the external evaluators of WY-FI (CRESR) undertook a full cost effectiveness exercise which built on these initial findings. This is explored in more detail in the next section.

4.1.2.2 The WY-FI model, cost implications for the whole system – the CRESR analysis

The costings model applied in the graphs below, considers the change in service use for **310 beneficiaries, across 18 areas of service use** and attributes national unit costs taken from the Cabinet Office/ Commission for the New Economy Cost Calculator (developed for the Troubled Families Programme).

This analysis focuses on the impact of WY-FI over six quarters (18 months) of data following the baseline quarter. The results have been scaled up to 823 WY-FI beneficiaries (the total number of WY-FI beneficiaries). Full details of the method are provided in the final evaluation done by CRESR.

Overall WY-FI is found to increase its beneficiaries' wider service use costs. The expected increase in service costs is £5,584 per service user over six quarters compared to the baseline. This implied for every £1 of WY-FI expenditure there is a further £0.49 in wider service costs.

However, this needs to be put into context. The data shows that **cost savings are generally associated with reductions in negative 'reactive' events**.

The largest cost savings occur due to reductions in (Figure 11 below):

- Crown Court proceedings (£234,000 or approximately £280 per service user)
- Arrests (£214,000 or approximately £260 per service user)
- Evictions (£200,000 or approximately £240 per service user)

Whereas **cost increases result from increases in more positive 'treatment' or 'preventative' events**. By far the largest cost increase (and influence on the overall result) is for 'days as a mental health service inpatient', which is predicted to increase by £2.9 million (Figure 11). Many of the costs related to 'treatment' **address previously untreated conditions**. These costs should reduce over time and are likely to prevent longer-term, often more expensive and reactive, service usages.

Increased costs have been identified despite beneficiaries reporting positive outcomes on metrics, for example Housing Outcomes Star (HOS) and New Direction Team Assessment (NDTA, alias the Chaos Index) score. This suggests that improvements in HOS and NDTA scores have been achieved because of the increases in wider service use costs. Therefore cost increases, at least in the short term, should be seen as a positive, rather than a negative, effect of WY-FI.

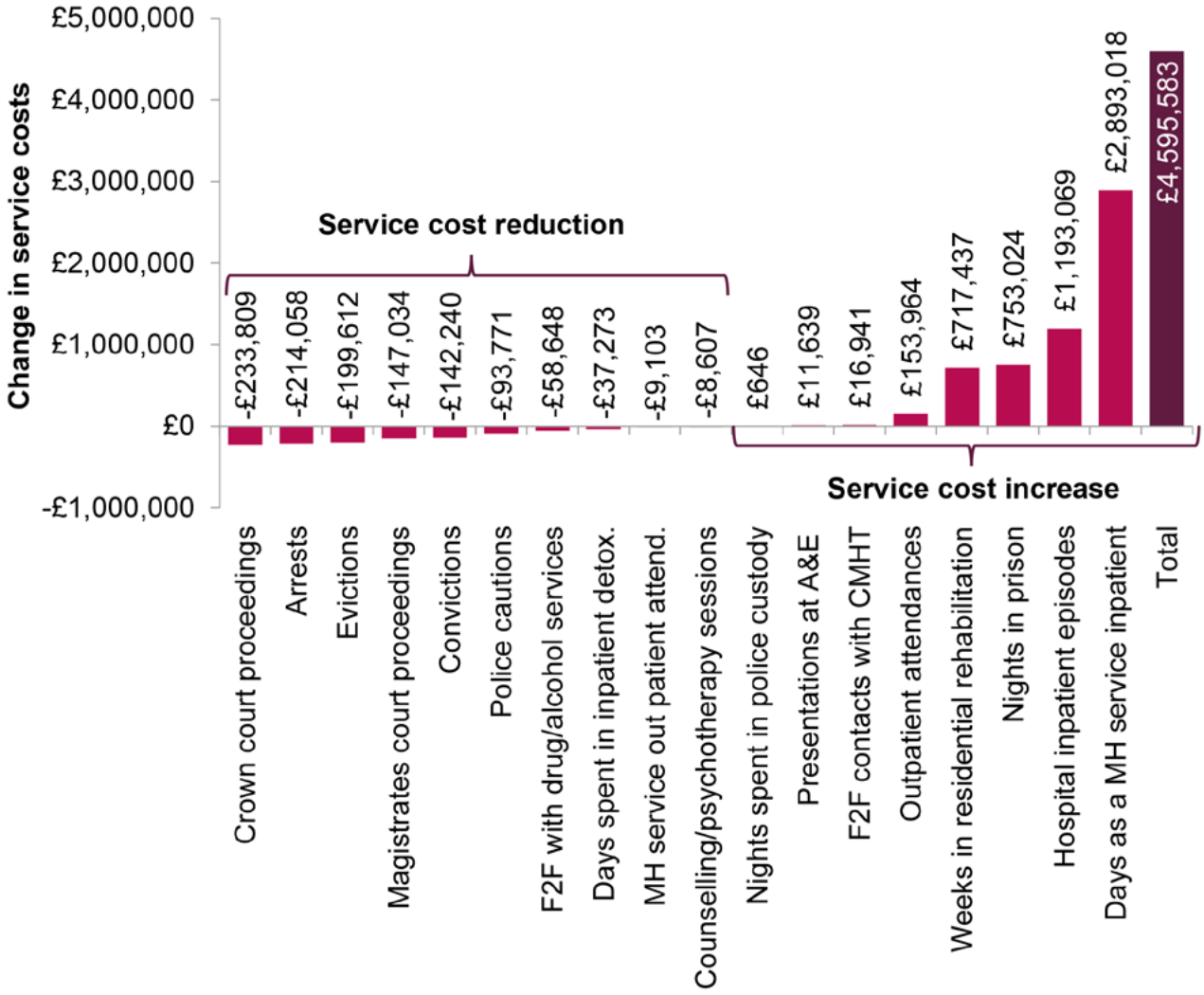


Figure 11: Change in service use costs, aggregated up for the whole WY-FI caseload

Figure 12 below considers the cost savings, or increases, by agency. It shows that six of the eight agencies considered are likely to experience cost reduction. Conversely two agencies experience an increased cost burden: the NHS (£4.66 million or £5,670 per service user) and local authorities (£211,000 or £211 per service user).

