Trauma-Informed Care in a Youth Justice Setting: A Qualitative Study of Staff and Service-User Experiences

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Abstract

Background: The impact of complex trauma on justice-involved youth is increasingly acknowledged, highlighting a need for Trauma Informed Care (TIC) initiatives in youth justice (YJ) settings. However, the evidence base on TIC implementation in such settings remains limited, and there is currently no published UK research.

Aims: We sought to qualitatively explore the experiences of staff, young people, and families involved with a local YJS in the East of England which had recently implemented a TIC initiative - the Trauma Recovery Model. We aimed to identify facilitators and benefits of TIC, and any challenges or barriers to its implementation.

Method: Staff, youth, and families were recruited purposively via email and/or identified through local research collaborators and YJS case workers. Participants were interviewed remotely following a semi-structured interview guide. Interviews were transcribed and analysed using reflexive thematic analysis.

Results: We conducted 23 interviews, comprised of staff (n=19) from a range of professional backgrounds, youth (n=3), and parent (n=1) participants. Themes derived from our analyses demonstrated several benefits of TIC implementation, with relational improvements between staff and youth particularly highlighted. Clinical supervision and oversight were considered crucial to TIC success, as both a facilitator of trauma informed practice and a resource for staff who required reflexive and safe relational support. Whilst TIC implementation within the service was widely well-received, staff expressed some ambivalence about its application in justice organisations and identified several structural, systemic, and individual barriers to its long-term success.

Conclusions: Findings suggest that TIC can be implemented in UK settings serving justice-involved youth, which is promising. Results highlight some unique considerations for the delivery of TIC in YJ contexts, indicating that TIC in such settings will need to be conceptualised and operationalised slightly differently. Further rigorous and co-produced research investigating TIC across a range of YJ settings is needed.

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List of Abbreviations

ACE – Adverse Childhood Experiences

CBT – Cognitive Behavioural Therapy

CCE – Child Criminal Exploitation

CF – Compassion fatigue

CJS – Criminal Justice System

CJSs – Criminal Justice Services

CPTSD – Complex Posttraumatic Stress Disorder

CSA / CSE – Child Sexual Abuse / Child Sexual Exploitation

ECR – Enhanced Case Management

EMDR – Eye Movement Desensitization and Reprocessing

LA – Local Authority

OM – Operational Manager

PTSD –Posttraumatic stress disorder

RCT – Randomised Control Trial

STS – Secondary traumatic stress

TA – Thematic Analysis

TF – Trauma Focused

TI – Trauma Informed

TIA / TIAs – Trauma Informed Approach / Approaches

TIC – Trauma Informed Care

TRM – Trauma Recovery Model

VT – Vicarious traumatisation

YJ – Youth Justice

YJB – Youth Justice Board

YJS / YJSs – Youth Justice Service / Services

YJW – Youth Justice Worker

YOT - Youth Offending Team

YP – Young person; or Young people

List of Youth Court Disposals

- **Youth Cautions and Conditional Cautions**: Out of court disposals which are alternatives to prosecution. Typically for first time or low-level offences. The young person must admit guilt and may have to comply with the YOT regarding any conditions that are imposed.

- **Referral Order:** A community sentence of between three and 12 months. Typically for young people who appear in court for the first time and who have pleaded guilty but can be imposed in other circumstances. The young person agrees to a contract with a panel of community volunteers and the local YOT, which includes rehabilitative and restorative elements to address their behaviour. The most commonly used community sentence.

- **Youth Rehabilitation Order**: a community sentence with that can run for up to three years. Involves one more of 18 total possible requirements which the court can select from to address a young person's offending, including a curfew, conditions, or unpaid work.

- **Detention and Training Order**: The most common custodial sentence available to youth aged 12-17. Sentences can range between 4 and 24 months, with half served in custody and half under community supervision.

- **Longer term custodial sentences or Detention at Her Majesty's pleasure:** custodial sentences available to Crown Court for the most serious offences. Mandatory sentence for murder or any offence where the sentence is fixed at life imprisonment.

1. Chapter One: Introduction

1.1. Overview

This thesis aims to explore the experiences of staff, youth, and families involved in the implementation of a Trauma Informed Care (TIC) model within a local Youth Justice Service (YJS). This chapter provides background to the project, beginning with an overview of the literature on trauma as it pertains to this study, and definitions of key terms. In light of the expansive literature on the impact of trauma across the lifespan, this introduction focuses on experiences of trauma, particularly complex trauma, in childhood and adolescence, and their relationship with youth offending and delinquency. The historical and current context of Youth Justice (YJ) in the UK will be discussed, with reference to current policies and procedures. An overview of TIC definitions, principles, and core components will also be provided, including discussion of how system-wide TIC initiatives have been operationalised in child-serving settings and definitions of the constructs of secondary traumatic stress (STS), compassion fatigue (CF), and burnout. This chapter will then provide a mixed-methods systematic review of the literature examining the effectiveness of TIC in YJ settings. A narrative and meta-synthesis of peer-reviewed quantitative and qualitative research is then presented. Gaps in the current literature are identified, alongside a rationale for the current study and a brief overview of the current study context.

1.2. Introduction

A substantial and growing body of research attests to the considerable role that early trauma and abuse play in the development of later offending behaviour. High rates of trauma and PTSD amongst justice-involved children and young people have led to a growing call for youth justice services (YJSs) to adopt practices, policies, and procedures which acknowledge the impact of trauma and mitigate the risk for further traumatisation, referred to broadly as Trauma Informed Care (TIC). While the need for trauma-informed YJSs has been repeatedly highlighted, the evidence on the implementation or effectiveness of TIC in such settings remains limited. One such TIC initiative was recently implemented in a YJS in England, thus providing a novel opportunity for the perspectives of those involved in this system-wide trauma-informed approach (TIA) to be fully explored. This may serve as an important new research direction to inform wider service delivery and planning across YJSs in the UK, as well as other relevant settings serving trauma-exposed youth.

1.3. Trauma and Complex Trauma in Childhood and Adolescence

1.3.1. Introduction and Definitions

Trauma is a somewhat subjective concept, with no universally agreed definition. Considered broadly, trauma encompasses events or circumstances that are perceived and experienced as life-threatening or harmful (SAMHSA, 2014). Trauma encompasses experiences of interpersonal violence, such as rape or physical assault, as well as accidents and other non-interpersonal

traumas such as life-threatening illnesses, traumatic bereavements, or natural disasters (Frans et al., 2005). Exposure to trauma can be through directly experiencing the event; witnessing it happening to others; learning that the traumatic event occurred to a close family member or friend; or through repeated and/or extreme exposure to aversive details of it, for instance during the course of professional duties (e.g. first responders) (American Psychiatric Association, 2013). More specifically, child abuse or maltreatment is defined as, "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust or power" (World Health Organization, 2020).

As well as different trauma types (e.g. sexual, physical, or emotional abuse; neglect; domestic violence), several dimensions of maltreatment also exist, many of which may play a role in determining the depth or pervasiveness of their effects on development or functioning. These include severity and level or threat of violence; frequency and duration (i.e. a single incident, compared to repeated or chronic exposure); developmental period at which exposure occurred; and relationship with the abuser, with traumas perpetrated by those an individual relies on or trusts (also termed betrayal trauma) often demonstrating the most negative outcomes (Kerig et al., 2009). Trauma types are also known to frequently co-occur, with exposure to multiple, different types of events (also referred to as cumulative, poly-victimisation) identified as particularly harmful (Finkelhor et al., 2007; Ford et al., 2018; Pane Seifert et al., 2021).

Many of these dimensions are often conceptualised as complex trauma, which refers to types of traumatic events that occur repeatedly and cumulatively, typically over a period of time or within specific relationships and contexts (Courtois, 2004). Complex trauma is usually relational and/or interpersonal in nature, and includes experiences of attachment trauma, such as abandonment or neglect (Ford, 2017). While complex trauma often refers to events occurring early in development (e.g. childhood abuse) it has been expanded to include forms of traumatisation extending into adolescence and adulthood, such as domestic violence, gang violence, or torture (Sweeney et al., 2016).

1.3.2. Prevalence and Impact

Findings from epidemiological research have highlighted that trauma exposure is prevalent amongst young people. A large body of predominantly US research has reported that between 15-82.5% of young people report exposure to a traumatic event (Breslau, 2009; McLaughlin et al., 2013; Perkonigg et al., 2000). In a recent representative UK cohort of children and young people, 31.1% of participants reported trauma exposure, and 7.8% experienced PTSD by age 18 (Lewis et al., 2019). A substantial evidence base has also confirmed that early trauma exposure is associated with a large health burden. Findings from the seminal Adverse Childhood Experiences (ACE) studies in the US established strong links between childhood trauma and a range of later

physical and mental health problems (Anda et al., 2006; Dube et al., 2001; Edwards et al., 2003; Felitti et al., 1998). Research has consistently demonstrated a graded relationship between the number of childhood adversities experienced and a wide range of negative outcomes across multiple domains over the lifespan, including risk of early death (Anda et al., 2010; Hughes et al., 2017). Trauma-exposed young people are at an elevated risk of developing later psychopathology (including depression, PTSD, conduct disorder, or substance misuse), suicidality and self-harm, aggression, and functional impairment (Danese, 2020; Lewis et al., 2019; Van der Kolk et al., 2005; Wamser-Nanney & Vandenberg, 2013). The harmful effects of complex trauma are even further pronounced, with youth exposed to complex trauma having been found to develop broader, more severe psychopathology and poorer cognitive function compared to both trauma-unexposed and non-complex trauma exposed youth (Cloitre et al., 2013; Ensink et al., 2017; Lewis et al., 2021a, 2021b; Van der Kolk et al., 2005).

1.3.3. Trauma and Delinquency

Trauma disproportionately affects children and young people involved with the criminal justice system (CJS) (Pickens, 2016). The experience of trauma amongst justice-involved youth is widely prevalent, with an estimated 70-90% having experienced one or more types of trauma (Abram et al., 2004). Most report cumulative traumatic exposure to numerous forms of adverse experiences, including physical and sexual abuse, witnessing domestic violence, and school or community violence (Kerig, Chaplo, Bennett, & Modrowski, 2016; King et al., 2011). Compared to non-offending youth, juvenile offenders are not only more likely to have experienced a greater number of traumatic events, but are also significantly more likely to meet criteria for PTSD (Dierkhising et al., 2013). A graded positive association between frequency of maltreatment and youth violent behaviour has been demonstrated (Zingraff et al., 1993). A substantial body of longitudinal research has demonstrated that exposure to trauma predicts later youth offending (Kerig, 2019b; Trickett, Negriff, et al., 2011; Widom, 2017). Several theoretical models have been suggested as possible explanations for linking early trauma and neglect to the development of criminal and antisocial behaviour (Kerig, 2019b; Kerig & Becker, 2012; Morizot & Kazemian, 2015). A brief summary of some key psychological theoretical mechanisms is provided below.

From a developmental psychopathology perspective, childhood trauma is understood as a violation of the 'average expectable environment' necessary in supporting healthy development of a child's emotional, cognitive, social, and biological functioning (Cicchetti & Valentino, 2006). In accordance with attachment theories of child development, the 'safe base' created by a secure attachment relationship is considered fundamental to numerous developmental capacities which may protect against the development of criminal or antisocial behaviour. Disruptions to this attachment relationship through early abuse or neglect can thus significantly compromise such capacities, including perspective-taking, empathy, emotion regulation, and self-control, which may contribute

to antisociality (Cicchetti & Toth, 2005; Cicchetti & Valentino, 2006; Wenar & Kerig, 2000). Central to this developmental psychopathology perspective is that the timing or developmental stage at which trauma occurs will result in differential effects on the functioning and impairment, based on the developmental tasks or stage-salient issues relevant for that developmental period (Cicchetti & Valentino, 2006; Kerig & Becker, 2015). This overarching perspective, in acknowledging an individual holistically as an integrated system, also recognises the importance and relevance of biological processes (including genetic, neuropsychological, neurochemical, and epigenetic factors) which are affected by maltreatment and which may contribute to the development of delinquency, such as those involved in responding to stress, regulating behaviour, and managing emotions (Kerig & Becker, 2012, 2015).

Social learning theory has also been proposed as a possible rationale for the link between early trauma and delinquency, particularly the core principles of differential reinforcement and modelling (Akers, 2017). In brief, it has been suggested that children who witness or directly experience violence at home by caregivers may model this behaviour in later life, especially if violent or antisocial behaviour is perceived to result in reward (e.g. acquiescence to one's wishes, interpersonal dominance over others) (Baker & Mednick, 2012; Farrington, 1989; Kerig & Becker, 2015). This has been proposed as a theory of particular relevance for understanding the increased risk of delinquency amongst maltreated boys, in light of evidence that fathers are disproportionately more likely to be the perpetrators of family violence which may consequently be mirrored or imitated (Gelles, 1997; Kerig, 1999).

Another widely utilised theoretical mechanism linking maltreatment and delinquency is general strain theory (GST), which argues that being born into an aversive environment characterised by complex trauma would represent a significant source of strain for children and young people, to which they have few resources to adapt (Agnew, 1985). GST proposes that such experiences are likely to generate strong negative affect, which in turn may lower the individual's inhibitions and increase desires for retaliation or revenge (Agnew, 1997). In this sense, delinquent behaviour is understood to arise as a function of young people's maladaptive attempts to cope with, or escape from, maltreating and adverse environments. Furthermore, delinquency is likely to generate additional strain through negatively influencing parent-child and peer relationships or engagement with educational or occupational opportunities (Agnew, 2001).

Trauma-specific theories, which explore the particular ways in which posttraumatic reactions following trauma exposure may interfere with normative development and heighten risk for antisocial and offending behaviour, have also been suggested and investigated in the empirical literature. Trauma exposure in childhood may interfere with the normal development of fear circuitry considered essential in informing an adolescent's ability to appraise and respond to

dangerous situations, thus increasing engagement in risky, dangerous and self-destructive activities including criminal and antisocial behaviour (Pynoos et al., 2009). Adolescent delinquency in the wake of childhood trauma has also been conceptualised as a posttraumatic defence against the acknowledgement of vulnerability (Ford et al., 2006). According to this 'trauma coping model', maltreated youth may adopt a façade of rigidity, distrustfulness or callousness to mask internal vulnerability, hopelessness or fear, with engagement in risky, antisocial or criminal behaviour amongst victimised youth understood as "a desperate attempt to redress injustice and regain a sense of control" (Ford et al., 2006).

Yet, despite well-established evidence and theoretical explanations of the association between childhood trauma and youth involvement in the justice system, the specific mechanisms underpinning this relationship are not fully understood, with several having been proposed and tested in empirical research (Kerig, 2019b; Kerig & Becker, 2012, 2015). One commonly investigated mechanism is that the relationship between childhood trauma and delinquency is mediated through PTSD symptoms or specific posttraumatic reactions, with many studies identifying particular roles for symptoms such as hypervigilance to perceived threat, traumatic re-experiencing, attempts to avoid reminders of traumatic experiences, or posttraumatic risk-seeking (Chaplo et al., 2017; Ford et al., 2018; Kerig et al., 2009; Modrowski et al., 2021). Other emotional processes linked to complex trauma, such as dissociation, anger, acquired callousness, affect dysregulation, or the numbing of emotional responses, have also been frequently cited, suggesting pathways whereby offending behaviour occurs through the use of maladaptive strategies in the wake of trauma, many of which may function to enable the youth to escape from painful emotions (Chaplo et al., 2015; Ford et al., 2018; Kerig & Modrowski, 2018; Kimonis et al., 2011; Mozley et al., 2018). However, limitations of this evidence-base, such as its reliance on cross-sectional samples, hinder the ability to draw causal inferences about the mechanisms through which childhood trauma predicts delinquency. Moreover, research has demonstrated that offending behaviour predicts re-victimisation and further exposure to potentially traumatic experiences (Jennings et al., 2012; Kerig, 2019b), suggesting that the relationship between trauma and delinquency is likely to circular in nature, and not just a linear pathway.

Important gender differences have also been highlighted across the relevant literature. Justice-involved girls are more likely than their male counterparts to have directly experienced trauma, as opposed to observing family violence (Cauffman et al., 1998; Kerig & Schindler, 2013; Kerig et al., 2009), and some research has indicated that maltreatment is more strongly predictive of delinquency amongst girls than boys (Maxfield & Widom, 1996; Widom & White, 1997). One factor which may explain these noted gender differences is that, amongst trauma-exposed, justice-involved youth, girls are overwhelmingly more likely to have experienced sexual abuse (Abram et al., 2004; Cauffman et al., 1998; Kerig & Becker, 2012), a form of complex trauma that has been

repeatedly identified to have uniquely harmful effects on youth development (Fergusson et al., 2013; Fergusson et al., 2002; Trickett, Negriff, et al., 2011; Trickett, Noll, et al., 2011). Some research has suggested that sexual abuse is differentially predictive of girls delinquency, compared to other forms of trauma exposure (Kerig & Becker, 2015; Trickett, Noll, et al., 2011). Yet, girls display offending behaviours at significantly lower rates than boys, and they remain underrepresented in research on the YJ system, making it challenging for such gender differences to be elucidated in greater detail (Kerig & Modrowski, 2018). Moreover, this has led some researchers to query whether risky behaviours, more than overt criminal behaviour, may be more relevant to girls' delinquency, such as truancy and running away from home, self-harm, substance misuse, commercial sexual exploitation and sex-work, or relational aggression (Kerig, 2019b).

Another emerging area relevant to research on trauma and delinquency with important gender considerations is that of Child Criminal Exploitation (CCE) and "county lines", the widely used term to describe drug trafficking crime (Stone, 2018). While the evidence-base on county lines is very new, available literature has highlighted that county lines is a particular risk for justice-involved boys, and that youth subjected to CCE are exposed to considerable grooming and poly-victimisation, from exposure to normalised heroin and crack cocaine use, to threats of harm, captivity, and physical brutality (Coomber & Moyle, 2018; Robinson et al., 2019; Stone, 2018). Available evidence has also suggested that vulnerable and disadvantaged youth are often targeted by drug trafficking gangs, highlighting ways in which youth already exposed to trauma and adversity are placed at risk of both further victimisation and repeated contact with the YJ system (Baidawi et al., 2020; Coomber & Moyle, 2018).

1.4. The Youth Justice System in the UK

In England and Wales, a distinct justice system exists for children and young people ages 0-17 (Toogood, 2018). The YJ System places greater emphasis on prevention and diversion of offending, with custody intended to be used only as a last resort (Toogood, 2018). Organisational aims of the YJ system are to: reduce the number of children in contact with the system; reduce reoffending; and to improve the safety, wellbeing, and positive outcomes of children in the system. All services provided by the YJ system are distinct from those working with adults. Youth Courts consist of specially trained magistrates with different sentencing powers, and the sentencing framework for youth typically emphasises restoration, rehabilitation, and a higher threshold for use of custody (Toogood, 2018). Custodial estates are also separate, comprising Secure Children's Homes (SCHs), Secure Training Centres (STCs), and Young Offender Institutions (YOIs). The Youth Justice Board (YJB) is a non-departmental public body which monitors the YJ system and the provision of YJ services, and advises on national standards (Youth Justice Board, 2021). Community services are provided by youth Offending Teams (YOTs; now often referred to as YJSs), which are overseen by local authorities and the YJB (Taylor, 2016).

YOTs were established by the 1998 Crime and Disorder Act, with a view to establishing a more systematic and consistent response to youth offending and reoffending, issues which were perceived to be causing widespread problems in local communities (Taylor, 2016). In its original conception, community YJSs were developed to particularly address low-level anti-social behaviour and "nip in the bud" early signs of criminal behaviour (Taylor, 2016). In recent years, community YJSs have evolved in many parts of England and Wales, driven largely by continued dramatic reductions in the number of children entering the YJ system, and reductions in funding from local authorities and central government (Taylor, 2016). Community YJSs are multi-disciplinary services which require the cooperation of several statutory partners, namely the local authority (including children's social care and education), police, probation service, and health (Youth Justice Board, 2021).

The YJB currently promotes a "child-first, offender second" ethos, which emphasises a strengths-based, child-focused, and collaborative approach (Youth Justice Board, 2021). Work delivered by community YJSs can include traditional offence-related interventions (e.g. anger management, thinking skills), diversion interventions (such as education or work opportunities), interventions to address harmful sexual behaviour, or specific work addressing gangs and county lines involvement (Youth Justice Board, 2021). In recent years, YJSs across England and Wales have shifted away from 'risk' paradigms of understanding youth offending, following increasing critique regarding both the methodological viability of risk prediction, as well as the potential damages relating to labelling and stigmatization of young people associated with such 'risks' or 'deficits' models (Wigzell, 2021). Instead, YJSs have been increasingly informed by desistance theories, which seek to understand and explain the process through which individuals give up offending, rather than attempting to understand why individuals offend (Wigzell, 2021). This paradigm thus places more emphasis on strengths, resources, self-efficacy, and nurturing factors which support desistance from offending, such as education, employment, alternative activities, or family networks (Wigzell, 2021). Yet, despite this increasing interest in desistance thinking in YJSs, evidence suggests that there remains a lack of knowledge or understanding of desistance and how to translate it into practice and that offence-related factors, and offence-focused work (such as cognitive behavioural approaches) remain the focus of most youth disposals (Bateman, 2020; Smith & Gray, 2019).

Published figures demonstrate continuous, significant declines in rates of the number of children having contact with the YJ system each year (Taylor, 2016). The introduction of targeted prevention strategies, diversion programmes, restorative justice interventions, and changes to the way that crimes are recorded, have all been identified as contributing factors to this continued fall in numbers (Bateman, 2020). However, published reports have also highlighted serious concerns regarding the safety of the youth secure estate (Bateman, 2020) and the perennial failure of the YJ system to address the disproportionate over-representation of young people from racialized (e.g.

BAME) groups (Lammy, 2017). Furthermore, the reduction in overall numbers of children and young people coming into contact with the YJ system has also highlighted that those who remain in the system are often the most challenging to rehabilitate, with higher levels of adversity and more significant and complex needs (Bateman, 2020; Taylor, 2016). In light of this, the YJB has highlighted the need for improved coordinated, sequenced interventions to address this group, including an increasing interest in relational and trauma-informed approaches (YJB, 2017; Youth Justice Board, 2021).

1.5. Trauma-Informed Care

1.5.1. Definitions and Core Principles

Distinct from trauma-specific or trauma-focused services, which deliver evidence-based interventions for the treatment of trauma sequelae, Trauma-Informed Care (TIC) is understood as a system development model grounded in a comprehensive understanding of how trauma may affect an individual's development, and an awareness of the ways institutions may re-enact traumatic dynamics (Sweeney, Clement, Filson, & Kennedy, 2016). Trauma-informed initiatives, also known as Trauma-Informed Approaches (TIAs) are structured and delivered in ways that recognize signs and symptoms of trauma, and respond by integrating this knowledge into policies and practices to minimise re-traumatisation (Sweeney et al., 2016). Harris and Fallot (2001) emphasised that before changes to clinical services can be made, the structure and culture of the organisation must be addressed. More recently, several publications have aimed to further synthesise the core principles, values, and tenets of system-wide TIC, which are summarised in Table 1 (SAMHSA, 2014; Sweeney et al., 2018; Treisman, 2018). While models of organisational TIAs differ in how TIC is defined and operationalised, the overarching principles typically centre around increasing services' awareness and recognition of trauma and its impact, building trustworthy collaborative relationships, and improving consistency and communication between service providers, clients/service-users, and other linked sectors or agencies (Bunting et al., 2019). TIC also prioritises change to organisational procedure and the reduction of certain practices (e.g. restraint or seclusion) which may inadvertently re-traumatise or exacerbate the detrimental effects of trauma (SAMHSA, 2014; Sweeney et al., 2016; Sweeney et al., 2018).