Other key points:

- It is important to consider early intervention and prevention to divert people from chaos, otherwise the 'pool' of people with multiple and complex needs will continue to be replenished as people are left to slide from crisis into chaos.
- A spike in costs is shown during the first 12 month following a service user's engagement. In the second year the evidence suggests there are signs of reducing cost increases and cost savings.
- Ensuring service users achieve a planned exit is important to limit or reduce costs. Analysis revealed that average service usage costs increased by a far greater amount for beneficiaries with an unplanned exit (£7,813) compared to beneficiaries who had a planned exit (£2,543). However this also shows that achieving a planned exit is associated with increased service use costs beyond the WY-FI service, to overcome beneficiary needs and promote independence.
- Finally, addressing factors which may lead to a prison stay should be prioritised. More detailed analysis identified a large difference in the increase in service use costs between beneficiaries who recorded a prison stay after starting on WY-FI compared to those who did not: £10,624 and £515.

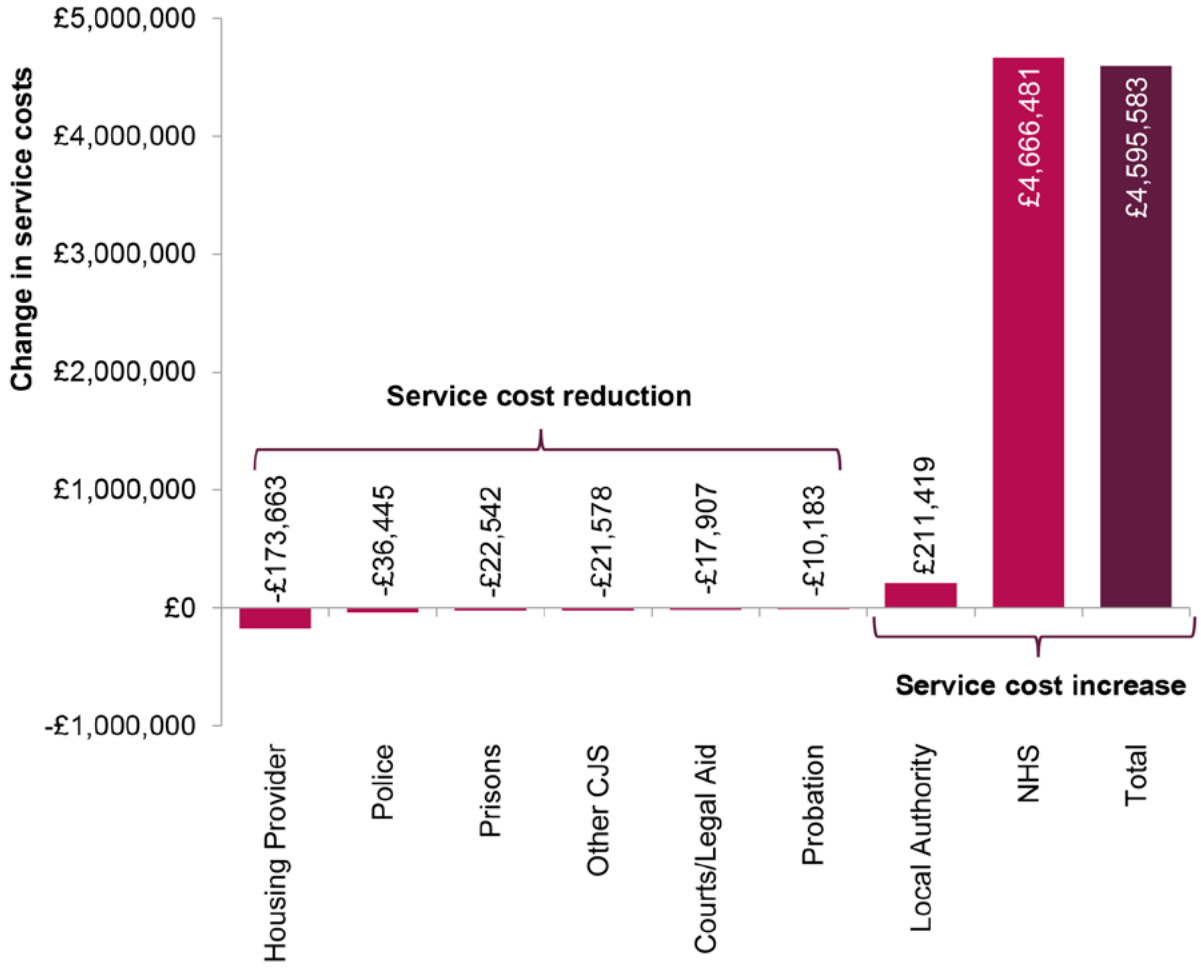


Figure 12: Cost change by agency

Cost effectiveness

Following an initial spike in costs during the first 12 months whilst a service user re-engages with services, the evidence shows there are cost *savings* at around 18 months.

Figure 3 - Average change in service use costs (average for quarters versus the baseline)

Figure 13: Average change in service use costs (average for quarters versus the baseline)

Working through strategic leadership can make explicit the **interdependencies** between **agencies and commissioners** across the public sector in terms of **investment, savings, service efficiency and effectiveness**. This mirrors the local level multi-agency working for delivering better outcomes for individuals.

4.1.3 What does the literature say about scaling these findings into a life-course system for health and social care?

Research has shown that a child's risk of adversity is shaped/influenced by the social determinants of health including overcrowded and poor housing conditions and insecure employment combined with financial pressures which make conflict within households far more likely. The Crest report (for the West Yorkshire VRU) cites a 2014 study which found that in England's most deprived areas **child protection plan rates for emotional abuse were nine times higher** than in the most affluent areas; for **neglect, seven times higher**; and for **physical and sexual abuse, six times higher**.

Whilst macro-economic strategy is perhaps beyond the scope of even the WYHHCP there are elements of economic activity that partners can control. The health and social care workforce and allied services form a significant part of the West Yorkshire workforce. There is considerable economic influence in terms of supporting local supply chains, growing local employment opportunities and supporting a training infrastructure.

The diagram on the following page from Director of Public Health - NHS Highland, 2018 shows how the flow of expenditure increases the later identification and interventions are made. Furthermore it makes explicit the relationship between adversity, trauma and economic stability for families and individuals a central component of tackling adversity and trauma and promoting resilience.