1.5.2. Implementation and Operationalisation in Child-Serving Settings

TIAs have been implemented across a range of settings serving vulnerable, complex and/or multiply traumatised youth, including: social services and child welfare (Bunting et al., 2019), residential and out of home care (Bailey et al., 2019), family courts (Mackie et al., 2020), psychiatric inpatient (Bryson et al., 2017), outpatient mental health (Bendall et al., 2020), foster care (Kerns et al., 2016), and schools (Maynard et al., 2019). Reviews of TIC implementation across these child-serving settings have raised similar concerns regarding methodological problems within the TIC literature, including small sample sizes, the absence of experimental designs and adequate control groups, short follow-up periods, high attrition rates, and the inability

to disentangle the specific effects of TIC from broader service outcomes. Despite these limitations, several reviews have indicated preliminary support for the efficacy of TIC in improving outcomes for children and families (Bryson et al., 2017; Bunting et al., 2019). However, there remains a lack of consistency and consensus on how services should specifically operationalise and integrate TIC principles into organisational processes and culture, or which components are most essential to TIC efficacy (Hanson & Lang, 2016; Levenson, 2020). For a summary of some of the core components of TIC initiatives implemented in child-serving settings, see Table 2.

1.5.3. Vicarious Trauma, Secondary Traumatic Stress and Burnout

Many TIC initiatives have emphasised the importance of acknowledging the potential impact of working with traumatised individuals on staff. Several theoretical concepts have emerged to describe the phenomenon of traumatic responses caused by repeatedly hearing, reading, or being otherwise exposed to clients' painful and graphic experiences of trauma: Secondary Traumatic Stress (STS; Stamm, 1995); Compassion Fatigue (CF; Figley, 1995); and Vicarious Trauma (VT; McCann & Pearlman, 1990). These terms share definitions and are often used interchangeably in the literature, however there are some core conceptual differences between them. STS, defined as the natural, consequent behaviours and emotions arising from knowledge about a traumatising event (Figley, 1999), includes symptoms which are characteristic of trauma sequelae, including nightmares, intrusive imagery, and avoidance (Newell & MacNeil, 2010). CF describes an overwhelm of professionals' systems of empathy and compassion, resulting in reduced capacity for, or interest in, bearing the suffering of clients; manifested symptoms similarly parallel those of PTSD (Figley, 1995). VT focuses primarily on disruptions to professionals' schemas or beliefs about self and others as a result of engagement with clients' traumatic histories, such as associated cognitive distortions in the areas of trust, safety, dependency, power, esteem, and intimacy (McCann & Pearlman, 1990; Newell & MacNeil, 2010). While such terms differ conceptually, they do converge, and for the purposes of consistency, this thesis will use the term secondary traumatic stress (STS) to encompass all three concepts, unless individual studies specify otherwise. Burnout, while inextricably linked to STS, is conceptualised slightly differently, considered more broadly as a reaction to the demands of one's job and environment, and not specifically those working with traumatised individuals (Newell & MacNeil, 2010; Sutton et al., 2022).

Table 1 Principles of Trauma Informed Care

Harris and Fallot (2001)	SAMHSA (2014)	Sweeney (2018) [a]	Treisman (2018)
1. An organisational commitment to change 2. Universal screening to realize the prevalence and impact of trauma 3. Training and education of all staff on the signs and symptoms of trauma 4. Recruitment of people with the right attitudes, or the use of trauma champions (e.g. peer support workers) 5. Reviewing policies and procedures, and changing those which are potentially damaging, to integrate knowledge and actively avoid re-traumatisation in the service delivery setting	1. Safety 2. Trust and transparency 3. Peer Support 4. Collaboration and mutuality 5. Empowerment, voice and choice 6. An acknowledgement of cultural, historical, and gender issues *The Four R's* • **Realise** the widespread impact of trauma, stress, and adversity • **Recognise** the signs and symptoms of trauma in staff, clients, and all others in the system • **Resist** re-traumatisation • **Respond** by fully and meaningfully integrating, embedding, and infusing knowledge about trauma into policies, procedures, language, culture, practices, and settings	1. Seeing through a trauma lens 2. Appreciation of invisible trauma and intersectionality 3. Sensitive discussions about trauma 4. Pathways to trauma-specific support 5. Preventing, eliminating, and mitigating potential sources of coercion and force, accompanying triggers 6. Trustworthiness and transparency 7. Collaboration and mutuality 8. Empowerment, choice, and control 9. Safety 10. Survivor partnerships	1. Trust and multi-layered Safety 2. Relationship focused 3. Integration and connection 4. Noticing, acknowledging, magnifying, and celebrating strengths, skills, resources, hope, positive qualities, protective factors & resilience 5. Cultural humility & responsiveness 6. Agency, mastery, choice & voice 7. Communication, collaboration & transparency 8. Curiosity, reflectiveness, empathy, compassion & understanding 9. Behaviour is communication

[a] *adapted from: Elliott, 2005; Bloom, 2006; and SAMSHA, 2014*

Table 2 Common components of TIC within settings serving vulnerable youth

Workforce development	Trauma focused services	Organisational environment and practices
• Training of all staff on the impact of abuse and trauma • Measuring staff knowledge/practice • Strategies/procedures to address/reduce traumatic stress (secondary trauma) among staff • Knowledge/skills in accessing evidence-based services • Defined leadership position for trauma services	• Use of standardised trauma screening/assessment measures • Availability of evidence-based, trauma-specific practices • Trauma history always included in case/service plan	• Within agency collaboration/service coordination • Outside agency collaboration/service coordination • Positive, safe physical environment • Reducing use of restrictive/potentially re-traumatising practices (e.g. restraint, seclusion) • Written policies that include mention of trauma • Consumer engagement/input in system planning

Adapted from Bunting et al (2019) and Branson et al. (2017)

1.6. Mixed-Method Systematic Review – What is the effectiveness of system-wide TIC initiatives in the YJ system?

1.6.1. Background and Aims

Accumulating evidence suggests that young offenders with significant histories of trauma and/or PTSD may represent a particularly vulnerable group, placed at an increased risk of psychiatric comorbidity, self-harm and suicidality, violent behaviour, and recidivism (Abram et al., 2007; Ford, Charak, Modrowski, & Kerig, 2018; Kerig & Becker, 2012), highlighting a need for better identification and appropriate treatment of trauma-related difficulties. However, trauma-specific interventions represent only one aspect of effective service delivery. Not only does involvement in the CJS place youth at risk of exposure to further trauma, but it may also expose them to punitive practices and procedures which may exacerbate posttraumatic reactions (Levenson & Willis, 2019; Pickens, 2016). Several potentially invasive and coercive practices common within YJ settings, such as "stop and search" practices by police, restraint or seclusion procedures, may be experienced by youth as triggering historic traumas, resulting in emotional or behavioural reactions which may further impede rehabilitation (Ko et al., 2008). Thus, increasing focus is now also being placed on the role of organisational behaviour, with the development of trauma-informed and trauma-responsive systems.

The need for TIC In YJ settings has been repeatedly highlighted, yet trauma-informed services remain underdeveloped, with relatively little consensus on how they are best defined or operationalised (Branson, Baetz, Horwitz, & Hoagwood, 2017). Furthermore, the evidence base on the effectiveness of trauma-informed service delivery within correctional settings is very limited (Levenson & Willis, 2019). It is essential to clarify which trauma-informed practices or policies produce the most positive impact for youth, staff, and the broader organisational environment. While a narrative synthesis of definitions and core components of trauma-informed juvenile justice systems has been published (Branson et al., 2017), to our knowledge there has been no previous systematic review examining which TIC programmes have been implemented and evaluated in YJ settings.

Thus, we aimed to systematically investigate and summarise the current evidence base on the effectiveness of TIC initiatives implemented in YJ systems. This review also aimed to explore and synthesise the experiences and perspectives of those involved in the implementation of TIC models (i.e. staff, youth). Our specific research questions were as follows: 1) Do system-wide TIC initiatives improve outcomes for youth, staff, and wider YJ organisations? 2) What are the common essential ingredients of effective interventions, and what factors act as facilitators or barriers to successful implementation?

1.6.2. Methods

1.6.2.1. Design

This review adopted a mixed-method approach outlined in Pearson et al. (2015). Two parallel syntheses were conducted but methodologies and initial results were segregated prior to a final 'mixed-methods' synthesis, in line with recommended frameworks (Sandelowski et al., 2006). The rationale for conducting a mixed-methods review was twofold. First, several papers identified in a scoping review were mixed-method studies, indicating a default need for the synthesis to also be mixed. Second, a thematic synthesis of qualitative data was used to contextualise and elucidate further information from quantitative data, including generating possible reasons for the success and/or failure of TIC programmes (Pearson et al., 2015).

1.6.2.2. Search strategy

A systematic search of the TIC literature in CJS settings working with children and young people was conducted, last updated on July 26th, 2021. The search included three online databases (Embase, MEDLINE, PsycInfo), reference lists of identified papers, and relevant systematic reviews (Branson et al., 2017; Hanson & Lang, 2016; McKenna & Holtfreter, 2021). Search terms were developed using the PICO structure, then expanded using MeSH terms and subject headings in each of the three databases searched and combined using Boolean operators. Terms were as follows: ["trauma-informed" OR "trauma-responsive" OR "trauma focused" OR "trauma responsive" OR (trauma AND "staff training")] AND [Child* OR youth OR "young person" OR adolescen* OR juvenile OR (child* AND parent*)] AND [Juvenile OR correctional OR probation OR "youth justice" OR "law enforcement" OR court OR "diversion program" OR detain* OR detention* OR correction* OR prison* OR penal].

1.6.2.3. Inclusion and exclusion criteria

We identified published, English-language studies which reported on the implementation of system-wide TIC initiatives in settings working with children and young people involved in the CJS. Studies were included if they assessed staff or whole-system TIC initiatives and reported on TIC implementation in settings and/or with staff working with justice-involved children and young people (target population maximum age of 18-25), using quantitative and/or qualitative data.

Quantitative evaluations of TIC models could involve examination of outcomes at any level, including: individual (child/young person improvements; mental health outcomes); staff (training adherence; understanding and awareness; satisfaction); or system (reductions in incidents; restraint or seclusion practices). Quantitative studies must have collected quantitative data on at least one youth, staff or agency-level outcome at a minimum of two time points (i.e. pre and post-intervention) in order to generate measures of change over time. Qualitative studies had to elicit accounts from participants about their experiences, for example by interviews or focus group (studies only using observational data were excluded, as were case studies).

Studies meeting the following criteria were excluded: 1) programmes targeting adult criminal justice settings, or only the parents or caregivers of young people; 2) papers evaluating trauma-focused interventions (i.e. assessment or treatment of trauma sequelae) without an organisational component; 3) case studies or descriptive studies (i.e. describing an overview of an implemented TIC model without evaluation); or 4) did not explicitly identify the youth samples as being justice-involved (e.g. child welfare settings, foster care).

1.6.2.4. Procedure and study selection

This systematic review protocol was pre-registered in PROSPERO (CRD42021255446) and followed study extraction guidance from Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher et al., 2015). A flow chart of this selection procedure can be found in Figure 1. The initial search yielded 652 papers after removal of duplicates. Six potentially eligible papers were further identified from relevant systematic reviews and reference lists of other papers. Following title and abstract screening, 40 potentially eligible papers were identified for full-text review. Remaining full text studies were then evaluated against the inclusion and exclusion criteria, resulting in a final total of 16 studies which were included in the present review. Reasons for exclusion at full-text stage are listed in Figure 1. We included three studies (Damian et al., 2017; Damian et al., 2018; Damian et al., 2019) which used the same data set, and another two papers (Elwyn et al., 2015, 2017) which examined the same TIC initiative, but all papers reported distinct findings and thus were all included in the final review.

1.6.2.5. Data extraction

Data was extracted from included studies for the purpose of quality assessment and evidence synthesis, using a standardised template. Extracted information included: study setting, study population, participant demographics and baseline characteristics; intervention details and control conditions; study methodology; recruitment and withdrawal rates; outcomes measured and tools used; and follow-up periods. Data was extracted by a single evaluator (EF-I).

1.6.2.6. Assessments of Quality

Quality appraisals of included quantitative studies were performed using the Effective Public Health Practice Project tool (Armijo-Olivo, 2012), which allowed for assessments of quantitative studies with varying methodologies. This tool examines six core components of potential bias, including selection bias, adjustment for potential confounders, methods of data collection, and withdrawals or dropouts – see tool for further detail. Studies were given a score of weak, moderate, or strong on each of the six components, as well as an overall global quality score. Quality assessments were conducted by a single appraiser.

Each qualitative article was assessed using the Critical Appraisal Skill Programme tool (CASP Checklist, 2018). This tool does not provide an absolute score of quality but facilitates

consideration of clarity of aims, appropriateness of methods, design and recruitment procedures, suitability of data collection, researcher reflexivity, ethics, analytic rigour, and clarity of findings.

1.6.2.7. Data analysis

Quantitative studies

The use of meta-analytic techniques, while considered, was precluded for two reasons: 1) an absence of RCTs identified by the search, and 2) the heterogeneity of outcomes explored by included studies, with no outcome explored by ≥4 studies (Cuijpers et al., 2017). Instead, data was analysed using narrative synthesis (Popay et al., 2006). This procedure involved the extraction of key characteristics of the intervention(s) described within the included studies, a preliminary synthesis of findings from each study, an assessment of methodological strength, and an exploration of relationships between extracted data (Popay et al., 2006). The review compared the TIC components implemented by the included studies, described individual study outcome measures, and finally illustrated whether studies reported a positive, negative, or no effect for each given outcome (Popay et al., 2006).

Qualitative studies

All articles with qualitative data were entered into NVIVO for analysis. Following the principles of inductive reflective thematic analysis (Braun & Clarke, 2006), initial immersion in the data was sought through reading and re-reading each paper. Codes were then allocated to salient features of the data, looking for shared themes in addition to nuances or exceptions within themes. Following guidance outlined by Sandelowski et al. (2006) only study findings were coded, and raw data from study participants were not included in the final coding process, in order to avoid attempting to re-analyse data selected and presented in original articles as participant quotes. Findings were thus defined as author interpretations, discoveries, or judgements (Sandelowski et al., 2006). Consistent with principles of inductive thematic analysis, codes were derived from the data, refined and developed through discussion with research supervisors, and synthesised to develop an overarching set of themes and sub-themes which captured the experiences of participants across studies. Examples and illustrative quotes were provided to evidence this analyses.

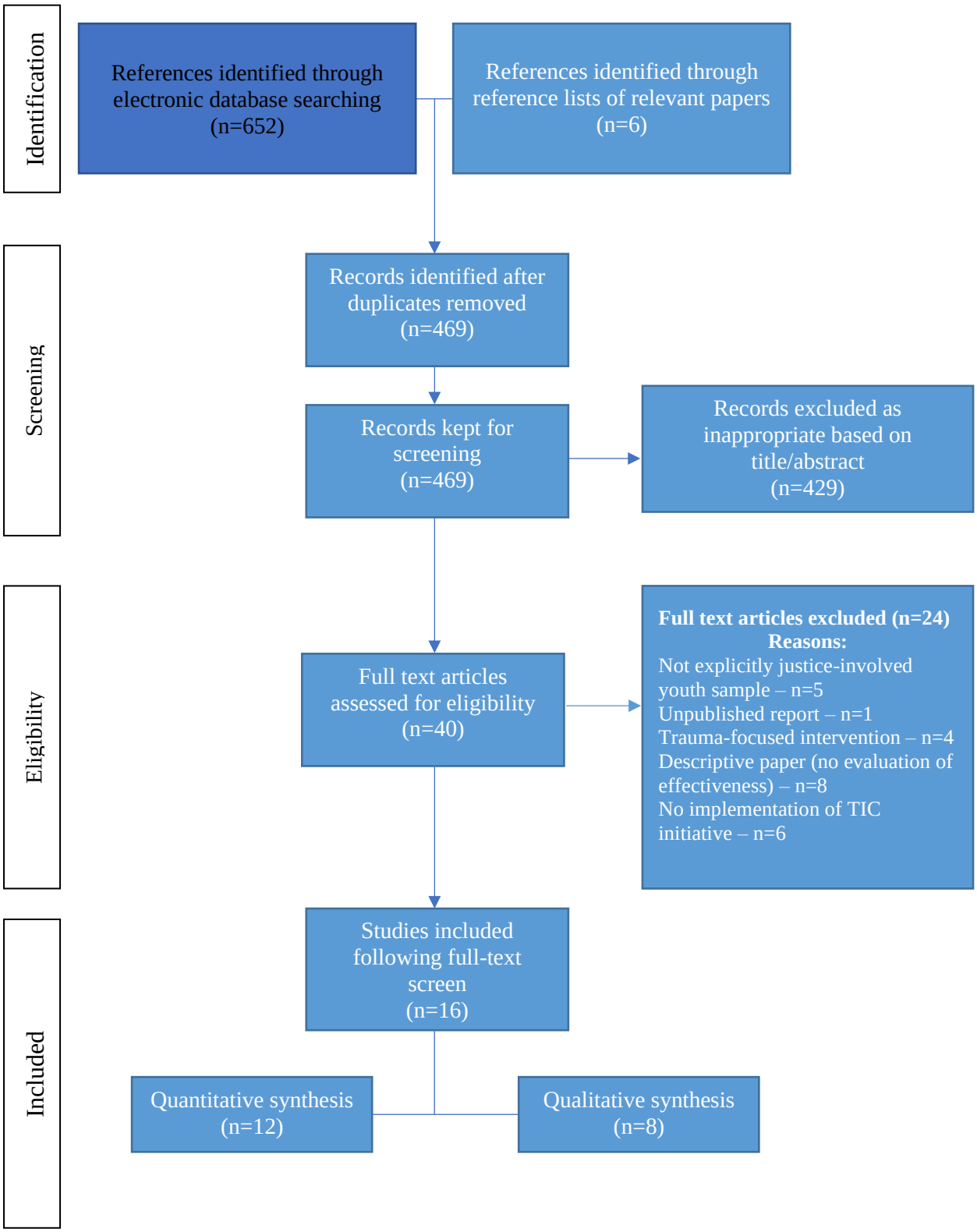


Figure 1 Flowchart of study selection

1.6.3. Results

1.6.3.1. Characteristics of Included Studies

The 16 identified studies reported on a combined sample of 4200 participants (M=2123, F=1728), comprised of 3546 youth and 654 staff members. Of these, 12 studies analysed quantitative data, and eight articles included qualitative data. Table 3 provides a summary of key features of included studies.

All included studies were conducted in high-income countries, with most conducted in the USA (n=15), and one conducted in rural Canada (Baker et al., 2018). Many (n=9) studies reported on TIC initiatives implemented in residential secure juvenile justice settings, including secure children's homes and youth offending institutions. Two studies evaluated TIC approaches implemented in court settings which served justice-involved youth (Bath et al., 2020; Ezell et al., 2018). One community study (Dierkhising & Kerig, 2018) examined the effectiveness of a university-level training program for community outreach staff working with gang-affiliated youth. Four articles (three of which reported on the same dataset) evaluated multi-agency, city-wide TIC initiatives, comprised of professionals from several youth-serving settings, including the CJS (Damian et al., 2017, 2018; Suarez, Jackson, Slavin, Michels, & McGeehan, 2014).

Of the 12 studies which included analysis of quantitative data, most (n=10) measured the effectiveness of TIC programmes using cohort (pre-post) designs. Two (Baetz et al., 2019; Olafson et al., 2018) utilised cohort analytic (two-groups) designs. One study (Marrow, Knudsen, Olafson, & Bucher, 2012) reported the results of a controlled trial, whereby TIC was compared to treatment as usual, however treatment was not randomly allocated. No RCTs were identified. Most included papers measured outcomes using self-report methods, utilising validated self-report questionnaires (n=9), and/or survey data developed for the purposes of evaluation (n=5). Five studies examined administrative data to assess behavioural outcomes following implementation of TIC, such as incidence rates of youth assaults, or staff use of seclusion and restraint practices (Bath et al., 2020; Elwyn et al., 2015; Hidalgo et al., 2016; Marrow et al., 2012; Olafson et al., 2018). Of the eight studies which included qualitative data, seven collected data using semi-structured interviews, and three studies (Baker et al., 2018; Elwyn et al., 2017; Kramer, 2016) also included the use of focus groups.

Table 3 Key characteristics of included studies

Author, Date	Study design	Intervention	Number allocated, study population	Completion rate N(%)	Study setting	Country	Main Data Collection, Analysis	Baseline demographics (where reported) Age range (years), Mean (SD)	Female n (%)	Follow-up data available
Baetz 2019	Cohort analytic	TT & STAIR	Site A n=1197 Site B n=1588 Youth	Site A: 190 (16%) Site B: 141 (9%)	Secure juvenile justice facilities	USA	Records, Binomial regression	9-18 15 (NR)	Site A: 239 (26.2) Site B: 688 (23.5)	B, T1, T2, 4yrs
Baker 2018	Mixed	RC	116 (staff)	(100)	Residential school	Canada	Quant: Self-report, t-tests Qual: Interviews, Content analysis	21-66 38 (11)	79(68)	B, EI
Bath 2020	Cohort	STAR	364 (youth)	(100)	Specialist Court	USA	Records, t-tests	16(1)	360(98)	B, T2
Damian 2017, 2019	Mixed	TIC*	90 (staff)	(98)	City-wide	USA	Quant: Survey, t-tests Qual: Interviews, Content analysis	43(13.6)	67(74.1)	B, EI
Damian, 2018	Qual	TIC*	16 (staff)	NR	City-wide	USA	Interviews, Content analysis			
Day 2015	Cohort	HTL	143 (youth)	N=70 (49)	Residential school	USA	Self-report, t-tests	NR	143 (100)	B, EI
Dierkhising 2018	Cohort	TIC*	32 (staff)	29 (90)	Community	USA	Self-report, t-tests	40.2(9.15)	15 (50)	B, EI
Elwyn 2015	Cohort	Sanctuary	30 (youth)	NR	Secure juvenile justice facility	USA	Records, t-tests	13-18 16 (NR)	30 (100)	B, EI, 2yrs
Elwyn 2017	Qual	Sanctuary	17 (staff)	45%	Secure juvenile justice facility	USA	Interviews and focus groups, Content analysis			

Author, Date	Study design	Intervention	Number allocated, study population	Completion rate N(%)	Study setting	Country	Main Data Collection, Analysis	Age range (years), Mean (SD)	Female n (%)	Follow-up data available
Ezell 2018	Qual	TIC*	15(staff)	NR	Juvenile Court (4 sites)	USA	Interviews, Thematic analysis			
Hidalgo 2016	Mixed	PATHS	297 (staff)	NR	Secure detention centres for migrant youth (4 centres)	USA	Quant: Self-report and Records, t-tests Qual: Interviews, analysis NR	NR	NR	B, T1(6mos), T2 (12 mos)
Kramer 2017	Qualitative	Sanctuary	20 (staff) 13(youth)	NR	Residential treatment centre	USA	Interviews and focus groups, Content analysis			
Marrow 2012	Controlled trial	TARGET TAU	36 38 N=82 (youth)	NR NR N=74 (90)	Secure juvenile justice facility	USA	Interviews and records, t-tests	11-19 17.4 (NR)	7 (18)	B, T1, 3m
Olafson 2018	Cohort analytic	TT & TGCTA	142 (youth)	69 (49.6%)	Secure juvenile justice facility	USA	Interviews and records, t-tests	13.6-18.4 16.6 (NR)	11(15.9)	B, EI, 9m
Suarez 2014	Cohort	PK (TIC*)	69 (youth)	28 (40)	City-wide	USA	Interviews, ANOVA	11-18 15.4(1.7)	69(100)	B, T1, 6m

TT- Think Trauma; STAIR- Skills Training in Affective and Interpersonal Regulation; TARGET- Trauma Adaptive Recovery Group Education and Therapy ; TAU- Treatment as Usual; STAR- Succeeding Through Achievement and Resilience; PK- Project Kealahou; HTL- Heart of Teaching and Learning; TIC*- Trauma-informed curriculum developed by authors; RC- Risking Connection; TGCTA- Trauma and Grief Component Therapy for Adolescents (Saltzman et al., 2016)

1.6.3.2. Quality appraisals

Quantitative studies

Summary scores and quality ratings for each of the quantitative studies included in this review are reported in Table 4. Individual ratings were given for each of the six sections included in the EPHPP tool: selection bias, study design, confounders, blinding, data collection, and withdrawals and/or dropouts. No study was rated as strong in the area of selection bias, due to all being non-randomised, having small sample sizes with no power justification, and/or recruiting participants from only one or two sites. One study, a controlled trial, was rated as moderate for study design due to the presence of a control group, despite treatment not being randomly allocated (Marrow et al., 2012). All other studies which employed cohort designs and no control group were rated as weak. All studies scored weakly on the area of confounders, as relevant confounding variables were not adjusted for in the design or statistical analysis. No study employed blinding techniques, and so all were scored weakly on this variable. Most studies (n=6) scored strongly on data collection methods as they assessed outcomes using validated self-report questionnaires or administrative data; however, a few were scored weakly or moderately due to reliance on non-validated survey data developed for the purposes of the study. Most studies were rated as strong on the factor of dropouts, except for four studies which reported attrition rates of over 40% (Day et al., 2015; Elwyn et al., 2015; Olafson et al., 2018; Suarez et al., 2014). Considering the ratings given for each sub-scores, all studies included in this review were given overall global ratings of weak.

Qualitative studies

There was noted variability in quality on the element of the Critical Appraisal Skills Programme (CASP) tool assessing rigour of data analysis, with some studies producing more descriptive or superficial analysis while others provided more in-depth interpretations of the data. Few articles explicitly examined the relationship between researcher and participants. Sample sizes were relatively small, as is characteristic of qualitative research, and samples were also largely homogenous, consisting almost entirely of staff. While this limitation is partly mitigated by combining samples and findings in meta-synthesis, several qualitative studies did not report sample ethnic, gender, or age information, limiting our ability to consider representativeness of the overall combined sample.

1.6.3.3. Characteristics of TIC interventions

Substantial heterogeneity was observed in the content and models of TIC described by studies. Some (n=9) evaluated established TIC models such as the Sanctuary model (Bloom & Sreedhar, 2008), Think Trauma (NCTSN, 2012), or TARGET (Ford & Russo, 2006), however studies rarely evaluated the same model. The most common TIC models were Sanctuary (n=3, two of which

reported on the same pilot) (Elwyn et al., 2015, 2017; Kramer, 2016) and Think Trauma (NCTSN, 2012) (n=2) (Baetz et al., 2019; Olafson et al., 2018). Other studies reported on TIC initiatives which had been developed by the researchers – see *Table 3* for details.

Staff training was the most commonly evaluated component of TIC initiatives. All 16 studies described the use of staff psychoeducation in trauma-informed principles and how trauma and its sequelae may manifest within the children and young people they worked with. The length and frequency of training varied considerably across studies, ranging from 1-3 day courses (Baker et al., 2018; Hidalgo et al., 2016; Marrow et al., 2012; Olafson et al., 2018), to trainings held weekly over a period of eight-weeks (Dierkhising & Kerig, 2018) or monthly training sessions held over a nine-month period (Damian et al., 2017, 2018). Eligibility and allocation of staff training also differed. While most residential facilities implemented mandatory, whole-system training protocols (Baetz et al., 2019; Baker et al., 2018; Day et al., 2015; Elwyn et al., 2015; Olafson et al., 2018), in other studies training was optional and based on eligibility or suitability (Damian et al., 2017, 2018; Dierkhising & Kerig, 2018; Suarez et al., 2014). The adoption of strategies to promote fidelity to training, for example through provision of refresher courses, were referenced in two papers (Day et al., 2015; Ezell et al., 2018).

Other components of TIC described by studies included: screening and referral of youth for trauma symptoms (n=2); modifications to the physical environment, such as designing trauma-informed de-escalation rooms for youth (n=4); ongoing consultation or supervision of staff by trained trauma-informed practitioners, including discussion of cases at multi-disciplinary, trauma-informed meetings or use of 'trauma champions' (n=8); and enhanced case management, whereby youth received heightened contact or care (i.e. increased frequency of contact, 24 hour crisis lines) (n=2). Six studies implemented skills-based or trauma-focused group interventions for children and youth alongside organisational TIC interventions. Table 5 provides a summary of TIC components in included studies.

Table 4 Quality appraisal scores for quantitative studies

Study	Selection bias	Study design	Confounders	Blinding	Data collection and methods	Withdrawals/dropouts	Global rating
Baetz 2019	M	W	W	W	M	M	W
Baker 2018	M	W	W	W	S	S	W
Bath 2020	M	W	W	W	M	M	W
Damian 2017	M	W	W	W	S	S	W
Damian 2018	M	W	W	W	S	S	W
Day 2015	M	W	W	W	S	W	W
Dierkhising 2018	W	W	W	W	W	S	W
Elwyn 2015	M	W	W	W	M	W	W
Hidalgo 2016	M	W	W	W	M	M	W
Marrow 2012	M	M	W	W	M	S	W
Olafson 2018	M	W	W	W	S	W	W
Suarez 2014	W	W	W	W	S	W	W

W- Weak; M- Moderate; S- Strong

Table 5 Summary of TIC components in YJS settings

	Staff training	Trauma Interventions/ Groups for Youth	Consultation and supervision	Identified staff "Trauma champions"	Enhanced contact with youth	Modification to environment/ policies	Screening and referral for trauma/ symptoms
Baetz 2019	✓	✓					
Baker 2018	✓						
Bath 2020	✓		✓		✓		✓
Damian 2017, 2018, 2019	✓						
Day 2015	✓		✓			✓	
Dierkhising 2018	✓						
Elwyn 2015, 2017	✓	✓	✓				
Ezell 2018	✓						✓
Hidalgo 2016	✓		✓	✓		✓	
Kramer 2017	✓	✓	✓				
Marrow 2012	✓	✓	✓			✓	
Olafson 2018	✓	✓	✓			✓	
Suarez 2014	✓	✓	✓		✓		
N(%) studies	12(100)	6(50)	8(67)	1(8)	2(17)	4(33)	2(17)

Table 6 Quantitative outcomes measured, summary of effects, and tools used

	Youth						*Staff*			*System*						
Study	**PTSD**	**Depress.**	**Anxiety**	**Anger**	**Self-Esteem**	**Emo/ Behav. Problems**	**TIC know.**	**TIC attit.**	**VT/CF**	**Safety (youth)**	**Safety (staff)**	**Org. culture/ climate**	**Violent incidents**	**Restraint/ seclusion**	**Reoff.**	**MH Ref**
Baetz, 2019													- AD			
Baker, 2018							+ TICBM	+ TICBM	+ ProQol							
Bath, 2020						- AD							- AD		- AD	+ AD
Damian, 2017									+ ProQol		+ SAQ	+ SAQ				
Damian, 2019							+ Survey	0 Survey								
Day, 2015	- CROPS				0 RSE					0 SNS		0 Survey				
Dierkhising, 2018							+ Survey	+ Survey	0 ProQol							
Elwyn, 2015											0 Survey		- AD	- AD		
Hidalgo, 2016											+ TABS	+ JSQ	0 AD	0 AD		0 MHCI/ AD
Marrow, 2012	0 UCLA PTSD-RI	- MFQ	0 SCARED										- AD	- AD		
Olafson, 2018	- UCLA PTSD-RI	- TSCC	0 TSCC	0 TSCC										- AD		
Suarez, 2014		- RADS	0 RCMAS			- CBCL										
N (%) studies	**3 (25)**	**3(25)**	**3(25)**	**1(8)**	**1(8)**	**2(17)**	**3(25)**	**3(25)**	**3(25)**	**1(10)**	**3(25)**	**3(25)**	**5(42)**	**4(33)**	**1(8)**	**2(17)**

+ = significant increase/positive effect; - = significant reduction/negative effect; 0 = no difference/no effect Survey – outcome measure(s) developed by evaluator(s); VT/CF- Vicarious traumatisation and compassion fatigue; AD- Administrative data; SNS- Student Needs Survey (Burns, Vance, Szadokierski, & Stockwell, 2006); CROPS – Child Report of Posttraumatic Symptoms (Greenwald & Rubin, 1999); RSE- Rosenberg Self-esteem Scale (Rosenberg, 1965); SAQ- Safety Attitudes Questionnaire (Sexton et al., 2006); ProQol – Professional Quality of Life (Stamm, 2009); TICBM- Trauma-Informed Care Belief Measure (Brown, Baker, & Wilcox, 2012); TABS- Trauma Attachment Belief Scale (Pearlman, 2003); RADS- Reynolds Adolescent Depression Scale, Second edition (Reynolds, 1986); RCMAS- Revised Children's Manifest Anxiety Scale, Second edition (Reynolds & Richmond, 2008); CBCL- Child Behaviour Checklist (Achenbach et al., 1983); MHCI- Mental Health Capacity Instrument (Feigenberg et al ., 2010); JSQ - Job Satisfaction Questionnaire (Andrews &Withey, 1976)

1.6.3.4. Evidence of effectiveness of TIC - Quantitative studies

A summary of the outcomes measured in each study is displayed in Table 6.

Youth-level outcomes

Five studies examined the effectiveness of TIC in improving outcomes for justice-involved youth (Bath et al., 2020; Day et al., 2015; Marrow et al., 2012; Olafson et al., 2018; Suarez et al., 2014).

Three studies examined whether the implementation of TIC resulted in a significant reduction in PTSD symptomology among youth, with two (Day et al., 2015; Olafson et al., 2018) reporting clinically significant reductions in PTSD symptoms post-intervention. Three studies (Marrow et al., 2012; Olafson et al., 2018; Suarez et al., 2014) also reported significant reductions in symptoms of depression following implementation of TIC. One study (Bath et al., 2020) examined youth offending behaviour as a key outcome of TIC in a specialist court and reported significant reductions in the mean number of criminal citations post-court supervision. Other youth-reported outcomes investigated by studies included anxiety, anger, and self-esteem, with no evidence of a reduction in symptoms.

Reported improvements in mental health symptoms among youth participants must also be considered in light of methodological limitations. Three of the studies which examined youth outcomes also employed group interventions targeting trauma-related psychopathology, alongside organisational changes, making it challenging to unpick the specific effects of wider-system TIC components. Furthermore, youth dropout rates were high, and no study employed blinding techniques to reduce the risk of reporting or investigator bias.

Staff-level outcomes

Staff-level outcomes were assessed by five studies (Baker et al., 2018; Damian et al., 2017; Damian et al., 2019; Dierkhising & Kerig, 2018; Hidalgo et al., 2016). These included measures of: understanding, awareness or knowledge of TIC principles (n=3), attitudes and confidence in delivering TIC (n=3), job satisfaction (n=1); feelings of safety (n=1) and empathy, compassion fatigue, or vicarious traumatisation (n=3).

There was some evidence that TIC initiatives improved outcomes for staff. Three studies reported that, following implementation of TIC training programmes, staff reported a statistically significant increase in their understanding and awareness of TIC principles, and a positive improvement in their attitudes towards trauma survivors (Baker et al., 2018; Damian et al., 2018; Dierkhising & Kerig, 2018). Three studies reported similarly significant increases in staff-reported feelings of confidence, safety, or satisfaction while at work (Baker et al., 2018; Dierkhising & Kerig, 2018; Hidalgo et al., 2016). However, in most studies, post-tests were administered immediately

following completion of training. Only one study (Hidalgo et al., 2016) investigated whether such initial improvements in staff knowledge or attitudes were meaningfully retained, which found some evidence of statistically significant improvements in staff self-reported levels of distress and job satisfaction 12-months post-implementation.

Three studies further explored the impact of TIC training on staff-reported levels of burnout, CF or VT (Baker et al., 2018; Damian et al., 2017; Dierkhising & Kerig, 2018). There was no evidence that the implementation of system-wide TIC interventions resulted in improvements in staff CF, or that levels of burnout were substantially reduced following training in TIC principles. In two studies, staff VT scores significantly increased post-implementation of TIC, suggesting that these staff outcomes worsened following TIC interventions (Baker et al., 2018; Damian et al., 2017).

System-level outcomes

Eight studies examined the impact of TIC on organisation-wide outcomes, and included both self-reported measures of organisational culture and climate (Damian et al., 2019; Day et al., 2015; Elwyn et al., 2015; Hidalgo et al., 2016) and behavioural outcomes, including incident rates of youth assaults, offending behaviour, or use of restraint and seclusion procedures (Baetz et al., 2019; Bath et al., 2020; Elwyn et al., 2015; Hidalgo et al., 2016; Marrow et al., 2012; Olafson et al., 2018). No study examined the effects of organisational TIC on staffing rates or turnover, or any other measure of staff and youth relational quality.

Although evidence of staff and/or youth perceptions of organisational improvements following TIC interventions was inconsistent, five out of six studies which examined the impact of TIC on behavioural incidents recorded on units demonstrated statistically significant reductions post-implementation (Baetz et al., 2019; Bath et al., 2020; Elwyn et al., 2015; Marrow et al., 2012; Olafson et al., 2018). However, many also included a group intervention for youth, alongside staff training and environment modification. Furthermore, administrative data used to measure organisational outcomes (e.g. violent incidents, reoffending) were often reported as counts, not rates. Taken together, this meant it was unclear whether reductions in behavioural outcomes were attributable to system-wide TIC programmes, to other trauma-specific interventions, or to temporal changes in facility census.

1.6.3.5. Meta-synthesis of qualitative studies

Three main themes are detailed below, each of which consisted of two subthemes. Overarching themes and subthemes include discussion of what is considered helpful or unhelpful; staff and client preferences; benefits; challenges and obstacles; and recommendations for future implementation.

Theme 1: The relationship as a key agent of change

Staff and youth relationships

Study findings suggested evidence of significant therapeutic relational change. Implementation of TIC was perceived to improve the nature of relationships between staff and youth, which were described as more trusting, mutually respectful, and understanding

The framework within which staff and residents relate has also changed. In the past there was no attempt to understand the reasons for behaviours, to listen, to discuss or explain the reasons for staff decisions… Now there is much more listening, discussion, and explanation (Elwyn et al., 2017).

It appeared that a key factor in such relational improvements were shifts in how youth behaviour was both perceived and described, and changes in how staff communicated both with and about young people and their difficulties. The accessibility and applicability of trauma theoretical trainings appeared to be a central facilitator of this conceptual shift.

A "huge shift" in the language used to describe youth, their behaviours, and their progress in conversations, meetings, and documentation (Baker et al., 2018).

Shifts in therapeutic relational quality also appeared to be a central factor in effecting other more 'measurable' outcomes of TIC initiatives, such as improvements in youth wellbeing.

The residents spoke of the paramount importance of having positive staff support in an empathic relationship… Making use of the formal relationships with clinical staff and the informal relationships of residential staff in community meetings help to heal the [residents'] symptoms of trauma and loss (Kramer, 2016).

In several studies in residential or secure settings, it was noted that client-facing staff particularly appreciated training in practical, applicable skills that they could use in their interactions with youth, such as skills in responding to youth distress and dysregulation. It appeared that, through equipping staff with trauma-informed strategies they could apply in their day-to-day work, staff felt more competent in responding to youth in crisis, which possibly reduced their need to rely on more restrictive practices, like restraint or seclusion.

Many staff members commented on the fact that since the PATHS training, they and others were better equipped to effectively and safely manage the children… YCWs in a Staff Secure residential facility, in particular, noted a reduction in the need to use restraints (Hidalgo et al., 2016).

Relational improvements appeared bi-directional, with many studies also reporting observed positive changes in how youth approached and engaged with professionals. Enabling opportunities

for youth empowerment and accountability, two central TIC principles, appeared particularly relevant to such improvements. For example, in settings where youth were actively involved TIC delivery and held mutually accountable for upholding its values, it was reported that they had responded well. It was noted that youth took ownership of the model, becoming more respectful in their interactions with staff and other young people, and more considerate of the potential impact of their responses and behaviour on others.

Residents have learned to represent their needs in a respectful way…and feel that they can achieve what they have requested when articulated appropriately. This was evidenced by residents speaking about their treatment goals during ISP meetings (Kramer, 2016).

Study findings also highlighted improvements in building relationships with clients' families and wider systems as a promising benefit of TIC implementation. There appeared to be increasing recognition of the importance of strengthening young people's caregiving systems, to promote positive relationships and prevent further re-traumatisation by both family and professional networks.

TIC techniques, including improved communication, were also noted to improve the relationships among group homes within the division, among departments within the larger care system, and between the families of youth in care and external service settings such as schools (Baker et al., 2018).

Staff, supervisory, and team relationships

TIC principles also became embedded into professional relationships, and a common benefit of TIC implementation across studies was that it had improved how staff and supervisors interacted with each other.

Subsequent to Sanctuary Model implementation, there has been shared responsibility, and everyone has been willing to take on other roles or tasks as necessary. For example, supervisors will cover the shifts of aides, counsellors will provide transportation, and everyone will take on tasks assigned to other staff or residents as necessary (Elwyn et al., 2017).

Key TIC processes commonly referred to were staff teams becoming more collaborative, cohesive, and supportive through improved open communication. This led to increased insight into the emotional impact of their work on staff wellbeing, which in turn engendered feelings of empathy for colleagues. Staff reported feeling more supported and understood by senior management, and that in some cases staff wellbeing was prioritised, indicating that TIC implementation had improved the quality of supervisory and managerial relationships.

Supervisors approached floor staff with the attitude that they were "doing the best they can," allowed them more independence, recognized floor staff's expertise, gave them a "voice"

during the treatment planning process, and approached supervision in a relational way . (Baker et al., 2018)

While improvements in staff to client interactions were often a primary focus of initiatives, the success of TIC also related to improvements in staff to staff, or supervisor to staff interactions, as these facilitated organisational climate shifts.

Theme 2: The role of engagement and buy-in as both a help and a hindrance

Staff involvement and engagement were perceived to be integral to the success of TIC initiatives across studies. It was clear that, for TIC models to be effective, their principles needed to be fully embedded into practice, integrated into all areas of service delivery, and consistently upheld by all members of the YJ setting.

Facilitators of buy-in

In many studies, staff training in TIC was perceived to have a positive impact on subsequent staff attitudes. Yet, there was an impression from studies that changes in practice occurred not behind a desk but 'out on the floor', and that managers and key staff-members needed to actively demonstrate and role-model TIC values in practice for them to be more widely implemented not just by staff, but also by young people.

This culture change was seen as being in line with the values and goals of the division, and also as being driven in large part by staff training and resultant changes in staff attitudes and behaviours (Baker et al., 2018)

Like staff members, the resident girls were initially resistant to implementation of the model. But authentic practice and active modelling of the Sanctuary Model principles made a difference (Elwyn et al., 2017).

Consistent with TIC principles, there was also evidence that recruiting and promoting staff who were aligned with trauma-informed values was necessary to ensure that teams remained committed to promoting these models.

Over a few years there was a coalescence of members of the staff into a team who were invested in the model and the new practices. As new hires came in, they were screened based on the Sanctuary Model (Elwyn et al., 2017).

The importance of wider applications of trauma-informed principles to settings relevant to youth was also recognised. It appeared that, for TIC to be effective, there needed to be buy-in from clients' other caregiving systems, such as families and professional networks.

A couple of participants emphasised the importance of educating clients about trauma and explained that the challenge was not solely in improving organisations' and providers' capacity to be trauma-informed, but that part of the responsibility is with the youth and families (Damian et al., 2018).

In situating families as central stakeholders in improving client outcomes, several respondents remarked on how dynamics with families often forced court personnel to recognize and engage caregivers as partners in minimizing the ongoing transmission and impact of trauma in youths' lives (Ezell et al., 2018).

Buy-in as a barrier, and the role of conflicting attitudes and beliefs

In a similar vein, a frequently cited barrier to TIC effectiveness was a lack of staff buy-in. Across studies, there was acknowledgement that some staff remained resistant to changes proposed by TIC implementation. It was evident that this reluctance to apply TIC principles, even by a few staff members, could influence the entire team and thus undermine the effectiveness or sustainability of TIC models.

[Staff] noted that it could be challenging to work on a team in which some staff have not bought into TIC (Baker et al., 2018).

Staff aversion to change was largely attributed to beliefs and priorities which were perceived to contradict the underlying principles of TIC.

Staff who do not agree with the Sanctuary model as an effective trauma-focussed protocol may be less committed to its guiding principles and to comply with utilising its strategies, and may believe that there are other confounding variables that account for change. (Kramer, 2016)

Certain assumptions or negative perceptions of TIC acted as barriers to its uptake, thus hindering the effectiveness of initiatives. This included beliefs that TIC was too "soft" or did not hold youth accountable for their actions. In several studies, there was an acknowledged conflict between staff with 'old school' beliefs around offending, and those who bought in to TIC.

Respondents remarked that their external counterparts largely dismissed trauma-informed thinking as a faddish movement which ignored what they saw as the genesis and primary source of delinquency: poor parenting and some children being inherently bad. Multiple respondents, including a probation officer (Court Site 4), perceived this mentality as reflective of a larger generational schism (Ezell et al., 2018).

TIC was often perceived as another task staff had to complete alongside already heavy workloads, or considered too abstract to apply in practice.

Participants' responses in the semi-structured interviews reinforced quantitative findings regarding the uncertainty of how to connect what was learned during the intervention to their respective workplaces and daily interactions with traumatised youth and families (Damian et al., 2019).