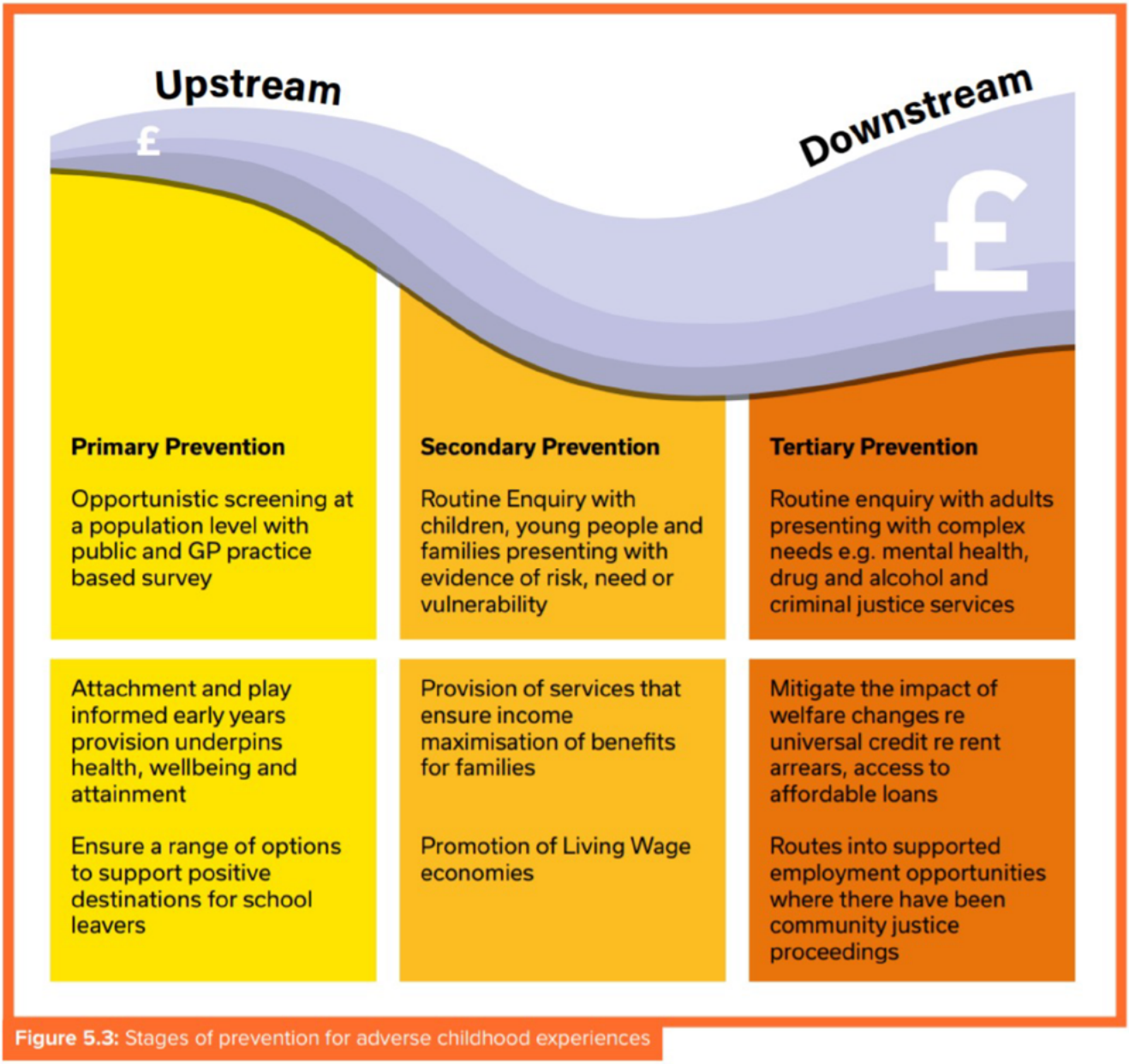


Figure 14: Director of Public Health - NHS Highland, 2018

4.1.4 Health inequalities impact on access to intervention and support

In his original essay, The Inverse Care Law, Hart notes that "medical services are not the main determinant of mortality or morbidity; these depend most upon standards of nutrition, housing, working environment and education, and the presence or absence of war". Studies show that inequalities in these aspects of life are, in part, inter-generational, the environmental limitations of the parents being handed on to their children. The increasing volume of literature on the disproportionately adverse impact of the government's programme of austerity on young people, women, disabled people, BAME people and otherwise marginalised groups indicates that there is a real likelihood of future cohorts experiencing increased ACEs, multiple disadvantage and exclusion.

In the West Yorkshire VRU Report (2021) 'Serious Violence in West Yorkshire Strategic Needs', higher levels of mental health problems than the national average are evident in West Yorkshire. All five local authorities within West Yorkshire have a higher prevalence of mental health disorders than the England average. 26,000 children experience mental health disorders in Leeds and Bradford and significant levels of unmet need were highlighted in a survey of CAMHS practitioners, parents, children and young people in Bradford and Craven. Nearly half agreed that it was difficult for a young person to access support when they first experienced mental health issues. BME children were significantly (20%) less likely than all children to report that they knew where to go for help if they, or a friend, experienced a mental health problem.

Meanwhile, three-quarters of parents reported that it had been difficult to access support for their children, and two-thirds had found it difficult to access support for their child in a crisis. Over three quarters of professionals reported that it was difficult for 4-16 year old children to access support for mental health needs and 72% said that it was difficult to access support in a crisis. The primary unmet mental health needs in Bradford and Craven include the emotional impact of social isolation and poverty; the impact of adverse childhood experiences; SEN and neurodevelopmental needs; support for young adults; support for children in care; and support for BME young people, who are being held back by stigma and a lack of culturally competent provision.

4.2 What do we mean by a "Trauma Informed Approach?"

4.2.1 What is and isn't trauma informed practice?

Trauma informed practice follows key principles which influence engagement and relationships with all stakeholders within a service, organisation or sector: service users; all staff (paid and unpaid); commissioners and other funders; partners; community and voluntary groups, etc.

These principles are:

- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment, Voice, Choice
- Cultural, Historical & Diversity Awareness

  SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)

As a minimum, trauma informed practice seeks to minimise (ideally, prevent) re-traumatisation.

Trauma informed practice is not merely being aware that trauma may exist in someone's life or being aware of the causes of trauma. It is not asking about trauma. It is not a different approach that only applies to those who have been traumatised.