Staff reluctance in discussing trauma with clients were also cited as barriers to the overall effectiveness of TIC. This was possibly due to staff feeling ill-equipped or untrained, or because of anxiety and fear about the impact of this on youth.

Exploring the psychosocial histories of clients (and, by extension, families) could be viewed as an invasive, accusatory, or otherwise negative, meaning-laden act. (Ezell et al., 2018).

<u>Theme 3: Organisational processes, systemic factors, and their impact on outcomes</u>

Organisational processes: what works

The importance of a wider organisational culture shift, as both a benefit and crucial component of TIC success, was a key theme across many studies. Particularly in secure or residential settings, changes in unit atmosphere or climate were frequently noted, with environments described as safer, calmer, and less tense.

The commitment to a culture of social learning and social responsibility builds, teaches, and models cognitive, sharing, social justice, and social connection skills vis-à-vis establishing healthy attachment relationships and a healthy organisational culture. The outcomes for residents, as evidenced by their own words, are: less victim-blaming, punitive, and judgmental responses (Kramer, 2016).

One commonly identified organisational process which appeared integral to TIC longevity was a shift in organisational priorities. Shifts away from enforcement and punishment, towards cultures favouring flexibility and creativity, were features of TIC implementation which were particularly valued by staff.

Participants also observed greater organisational awareness of the need to prioritize empathy and meeting clients where they are at, as opposed to being solely focused on completing paperwork (Damian et al., 2017).

Changes in how organisations approached power dynamics and decision-making were also regularly cited as facilitating cultures of safety, trust, and democracy, consistent with TIC principles. Several noted the introduction of systems and processes which enabled more opportunities for youth voices to be heard, and for them to enact changes to rules and procedures.

Staff spoke of having a Resident Core Team or student government to facilitate giving the residents a voice, of their being "active strategists" by learning how to negotiate power in their overall treatment while in placement (Baker et al., 2018).

The complex interplay of changes in organisational culture and other TIC outcomes (such as improved communication or interactions with youth) was also highlighted. For example, shifts in organisational culture or structural changes such as amending organisational environments or policies, were identified as key factors in facilitating better interactions with youth.

The analysis revealed that the perceived strength of the PATHS program was its focus on organisational 'playfulness' and its ability to improve communications. A playful environment improved communication, which, in turn, improved the staff's ability to reduce youth's emotional dysregulation and staff stress (Hidalgo et al., 2016).

Participants described how their respective agencies adjusted the physical layout of their workplace to be more welcoming and to serve as a calm, safe space for clients. They reported that a change in the physical space facilitated more positive interactions between them and their clients. (Damian et al., 2017)

What's unhelpful

This subtheme describes structural and organisational factors which hindered the effectiveness of TIC initiatives. Across studies, one of the most referenced structural challenges to effective TIC implementation was a lack of coordination or engagement across agencies linked to YJ settings. This impacted how knowledgeable staff felt regarding resources available to youth, and how effective services were in referring traumatised youth to appropriate services.

One social services participant described that many clients are served by multiple systems, but that those systems do not engage with each other (Damian et al., 2018).

Across the board, respondents spoke to difficulty in building support and alliances related to trauma-informed practice with non-court stakeholder entities—namely, police, K-12 teachers and school administrators, and government officials (Ezell et al., 2018).

Constraints on resources were highlighted as significant contextual factors which impacted TIC effectiveness. Staffing pressures and high caseloads were repeatedly highlighted as barriers to TIC, as staff had limited capacity to engage with youth effectively and staff shortages prevented youth from accessing care. Some studies also indicated that most YJSs lacked appropriate clinical staff trained in how to recognise and manage trauma and its sequelae. Resource constraints were also perceived to impact processes through which staff could effectively model TIC principles and adequately manage associated issues such as VT or burnout.

Caseworkers/residential care workers reported that there were few options at work to deal with VT [vicarious traumatisation] and that the options that did exist were limited by the nature of the job. For example, one noted that it is hard to talk to a supervisor who has an "open door policy" when there is no staffing support for a break (Baker et al., 2018).

Socioeconomic pressures in local communities, and the influences of contextual factors and population changes such as increasing rates of poverty, drug use, and complexity of cases, were also highlighted as barriers to effective TIC in YJ settings, impeding engagement and accessibility. Limited or low-quality local community services were also cited as a challenge, particularly if the TIC initiative involved implementing a trauma screen, as it was felt that there were insufficient resources to meet the identified need.

Respondents from each site described a fragmented patchwork of mental health services in their respective rural communities, framing local mental health clinicians as largely unskilled in providing comprehensive trauma-informed assessments and/or evidence-based trauma treatment. (Ezell et al., 2018).

1.6.4. Discussion

1.6.4.1. Summary of main findings

This mixed-method systematic review investigating the implementation and effectiveness of TIC interventions in YJ systems is based on 16 studies, reporting on a combined sample of 4200 participants (M=2123, F=1728), comprised of 3546 youth and 654 staff members. While outcomes did not have sufficient data to permit a meta-analysis, narrative synthesis of quantitative data suggested mixed support for the effectiveness of TIC in YJ settings. Our meta-synthesis of qualitative data provided additional context to quantitative evidence, highlighting TIC as an interpersonal intervention that targets relationships between providers and service-users as a treatment for trauma. Available qualitative evidence suggested that TIC was effective at a relational level, with noted improvements in communication, trust, and mutual trust identified as key components of TIAs. However, several obstacles and barriers to successful TIC implementation in the YJ system were also highlighted, many of which may help explain the lack of robust evidence from quantitative studies of TIC efficacy.

Evidence from both quantitative and qualitative studies suggested that system-wide TIC interventions may be most effective in improving outcomes for staff. Results from quantitative studies indicate that TIC models might have a positive effect in increasing self-reported levels of knowledge, understanding, and confidence. Such findings, while preliminary, were bolstered by qualitative data highlighting a staff dispositional shift towards traumatised youth and delinquency, which in some cases facilitated improved communication and interactions between staff, youth, and others in the network. However, available qualitative evidence also suggests that this implementation process takes time and requires consistent engagement and commitment from

staff at all levels. Furthermore, while TIC was generally well received, resistance to its principles and aversion to change by some staff was a commonly cited challenge. It is less apparent, therefore, whether staff-reported changes in knowledge, attitudes and behaviours related to TIC can be retained over time, or whether a lack of professional buy-in may serve to undermine TIC effectiveness.

As an organisational model of service-delivery, changes and improvements at a system-level are arguably both mechanisms and outcomes of TIC (Harris & Fallot, 2001). Improvements in perceptions of organisational culture were noted across quantitative and qualitative data. Many of these organisational benefits aligned with core principles of TIC, such as improvements in feelings of safety, empowerment, and collaboration, or shifts away from restrictive or punitive organisational priorities (SAMHSA, 2014). Processes such as role-modelling, staff recruitment, and updates to system environments, policies, and procedures were highlighted as key facilitators of organisational changes. Preliminary evidence from quantitative data suggested that implementation of TIC may consequently result in improved organisational outcomes including reductions in assaults, restraint, or seclusion. However, all studies which reported such findings were set in residential secure settings, with most also employing other interventions for youth, so to what extent it was the TIC intervention itself that was causal was not possible to tease out in this review. Furthermore, methodological weaknesses (i.e. pre-post cohort designs, uncontrolled confounding) mean that the reductions in behavioural incidents assessed via administrative data cannot be causally attributed to TIC, specifically. Findings from our meta-synthesis of qualitative data indicated that relational improvements between staff and youth may act as a key change agent in effecting such institutional outcomes, highlighting that TIC may help through facilitating more trusting, respectful, and collaborative interactions, while also equipping staff with additional skills and confidence to respond to youth distress and dysregulation. However, no quantitative study identified by this review included a measure of relational quality or attachment. Taken together, such issues highlight the wider challenges of evaluating TIC programmes (Becker-Blease, 2017; Hanson & Lang, 2016). System-wide TIC initiatives are often not interventions in a classic sense, frequently involving dispositional and relational shifts in organisational cultures that are harder to quantify, raising the question of whether their evaluation using more traditional means (i.e. RCTs) is feasible, or even appropriate.

Evidence of the effectiveness of TIC on youth outcomes was perhaps the most limited across both quantitative and qualitative studies. While a few quantitative studies reported clinically significant reductions in symptoms of PTSD and depression among youth following TIC implementation, most also introduced trauma-focused group interventions for youth, which likely contributed to overall reported effects. Substantial selection bias (small sample sizes, no randomisation) and high dropout rates further limit any conclusions drawn. There was also a noticeable lack of service-user

perspectives across qualitative studies, with only one study (Kramer, 2016) including focus group data from residents, further impeding our ability to determine the impact of TIC on youth.

1.6.4.2. Implications

Weak evidence of improvements for youth following TIC implementation may be cause for concern, given that evidencing client-level outcomes are often a priority of TIC. Yet such findings also raise wider issues of what TIC, as a system-wide model, can and cannot be expected to achieve. TIC is not equivalent to trauma-focused interventions, and the most common components of TIC models identified by this review were interventions aimed at staff (e.g. training, consultation). This calls into question whether it is realistic or feasible to expect staff and organisational initiatives to reduce trauma-related symptoms or other markers of distress, in the absence of direct engagement and work with youth. Staff training alone is unlikely to be enough to create meaningful change for young people or the wider system (Purtle, 2018). Indeed, the strongest quantitative support for effectiveness of TIC came from initiatives which incorporated both system-wide changes and interventions for youth, and the empowerment and active involvement of youth were identified as achievable markers of change based on qualitative data. This reiterates the need for TIC to be a whole-system approach that involves agency and organisational adaptations, but which also ensures improved youth-level interventions, such as identification and treatment of trauma sequelae, in parallel (Branson et al., 2017). However, many justice-involved young people will not be able to engage in trauma-specific interventions, given the potential for destabilisation or environmental risk (Ford et al., 2016; Levenson & Willis, 2019). Furthermore, the evidence base for trauma-focused interventions in criminal justice settings is mixed (Baetz et al., 2021; Malik et al., 2021). Thus, service provision which focuses solely on individual- or group-based treatments for trauma sequelae, without consideration of the role of the wider system, is also likely to be inadequate in such a complex, high-risk population.

One surprising finding from our quantitative synthesis, which was minimally addressed in qualitative studies, was that staff levels of burnout and STS were not improved by TIC initiatives, and in some cases appeared to increase post-implementation. Many of the hallmarks of effective system-wide initiatives (such as universal trauma screens for youth or training in TIC principles) expose professionals working in the YJ system to trauma-related material (Kerig, 2019). Furthermore, staff TIC training may inadvertently trigger the individual trauma histories of front-line justice staff, further increasing the risk of STS reactions (Turgoose & Maddox, 2017). The development of an effective trauma-informed YJ system should include strategies to prepare and protect professionals from the potential effects of exposure to secondary trauma, as well as provision of adequate support for staff when implementing TIC programmes, such as regular supervision, reflective practice, or consultation from qualified trauma-leads (Pickens, 2016). However, the potential impact of TIC on the well-being of staff was not explored in depth by most

qualitative studies identified by this review, highlighting an important gap in the current evidence-base which warrants further attention.

Findings from this review reiterate that TIC represents a substantial cultural shift, perceived by some staff groups to contradict the primary goals of the YJ system, such as deterrence and punishment of offending behaviour, which is likely to require attention at the level of staff values and moral injury (Levenson & Willis, 2019). A central barrier to evaluating effective trauma-informed justice systems is the lack of agreement on how TIC is best defined and operationalised, and findings from this review suggest that further work is still required in developing a shared trauma-informed 'language' or 'lens' in YJ settings (Branson et al., 2017). Other system pressures common within YJ settings, such as complex caseloads, rapid staff turnover, and underfunding, were also identified as posing significant challenges to relational practices of TIC frameworks. The aims of TIC models are not the same as trauma-specific interventions, and such systemic factors must be made important considerations for future implementation planning, in order to maximise the effectiveness of TIC initiatives. For example, organisations will need to ensure that staff have their own personal and professional value systems considered and worked with. The use of a TIC fidelity scale (Fallot & Harris, 2014), now publicly available, would help to promote TIC consistency and agreement across YJSs.

1.6.4.3. Limitations

This review was limited by its inclusion of studies with substantial heterogeneity. Studies evaluated TIC across a wide range of settings (i.e. community, secure homes, city-wide), and sample characteristics also differed substantially, with studies reporting on samples of youth and/or staff from diverse sociodemographic or social/professional backgrounds. Practical definitions of TIC varied across studies, with many evaluating TIC curriculums developed in-house by evaluators. While staff training was implemented in all included studies, substantial variations in the content and length of this training were noted. Quantitative outcomes were assessed at several levels, using a variety of measurement tools. These differences made it challenging to draw comparisons between studies and precluded the use of meta-analytic techniques to synthesize quantitative data.

This review also relied on studies with significant methodological limitations. As most were naturalistic studies, none utilised randomised-control trial study design, and only one study employed the use of a control group. Qualitative synthesis was based on a relatively small number of total studies (n=8) which varied considerably in quality, with many producing more descriptive data and superficial analysis. Sample sizes across studies were generally small, and few studies controlled or adjusted for other factors which may have contributed to the effects of TIC, making it challenging to attribute improved outcomes to specific TIC intervention components, particularly in study settings where other initiatives were ongoing or implemented simultaneously during the

follow-up period. All the studies identified by this review were conducted in North America, further limiting the generalisability of this review's findings, for instance to YJ systems in other countries, including the UK.

Another limitation of included studies was the relative lack of information provided on the implementation of TIC in other relevant community YJ settings, such as police stations, probation, and YJSs. Most included studies were set in secure residential facilities such as juvenile detention centres and residential schools. While the need for TIC in secure settings is often emphasised (Branson et al., 2017), not all justice-involved children and young people will be detained. Challenges to successful TIC implementation in community justice settings are likely to differ, and other potentially important outcomes for youth (i.e. school attendance, engagement with family, drug and alcohol use, recidivism) were not explored by most included studies. Given that prevention and successful rehabilitation remain central tasks for staff in YJSs, future research is needed to ascertain whether TIC practices have an impact on youth once they are residing in the community.

In addition to limitations inherent in the papers included, there are also some limitations of the current review. Due to practicality and time constraints, only a limited number of databases were searched; it is therefore possible that some papers were missed. While our review was not restricted to certain global regions, only those published in English could be included, increasing the possibility of publication bias. Finally, screening, extraction, and quality appraisal were all conducted by a single evaluator, limiting reliability.

1.6.5. Conclusions

This mixed-methods systematic review was the first to synthesise both quantitative and qualitative research on the implementation and effectiveness of TIC in YJ settings. Available evidence indicates mixed support for their efficacy. TIC may be beneficial in improving how staff perceive and relate to justice-involved youth, with relational improvements possibly acting as key change agents in effecting wider outcomes, such as the use of coercive interventions and organisational safety. However, current evidence is weak, and further, high-quality evaluations of the implementation of TIC initiatives across a range of YJ settings must be made a clinical and research priority.

1.7. Present Empirical Study

1.7.1. Background

1.7.1.1. Trauma Recovery Model

The Trauma Recovery Model (TRM) is a trauma-informed systems intervention which aims to mitigate the impact of developmental trauma on children and young people through a series of sequential, relational stages (Skuse & Matthew, 2015). Originally designed for application in secure children's homes, the TRM draws on: theories of attachment and child development; evidence pertaining to the mental health of young people in the YJ system; and effective practice, clinical interventions, and treatment attrition (Evans et al., 2020). The model emphasises that trauma occurring early in development and/or damage to early attachment relationships between children and their caregivers can lead to both internalisation (e.g. anxiety, depression, self-harm and suicidality) and externalisation (e.g. aggression, impulsivity, offending) of difficulties (Skuse & Matthew, 2015). According to this model, young people who have experienced complex trauma can often become stuck in earlier stages of emotional development, which can hinder their ability to think abstractly, mentalise, or empathise with others and thus significantly impacts their ability to engage with or benefit from interventions such as Cognitive Behavioural Therapy (CBT) (Skuse & Matthew, 2015). The TRM thus involves gradually taking children and young people through a series of developmental stages, progressing them to the next level only once needs in each preceding level have been met. Application of this model assumes that once the developmental needs of the child are met, the presenting problems will begin to fade (Evans et al., 2020). Figure 2 depicts the stages of this model.

ANNEX B

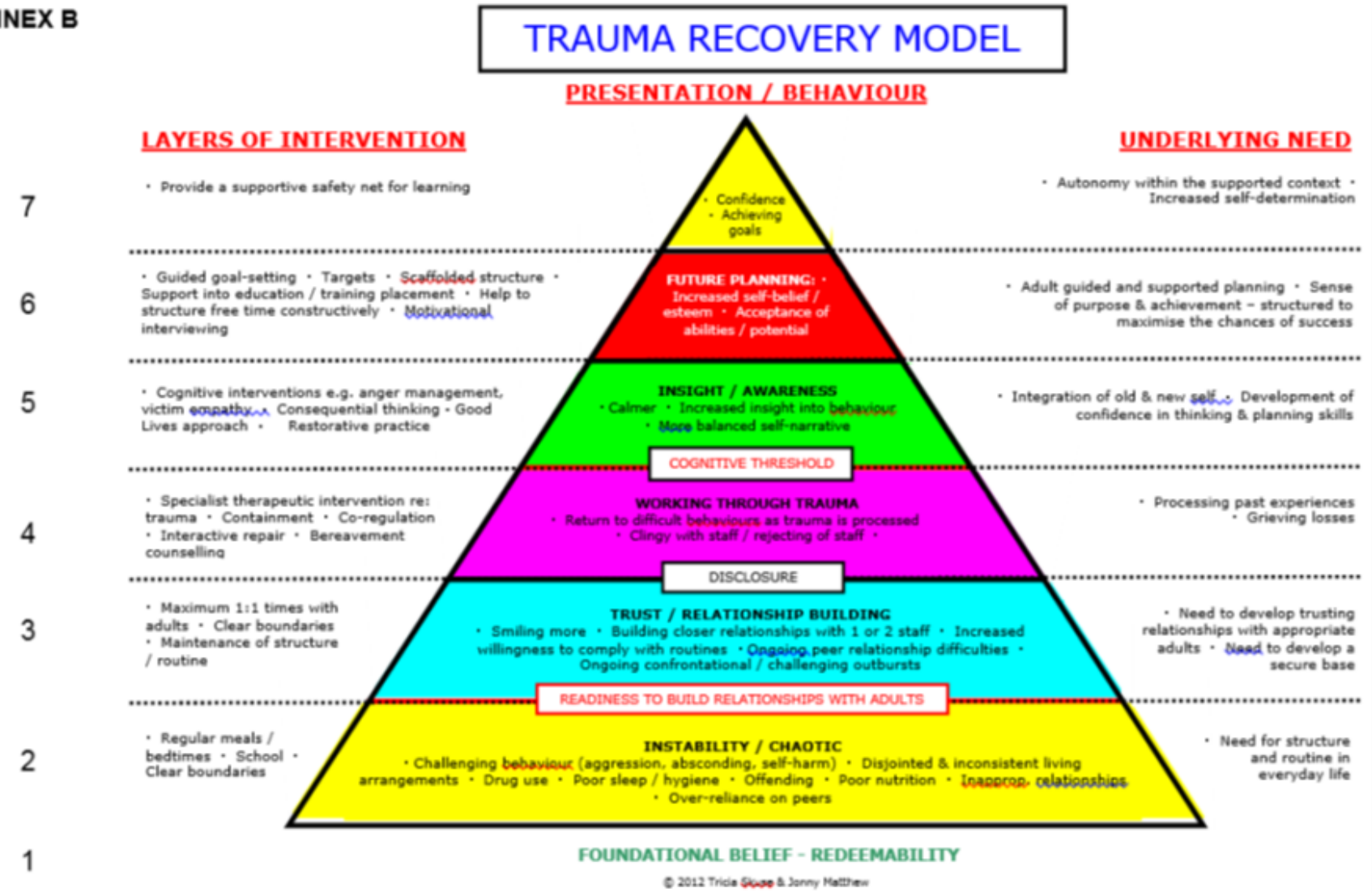


Figure 2 The Trauma Recovery Model

The initial levels of the model draw on Maslow's hierarchy of needs (Maslow, 1943) which theorizes that basic physiological and safety needs must first be met in order for psychological growth to occur. In line with this, early stages of the model emphasise providing consistency, and supporting the young person to establish structure and routine in their every-day life, such as safe accommodation, and consistent boundaries or expectations of behaviour. Once basic needs are met, the focus of the model becomes supporting young people to build trusting, constructive relationships with staff (Skuse & Matthew, 2015). Within this model, the relationship with the practitioner is viewed as the vehicle through which other changes can occur (Evans et al., 2020). The TRM posits that it is only once children feel safe and trust adults, that they can begin to engage with or disclose current and/or historical trauma, enabling staff to work sensitively to support them in processing their experiences and/or refer to specialist services for trauma-focused interventions (Cordis Bright, 2017). According to the TRM, it is only once young people have reached this stage, that they are capable of engaging in more cognitive, traditional offence-related work such as thinking skills, empathy, or restorative approaches (Skuse & Matthew, 2015). Despite evidence of pilot implementation across residential settings serving justice-involved youth, few empirical, peer-reviewed evaluations of the efficacy of the TRM have been published (Pates et al., 2018; Rivard et al., 2003; Rivard et al., 2004).

1.7.1.2. Enhanced Case Management

Developers of the TRM proposed that this model could be applied within the community YJ system. In 2013, a pilot-study was developed whereby TRM was integrated into three Youth Offending Teams (YOTs) in Wales to work with complex cases, and called Enhanced Case Management (ECM) (Cordis Bright, 2017). This pilot intervention had six key components, which are summarised in Table 7.

An unpublished report evaluating this pilot highlighted some promising benefits, including: improved engagement from young people; improved youth outcomes (e.g. life skills, reduced substance misuse); facilitation of more collaborative and integrative working with other agencies; reductions in the frequency and severity of re-offending and increases in intervals between offences; and staff-reported improved awareness, understanding, and confidence when working with children with complex needs (Cordis Bright, 2017). Following recommendations from this evaluation report, a wider trial of this approach commenced in 2017 in all seven local authorities in South Wales, and it was also endorsed for national implementation (Evans et al., 2020).

Table 7 ECR and TRM intervention components

Wales Enhanced Case Management pilot (2017)	YJS Trauma Recovery Model pilot (2019-2021)	YJS Trauma Recovery Model wider roll-out (2021-present)
1. Training for all YOT **managerial and practitioner staff, including refresher trainings** 2. **Multi-agency case formulation meetings,** led by a clinical psychologist 3. **Formulation report** written by a clinical psychologist and informed by the formulation discussion, outlining recommendations for intervention type and sequencing 4. **Clinical supervision of practitioners**. Clinical supervision was offered to all YOT staff who were managing cases under ECM, provided by a qualified clinical psychologist once every two months. 5. **Regular reviews and ongoing consultation**. These allowed for formulations to be revisited, and adjustments made taking into account a child's progress, novel information, or any challenges. 6. **Guidance and support to YOT middle and senior management** to facilitate and enable more relational ways of working and the development of trauma-informed organisational practices.	1. **Initial two-day training** for all YJS managerial and practitioner staff in trauma theory and TRM 2. **Multi-agency trauma-informed case formulation meetings**, led by an Educational Psychologist, followed up every six weeks. 3. **Skills workshops** provided to practitioners monthly by an Educational Psychologist, to develop ongoing strategies to support application of trauma informed practice, such as emotion regulation and challenging systemic dynamics 4. **Clinical supervision of practitioners** offered monthly by the supervising Educational Psychologist to explore issues relating to applying the model in practice, secondary traumatisation, compassionate fatigue, and the interaction with their own personal difficulties 5. **Monthly supervision to YJS middle and senior management** by the Educational Psychologist to facilitate support of TRM practitioners 6. **Managerial steering group** held monthly to support development and roll-out of the programme, evaluate progress, and track outcomes.	1. **Initial two-day training** for all YJS managerial and practitioner staff in trauma theory and TRM 2. **Multi-agency case formulation meetings**, led by an Educational Psychologist, which considered past issues, triggers, current issues, strengths, and any barriers to change 3. **Skills workshops** provided to practitioners monthly by an Educational Psychologist, to develop ongoing strategies to support application of trauma informed practice, such as emotion regulation and challenging systemic dynamics 4. **One-off training in reflective supervision techniques** for all managerial staff 5. **Guidance and support to YJS middle and senior management** by the supervising Educational Psychologist 6. **Managerial steering group** held quarterly for all managers involved in the pilot to support development and roll-out of the programme

Note: Table provides a summary of the core intervention components of the original ECR pilot, the current study TRM pilot from 2020-21, and the wider TRM roll-out across the YJS starting in 2021. Information adapted from Cordis Bright (2017) and Borrett (2021).

1.7.2. Current Study Context

In April 2019, a Local Authority in the East of England piloted the TRM in one YJS team, with a view to future widescale roll-out across the service. The pilot-study was funded for a two-year period, ending in early 2021. The TRM pilot involved several similar components to that of the ECM (*see Table 7*). Initial service-wide training to all YJS staff (i.e. not just those directly involved in the pilot) on complex developmental trauma, PTSD and TIC principles was provided by a qualified Clinical Psychologist, who provided on-going supervision and training for a further period of time due to staff changes. The YJS practitioners involved in the pilot then received specific TRM training by a qualified Educational Psychologist, who had been trained in the model. Other components of the TRM pilot were: trauma-informed and multi-agency case formulation meetings of eligible young people; monthly skills workshops delivered by the supervising psychologist, to help practitioners build practical competencies in applying a TIA; monthly clinical supervision of practitioners managing cases under the pilot; supervision and consultation to managerial staff by the supervising psychologist; and a steering group consisting of managers, held monthly to support professional develop and evaluate progress. Throughout the pilot period, a total of 12 young people were enrolled and worked with under the TRM (Borrett, 2021).

In March 2021, following the end of the pilot, the YJS formally adopted the TRM, and this approach was rolled-out to the remaining three teams across the YJS local area. While most aspects of TRM practice remained intact, some changes to TRM provision of clinical supervision and oversight were made as part of this wider roll-out, largely due to funding and budgetary restrictions. The teams continued to be supported by an Educational Psychologist who provided on-going formulation, consultation, and training. However, formal provision of individual clinical supervision of practitioners by a psychologist was cut from the wider roll-out of the TRM approach. Instead, line managers received an hour-long training to support them in providing emotional, pastoral care to practitioners they managed as part of managerial supervision.

1.7.3. Rationale and Justification

As indicated by the findings of our systematic review, there is currently no published empirical research examining the implementation of TIC in YJSs in England. We also found research examining the experiences of both practitioners and service-users within trauma-informed YJ settings to be minimal. This highlights a clear need for further qualitative research examining the implementation of TIAs in YJ settings, so that the psychological processes underlying the provision of TIC, and the experiences of staff and service-users, can be explored in greater depth. Results of our systematic review and synthesis of available evidence also highlighted a gap in the current literature on the potential impact of TIC on staff experiences of STS and burnout which warrants further investigation. Information from qualitative interviews can be used to provide additional insight to facilitate wider implementation of TIC in YJSs across the UK.

1.7.4. Aims and Objectives

The overarching objective of this thesis was to explore professionals' and youth experiences of a TIC initiative in a YJS. More specifically, this study aimed to:

1) Identify crucial components and facilitators of TIC implementation
2) Understand perceived benefits of employing a TIA for youth and families, staff, and the wider service
3) Identify any challenges of implementing TIC, including potential barriers to its effectiveness or wider-scale adoption in YJS settings

1.7.5. Research Questions

This study's research questions were as follows:

1) What aspects or components of TIC are considered most helpful or valuable?
2) What has the perceived impact of TIC implementation been, and how has it benefited youth, staff, and the wider service?
3) What are some of the challenges when implementing TIC in a YJS setting, and what are the obstacles to effective TIC implementation?
4) What has the impact of TIC implementation been on staff well-being, including experiences of STS?

2. Chapter Two: Methods

2.1. Study Design

The subsequent chapters of this thesis describe the findings of a qualitative study, which utilised semi-structured interviews to conduct a detailed exploration of the perspectives and experiences of staff, youth, and families involved in the implementation of a TIC initiative, the TRM, across a YJS in the East of England.

This study was undertaken alongside a local service evaluation of the original TRM pilot, which had already been commissioned and was underway prior to this study commencing. That evaluation, disseminated in August 2021 (Borrett, 2021), was conducted by an Educational Psychologist, and utilised pre-post questionnaires and survey response data from relevant stakeholders including youth on the pilot, parents, YJS practitioners, and managerial staff. The current qualitative study, which commenced mid-way through the TRM pilot, was conducted in parallel, complementing the existing evaluation by providing an in-depth investigation of the experiences of staff, youth, and families involved in both the original pilot and the wider roll-out of this TIA across the YJS.

2.2. Ethical Considerations

Ethical approval was obtained from the University of Essex ethics committee on August 12th, 2020 (ETH1920-1483) (see Appendix A). Favourable opinion was given by the Local Authority's research governance office on September 15th, 2020 (see Appendix B). Approval was also obtained from the local collaborators and team managers on site. As this study did not involve healthcare patient data, NHS ethics approval was not required. Several ethical issues were considered and planned for appropriately, as summarised below.

2.2.1. Informed consent and parental assent

During recruitment, interested individuals were contacted by the researcher, who explained the nature of the study in lay-terms and sent an information sheet and consent form (see Appendix C for the staff PIS). The PIS provided to youth and family members included simplified language and images to accommodate the varying learning needs of the population being interviewed (Appendix D). Potential participants were requested to read through the information sheet, ensuring they had time to read and process the information, and ask any questions if they wished before returning the consent form (Appendix E) and arranging an interview.

Parental assent was obtained for all young people under the age of 18, in line with the University of Essex ethics committee mandates. Parents of potentially eligible youth were first contacted by case managers, and then, with permission, contacted by the researcher by phone who explained the purpose of the project and youth participation requirements. If satisfied, parents provided written or verbal recorded assent allowing the researcher to contact their child.

Prior to the interview commencing, time was taken to explain the project, and discuss or clarify any questions participants may have. Plans for dissemination were also shared. Participants were reminded of their right to withdraw from the study at any time, without providing a reason, and that this could be done at any point until data was anonymised. Participants were also reminded that they could redirect or decline to answer any question.

All participants gave informed consent to take part. In most cases, this was obtained in writing. However, the remote nature of recruitment and data collection meant that written consent was not always possible, and some young people and families did not have the technological means to access, edit, or re-send consent forms via email. In such cases, informed consent/assent was obtained verbally, and recorded using an audio recorder, in line with recommended guidance (HRA, 2018).

2.2.2. Maintaining confidentiality and anonymity

All data collected in this study was fully anonymised and confidential. It was explained that interviews were anonymised from the point of transcription, and that original audio recordings were in the sole possession of the researcher. Original audio recordings were initially stored on an encrypted audio recorder and deleted once they had been transferred onto a password-protected computer. All data was kept confidential and used in line with the Data Protection Act (2018).

During transcription, any identifiable information, such as descriptions of locations or individuals, was removed. Participant transcripts and demographic data were identified using ID numbers, which were stored on a separate, password-protected database. All data (including consent forms) were kept electronically and saved on a password-protected computer.

Participants were informed that confidentiality would be upheld unless there was a legitimate reason for this to be breached. A plan was agreed prior to data collection, considering instances in which the researcher may be required to disclose information gathered in interviews (e.g. risk issues, concerning and/or unsafe practice) with allocated practitioners or operational managers, whereby the researcher's supervisor and local collaborator would be contacted first. At no point during data collection was the researcher required to breach confidentiality.

2.2.3. Safety and risk

This study involved conducting interviews with complex, justice-involved young people. As a result, considerations were made and planned to reduce any potential risk of harm to the researcher. A Standard Operating Procedure and risk assessment tool was developed prior to data collection to plan for any potential risks, and all local safety and security procedures were adhered to. Due to COVID-19 all interviews were ultimately conducted virtually, which drastically minimised the risk that youth participants may have posed. All telephone and video contacts with youth participants

was carefully planned and risk-managed through consultation with the young person's allocated practitioner.

2.2.4. Wellbeing of participants

Given the emotive and potentially triggering content of interviews, participants becoming distressed was considered a potential risk. A protocol was developed for potential instances in which participants became upset, which included: signposting staff to relevant support services, which were also listed on the PIS, and the offer of debriefing to participants after the interview to reflect and provide feedback on the interview process. Sensitive interviewing techniques were also employed, including therapeutic interactions of empathy and validation, compassionate language, and humour (where appropriate), which enabled the development of rapport between interviewer and participant.

As a local service evaluation was already ongoing at the time of the current study, it was also imperative that the researcher ensure that the topics explored as part of data collection were not replicating areas covered by the local YJS survey, in order to avoid unnecessary duplication and respondent burden through repetition. The interview schedule was therefore developed in consultation with local stakeholders. Efforts were also made to clarify with all potential participants the differences between these two projects, and the rationale and scope of the current study, at both recruitment and interview stage, to avoid confusion and potential disruption to the pre-existing evaluation.

2.2.5. Issues of power, transparency, and outsider status

There were several requirements made by the host site which the researcher, as an invited external guest, was requested to adhere to. Most notably, as part of the approval process the researcher was instructed that there could not be any direct references made to youth and families about the TRM, TIC, or the role and impact of trauma histories. Most youth had not been made aware that they had been enrolled in a TRM pilot, and the adoption of the TRM across the YJS had similarly not been made explicit to most young people or families. Stakeholders expressed concern about the potential for distress or confusion should this be mentioned as part of study recruitment or data collection, and the researcher was thus prevented from explaining to youth and family participants the specific nature or aims of this thesis at both recruitment and interview stage. Instead, the researcher was permitted to ask for general feedback on their recent experiences of the YJS.

Adhering to these requirements meant that the researcher held a significant position of epistemological power over youth and family participants. This was suggestive of conducting research *to*, *for*, or *about* participants, as opposed to *with* them. It thus also prevented the researcher from engaging in any meaningful patient and public involvement (PPI) or co-production as part of this study, something increasingly recognised as best practice in psychological research

(National Involvement Partnership, 2015; Waddingham, 2021). Such considerations were discussed in detail with research supervisors, and weighed against both a) the potential for harm, distress, and intrusion caused by the researcher sharing with participants information they were unaware of, or discussing trauma with someone they did not know or trust, and b) the ethical concerns associated with choosing *not* to conduct this research or include youth and families at all. On balance, it was decided that asking youth and families for their general feedback on the service they had received remained a justifiable research goal which could benefit young people involved in the YJS in the future. Ongoing reflexivity for the researcher was crucial within this process. It was hoped that by promoting self-examination in the various stages of research (e.g. reflective diary, supervision), ethical risks were reduced and benefits were increased from the study conducted.

2.3. Participants

Participants were purposively sampled from one local YJS. The study aimed to recruit participants from two groups: YJS staff and youth (including families).

2.3.1. Inclusion and Exclusion Criteria

Staff were eligible to take part in the study if they were employed to work in the Local Authority's YJS and had some experience of working under the TRM (either currently or previously). Staff from all disciplines and experience-levels were included, and proactive attempts were made to ensure the sample had representation from both practitioners directly working with young people and managerial staff (including the psychologist responsible for overseeing the project). This thesis explored the perspectives of both professionals involved in the original TRM pilot study, and staff from teams involved in the wider TRM roll-out. Initially, staff members directly involved in the TRM pilot were prioritised; as data collection continued beyond the pilot timeframe, the decision was made to recruit staff who were working under the TRM approach as part of the wider service roll-out, beginning in March 2021.

Youth and family participants were eligible if they had been case managed by the YJS at the time of TRM implementation. Young people under any court disposal (i.e. statutory, diversion) were considered eligible. Initially, young people who had been formally enrolled in the original TRM pilot (n=12) were prioritised. However, most of those on the original pilot were either not put forward by practitioners or were determined not to meet criteria and therefore excluded (see criteria below, or Figure 3). In light of these recruitment challenges, the decision was made to expand eligibility to include any young people who case managers identified as having been worked with according to TRM principles since the service's wider implementation of this approach in March 2021.

Youth participants were excluded if they: were considered too high-risk or otherwise unsuitable to participate (e.g. due to perceived risk or environmental instability), as determined in the first instance by the young person's caseworker, and then subsequently by the researcher or research

supervisors; were residing in the secure estate; were over the age of 18 (and had thus been transferred to adult probation); or if parental assent/informed consent could not be obtained. Relatively few young people were recommended by staff as potentially suitable. While reasons for this could not be determined, it may have been due to workplace pressure and additional demands (e.g. additional time, high workloads) or may suggest that practitioners were protective of their clients.

In light of the complex presentations of young people involved in the study, it was anticipated that a substantial proportion of eligible youth might decline to participate, or otherwise struggle to engage with the interview process. Thus, the researcher also attempted to interview parents or primary caregivers, to explore their experiences of working with the YJS and any impact they had observed on their child or family. Parents/caregivers were eligible to take part if they had a child who case managers had identified as potentially suitable, as per criteria stated above.

2.3.2. Sample

Figure 3 describes the recruitment and sampling process. Of the 18 staff members originally identified by research collaborators as having been involved with the TRM pilot, 12 took part in an interview. An additional seven professionals were subsequently recruited and interviewed from the wider teams where TRM was rolled out commencing in March 2021, resulting in a staff participant total of 19.

Nine young people were identified by YJS practitioners as potentially suitable to be approached by the researcher over the recruitment period. Two were determined to not be eligible to take part, and two declined to be contacted. One parent could not be reached after several attempts and thus the young person was excluded on the grounds that parental assent could not be obtained. In total, three young people and one parent took part in the study, resulting in a final participant total of N=23, comprised of staff (n=19), youth (n=3) and parents (n=1).

2.4. Procedures

2.4.1. Recruitment

All participants were recruited purposively by email and by referral by local research contacts within the team (HD, EB, JC, and KB) or YJS staff. Potentially eligible staff participants were first identified by local collaborators who provided contact information (i.e. email addresses) and in many cases made first contact with staff to introduce the study and the external researcher to team members. Potentially eligible youth and family participants were identified by YJS case managers, who facilitated introductions with the researcher. All recruitment and data collection procedures were conducted remotely between October 6th, 2020, and November 24th, 2021.

2.4.1.1. YJS Practitioners and Managers

Initially, the names of staff members involved in the original TRM pilot (n=18) were provided to the researcher by local collaborators and purposively recruited by the researcher. As recruitment progressed, and eligibility expanded to include staff from teams involved in the wider roll-out of the TRM, introductions were facilitated between the researcher and the managers of these teams, alerting them to the research study and inviting them and their staff teams to participate.

All potentially eligible staff were emailed to ascertain interest and request participation in the study, instructing potential participants to contact the researcher if willing. In many cases, staff were also approached directly by research contacts. The researcher was also invited to attend the beginning of TRM skills workshops (held virtually over Microsoft Teams) to introduce herself and make research appeals to staff members. Emails were also sent to operational and team managers, requesting them to promote awareness of the research study and identify any suitable practitioners. Follow-up emails were then sent by the primary researcher sporadically throughout the recruitment timeframe, explaining the nature of the study, and providing staff with the PIS. Staff members were asked to provide written informed consent via a consent form which was emailed to all potential participants. All consenting staff participants were entered into a "prize draw" to incentivize participation and bolster recruitment numbers, consistent with increasingly recommended practice (Head, 2009).

2.4.1.2. Youth and families

All potentially eligible young people and/or family members were identified by local research collaborators and YJS practitioners. Practitioners and managers were asked to identify young people and/or families they were currently or had previously worked with under a TRM approach, who may be willing to take part in an interview. Case workers were then asked to contact young people and families directly to briefly explain the study, assess interest and suitability (including any potential risk issues), and get permission for their contact details to be shared with the researcher.

Once young people and/or parents had confirmed their interest to their practitioner, the researcher then first contacted the parent or caregiver by phone or text message, to explain the purposes of the study and obtain informed parental consent to contact the young person and/or for a family member interview, if applicable. In most cases, all subsequent contacts between the researcher and young people were facilitated by their case workers. For example, the researcher was invited to virtually "join" a practitioner's session with a young person, or the case worker would facilitate a phone or video call between the young person and the researcher to make initial introductions, ensuring the young person felt comfortable before leaving to ensure privacy during interviews.

The rationale for using staff members as the gatekeepers to youth and family participants was threefold: 1) to improve accessibility and reduce participant burden (i.e. by requesting their

attendance at additional appointments); 2) to reduce and manage any potential risks posed to the researcher; and 3) to enhance and facilitate engagement with youth participants, through liaising with a professional they have an established relationship with. Such an approach was considered congruent with trauma-informed principles, which recognise the importance of relationships in helping to create a sense of safety for young people involved in the study.

In line with accepted practice (Head, 2009), all youth and family participants were compensated for their involvement in the research study and given a £10 Amazon gift voucher for their time. Youth participants under a court order were also able to count their contact with the researcher as a statutory contact. It was made explicit to all youth participants that there were no negative consequences if they chose not to participate in the study.

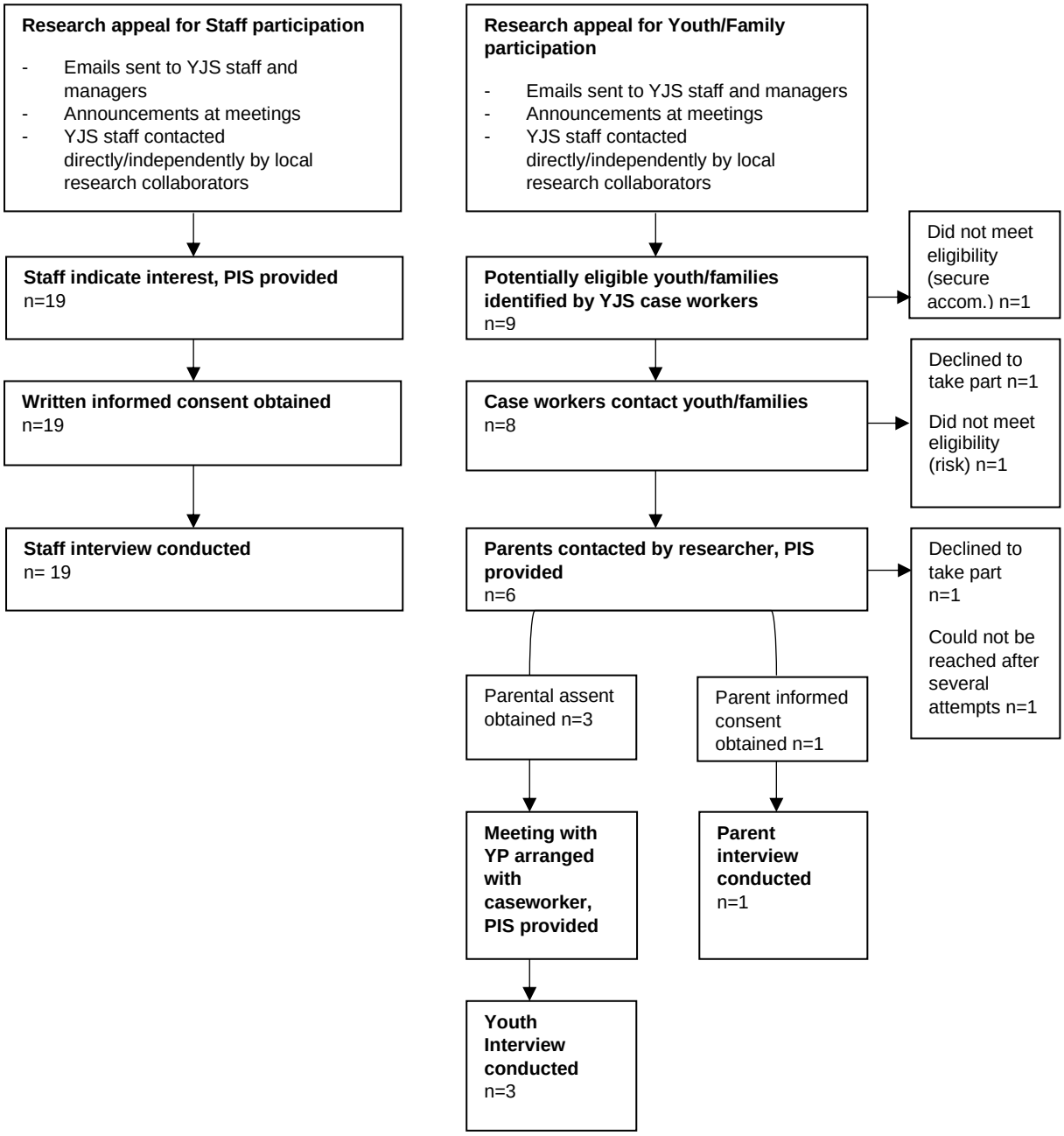


Figure 3 Flowchart of recruitment of study participants

2.4.2. Data collection

All consenting participants were invited to take part in a semi-structured qualitative interview with the researcher. Interviews took place between 8 October 2020 and 24 November 2021, and were conducted via videoconferencing software (i.e. Microsoft Teams, Zoom) due to COVID-19 restrictions. All interviews were recorded using a PIN-protected audio-recording device and later transcribed.

2.4.2.1. Demographic information

Self-report information on the following demographic variables was obtained: age; gender; ethnicity; professional qualification, title, and years working in YJS (for staff); court disposal (for youth). Staff demographic information was gathered using a brief questionnaire developed for the purpose of the study (see Appendix F).

2.4.2.2. Semi-structured interviews

Topic guides and semi-structured interview schedules were developed and reviewed prior to data collection. Interview schedules were informed by consultations with researcher supervisors and key stakeholders, such as the operational lead for the project and the Educational Psychologist leading the service evaluation. All interviews began with a rapport-building process before going on to probe more deeply into the topics. The interview style involved prompts and probes carried out through careful reflective practice techniques.