An organisation or service which claims to be trauma informed has undergone a transformation of culture. This change is apparent in how it engages with others and itself. It is focussed on the principles above and is continually and rigorously assessing all it that it does against them. It is inclusive, not punitive. Open, not obscure. Trusted and trusting. It shares power and encourages individual growth. It takes risks at the same time as ensuring safety.

Trauma Informed Care recognises that trauma is complex and likely to have a pervasive impact across different domains of the individual's life. This is why a system wide approach is advocated. Benefits of a system wide approach include:

- **All staff recognise the wide reaching and detrimental impact of trauma**. Staff recognise that issues stemming from trauma are usually multifaceted and complex. They understand the bigger picture of the individual's life and how they have come to this point. Recognition of trauma (for both staff and service users) is a key aspect of Trauma Informed Care.
- **Referrals and navigation will be easier**. As the system will be integrated, it will be easier for individuals to be referred to additional services if staff identify multiple needs. Accessing the right services can be extremely difficult for those with adversity and trauma. Accessing services can be complicated and long-winded. Trauma and adversity increases the likelihood of individuals having behavioural or educational needs, neurodiversity or mental health conditions - all which can impact the process of setting up and continuing with appointment. Integration will vastly improve individuals accessing the right services for their needs.
- **Intervention will be earlier**. A whole system trauma informed approach will mean early intervention. As mentioned in the previous point, referrals will be simpler and quicker - meaning earlier intervention. Staff will also be aware of the effect of trauma on the familial unit, meaning that children of those experiencing adversity will also get the help they require quicker. Trauma is cumulative - both individually and intergenerationally - so early intervention is key for building happy, fulfilling lives.

- **Prevention of Re-traumatisation**. People who experience trauma can be re-traumatised by stressors that remind them of past traumatic events. This can be conscious or subconscious. A lot of people who experience trauma, can be re-traumatised by rejection. Rejection can happen when moving from one service to the next, for example when transitioning from child's to adult's mental health services or being declined for a service. Due to the high demand and complexity of the system, it is easy for people to 'slip through the cracks' and not get access to the services they require. The individual takes this as rejection, and it re-traumatises them. Individuals who experience complex trauma, often feel like there is something inherently wrong with them and that they 'don't fit in'. The individual believes they aren't worthy of help or that people don't care about them. This prevents them from further reaching out for help, consequently worsening their situation. In a whole system approach, it is more unlikely for individuals to 'slip through the cracks' as it will be easy to plan and communicate with various services.

4.2.2 Who needs to be involved?

In time, everyone in the organisation/ service/sector/region has a part to play in the journey to becoming trauma informed. Initially, training on trauma and the principles of TIC should be delivered to all staff. This can be done internally, where the skills and knowledge exist, or external consultants can provide this. Policies and procedures need to be examined and reviewed. Evidence and data collection should begin to focus on the impact of all the changes being made. Recruitment, supervision and appraisal systems will need to focus on the behaviours and competencies required. Commissioners need to consider how contractual requirements impact, positively or otherwise, on the journey.

4.2.3 What are the optimum conditions to create an environment where trauma informed practice can flourish and be normalised; is 8 years enough?

Where trauma informed practice has become the standard operating procedure, every stakeholder has contributed to its success. The culture has shifted and everyone recognises the importance and benefits of the model. For this to have happened, everyone must have reflected on their own role and how they can contribute to the project. The project itself must have been delivered with the above principles in mind. The project leadership must model the behaviours and responses expected from a trauma informed service at every step. Culture shift is very difficult and is fragile. It can only take a small number of people with sufficient seniority to disrupt it and prevent positive change. Is eight years enough? It is important to remember that becoming trauma informed does not necessarily have a clear end point. We can always get better at what we do and how we do it. Significant change can be made in eight years if everyone is focussed on becoming more trauma informed. The initial aim should be to ensure no re-traumatisation takes place. This is the base level of trauma informed practice and could take eight years itself for a sufficiently large partnership.

4.2.4 Evidence from practice

4.2.4.1 Organisational commitment & partnership commitment

Former WY-FI partners have indicated a desire to become trauma informed. Reflective practice groups have been established and training on trauma, adverse childhood experiences and TIC is happening. Forward Leeds (The substance misuse and recovery service in Leeds) has committed to piloting a shift to trauma informed practice on behalf of Humankind. Calderdale Recovery Steps has shown positive regard for TIC and leads the reflective practice group for the locality. In Leeds, Barca have committed to adopting and applying a trauma informed approach, particularly with all their complex needs services. Reflective practice groups have been established there along with staff attending training provided by Karen Triesman. In Bradford, Bridge continues to be committed to being a trauma informed organisation and is in the process of starting a peer led reflective practice group. In Kirklees, The KBOP partnership is committed to TIC, has an established reflective practice group, and is looking to roll out TIC training across the whole partnership. All the above services have had some staff attend the WY-FI funded Complex Needs Training Suite provided by Community Links Training over the last three years.

4.2.4.2 Organisational culture

Conversations about Trauma Informed Practice are becoming normalised across many organisations formerly associated with WY-FI. This is an important first step in the shift in culture required for an organisation or service to become trauma informed. It is crucial that these conversations are happening within the leadership teams, however, as they have the power and influence to drive the cultural change.

4.2.4.3 Co-production; facilitating the inclusion of lived experience at all levels

Trauma informed practice cannot happen without co-production and inclusion of those for whom the service has been established. The principles of collaboration and choice dictate this clearly, unless services involve people with lived experience and commit to co-production they cannot become trauma informed.

4.2.4.4 Training or Development?

- Back office staff ~~training~~; development
- Management and Leadership (including Team Leader) ~~training~~ development
- Frontline worker ~~training~~ development

It is important to shift away from only using the word training when talking about staff development. Training has its place and is very important but it needs to be allied with ongoing development through reflective conversations with peers, supervisors and service users.

In WY-FI, we focussed on providing training for front facing staff. The complex needs training suite represents the culmination of the WY-FI's workforce development test and learn process. It provides a good foundation in the understanding of trauma and the principles of trauma informed practice.

The suite of training courses focussed on trauma informed practice piloted in years 5 and 6 ran again in WY-FI's final year. Learning from the first two pilots was applied to the content and structure of the course. This year, of course, the mode of delivery was forced to switch from classroom based sessions to a blended learning approach. Candidates were sent a collection of course materials to complete some self-directed learning for each element of the training. Each were followed by an online workshop with the trainer.