Staff were first asked to describe their role within the service, their familiarity with the TRM, and how they had used the TRM within their work. Interviews then explored their experiences of the TRM pilot (including how this differed from "typical" practice), which components of the TIC approach felt most useful or crucial, as well inviting them to reflect on the benefits and challenges of implementing TIC in the YJS. Staff were also asked about the personal impact of implementing TIC, such as whether it had affected their well-being, increased awareness of their own trauma histories, or had any effect on feelings of burnout or STS. Staff interviews lasted between 40 and 70 minutes, with most taking between 50 and 60 minutes.

As many young people and families were not aware of the TRM pilot (Borrett, 2021), the researcher was required to ask more generally for their feedback on their recent experiences of the YJS, their interactions with their case managers, and any perceived differences they had noticed or previous involvements with YJS. Youth and families were then asked to reflect on ways in which the YJS had helped them (if at all), any challenges they experienced, and any recommendations or suggestions for how care could be improved or changed. Youth/parent interviews lasted between 15 and 45 minutes. The interview schedules for youth, family, and staff interviews can be found in Appendix G.

2.5. Data Analysis

2.5.1. Epistemological position

The present study adopted a critical realist epistemological position (Willig, 1999). This position allowed for the material experiences, meanings, and realities of participants to remain a focus of analysis, while also acknowledging the meaning individuals make of their experiences, and the ways in which broader social contexts may influence meaning-making (Braun & Clarke, 2006).

2.5.2. Analytical approach

The present study employed a reflexive thematic analysis (TA) approach (Braun & Clarke, 2021b). According to Braun & Clarke (2021) this approach embraces core qualitative research values and the subjective skills the researcher brings to the process. Thus, a research team is not required to ensure coding "reliability" or "objectivity," and analysis is instead situated within an interpretative reflexive process which acknowledges the active role and subjective experience of the researcher (Braun & Clarke, 2021b). Themes were actively generated by the researcher, and treated as the "outcome" of data coding, consistent with recommendations for this qualitative approach (Braun & Clarke, 2021b). The rationale for using thematic analysis was twofold. First, the study involved a relatively large and heterogenous participant sample. Reflexive TA is a recommended method when capturing diversity in participant perspectives, as it focuses on identifying themes across the data set, rather than also the unique features of individual cases (Braun & Clarke, 2021a). Second, reflexive TA is not tied to a particular theoretical framework and can be employed from a range of epistemological positions, including essentialist and constructionist paradigms. This permitted the researcher to apply a broader and more flexible analytic and epistemological approach, which embraced reflexivity, subjectivity and creativity as assets in knowledge production, and allowed for patterned meaning across sub-groups of participants (i.e. staff, youth and caregivers) to be better illustrated (Byrne, 2022).

2.5.3. Consideration of other approaches

Other analytical methods were considered. Interpretive Phenomenological Analysis (IPA), which aims to provide detailed examinations of personal lived experience and sense-making, was ruled out because of the differences between staff and youth participants in both their lived experience and also their awareness of TIC implementation (Willig, 2013). It was felt that these differences in the extent to which TIC was made explicit to participants undermined the approach's aims of understanding how meaning is created through making the underlying assumptions of participants' experiences explicit (Willig, 2013). Furthermore, the rich detail of participants' lived experience gathered as part of this approach was determined to not align with the preliminary nature of the present study, and its primary aims of connecting staff and youth experiences to inform future organisational practice. Grounded theory (GT) was also considered, given that it is

seen as particularly valuable in fields of research where little is known about the investigated phenomena, and could have been helpful in generating a theoretical understanding of practitioners' experiences of TIC or how TIC effects change in a YJS setting (Clarke, 2003). While this may still be a valuable consideration for future research, it was felt that the primary aim of this thesis (i.e. to understand the experiences of TIC implementation and its feasibility in a YJS) did not lend itself to the development of a proposed theory, and instead initially required a broader analytical approach.

2.5.4. Phases of analysis

Analyses followed the seven phases outlined in the reflexive TA approach (Braun & Clarke, 2006). The initial few steps of analysis focused on the transcribing, reading and familiarisation of the qualitative data. Interviews were transcribed by the primary investigator. The researcher then familiarised themselves with the data, through the process of carefully reading and re-reading transcripts, and taking notes on noticeable aspects.

Once the researcher was familiar with the data, codes were identified within each transcript, supported by a computer software package (NVivo 12). Codes were conceptualised as analytic units or tools, capturing single semantic observations or insights about participants' perceptions (Braun & Clarke, 2006, 2021b). In line with recommendations for reflexive TA, coding of interviews was done without the use of coding framework developed prior to analysis. Instead, mind-maps were used to capture salient features in the data, and these were reviewed to develop a coding frame applied to each transcript.

Codes were then collated by the researcher to develop initial themes, defined as "patterns of shared meaning, united by a central concept or idea" (Braun & Clarke, 2013, 2014). Themes and sub-themes were then reviewed and tested, often through consultation with research supervisors, and a thematic map of the analysis was generated. Each theme was then given a clear definition and name. Finally, relationships between themes were further illustrated to reveal complex, multi-dimensional facets of a particular meaning or experience.

2.6. Reflexivity Statement

In Braun and Clarke's (2021) recent paper, it was emphasised that good thematic analysis should include a description of the epistemological and theoretical stance adopted by the researcher, and demonstrate personal reflexivity in how the researcher's personal experience and assumptions may have interacted with analysis and interpretation. In light of this, a reflexive diary was kept during the research process, and a statement summarising my position has been included here. This statement considers my prior assumptions and experience, an awareness of the position between the researcher and the researched, the role of the researcher in knowledge production, as well as an awareness of the wider social and political context within which this research was conducted (Braun & Clarke, 2019).

There are several areas of difference between me and my sample, and in many of these I possess significant privilege. I am a white, middle-class, and able-bodied woman. I have a post-graduate education and possess both MSc and PhD degree qualifications. I do not have direct lived experience of trauma or the criminal justice system. I also speak with a North American (Canadian) accent, which likely had the effect of positioning me as a foreigner or outsider relative to my all-British participant sample. These implicit and explicit areas of difference may collectively influence both how my sample experienced me, and how I approached and interpreted this research.

My interest in this research area stems from personal and professional experiences. My mother (who has given me permission to share her story) is a CSA survivor. Through my mother I have developed a deep understanding of the systemic and relational impact of trauma and seen first-hand the ways in which services can fail to sufficiently support or consider the needs of survivors. This personal experience undoubtedly underpins my beliefs around the injustice and harm caused by early developmental trauma, the resilience of survivors, and the need for more trauma-responsive systems. This also fuelled a growing professional interest in the nuances of victim-perpetrator dichotomies and the complex intersection between trauma and justice systems. In 2019 I completed a Psychology PhD examining the impact of trauma and PTSD on the male imprisoned population, which aimed to provide some of the first quantitative evidence-base towards the development and implementation of TIC practices in prisons across the UK. My professional and academic experience of working in a prison with traumatised individuals has shaped my position in relation to the conception of the study, research aims, and the interpretations made. From this position I held the assumption that trauma-informed justice systems were necessary and important, and that working in a trauma-informed way would yield significant benefits for the individuals served within such settings. However, I was also of the view that too often the development and implementation of TIC at staff and system-level was relatively superficial, and that criminal justice contexts were often trauma-inducing and challenging environments.

I also considered my position in relation to the values underpinning TIC, and to what extent aspects of the research project aligned with these. At its core, TIC represents a move towards collaborative relationships based on trust, collaboration, respect, and hope, emphasising the importance of accountability, transparency, and empowerment. There were acknowledged power imbalances in the relationship between myself (the researcher) and the researched, such as how and where the interview was conducted, differences in knowledge and awareness of TIC, or how I may be viewed by participants (e.g. as an external evaluator), and how these imbalances may have impacted the data collected. Most interviews took place within participant's homes (via videoconferencing software) with minimal opportunities for a trusting relationship to have been developed prior; this may have been experienced as unsafe or intrusive by some participants. Furthermore, as youth

and family participants had not been explicitly informed about the implementation of TRM, the very nature of the research interviews highlighted potentially significant issues relating to accountability and transparency, representing possible conflicts with the values inherent to TIC practices. This also raised theoretical questions relating to the differences in positions between me and my research subjects in terms of the language used and meanings generated from terminology at the core of TIC, namely how we both viewed the concept of trauma, and how this was referred to (or not) during research interviews. For example, while I was of the view that all youth participants had experienced some form of trauma (hence why practitioners had adopted the TRM), this was an assumption that was not made explicit during research interviews, and the young people involved in this study may not have viewed themselves as "victims" or "survivors" of traumatic experiences.

Finally, it was acknowledged that the research was being conducted during a global pandemic and national economic recession, both of which likely impacted the data collected. From a practical point of view, the vast majority of interviews were conducted virtually and remotely, creating a distance between me and participants, possibly impeding the development of rapport or preventing the observation of non-verbal cues which may have facilitated additional prompting or probing and deeper reflection. From a social constructionist position, it was also acknowledged by that the meanings participants and I ascribed to experiences of trauma, TIC, and the criminal justice system were likely influenced by the socio-political context within which the research took place. This political period was characterised by the onset of COVID-19 and subsequent feelings of deep global uncertainty and experiences of loss, anxiety and fear, disconnection and isolation, work pressure, job uncertainty, and/or loss of financial and/or employment security. Over the course of data collection there were also several national scandals and global traumas which specifically called into question the trustworthiness of police systems, such as the murder of George Floyd and the Black Lives Matter movement, or the UK Metropolitan Police scandals. Collectively, these socio-political events likely influenced how both I and study subjects experienced the wider CJS and many professionals within it, as a system demonstrated to repeatedly perpetuate racism, discrimination, and trauma.

3. Chapter Three: Results

3.1. Sample Demographics

Twenty-three participants were interviewed. Of the 19 staff who took part in an interview, over half (58%, n=11) were frontline YJ and restorative justice (RJ) practitioners who worked directly with young people. The remaining professionals were senior staff involved with the service from senior management positions, including assistant and operational managers. The majority of staff participants were female (63%, n=12) and white British (83%, n=15). Most (64%, n=12) had been involved in the initial TRM pilot. The remainder were recruited from other teams within the YJS where the TRM had been rolled out more widely. Table 8 describes the demographic and professional information of the staff interviewed in this study, which has been aggregated to protect the anonymity of staff. Participants were identified by pseudonyms (

Table 9).

The youth participant group consisted of three adolescents and one mother (Table 10). All three young people were male. Two were white British, and one was of mixed/black ethnicity. Two young people were on statutory orders, and one was engaged in a diversion programme.

Table 8 Staff participants demographic and professional information

Variable	N(%) or M(SD)
Total staff N=19	
Age (Range 32-59)	46 (8.3)
Professional Role	
Youth Justice/Restorative Justice Practitioner	11 (57.8)
Operational Managers	8 (42)
Ethnicity	
White British	15 (83.3)
Black British	3 (16.7)
Gender	
Female	12 (63.2)
Male	7 (36.8)
Stage of TRM intervention	
Initial Pilot	12 (63.2)
Wider roll-out	7 (36.8)

Note: Descriptive demographic and professional information for staff participant group (n=19). Age presented as mean (standard deviation). All other variables described as frequencies and percentages.

Table 9 Pseudonyms of staff participants

Pseudonym	Role
Betty	Manager
Clark	YJS Practitioner
Graham	YJS Practitioner
Melissa	Manager
Oscar	Manager
Tessa	Manager
Cameron	YJS Practitioner
Phoebe	Manager
Alison	Manager
Henry	YJS Practitioner
Fiona	YJS Practitioner
Lenny	YJS Practitioner
Hannah	YJS Practitioner
Olivia	YJS Practitioner
Max	Manager
Laura	Manager
Stephanie	YJS Practitioner
Rachel	YJS Practitioner
Monica	YJS Practitioner

Note: Pseudonyms and professional roles of all staff participants (n=19)

Table 10 Youth and family participant demographic information and pseudonyms

Pseudonym	"Sam"	"Ben"	"Lucy"	"Mike"
Role	Young person under YJS	Young person under YJS	Mother of a child under YJS	Young person under YJS
Age	17	17	Not recorded	15
YJS Order	Statutory	Statutory	N/A	Diversion

Note: some identifiable information (e.g. ethnicity) has been removed to protect anonymity

3.2. Overview of Results

Results describe the experiences of the YJS's TRM approach as a youth justice worker (YJW), an operational manager (OM), and a young person or parent (YP/P) within the service at time of implementation. Results are illustrated by participant quotations, with some text bolded for researcher's emphasis.

Four overarching themes were identified: Seeing Youth Justice through a Trauma Lens; Relational Practice and Repair; Trauma and Disruption in the Wider Caregiving Systems; and Role Conflict and Ambiguity. These four superordinate themes each consisted of at least two subthemes, and encapsulated information including: attitudes towards TIC; key components of TIC implementation; benefits and outcomes of the intervention; challenges and barriers to effective implementation; and recommendations for future services. Table 11 summarises these themes and subthemes.

Table 11 Overview of themes and subthemes

Theme	Subtheme	Illustrative Quotes
1. Seeing Youth Justice through a Trauma Lens	Delving Deeper to Unpick Youth Histories	You're looking at all these things that might have occurred many years previously that have been hidden from view … It's trying to understand all that, and how it influences and affects their behaviour… trying to unpick it. ('Oscar', OM)
	Widening the Lens to Cultivate Vulnerability	It's very easy to have that kind of secondary trauma and be re-traumatised again when you're working with the family and you're just going over it and over it. It's like grief, like a grieving process. ('Hannah', YJW)
2. Relational Practice and Repair	Every Interaction is an Intervention	I've never met my dad. And all other male figures that my mum has been with, have either hit me or her. So, like, I haven't really looked up to them. [YJ worker] is the first proper male figure that I've ever looked up to" ('Sam' YP)
	Clinical Supervision as a Tool for Relationality	The issues are so overwhelming for that young person, and because you are that stabilising force for them, you're taking on a lot of that emotional baggage… that can be quite overwhelming and having someone who's not in our direct team but outside of it, who you can debrief with and have a different perspective, that's been the most helpful part. ('Stephanie' YJW)
3. Trauma in the Wider Caregiving System	*Microsystem*: Families, home environments	We are working with children and young people who haven't just experienced historical trauma, they are still involved in trauma. How can we work with that and not induce further trauma, knowing that they are potentially still experiencing that now? ('Melissa', OM)

Theme	Subtheme	Illustrative Quotes
	Mesosystem: Links with Education, Social care	Each of them has their own different agenda, their own different policy and procedure, that doesn't match up. So, everybody is coming from different ways of working, we are not all doing joined up work coming from the same approach. ('Henry', YJW)
	Exosystem: Neighbourhoods, communities	
	Macrosystem: COVID-19, dominant governmental ideologies	
4. Role Conflict and Ambiguity	Agents of Care or Control?	Managers talk about all of the trauma and people's life stories and all of the things that have happened, and they're very traumatised young people…but you still have to breach them. The enforcement – it doesn't matter how traumatic their lives are or what is going on in their lives. ('Fiona', YJW)
	Practice vs Policy	
	Maintaining Balance and Hope in an Oppressive System	We, over the years, have got it totally wrong. We've been focusing on the wrong thing for a significant period of time. We were breaching young people, bringing them back to court, some of them ending up in custody which further damages them, all because we were focusing on the behaviour and not the cause behind it. ('Henry', YJW)

Note: Table summarising the four overarching themes generated from analysis using reflexive TA. Themes, including subthemes, are listed and illustrated using quotes from participants. Listed names are pseudonyms. YJW – Youth justice worker; YP- young person; OM – Operational manager

3.3. Seeing Youth Justice through a Trauma Lens

The first theme describes the dispositional shift observed within the service, referred to broadly as the 'trauma lens' (Sweeney et al., 2018) through which youth justice was viewed. While not strictly an intervention, this trauma lens was facilitated by several aspects of the TRM approach, such as training, clinical supervision, and organisational culture changes. Throughout interviews, the prevalence and widespread effects of trauma were repeatedly acknowledged. By applying this awareness of the multiple consequences of trauma, a conceptual shift emerged, whereby emotions and behaviour were understood and contextualised in light of a person's trauma history. This was primarily evident in its application to youth presentations, and youth offending in particular, encapsulated in subtheme 1. The second subtheme highlights ways in which staff applied a similar trauma lens to themselves, beginning to acknowledge both personal and professional influences of trauma on their work.

3.3.1. Delving Deeper to Unpick Youth Histories

Nearly all staff described young people who had experienced prolonged, cumulative, and complex trauma, including (but not limited to) physical abuse, sexual violence, neglect, abandonment, being in care, complex bereavement, and loss, as well as exposure to intergenerational trauma patterns such as domestic violence, parental substance abuse or mental illness, and parental offending. The sheer volume and complexity of the cases illustrated by staff repeatedly reaffirmed the necessity of adopting a trauma informed approach within the service.

Working with complex presentations was not a new task for practitioners, and most staff acknowledged that trauma and adversity had always been an implicit aspect of working with justice-involved youth. However, implementing TIC seemed to have made complex trauma histories, and their impact on subsequent behaviour, more explicit, enabling staff to shed light on significant events from young people's pasts which may have previously gone unnoticed or unrecognised. This active process of unpicking youth histories and making links with presentations and offending behaviour was considered a novel and unfamiliar way of working within the YJS.

It's very early days, but it's starting to trickle through. Before, unless it was very overt that trauma had occurred in that young person's background, then it wouldn't have been mentioned. 'Laura', OM

It is a new thing to a lot of practitioners and professionals, that actually you're looking at all these things that might have occurred many years previously that have been hidden from view … It's trying to understand all that, and how it influences and affects their behaviour… trying to unpick it. 'Oscar', OM

As a result of shedding light on the significance of trauma in young people's histories, a detailed and compassionate conceptualisation of youth offending was more readily applied, which

considered trauma reactions and responses. Offending behaviour or other youth presentations commonly perceived as dangerous or harmful were re-imagined as forms of communication, consequences of earlier experiences, or as ongoing forms of traumatisation.

Some of that other stuff gets forgotten about, what they're going through: have they had to carry drugs internally on them? That's going to be quite traumatic – someone has had to show them to do that, then someone's told them they have to do it, probably under fear of violence and coercion. 'Alison', OM

When [YJS worker] was working with me, I got attacked. So, I started getting paranoid, and started rolling around with weapons… I was carrying – I was going through a stage of carrying knives, because I felt like I needed to. Because I had just recently gotten attacked with a knife by that point. So, I was quite scared. 'Sam', 17

Through this trauma lens, staff were reminded that young people were not simply perpetrators or offenders, but survivors of trauma who in many cases were continuously exposed to ongoing threat. This dispositional shift also seemed to reiterate to staff that young people were still children, something which staff acknowledged was not always easy to hold in mind given the context of their work.

When they are in very adult environments, or committing offences that are really severe, you might see them more as an adult. I think you definitely can forget that this is a child. 'Monica', YJW

*When we think about criminal exploitation, people might see them as young adults and not as children, and they suddenly get flipped from a victim to a perpetrator. '*Alison', OM

A dispositional shift in favour of elucidating the 'root causes' of youth behaviour was observed, thus acknowledging youth offending as a coping strategy or trauma response. The following detailed excerpt is from an interview with 'Hannah', a YJ practitioner who provides a detailed illustration of this trauma lens being applied, and the value it added to her work. 'Hannah' shares her experience of working with a young boy who had been sexually traumatised within his family:

He started getting arrested for low level things, and then it started to increase, and he was constantly back and forth [from court]…At one point [he had] 70 something investigations opened against him. ***So, we've now got a highly traumatised 13-year-old boy, who's at risk of custody, when his basic needs are not being met. He doesn't feel safe at home***.

The TRM provided 'Hannah' with a framework for explaining the boy's trauma history and sharing this with other YJS professionals for the first time, thus enabling the application of a trauma lens which contextualised his behaviour.

It was after I'd had my TRM case, and I wrote the court report like the others that I'd seen. ***It was the first time the courts actually had any idea of what this kid had been through.*** *If you're only answering the questions on the [court] forms, there is not really any space to put that kind of background and contextual information in it…****the courts were taken aback by the fact that this boy had been through so much. And I just thought, this is shocking, because they don't know. They don't know what he's been through***.

In shedding light on previously unknown history, the boy's offending was instead conceptualised as a trauma response. This generated more compassionate and helpful responses by professionals, which in turn helped the child to recover and heal.

Now, everybody knows what's going on, and they're actually listening – Why is he sneaking out of the house at midnight and getting into trouble? Because he doesn't want to share a home with [the person] who raped him. So, it's looking at the bigger picture*. For him I think it's made a massive difference. And* ***evidence speaks for itself, his reoffending rates have reduced significantly****. 'Hannah' YJW*

Through this trauma lens, the appropriateness of traditional YJ interventions, which typically addressed and intervened upon behaviour and overt presentations (e.g. anger, knife crime), were re-examined. In bringing young people's trauma histories to light, staff appeared to gain new insight into the underlying needs of their cases, and could adjust their interventions accordingly.

She [YP] was initially sent through for harmful sexual behaviours that she had been displaying to others. But ***through the assessment, we were able to see that it wasn't about that, it was around her own vulnerability, from how she was parented as a small child, and the trauma she received as a young child through negligence by her mum****. So, you unpick all that, and I am now working with her in a completely different manner than originally when I first saw her*. 'Rachel', YJW

Another particularly salient dispositional shift observed amongst staff was that of how engagement and attendance were conceptualised in light of young people's trauma histories, and whose responsibility this was now considered to be. Practitioners acknowledged that the service had traditionally operated under a model where the onus to engage had been placed on youth. Young people were often penalised or brought back to court if they did not engage with the service under the terms of their order. Staff members reported that this "three strikes and you're out" mentality had been re-framed under the TRM, to acknowledge the barriers that attachment and relational trauma may pose to young people's engagement with professional services. The responsibility for engagement was instead being placed on practitioners, who were now expected to find creative and meaningful ways to ensure young people could feel safe and trusting enough to sustain their engagement.

I think there's probably been times in youth justice where we might have been quicker to close a case or look at that engagement as non-engagement. It's that shift in thinking about how that young person is engaging, the emphasis of how we engage is taken off the child and placed onto the practitioner… That then helps to build that consistency, instead of "well they're not engaging, we've tried three times, let's close it". 'Alison', OM

The power and importance of language echoed throughout staff accounts. Shifts in how staff described and communicated with youth were acknowledged as important benefits of the TRM, and signified the presence of a trauma lens: "*Plans are worded differently, very differently than how they used to be"* ('Tessa', OM)

They are using very different language than what they did before. When you see a practitioner working in a trauma informed way, compared to someone that isn't, I think you see a different way of working with a young person, how they relay things to that young person or put things across… that use of language is really important. 'Oscar', OM

Language was also considered an important tool in promoting and embedding the trauma lens throughout the service. Several professionals acknowledged that the word "compliance," frequently used in the service previously, was being phased out in favour of terminology which acknowledged the proactive role of practitioners, such as "engagement."

It's about the language – I need to go back and check, but certainly our compliance policy is now called compliance and engagement. But ideally, that would be called "relationships" - Does that make sense? Our two-way agreement – we have a two-way agreement around what young people can expect from us, and what we can expect from them. We could call that "relationships"… it's that kind of shift, isn't it? 'Melissa', OM

Many staff believed that the application of the trauma lens was not yet second-nature, particularly across teams where the TRM had more recently been rolled-out. Several staff identified the need for further adjustments to the language in service policies and procedures to consistently promote system-wide trauma ideology and ensure that this remained at the forefront of practitioners' minds.

If I think about some of the other frameworks we use, it's everywhere we look - it's embedded within documents, in processes, everything. And the trauma informed stuff is going that way, which is really good, because it's there to stay isn't it? This is the way we are working now; this is the way we need to approach and look at things. 'Phoebe', OM

There was also evidence that this trauma lens, while a conceptual shift and not a direct intervention, could be felt by service-users and facilitated improvements in the quality of interactions between staff and youth. Service-users described feeling understood and validated, instead of judged, and valued what they perceived as practitioners' ability to dig a little deeper.

They got to the reason why he does this. And what the triggers could be. Because the trouble is he doesn't always know himself. 'Lucy', Mother

The thing [YJW] didn't do, is what all my other case workers [had] done, which was read a file, and think they know me, before they even met me… Don't judge a book by its cover. Because, at the end of the day, you can read your files about a certain child, and think, 'Oh yeah this child is a wrong'un' and all that… But then you go to his house, and you see how he's living… 'Sam', 17

A few interviews also demonstrated ways in which the consequences of trauma had been explicitly acknowledged with young people, in order to build a shared contextual understanding of youth emotions and behaviour and provide a rationale for the TRM intervention. Examples of the TRM being discussed with youth and families highlighted further ways in which the trauma lens, along with underlying core principles of TIC such as choice and collaboration, were being adopted at all levels of the YJS.

I was able to explain the basic [TRM] triangle to him [YP] and his mum as well, and explain the basic foundations and the need to build on those. That helped them both to understand why sometimes things happen, and why sometimes people behave in the way that they do. It's just a way of putting things into a little bit of context for them. 'Fiona', YJW

Some young people hear that stigma and say, "Nah I'm not nuts, I'm not crazy, I don't need therapy." But we explained it to him, and asked 'Would you be happy to trial it, we're looking at new ways to help you feel comfortable so that over time you'll feel able to open up and talk about things.' 'Rachel', YJW

Despite these positive examples, there was also evidence that implementing the TRM engendered anxiety about how to discuss and address trauma. In most cases, the trauma lens remained largely implicit and unspoken with youth and families, with trauma-informed conceptualisations and conversations appearing to occur *around* as opposed to *with* young people. Throughout recruitment, I was reminded by several practitioners that most young people did not know they were being worked with in a trauma informed way.

Of course, the fact is that they don't know this is happening. So, the young person I'm working with now, this is their first order… so this is just the way he knows. Clark, YJW

There remained an evident apprehension about naming the TRM approach or even the word "trauma" with young people. Staff worried that youth may have different attitudes or perceptions towards the word "trauma", which could act as a barrier to their willingness to engage in work. Many staff expressed uncertainty about how to develop a shared trauma-informed language that would not be stigmatizing, confusing, or upsetting for youth.

One of the difficulties I find with TRM and any of these approaches, is that children don't understand it…. These are complex things…I often say to people, you don't necessarily have to show your cards, you don't necessarily have to say, "We are doing TRM model," because that doesn't make a lot of sense to people. 'Max', OM

We did try to work with him within this way… and he just couldn't manage it. He couldn't speak freely, he would get so angry, and it just didn't work. I don't know how to explain it, but it was just not the right model for him. 'Rachel', YJW

Underpinning this apprehension seemed to be fears that discussing trauma directly would risk "opening Pandora's box." There was an identification of anxiety and doubt about professionals' abilities to contain youth distress and respond to trauma responses appropriately.

When you're saying that actually this approach is to unpick some of that complex trauma, case workers are very mindful that they don't want to leave that person in a worse state than where they found them…It's like, well if I open this can of worms, and they actually engage and want to talk to me, then what I do with that then, where do I go with that? 'Laura', OM

Similarly, trauma was often not directly mentioned by staff when exploring features of the model identified as unique or favoured. Rather, staff frequently alluded to its core components without naming trauma directly, using terms such as "relationships-based" or "child-centred". Not only did this contribute to a feeling of ambiguity or vagueness in the specific role that trauma played, but it perhaps further reflected an ongoing discomfort around naming trauma explicitly.

3.3.2. Widening the Lens to Cultivate Vulnerability

Staff were also observed to view themselves and their work through a trauma lens. There was a noticeable consideration of the role that trauma played in professionals' personal and professional lives. Many staff perceived the TRM as having increased their awareness of STS, burnout, and the impact of personal traumas, and a more compassionate shift was observed in how staff conceptualised the emotional distress which inevitably arose from their work.

Several staff identified themselves as trauma survivors. Professionals shared how, by shedding light on the impact of trauma for youth, they were also often confronted with their own histories, and had reflected on the impact of their own trauma in greater depth through TIC implementation. In many cases, this was perceived to facilitate a greater sense of empathy and compassion, both for their young people but also for themselves.

I look back on a lot of the work I've done in the police, and the impact of that on me. I've been through trauma in my own life, as a young child, and it makes you really aware I think, of what some young people have to deal with. 'Oscar', OM

The young person that I was working with, his father had died a few years ago. My father had died a few years ago, and I had never been able to see him before he died and that was quite traumatic; it still plays on my mind. So yeah, it does bring out all this stuff from your own life. 'Rachel', YJW

Yet, in recognising staff as potential survivors of trauma, and not just those who worked with traumatised youth, additional complexities were revealed. The delicate balance of maintaining a trauma lens with clients who had perpetrated harm was highlighted as a potential challenge for staff whose trauma histories may be triggered by the nature of their clients' offences.

Someone I know was actually murdered by one of my clients this year… So, I was able to discuss that during clinical supervision. [Pseudonym withheld][1], YJW

When I'm allocating a case, I'm very mindful that that person may have been sexually abused themselves, they may have experienced domestic abuse, they may have experienced all these sorts of traumas themselves. I don't think enough consideration is given to them as people. I think that's one thing we can definitely improve on. 'Max', OM

Even in the absence of trauma histories, seeing themselves through a trauma lens appeared to encourage staff to take a more vulnerable, self-reflexive position. A shift was observed whereby staff increasingly acknowledged their vulnerabilities, and ways in which their personal histories may shape their beliefs or responses to youth.

I enjoyed the opportunity to look at behaviour, and past events, things that had influenced or affected [young people's] choices or points of view…. It was really great, because it also helps me as a practitioner too, to look at your own biases and your own history, you know, understanding that. 'Cameron', YJW

This practitioner came to the realisation during one supervision that actually he didn't really like this young person, and he couldn't really work with him effectively because that was getting in the way of stuff. That's a really brave thing to admit - it puts you in a really vulnerable position as a practitioner to say it's me actually, I'm the one responsible for this failure. 'Betty', OM

Many practitioners disclosed the significant emotional impact of working with complexly traumatised young people. Several described experiences akin to STS and vicarious traumatisation, such as intrusive images, nightmares, disturbed sleep, and emotional distress which paralleled that of their clients.

[1] Given the sensitive and potentially identifiable nature of this quote, the participant's pseudonym has been withheld to protect their anonymity and prevent linking to other quotes provided by this participant.

I've been able to see first-hand how working with young people and families exposed to trauma can make you unwell. When I was in a practitioner post, I carried a lot of high-risk cases. And then I became quite unwell myself with secondary trauma. I was really properly going through it… when you're reading documents, you're living within that trauma. It was like vicarious trauma. I was almost living experiences that hadn't happened to me. 'Tessa', OM

It's very easy to have that kind of secondary trauma and be re-traumatised again when you're then working with the family, and you're just going over it and over it. It's like grief, like a grieving process. 'Hannah', YJW

In viewing their cases through a trauma lens, some staff described feeling increases in anxiety, rumination, and despair, which often trickled into their personal lives: "*I don't hardly sleep, because I feel like he's constantly on my mind*" ('Stephanie', YJW). Others described experiences of STS in response to dealing with young people's offences, and the added emotional pressures and complexities of working compassionately with youth who posed a significant danger to others. 'Olivia' (YJW), described her desperate efforts to seek mental health support for a young person who was abusing animals: "*It really did spill into my home life, and obviously working at home as well… I started to have nightmares of rescuing animals from his house. So, it had obviously really impacted me".*

In many cases, professionals attributed experiences of STS and burnout to TIC implementation. Staff believed that the TRM approach was inherently more emotionally intense and demanding, and that staff were discussing and working with trauma histories in ways not previously explored within the service, which had a subsequent impact on staff. Staff perceived the implementation of TIC to be linked to instances of staff referrals to employee support sickness, absence, and turnover ("*We've had a lot more people within our team that have been signposted to the employee support scheme*" 'Laura', OM).

You're taking on a lot more emotionally than what you would have done if you're just sticking to "They've got to complete these targets and you're going to be out the door in a few months," on like a conveyer belt. Now, your understanding of a child is so much more, and you're all being told very traumatising aspects, so it can be quite overwhelming. 'Stephanie', YJW

Because of this very intense, therapeutic approach, the wheels are coming off people. We've had sickness, we've had all sorts of different things. Several people have been off with stress. You can't discount that it's a by-product of this approach. That actually, they haven't got the resources. 'Max', YJW

There were some noted differences in perspectives here, and not all practitioners agreed that the implementation of TRM had led staff to experience increases in STS or burnout. Many described working with complex trauma as "just the nature of the job" and normalised the subsequent effects

as not something novel or unique to TRM. Yet many of these same practitioners similarly acknowledged the presence of powerful personal defences which had protected against an internalisation of the emotional impact of their work.

That's working in youth justice. That's working with young people. Young people have always disclosed awful things to me, for the last 20 years. So, I've had several nervous breakdowns, I've had several types of burnout; it's just what happens unfortunately. 'Clark', YJW

I think my way of coping with it back then was to detach myself from that stuff. You can become quite desensitized to some of the situations that come up. I think that can be quite dangerous…not really talking about it because it's just deemed part of your job, you just get on with it. 'Phoebe', OM

Just as the application of a trauma lens to youth offending enabled staff to shed light on previously unrecognised psychological processes, so, too, did contextualising YJ work through a trauma lens seem to allow for professional experiences of STS, burnout, or personal trauma to be more explicitly revealed. Most staff believed that the implementation of TRM had increased staff self-awareness and provided staff with a language with which the impact of their personal and professional experiences could be discussed without fear of judgement. This, in turn was perceived to have engendered a shift in organisational culture which was more compassionate and accepting of vulnerability.

If we were having this discussion even two years ago, they would have been like, "This is a home issue, it's separate from work, and I need to deal with it myself." They wouldn't necessarily have brought it to manager attention to say, "I'm really struggling here, and I need some support with this." 'Laura', OM

I think people have become more honest about when they've been affected by a case. And I don't necessarily think they would have been before we had the pilot. I think people probably would have been a bit more cautious about saying, "Oh I can't take that." 'Tessa', OM

3.4. Relational Practice and Repair

The second superordinate theme describes how the TRM acted primarily as an interpersonal intervention, targeting relationships as the primary tool for change. The emphasis placed on healing interpersonal trauma through formation of trusting attachment relationships appeared central to the model's efficacy, and the most valued aspect by both staff and youth. Qualitative evidence indicated that the TRM was an effective intervention at a relational level, with several relational indicators, such as experiences of trust and mutuality, noted across interviews. It was also suggested that such relational improvements acted as a mechanism through which other more 'measurable' outcomes of TIC success for youth (such as increases in school attendance, or reductions in offending) could be attained. This theme is comprised of two sub-themes,

representative of the two core relational processes observed in the service as a result of the TRM. The first describes relational changes between staff and youth; the second explores the relationality professionals experienced through clinical supervision, and their ongoing need for safe, contained, and reflective support.

3.4.1. Every Interaction is an Intervention

One commonly identified benefit of TIC implementation was its prioritisation of building consistent, safe, and trusting relationships with young people. Staff clearly recognised the understandable difficulties young people had in trusting adults, particularly those associated with the justice system, and valued the opportunity to try to heal and repair this trauma relationally. Staff also seemed to have absorbed the theoretical underpinnings of the TRM emphasising the limited cognitive capacity traumatised youth have if core needs for safety and consistency are not met. Reflecting on this, professionals acknowledged the ineffectiveness of their more traditional approaches.

*Before, **it felt like we ticked some box just to do something and were doing things that we probably knew didn't really work, because the young person just isn't in the right frame of mind**. If a young person is homeless, and we are there talking about their offences, but they ain't got stable accommodation, they ain't going to be focusing on any of that, and you ain't going to be getting no work done. But yet we would go down there and focus on that piece of work, while they had all these concerns underneath, floating about, which we were totally ignoring*. 'Henry', YJW

This idea was echoed in accounts from youth, who emphasised how long trust may take to build, and how challenging it was for young people to tolerate more directive, offence-focused work in the absence of a trusting, collaborative relationship with their worker.

I think it just takes time. You've just got to have some time and leave them to have some time to understand you, really. You can't rush in. Because once you know you've got a good relationship with them, then you can get stuff out of them, and speak to them and try and help them. 'Mike', 15

By identifying direct work with young people as a relational intervention at its core, the TRM provided practitioners with more freedom and flexibility to work holistically with young people in ways which often extended beyond offence-focused work. Staff expressed relief in not feeling pressured to adhere to rigid, prescriptive statutory guidelines. Statutory contacts, service targets, and time constraints were perceived to detract from case-holders' capacity to spend time investing in relationships with youth. Practitioners described interventions provided under the TRM as more intuitive and natural, guided primarily by the young person and the sanctity of the relationship being built, as opposed to the directives outlined in statutory orders.

I was able to help young people and their families with stuff outside of the order. And that in itself builds that relationship. Things such as taking someone to a job interview and giving advice, or sitting in a car and talking about road signs when they want to get their driving licence … These little support aspects which sometimes you can't really do in a normal referral order, but in TRM that's the bread and butter: to just be there, to be constant 'Graham', YJW

In a similar vein, many frontline practitioners expressed beliefs that the TRM 'gave permission' to work in a preferred way. Within this group, TRM's emphasis on relationship building was not perceived as novel or unique, with several practitioners reiterating that they had 'always' known the power of relational work. Rather, for these professionals, the TRM was believed to provide formal, theoretical validation and approval by managers of their preferred (or already existing) practices.

Being given the permission to not have to put a target down to do a particular piece of work around anger management, peer pressure, call it what you like. It was just literally one target: relationship building, and then working on the young person's motivation to make changes. 'Lenny', YJW

I would say it is not different to really how we practice in our area anyway. I think it's just reaffirming what we already know and how we already practice. I think it's just reinforcing the values that we want to put in place within our team. 'Stephanie', YJW

Managers, on the other hand, were more likely to describe the model's approach to relational practice as novel and challenging for some staff to adapt to. While they agreed that this approach came naturally to some practitioners and aligned with their existing practice, they believed others struggled more with this therapeutic way of working*: "It's evident that not everybody works in a trauma informed way. I think they say they do, but it sometimes seems as if certain practitioners are more advanced in that approach"* ('Phoebe', OM). A few managers also emphasised that engagement skills alone were just one aspect of success; it was how this relationship was utilised as a mechanism for change that was more crucial, and more challenging.

Qualitative evidence from both staff and service users highlighted several relational indicators of change as a result of TRM implementation. Relationships between staff and youth were described in ways that encapsulated feelings of nurturing, trust, and respect: *"He is starting to really open up about what his intrusive thoughts have been. And he's actually asking for help"* (Lucy, mother). Providing youth with safety and consistency were repeatedly identified as the cornerstones of this.

The relationship feels more natural, the kind of connection with the young person is a lot stronger and they tend to have a lot more respect because they don't feel forced to do anything. At times I have felt like when you're having conversations, they will actually listen, and take it on board. 'Graham', YJW

There was also evidence of increasing collaboration and mutuality within relationships, and staff described slight shifts in power dynamics which provided youth with more choice and agency – from a "doing to" towards a "getting alongside" ('Melissa', OM).

Ninety percent of their interactions with adults, like police and teachers, is them being told what they shouldn't be doing. Whereas we were going in there and asking, 'Well why do you do that? Why does that happen?' And talking about where that came from … there's no judgement, there's no chastising. 'Cameron', YJW

It was always – do you want to do this? Or do you want to do that? He used to say like, "I think you should try to do this, it will keep you busy," but he never said "you have to do this" "'you have to do that." 'Sam', 17.

Youth descriptions of their relationships with staff evoked similar feelings of mutuality and openness and highlighted the powerful role that practitioners held as positive attachment figures in young people's lives. It was evident that youth participants felt safe within their relationships and deeply connected to their YJ workers.

[PRACTITIONER] goes above and beyond, whenever. It's amazing. As opposed to just – you know, a stranger, seeing them every week, and it's like "Ok you've got these questions to do, this is what you should do, this is what you shouldn't do." You know? It's like… Ugh. Where I would say me and [Practitioner] have a good friendship – we are very open and honest with each other. 'Ben', 17

I've never met my dad. And all other male figures that my mum has been with, have either hit me or her. So, like, I haven't really looked up to them. [Practitioner name] is the first proper male figure that I've ever looked up to. 'Sam', 17

Staff appeared to approach relationships with young people with a persistency and tenacity which normalised relational ruptures and the ways in which youth may test the boundaries of their relationship with practitioners. This, in turn, was noticed and appreciated by service-users.

Even if [YOUNG PERSON] isn't here or he's not engaging, they still don't give up, they keep trying. And that's the thing – he does test them, he does – he can be incredibly violent, he can be incredibly… terrible. But they still get to the point of trying to understand why he does this. 'Lucy', Mother

I thought a youth offending worker works for socials [social services]…Nah. Not my cup of tea. I wasn't giving him the time of day. But then, **he said to my mum, "Oh well this is understandable". He was kind of expecting me to go like that***. And then, I remember - I think it was at our first meeting, we started bonding properly. 'Cuz like,* **I got annoyed and walked out, and he**

came out and we just had a little chat. And after then, we've kind of been – I wouldn't see him as a youth offending worker, I would see him as more of a friend. 'Sam', 17

Staff and youth believed that developing open, trusting, and consistent relationships laid the groundwork for future changes in behaviour and wellbeing. Staff provided countless examples of improvements they had observed in youth worked with under a TRM approach, including reductions in offending behaviour, improved school attendance, or re-engagement with education and employment opportunities. Views were mixed on whether such outcomes could be attributed to the TRM alone, and several perceived progress under the TRM to be slow and often non-linear. Often, benefits were more relational or harder to quantify, such as youth opening up more to staff, being better able to tolerate distress and communicate with adults, or improving relationships with parents and families. Youth and families similarly identified the strength of their trusting relationships with case workers as a catalyst for further changes.

I've gone from drinking every day, and being involved with crime all the time, and getting in trouble with the police. To now, I don't do drugs, I barely drink, and I haven't had anything to do with the police in a whole year. 'Ben', 17

I used to get arrested all the time. Now, I haven't been arrested in maybe like 6 or 7 months or something. I'm back in school as well – before, I wasn't in school, I was just out causing drama. I'm not doing full days, but I'm doing three days a week. So that's still something. 'Mike', 15

3.4.2. Clinical Supervision as a Tool for Relationality

Improved relational practice was also a significant benefit for staff and professional relationships. Perhaps the single most valued component of TRM was the provision of individual and group supervision by a qualified Psychologist, which appeared to be integral to maintaining the overall efficacy of the trauma informed model. Practitioners identified clinical supervision as a crucial tool in supporting them to reframe cases and ensure that the trauma lens through which they viewed young people remained intact. Clinical oversight was considered particularly invaluable in discussing highly complex or risky cases, working through inevitable feelings of "stuckness" within cases, and generating new ideas which enabled them to continue engaging with young people and provide relational care.

It gives you some feedback about looking at your own practices, or alternative ways of adapting yourself to fit in with the family, rather than the family needing to change or adapt to fit in with us - we have to be the chameleon and adapt in with them. It gave us the tools to feel more comfortable changing some of our approaches. 'Henry', YJW

Several aspects of clinical supervision appeared to mirror the shift in relational processes observed in staff-youth interactions. Like youth, practitioners described feeling listened to and understood without judgment, and valued having an open and honest forum which felt safe and collaborative.

This safety was particularly important in facilitating staff reflexivity and supporting wellbeing. Across the board, staff valued having a reflective space where personal issues arising from the work could be explored and reflected upon.

The supervision never feels judgemental, it feels very supportive. It feels like, "Oh that's really good, you're doing a really good job", which is very encouraging as a case manager rather than, 'This hasn't been done, when are you going to get that done'. It feels like a really different shift in terms of the supervision I was given around difficult cases. 'Lenny', YJW

It's not just support around how we deliver that work with the young people, it's around supporting us as individuals. It's about how we feel as people delivering this work, and what things have happened within our life. 'Rachel', YJW

Corresponding processes of containment, regulation, and sense-making occurred, which appeared inextricably linked. As staff responded to youth distress, so, too, did they increasingly crave safe contained and reflexive support.

The issues are so overwhelming for that young person, and because you are that stabilising force for them, you're taking on a lot of that emotional baggage to an extent. I think that can be quite overwhelming and having someone who's not in our direct team but outside of it, who you can debrief with and have a different perspective - for me that's been the most helpful part of it. 'Stephanie', YJW

The above quote also illustrates how the position and role of the psychologist – as both a qualified professional with trauma expertise and also someone perceived as slightly external – was considered central to the helpfulness of clinical supervision. In the wider roll-out, supervisory arrangements were changed, and line managers were tasked with providing the individual reflective supervision instead of the psychologist. Comparing interviews from staff involved in the pilot to those from the wider roll-out, it was evident that the provision of separate clinical supervision by psychologists appeared integral to it remaining a non-judgemental and reflective space. Staff reiterated beliefs that this could not be replicated by managers, and expressed fears that without clinical oversight, the TIC model would become diluted by other managerial priorities.

Managers – they're not psychologists, they have management experience. One of our managers didn't even have experience of young people and youth offending, but she had absolutely quality management experience. You can't manage somebody and manage their caseload, while also working through this kind of model, because in the back of their minds they are thinking timeframes. It needs to be separate, it needs to not ever be diluted, and passed down. 'Hannah', YJW

I do think there is a risk of it just getting lost, like so many other things … obviously it's a financial thing, but if we had our supervisions with a psychologist, or if our line managers were psychologists, that would help. 'Olivia', YJW

Similarly, managers from teams in the wider roll-out acknowledged finding it challenging to effectively fulfil their new dual roles as both line managers and reflective clinical supervisors.

You're trying to be mindful of that trauma and be compassionate and responsive, giving them that safe space to be able to talk quite openly and freely, but then also on the other hand, you've got issues that come up around performance…It's hard to manage performance and other stuff– they are very different dynamics 'Phoebe', OM

In another mirroring of relational processes with youth, staff appeared to recognise the power dynamics inherent to managerial relationships with supervisees, and how this may pose barriers to meaningful engagement in reflective supervision if staff did not feel safe or understood.