In addition, it focusses on the development of reflective practice as a skill. For the learning in this programme to become embedded in practice, it needs to be supported within an organisational culture of the type described above.

4.2.5 Case Study: Introducing a trauma informed approach across Forward Leeds

4.2.5.1 Sharing Practice and knowledge

WY-FI has been making a contribution to another Humankind service. Forward Leeds aims to become a trauma informed service. As well as providing awareness training on TIC, there has been a focus on amending policies, assessments, the physical environments, and providing opportunities for reflective practice. This work is ongoing and has been influenced by the work done by WY-FI on engagement and building relationships of trust.

4.2.5.2 Having Trauma Informed Environments in Forward Leeds

Work is taking place throughout the service hubs to make them more trauma informed. This has included making waiting areas more inviting by:

- Having a 'Welcome' sign in the 12 most spoken languages in Leeds.
- Making seating areas more comfortable.
- Filming what the service looks like so service users can visit the Forward Leeds website and know what to expect before they come to appointments.
- Making staff areas more trauma informed and welcoming to improve well-being.

4.2.5.3 Other areas of trauma informed work in Forward Leeds include:

- Making assessment processes more trauma informed by thinking about language, what service users must disclose, the process of the assessment and looking into the culture of collecting information. This means understanding what is needed in that first assessment and what could be left out to make the process more inviting.
- Looking at challenging behaviour and how this is dealt with. Staff should not have to put up with any kind of aggression, but treatment can be emotive, and it frequently comes up. Therefore, understanding why a person is behaving in that way is vital, whilst finding solutions that do not exclude them from the service but still safeguards other service users and staff. Suggestions for what could be implemented here is supporting service users to sessions where they learn about communicating affectively or programmes that give service users the skills to understand why they need to engage properly in Forward Leeds. This needs to be explored in more detail, but simply excluding service users from services is not effective and costs more to services in the long run (WY-FI, 2020).
- Looking into more reflective practice, clinical supervision and peer supervision groups to give staff the most support they can have. This includes offering counselling for a longer amount of time if a staff member has a prolonged need.
- Looking into the interview process and how we can get the best out of applicants. This includes making the process more accessible by allowing them to see questions on a screen or piece of paper, offering them a note pad and pen and giving them the opportunity to write anything down. This will get the best out of candidates

by supporting them through the process and making sure Forward Leeds are employing the best people.

- Sharing updates on the staff bulletin about how Forward Leeds are becoming more trauma informed. Encouraging all levels of staff and service users to be involved in developing this side of Forward Leeds, whilst taking into consideration their caseload and whether they have the capacity to work on additional projects.

4.3 Conclusions and Recommendations: What different things need to happen at place and systems levels to deliver a trauma informed health and social care system across the life-course in West Yorkshire?

4.3.1 Conclusion

The health and social care system is complex, it is not controlled, and the system has grown like Topsy. Change in one part takes time to have an impact on another part. There are many conflicting priorities - between services, between professionals.

People are complex. The drivers that motivate them are emotional, physical, neuro-biological, financial, cultural, and historical. People grow organically moving on a spectrum between nature and nurture, between illness and wellness.

The atmosphere is complex. Between knowledge and science, opinion and stigma, policy and politics, and practice, people who are experiencing trauma or the consequences of trauma and adversity are both finding and failing to find their future selves.

People on the margins are not binary, neither good nor evil, deserving nor undeserving. They have needs but often they are the not the needs that present on the surface. Those needs are not the ones that necessarily come to the attention of the system first.

Working with, and reading the case notes of, people at the margins of the system highlights these fundamental dualities of existence and of definition. Dualities such as being perpetrator and a victim, a parent and a child, of conditionalities and freedoms.

Able to neither access rights nor exercise responsibilities in the way that other people do hardens them in some ways but does not alter their fundamental vulnerability. As they harden, this system, its rejection of them, hardens around them leaving smaller gaps for their vulnerabilities to squeeze through.

But the people at the margins are not, for the most part, the disease that the system is trying to cure. The system may pathologise them, to 'treat them' however they are symptoms of distortions in the system in itself.

These distortions are the products of the system that works for most people most of the time. A system that operates on mutual expectations of providers and users of efficiency and effectiveness. Of what is in the public good, of the proper use of public money. When these expectations are confounded on one side or the other the distortions arise.

The health and social care system is buffeted back and forth in the 'atmosphere' alternately starved of oxygen in a general sense, subject to minute control in other aspects. This has been the case since the political consensus on the public good of the delivery of health and social care was eroded, and now stands as an empty rhetorical soundbite.

Perhaps the vanguardism that led to the creation of a health and social care system did not extend to connecting it to other policies such as education, criminal justice, housing or human rights, and left it isolated culturally and in competition for resources.

The individually excellent components of the system have been shaped and honed by decades of research and practice into a myriad of distinct specialisms and the system has grown those specialisms around the challenges and needs that present themselves. Much less attention has been paid to how they interact with each other.

The characterisation of the health and social care services has habitually been prefaced by words like "beleaguered", "under threat", "cash-strapped", "overworked" and "undervalued". Instinctively it is as pathologised as the people who are marginalised from it. A healthy health and social care system is the first step to a healthy population. A healthy health and social care system is one that interacts healthily with the overlapping support systems that everybody needs. A health and social care system that can survive in many different environments, one which can adapt to changing circumstances without losing its essential DNA.

Realistically it is not so much what is in the health and social care system that matters. The solutions lie not simply in providing ever more sophisticated and expensive interventions for people who experience trauma and adversity in their life-course "medical services are not the main determinant of mortality or morbidity; these depend most upon of standards of nutrition, housing, working environment, and education, and the presence or absence of war" (Hart, 1971). We need to build from what we have and ensure people are not re-traumatised or excluded by the systems of health and social care and reduced to accessing support in crisis.

As the German philosopher, Walter Benjamin wrote to the playwright and poet, Bertolt Brecht in the 1930's "Don't start from the good old things but the bad new ones."

4.3.2 Recommendations

The following recommendations are indicative of the range and scope of considerations that are pointed to by the literature and practice reviewed in this report. Some are specific actions, others are outcomes that will need further development to work towards achievement in West Yorkshire.

To produce a comprehensive transformation of services at system and place is a matter of duration. It will require leadership in the system, in places, in services and specialisms. It requires leadership at all levels politically (with capital "P" and a lower case "p"), at officer and citizen level. Change will not happen all at once, nor will it necessarily happen in an orderly fashion. Leaders of this transformation will need to be fleet of foot and mind, to take opportunities where and when they present themselves to advance the changes required. Likewise they will also have to build strong defences to secure the progress made when the conditions are adverse.

The leadership of this change cannot reside in a few individuals at the head of the pyramid. The central tenets of trauma informed approaches have to be embedded in a succession of staff at all levels as they take on new roles and rise in seniority over the next eight years. And we must recognise that the work will not finish in the next eight years. By 2030, if we achieve the ambitions of the strategy we will have the foundations of a trauma informed health and social care system. Like trees in an orchard, planting them is not the end of the task. We will need to tend and prune, pollenate and plant, harvest and

protect the orchard for future generations for that is only when the true impact of this strategy will bear fruit.

Finally, commitment to this strategy is to commit to seeing the structure, design and delivery of public health and social care services in a completely different way to the orthodox thinking of tendering and procurement processes, Best Value and New Public Management. That is not to say that all aspects of these "efficiency models" have to be thrown out. But (and it is the elephant in the room), the need to have to make an explicit move to a trauma informed health and social care system is in itself an acknowledgement that the needs of the procedural machinery of service delivery have become more important than the needs of the people that they were originally designed to serve.

4.3.2.1 Public Health approach

Only a public health approach can encompass a) the breadth of agencies that need to engage with this agenda; and b) explicitly engage in both the preventative element in tackling future disadvantage as well addressing the immediate and ongoing needs of adults who currently face multiple disadvantages and exclusions. There is a ready accountability mechanism, leadership, access to and influence over resources to make this happen in the public health structures already in place at the system level.

In the review of evidence we have seen examples of how system leadership can mesh with place-based leadership and action. This is a reciprocal form of leadership – each has their own spheres of influence and action. Without each other to learn from and lean on, our mutual aims cannot be effectively achieved. There will always be questions of resource allocation but we must be mindful that this is a process, and experience such as that in WY-FI shows the ebb and flow of resources between the regional level and the centres of activity over time. We must all recognise the assets that exist at all levels in the system. This runs right through from intangible assets such as influence, reputation and knowledge through to staff, finance and buildings right down to the assets citizens have to help them tackle the adversity and trauma which they experience.

Specifically:

- Support and grow local ATR partnerships, either newly created or built on existing "vulnerable people" multi-agency partnerships, and co-ordinate action between.
- Resource the connection between place and system by funding strategic place-based leads for ATR across the life-course. These roles would facilitate the transfer of evidence, opportunity and knowledge between place and system through ATR partnerships at both levels.
- Build the voice of lived experience as a central tenet of a trauma informed health and social care system

4.3.2.2 Collaborative working across sectors

All the evidence we have reviewed requires the collaboration of agencies in ALL sectors to prevent and mitigate the effects of trauma and adversity. The question is: "If you do not join in, does that mean you don't want to address trauma and adversity wherever you live and work?" The scale of this collaboration is genuinely bewildering to achieve a full system change, particularly in the themes of growing resilience. But we have to remember collaboration does not mean assuming control. Collaboration is about harnessing the shared energy and drive in achizeving common goals. If making change to improve the quality of everyone's lives isn't a common goal then we have nothing. Because that is what a trauma informed health and social care system does. And the evidence directs us to a range of reciprocal benefits between health and the built environment, between mental health and the economy, between park maintenance and violence, between the reduction in inequalities and happier, stronger communities.

Specifically:

- Try not to replicate structures that already exist. Instead bring them to an understanding and prosecution of this agenda. This is done "by showing, not telling". Invite learning through doing. There is scope in all multi-agency partnerships for joint projects that generate learning and for that learning to become embedded in practice, between organisations and between partnerships.
- Be inclusive. The exercise in mapping ATR services showed where the lines of least resistance are and how information flows in a short period of time. There were mixed levels of response from the non-public sector organisations. The generalist non-commissioned groups who are often on the front-line of dealing with trauma, adversity and multiple disadvantage were often absent in the survey returns. Further rounds of ATR mapping should be adapted to pick up a wider range of service providers.
- Bring the voices of lived experience to all the tables. The "voice of lived experience" is not a sector per se, but what part does co-production play in the emergent collaboration and partnerships? We need to make all levels of the system more transparent and more inclusive of the voices of lived experience.
- Pooling budgets and assets – this is a challenge but can be done where there are outcomes for both parties.
- Have confidence in your colleagues at all levels. Communicate with them, listen to them. This is an open enterprise, it requires a culture of communication within organisations and between agencies. That way colleagues will be confident to act on their own initiative with their counterparts elsewhere in the system. That confidence is part of the distributed leadership that change on this scale requires.

4.3.2.3 Across the life-course

That the transition from children's to adult services is a not so much a crack in the service user journey as a potential crevasse should not need rehearsing here. The legal, medical, judicial definitions of child and adult are at odds with our understanding of the social development of humans, they are inconsistent with each other and the literature on maturation. That they are fixed is a given and one that a trauma informed system has to work around. Over the last decade the evidence has become established statistically in the links between childhood trauma and adversity and adult experience of multiple disadvantage and exclusions.

The evidence from the ATR mapping survey and the testimonies of people with lived experience shows that although there are pathways within specific service units for transition between 16-25 years there is little formal connection between services for transition either in the same organisation or less still between organisations. The evidence for adults shows that there is only a small proportion of adults experiencing multiple disadvantage under the age of 25, the same is true of numbers in drug and alcohol services. Other evidence indicates that they were likely to be known to services as children but in the decade that followed they became "lost" to services until they hit a level of need that was significant enough for them to access adult services, by which time their needs and exclusions had become entrenched.

Response to trauma requires not only the integration of support along the life-course but also pathways of person-centred support across the services and agencies that are the anchors in communities.

Specifically:

- Further rounds of ATR service mapping are undertaken that explore the area of transitions from services and exits from service more fully.
- Services undertake routine enquiry into adverse childhood experience at the earliest appropriate opportunity in the engagement process across the life-course.
- Services develop more flexible access for people who disclose trauma and adversity, including the possibility of re-entry into services.
- Improvements in information sharing through "no wrong door" engagement and referrals from one service to another, including disclosures about ATR.

4.3.2.4 Cost implications

This approach is for everyone who has experienced trauma and adversity - that is, most people. This approach is especially to ensure the inclusion of the 1% (25,000 people) of the West Yorkshire population who experience multiple needs as adults, by identifying and preventing or addressing trauma and adversity in a much greater proportion of children and young people. This is not a zero-sum game, not even financially. Supporting some people and communities in this way will benefit everyone. It leads to a more effective (even if on the face of it a less "efficient") use of public monies and a reduction in "failure demand" for crisis services.

The connection between investment and benefit must be re-connected across the whole life-course. The system needs to become "re-integrated" financially as well as in terms of support. In a straightforward example: adults who misuse alcohol and/ or drugs to deal with trauma risk exposing their own children to ACEs due to the related impacts on parent-child interaction and relationships.

The value of the work is almost always in the way in which it was done rather than precisely what was done. A smile costs nothing, and neither does having empathy but we have designed a system which, to those most in need, the most vulnerable can be experienced as alienating to the point of being psychopathological.

The high caseloads, the tick box exercises, the arbitrary use of service thresholds, the specialisms are all justified in the name of efficiency and value for money. These efficiencies mean little when they are not connected to each other and work against each other. They mean nothing when we do things "to" people and not "with" them. The scarcity of resources leads to an understandable focus on rationing. It answers the question "who is deserving of help?" not the question "who most needs help?" Fortunately these efficiencies become redundant when we empower people to do things for themselves.

Specifically:

- Build the data to model the cost savings of trauma informed approaches across larger populations based on service usage, paying attention to the difference in services used as well as the quantity of service use over time.
- The ATR mapping shows services and their nature, it doesn't show consistent information about service capacity, staff caseloads, effectiveness or exits and outcomes. These should be considered for inclusion in further iterations of the ATR Mapping Survey.
- One of the inefficiencies identified in the ATR Mapping Survey is short term and pilot nature of funding for services that support people experiencing the consequences of adversity and trauma. We have already seen longer and more flexible funding arrangements for some services – it is essential we see a) longer and more sustainable funding agreements; and b) funding agreements operate on the same timescales for services where there is mutual dependence for joint working individuals or where there is a need for sequential support.

4.3.2.5 Training and development on ACEs and complex needs

Workforce development is central to the transformation of the system to becoming trauma informed. Initial training in ACEs, complex needs, and advocacy on behalf of service users should be delivered to all staff, followed up with ongoing development through practice development groups. These allow practitioners the space to reflect and critique their own work and that of peers, supervisors and service users. Multi-agency practice development groups have been particularly effective at developing a shared culture at a place level. Work to date in West Yorkshire and in other Fulfilling Lives projects shows that some things are apparent in effective steps towards transformation include:

- An initial system-wide training offer should be developed and rolled out across all agencies and organisations, at all levels and grades, in the ATR and Multiple Disadvantage Partnerships at the place level. This can be developed and resourced through central co-ordination. Particular attention should be paid to the participation of third sector organisations. Consideration should also be given to the inclusion of non-commissioned, peer-led and community organisations.
- Recruitment, supervision and appraisal systems will need to focus on the behaviours and competencies required in a trauma informed system.
- Organisations and agencies will need to examine and review their policies and procedures in the light of developing practice.
- Evidence and data collection should begin to focus on the impact of all the changes being made. Data sharing agreements that already exist should be assessed and if necessary new data sharing arrangements put in place. Consideration should be given to the use of common assessment tools and possibly a common data framework.
- Commissioners need to consider how contractual requirements impact, positively or otherwise

There are further recommendations on training and development for staff in the preceding section (4.2). These are important statements of culture in the system and one of the ways in which new ideas can be introduced across the health and social care workforce, at all levels of employment as incoming employees can absorb these ideas in induction and have them subsequently reinforced. In a relatively short time these will be widely accepted through the workforce. This needs to happen at place and system levels.

4.3.2.6 Learning and evaluation

Rates of disadvantage and gaps in inequalities are increasing. Rates of addiction, mental illness, homelessness and inadequate housing, and deprivation are all becoming more prevalent. The pandemic has plunged a section of people who are teetering on edge into hardship. This means that a new population will be engaging in services. As we know, prevention is better than the cure and getting access to the appropriate services as early as possible equates to better life chances. The evidence so far about the experiences of young people in the pandemic is incentive enough for us to keep analysing the data to predict future service demand. We also need to keep abreast of changes in ATR service use among adults to help predict future trends and patterns.

Specifically:

- We have already seen the value of a deep dive into specific cohorts in the population of adults experiencing multiple disadvantage (both data and case records). It is important to extend this to other services to understand the experiential impact they have for their service users, families and communities.
- Evaluation of the staff experience should be explored as a significant indicator of the change process having been embedded in practice and organisational culture.
- It is important for staff at all levels to come together in and between organisations to share their experiences and learning, building on the Knowledge Exchange event hosted by the Improving Health Team in 2021.

4.3.2.7 Resilience

Based on the evidence the following elements need to be considered in relation to the health and social care system as aspects of the risk and protective factors for resilience in the diagrams 14 and 15 below.

- Community:
  - Strengthening economic support for families
  - Promoting social norms
  - Protect against violence/adversity
- Intervention – treatment:
  - To reduce harm
  - Prevent future problems
- Individual level:
  - A strong start in life
  - Safe/stable/nurturing relationships
- Parenting skills:
  - Recognise impact ACEs had on parents when they were children
  - Parenting programmes
- Intergenerational transmission
- Focus on strengths rather than vulnerabilities

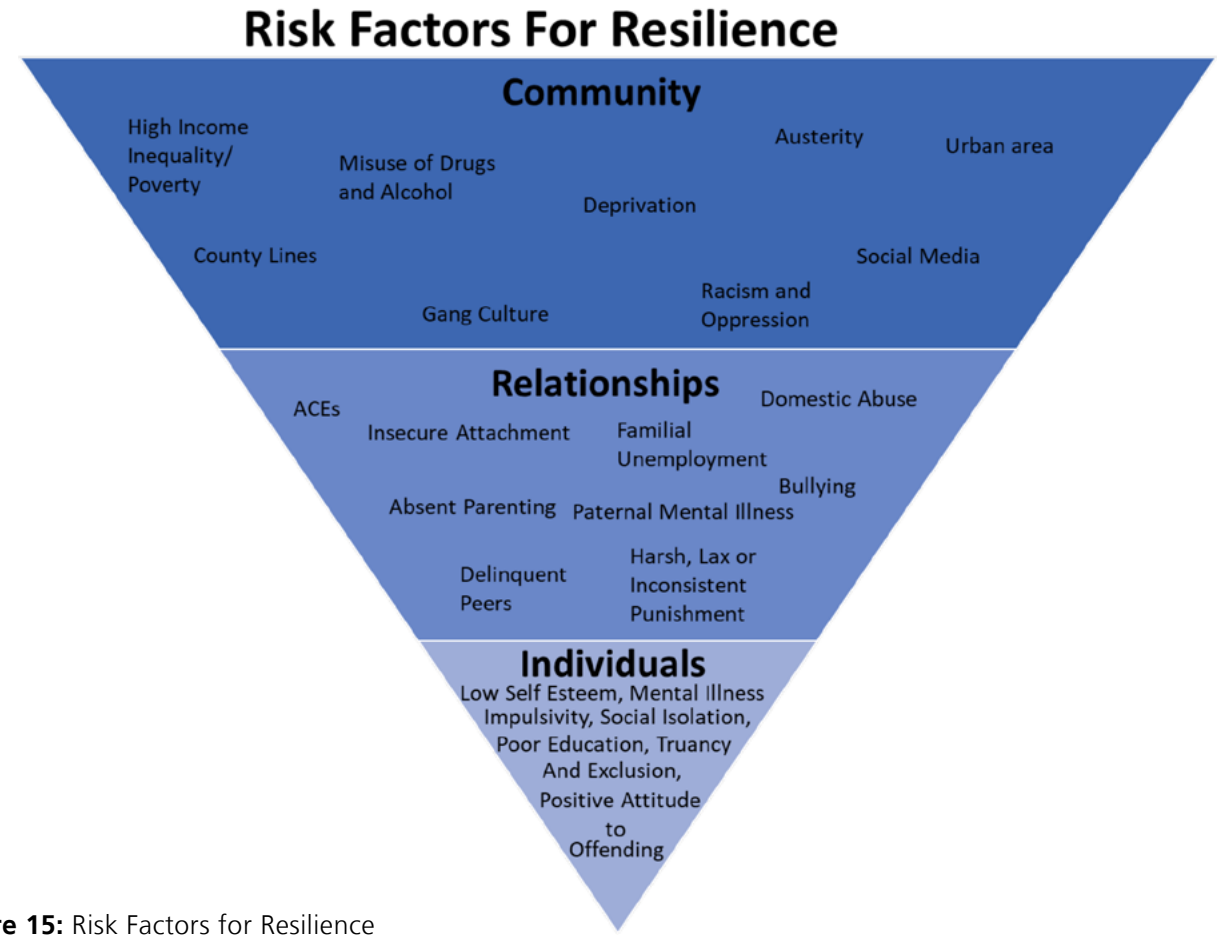


Figure 15: Risk Factors for Resilience

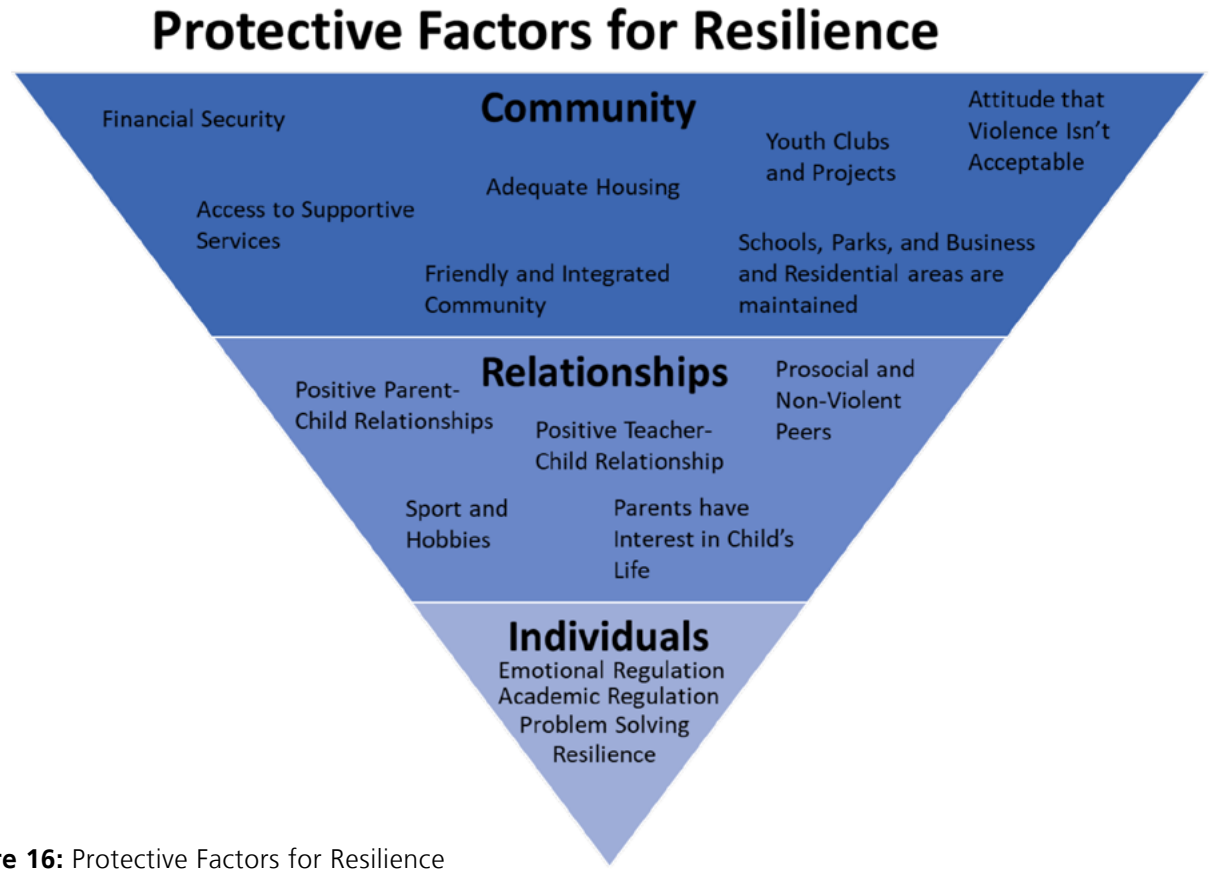


Figure 16: Protective Factors for Resilience

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