I had a practitioner say to me just last week that he felt judged by his management. His manager was saying "why didn't you do this this and this" and he felt like they were judging the way he was behaving and the decisions he was making, and it wasn't a comfortable place for him to be 'Betty', OM

Overall, both practitioners and managers expressed beliefs that delivering such an intensive, therapeutic trauma-informed approach to young people would be ineffective, and even unsafe, in the absence of sufficient clinical supervision and oversight from a professional with the appropriate expertise and experience.

I think I'm quite good with people, and able to listen and understand, but ***I'm not a psychologist. And I just don't think that I am as capable as someone who does that day in and day out****…I think people need clinical supervision.* 'Max', OM

Clinical supervision is not cheap. But for me, it's an absolutely invaluable resource. ***If you don't look after your staff, they can't look after the children and families that they work with****. So, first-hand clinical supervision is remarkable*. 'Tessa', OM

3.5. Trauma in the Wider Caregiving System

The third superordinate theme describes the roles that trauma, instability, and disconnection in young people's wider ecological systems played in the overall success of TIC implementation. Results are structured loosely according to the five systems outlined in Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1977) working out from the microsystem (i.e. young people's families and immediate caregiving systems), to the macrosystem (i.e. governmental ideology and the ongoing COVID-19 pandemic context).

3.5.1. Microsystem: Families, home environments

One challenge repeatedly identified by staff was that, given the nature of community YJ work, it was often difficult to establish a safe and secure environment for young people whose family and home lives remained chaotic, unstable, and actively traumatic. This was perceived to undo progress made under the TRM, as young people experienced further re-traumatisation in their personal lives which undermined relationship building and thinking work.

The chaos was pretty much to the point where the young person went to a halfway house, like a hotel for those who are homeless or come out of prison. They went from an eight [out of 10] – so loads of positives happening, loads of positives with school, welfare, mental health, everything was on the way up – down to a two. 'Graham', YJW

Staff acknowledged that creating stronger links with families and supporting parents was integral to enabling more consistent trauma informed thinking within young people's home contexts. However, working with families was also acknowledged to be challenging. There were concerns around parents feeling blamed or criticised, holding different attitudes, or continuing to re-enact unhelpful trauma dynamics.

[The parent's] way of disciplining was very much based on a strict, zero tolerance approach: communication was minimal, punitive… it was like 110% in terms of negativity…How do I unpick the fact that I do this positive work with the young person, and no matter what, they go home and that's just the way that mum is? 'Graham', YJW

In working with families, practitioners were also tasked with unpicking complex intergenerational trauma patterns. Parents and caregivers were recognised as often requiring significant support to address their own difficulties, creating additional demands on practitioners as they attempted to establish themselves within young people's lives.

I didn't want to make mum reliant on me as her total support network. I wasn't her friend. I was a professional there working with her son. And yes, I would support her as much as I could, but she needed more support than what I could give her. If [the YP] left or wasn't there, mum would quite happily take over that space with her own needs. That's where the boundaries were getting a little bit crossed. 'Fiona', YJW

The nuanced challenges of establishing a safe and secure home base for young people were further highlighted in cases where parenting and caregiving responsibilities had been taken over by state services. Agencies such as children's homes and supported housing providers were identified as key stakeholders in ensuring that TIC was embedded and upheld. However, their ethos and structure were also identified by some to undermine TIC values, worsen youth behaviour, and contribute to the criminalization of young people.

I think in the past, supported housing providers were seen almost as paid parents and weren't always involved in the care planning of young people. Whereas they see young people more than anyone else. So, it's about giving them a seat at the table, and making sure that their views and opinions are listened to. 'Clark', YJW

The young female I had, all of her offences were committed within the children's home. She was on a full care order, and it was about the parenting - the local authority being the parent. ***If this was your own child, would you criminalise to the extent that this young girl was being criminalised?*** 'Fiona', YJW

3.5.2. Mesosystem: Healthcare, Education, and Social Care

Disjointed and inconsistent working with other agencies in young people's caregiving systems was also identified as a primary challenge to effective TIC. Social services, education, and healthcare were all referenced as important systems within which TIC was sparsely implemented and sorely needed. While multidisciplinary formulation meetings were a foundational component of the TRM model, staff reported finding it difficult to ensure that a TIA was upheld consistently by other agencies. Inter-disciplinary work was often described in ways which evoked strong feelings of disjointedness and disconnection.

Each of them have their own different agenda, their own different policy and procedure, and that doesn't match up. So, everybody is coming from different ways of working, we are not all doing joined up work coming from the same approach. 'Henry', YJW

This disjointedness appeared to pose a risk of services 'passing the buck' or unnecessarily duplicating work. A lack of available resources or streamlined referral processes for youth to access other services was similarly identified as significant challenge which often left youth without appropriate support. Repetitive, inconsistent responses from disjointed systems were identified by both staff and families as a significant barrier to accessing help, as depicted in the following quote from Lucy, a mother whose son required urgent mental health support.

When [YP] went to the hospital, the crisis team came and said, "Well unfortunately you are in the wrong county. If you were in the other county, then perhaps we could have admitted him." ***We'd been waiting hours and hours to speak to someone, and you get that response…*** *by the time [local crisis team practitioner] arrives, all they do is ask the same questions we've been asked before, [which] have been hard enough for him to answer the first time. They'd been written down, but she didn't read it. And* ***you're just thinking… you're in such danger of people just shutting down and you just losing them.*** 'Lucy', Mother

Improving links between youth justice and other services, particularly education and mental healthcare, was repeatedly identified by both staff and families as central to ensuring a holistic, preventative TIA. YJ staff recognised their role as promoters of TIC, and reflected on how active

modelling of this approach during professional meetings could be used to generate buy-in from other systems at the table. Yet, this mesosystem of various agencies was also felt to act in ways which were potentially harmful and in directly opposition to TIC values.

I had a teacher in a meeting refer to the children that hang around outside the school as "thugs." One of the young people is someone I work with, and he hangs outside that school because he's been sent to a pupil referral unit and so he's waiting outside for his friends. When she called them thugs… that bothered me so much. 'Olivia', YJW

Staff also described a lack of consensus or understanding across agencies about what TIC was or what it entailed. The introduction of TIC within YJS in some cases appeared to deepen rifts and further contribute to disjointed working, reducing the shared language professionals could use to discuss youth. As services continued to focus on their specific "tasks" without a meaningful and coherent narrative, staff repeatedly expressed a need for all agencies to be "singing from the same song-sheet" (Cameron, YJW).

It's not that social care are anti TRM, they just don't see the point of it… they were questioning why, we've got SOS [Signs of Safety], everything is working fine, of course we will work in a child centred way, so what on earth are you doing, youth justice, bringing another thing in? 'Max', OM

3.5.3. Exosystem: Neighbourhoods, communities

Local neighbourhood contexts were also perceived as having a significant influence on youth offending, and staff raised questions about how the YJS could safely and appropriately address trauma with young people when the 'threat' posed by community violence and neighbourhood deprivation remained active and ongoing.

We are working with children and young people who haven't just experienced historical trauma, they are still involved in trauma. How can we work with that and not induce further trauma, knowing that they are potentially still experiencing that now as part of gangs and county lines? 'Melissa', OM

Staff identified a need for TIC delivery in the YJS to include a more thorough consideration of local areas and neighbourhoods, so that associated risks could be better understood, and community service links improved.

I think we totally forget about the community and the environment that the young person lives in…. they are in an environment which can be a huge factor for their behaviour. 'Henry', YJW

3.5.4. Macrosystem: COVID-19, dominant governmental ideologies

The implementation (and evaluation) of TRM was also perceived to be influenced by wider ideological and cultural contexts. The COVID-19 pandemic and national lockdowns, which began

mid-way through the TRM pilot, were believed to have significantly impacted the effectiveness of certain aspects of TIC delivery, such as relationship-building with youth or their wider networks.

I think TRM has been massively frustrating, because I've seen it work so, so well when you're seeing the young person, but when you're just doing a video call or a telephone call, it feels like it's non-existent really, you know? 'Lenny', YJW

Before, I was going into the home, I met the family, I became part of the furniture. It seemed like we were doing some really beneficial work with the community and the young people were starting to trust us. We can't get that kind of commitment between me and a laptop. 'Henry', YJW

Most staff continued to work from home, which further generated feelings of disconnection, isolation, and silo-working amongst staff. Staff described feeling unaware of the goings-on of their colleagues, and opportunities for informal staff discussions and support were believed to have reduced in the shift to remote working. In several cases this appeared to reduce how 'live' the TRM approach felt to staff, limiting their ability to discuss, share, or model trauma-informed practice with colleagues.

I don't really see anyone. We're not in physical contact with one another, and we don't tend to get involved in other people's cases, unless we are covering for some reason. So, to be honest, I don't even know what practitioners are working on the TRM. 'Fiona', YJW

The impact of economic structures on the longevity and success of TIC in youth justice was also considered by many professionals. Staff widely believed that the TRM approach required further financial investment, particularly in terms of staffing resources, and acknowledged that services were already experiencing significant financial strain which made additional funding unlikely. Staff believed that financial investment in CJ services was not a political priority, particularly since the pandemic.

Budgets have just gone to hell. Realistically speaking no one is going to find money that just isn't there. So, my biggest concern would be that it just isn't staffed correctly by the right amount of people. 'Cameron', YJW

The big constraint is money. The government is less likely to give [us] money moving forward. Because emergency services will be the top agenda, and everything else will be secondary. 'Graham', YJW

Beyond financial implications, governmental priorities were considered a significant barrier to the long-term success of TIAs in youth justice. Staff described worries that current political ideology and societal culture were not aligned with taking a more compassionate view towards offenders, and that this could undermine the system's ability to implement TIC.

I really, really fear that we have a home secretary, Priti Patel - we have people who seem to be really unsuited to this approach, being put in positions of power… I just fear that there is a real danger that actually we're going to be coerced or steered in a very, very different direction. 'Max', OM

3.6. Role Conflict and Ambiguity

The final theme encapsulates the discomfort and anxiety that staff experienced in the transition to TIC, largely underpinned by existential questions relating to their professional roles and responsibilities, and the priorities of the wider YJ system staff were situated within. In learning to become more aware of trauma and its impact on youth, YJS staff also examined their own practices and those of the wider CJS, generating areas of dissonance. Three core dilemmas were observed, represented by three subthemes. The first describes the observed internal conflicts which emerged as staff incorporated TIC ideology within their established roles as enforcement agents. The second subtheme highlights perceived contradictions between practice "on the ground" and the service's strategic policies, management, and organisational priorities, which further compounded role ambiguity. The final subtheme describes professionals' struggles to balance unrealistic expectations and restore agency and hope in a system which was widely recognised as oppressive and harmful.

3.6.1. Agents of Care or Control?

An apparent consequence of viewing the YJS through a trauma lens was that it generated further dilemmas around how to balance a child's vulnerability against their risk. Many staff struggled with how to balance the safety and wellbeing needs of their young people against their public protection priorities and believed that aspects of TIC were overshadowed by the YJS's primary role as an enforcement agency.

Managers talk about all of the trauma and people's life stories and all of the things that have happened, and they're very traumatised young people…but you still have to breach[2] them. The enforcement – it doesn't matter how traumatic their lives are or what is going on in their lives. 'Fiona', YJW

Many practitioners expressed feeling conflicted about maintaining a trauma-informed approach when offences were severe. This dilemma was underpinned by perceptions that the TRM may excuse or lessen responsibility for youth offending.

[2] A breach is when a young person fails to comply with the conditions of their disposal. A breach of a statutory order or conditional discharge is an offence of failing without reasonable excuse to comply with requirements of an existing statutory order or the conditions of discharge (GOV.UK, 2021)

This [model] brings you towards being more child focused and thinking about the vulnerability of that child … Which is really hard when you've got really serious offences. To be able to say, actually, this person needs all these things, but they've done something really horrific. It's like, "Well why are you doing that, when they've done this?" 'Monica', YJW

There was an identification of tremendous internal and external pressure to "Do" something about offending. For many workers this appeared to undermine their beliefs in the viability of TIC, and fuelled concerns that TIAs were ineffective. Several staff expressed fears that TIAs were too "soft" or "weak." Such perceptions appeared to generate further uncertainty and discomfort, as staff adjusted to a novel approach which they considered to be in stark contrast to the structure and rigidity of more traditional YJ work.

*It's always, "What are you doing, they keep reoffending." When you're trying to explain, it does sound like**… "Oh my god I haven't got a very strong argument here," because you feel… yes, ok maybe it is being ineffective about the offending, but there are other ways where it is effective. But when you're standing and trying to explain it [to courts] it sounds very weak***. 'Fiona', YJW

*It's not a way of delivering youth justice the way we have done in the past**. It's always been very regimental, very structured. Some people may, and I don't mean this in a negative way, but some people may find this approach a bit pink and fluffy…*** 'Rachel', YJW

Participants identified a juxtaposition between the TRM and traditional YJS work, and there was a desire for clarity on how to rectify the dissonance between both approaches. Staff appeared to feel caught in the middle of what they perceived to be two opposing roles: to care, or to control. TIC was thus perceived as potentially undermining professionals' authoritative position. Discussing trauma with youth was seen by some as inappropriate work for YJS staff to do, particularly in light of the power dynamics inherent to this enforcement position. There was a frequent conflation between adopting a more caring and therapeutic stance as part of TIC and delivering therapy or trauma-focused interventions. As highlighted in Theme 1, many staff expressed wariness and discomfort about addressing trauma directly with youth, querying their competency and qualifications, and worrying they would be out of their depths. This anxiety seemed to prompt a desire to clarify and delineate the roles and expectations of a YJ practitioner from that of other services more established in caring roles, like mental health.

If we are then building a relationship and working on that young person's trauma… is that then our role? That's a bit controversial, but is that our role? I don't know… Talking about trauma, is this not something they should be doing with a psychologist? Sometimes they don't want to talk to you because we are basically the police in their eyes [laughs]. 'Monica', YJW

To start with I did feel as if… well hang on we're going to be Jack of all trades now? We have no experience in delivering this model, and what is it that you're expecting us to do? We're

not CAMHS, we're not mental health… I think I wasn't alone within my team, thinking that. And I know some people within my team still feel like that. 'Rachel', YJW

Staff identified an incommensurability of TIC principles with some of their enforcement duties, leading some to question certain service practices and obligations. 'Breaching' young people for failing to comply with the terms of their statutory orders was widely interrogated in light of TRM implementation. As staff made sense of these dual professional roles and identities, they began to critically reflect on their beliefs, assumptions, and actions in ways which exemplified experiences of moral injury.

I used to question myself, because in some ways breaching is important – It's about having those boundaries, and they need to know exactly where they stand. But then there was also the other side too - for the TRM, you don't always breach. I was sort of in the middle, between the management and the TRM, and I was like, "where do I go with this?" 'Fiona', YJW

It's really easy to turn around and say "Well actually, let's just breach someone. Let's just take someone back to court". It's an easy process, and it's simple to do. But actually, what are the benefits for everyone concerned by doing that? 'Oscar', OM

3.6.2. Practice vs Policy

Discord was also identified between TRM principles and the organisational expectations and bureaucratic demands placed on workers by the service. Staff were mixed on whether an organisational shift had taken place across the YJS. While most agreed that real shifts in practice and direct work were now being promoted, many reported that minimal policy or procedural changes had occurred to reflect these adopted changes.

Many wished to prioritise time with youth and families in line with the model's attachment-based ethos, but the continued demands of the work and the build-up of bureaucratic tasks were felt to often prevent this. Participants reported that original service timescales for completing assessments and interventions had not been updated to acknowledge the time relationships took to build. Many staff expressed feeling rushed or pressured to adhere to the model within timeframes which were perceived to be unrealistic, and this was identified as a significant barrier to TIC effectiveness. Similarly, despite the TRM's emphasis that cognitive interventions should not be completed with youth too prematurely, staff described continued pressure to meet prescriptive targets to complete offence-focused work, particularly if young people received disposals where directives about interventions often came from panels[3] outside of the service.

[3] Youth offender panels consist of two trained community volunteers, alongside a member of the local YJS. Panels work with children who have received Referral Orders to develop an individual contract which aims to repair harm and prevent future offending. The contract is then supervised by the local YJS (YJ Hub, 2022).

Whilst we can be flexible, we also –we are time-bound to an extent. We have certain things that are put in court orders that we have to deliver on. 'Tessa', OM

Certain panels, when they come to review – If I was to say at the end of the three months, "well we haven't done the knife crime work, we haven't done the drug and alcohol work, but we've done some TRM work…" Education would be needed to be given around accepting that that was ok. 'Lenny', YJW

Managers and frontline workers appeared to differ in their views on whether such service targets posed a significant barrier to TIC. While most managers agreed that service timescales or statutory expectations could pose challenges to effective trauma-informed working, they generally believed that the responsibility to work around these flexibly lay with the practitioners themselves. Service targets were perceived as needing to be addressed on an individual case-by-case basis, rather than through a system-wide top-down rehauling of procedures.

We do have discretion as managers to override on some of those timescales, but it needs to be legitimate. I think if somebody is saying, "I can't have a relationship with this YP just yet, it's going to take a couple of weeks", then that's fine, I don't mind putting overrides on the tool. But they just need to be really clear about that and the work they are delivering and what they are anticipating needs to happen. 'Phoebe', OM

Yet, many practitioners described feeling controlled by the demands of the wider service, and believed that much of senior management and the wider service still prioritised a target-driven, performance approach. Participants reported feeling caught in a balancing act between maintaining fidelity to the TRM and managing the continued mandates of the service. This continued authoritarian pressure and punitive culture (i.e. if timescales were not met) was believed to filter down into their work with young people. There was a desire for people at "the top" to be more connected to practice "on the ground," and for structural changes to policy and procedures to reflect TRM implementation. Many staff expressed fears that, without these changes, the service risked reverting back to its "old" ways of working.

I really like it, I just wish it felt like it was actually being practiced above…. there's just a bit of a conflict about what the YJB is saying, and what we are being informed by our managers. 'Olivia', YJW

Look at the structure, look at the polices. For it to be beneficial and really effective, it needs to be done…Because you're going to have different management, with different opinions, some of them saying "I can't see nothing wrong with the way we worked in the first place". You're going to have some that embrace it, but there's going to be no consistency, and that's not going to work. 'Henry', YJW

There was also a clearly expressed need for clarity on how to apply the model practically and to which cases. Perspectives differed on whether TRM should be a universal approach applied to all young people in the service, or a specific intervention for complex cases where trauma histories had been identified. Staff described feeling overloaded and overwhelmed by the sheer volume of approaches introduced by the YJS over the years. The presence of multiple different models contributed to a fuzzy, unclear picture of the service's priorities, and there was an evident lack of clarity around how these complemented each other. Several practitioners and managers believed that this confusion posed a risk to TRM fidelity and effectiveness.

I think where we are struggling still, is with those cases where they are not screaming trauma, complex needs. And actually, how TRM can support those cases as well. 'Laura', OM

We laid out all of the theories and models that we're currently working with, and it included TRM, it included SOS [Signs of Safety], it included HSB [Harmful Sexual Behaviour], it included contextual safeguarding…Desistance theory…It included all these different things. ***Our practitioners are really good, but they are feeling overloaded by methods of working. And they don't know which one to use, and whether they fit together***. 'Max', OM

This perceived conflict between the organisation's priorities and TRM practice, coupled with the patchwork of models and approaches being promoted simultaneously, appeared to embolden feelings of cynicism or ambivalence about the feasibility or longevity of TIC within the YJS. One practitioner expressed doubt about senior management's commitment to the TRM in the longer term:

> Clark: *It would need to be funded… which I can't see happening–* ***something is flavour of the month****. They put lots of work into making something work, they get lots of people to evaluate, and then* ***the powers that be are constrained by their budget and by austerity measures, and it just gets swept under. Or you get a light version****, that's what usually happens.*
>
> Interviewer: *And in your mind, what does that usually look like?*
>
> Clark: *Less support… the way it could be rolled out is that everyone works this way but with less support for staff.*

What may have initially been expressed as flippant sentiments were later revealed to be eerily accurate predictions. Just months after this interview took place, the TRM was rolled out across the wider service without the same package of clinical supervision support for staff.

3.6.3. Maintaining Balance and Hope in an Oppressive System

Throughout interviews, a further dissonance was identified between the service's promotion of TIC, and the oppressive and often-harmful actions of the wider CJS the team was situated within. Staff appeared to struggle with the continued punitive approaches taken by other YJ agencies and described feeling personally and professionally conflicted about the harm and trauma youth were

exposed to at the hands of this system. The discomfort this evoked appeared to generate a further dilemma for staff about how to promote and implement TIC within a system frequently viewed as broken and oppressive.

Staff described other CJ agencies, particularly the courts and police, as frequently ascribing to more punitive, less compassionate views of justice-involved youth. Despite evidently close working relationships with police, and a few participants identifying as ex-police officers themselves, there was a general consensus by professionals that police attitudes towards young people were often unhelpful, perpetuating difficulties.

I've met some great police officers, but some go in to catch and convict. Police officers that I've dealt with – they've said things where I've just thought, if I said those kinds of things about children, I would get sacked. I would just have to go and get my coat because it would be completely unacceptable. 'Max', OM

Similarly, courts were described as antiquated and fundamentally lacking in an understanding of trauma and its principles. Conflicting approaches taken by courts and the YJS seemed to result in a considerable disjointedness. For example, a few staff members spoke of the lag and delay in court hearings, which resulted in young people being sentenced for historical offences committed numerous months prior. This lag between offending behaviour and court outcomes was felt to damage progress and hinder success, as cases progressing well through the model had subsequently been convicted of crimes committed long before their work with the service had begun.

I think that is a real issue with the wider system that we sit in. These young people are going back to court to face charges that are so historical for them. These young people can't think about what was happening in the moment, let alone 9/10 months ago, and they are expected to be accountable for those actions that have long since moved on for them. 'Betty', OM

Across the board, there was a belief that other CJSs either disagreed with TRM or did not fully understand it, due to more traditional "black and white" views on youth offending. This was perceived to create a tension with other CJS agencies, particularly with the police, whose size and independence were identified as obstacles to working with them collaboratively: "*Two organisations that should be working more closely together, but actually there's friction, there's tension, there's disagreement"* (Max, OM). Many staff described feeling dismissed, pressured, and disrespected when presenting a trauma-informed perspective in multi-disciplinary meetings.

*When you are sitting in a multi-agency safeguarding review or a safeguarding meeting, and the TRM is mentioned…that is when they are quite opinionated on the actual model. Or trauma itself. **They see the behaviours, and they want the behaviours stopped, they are not particularly interested in the underlying reasons or the causations for those behaviours, this young person is***

causing extensive amounts of damage or is being incredibly violent, and they want that stopped, what are you doing to stop it. 'Fiona', YJW

Professionals identified this clash in ideologies between the multiple agencies making up the CJS as a central underlying challenge which generated an incoherent conceptualisation of youth and their risk, resulting in fragmented and disjointed responses. Several staff believed that the propagation of trauma-informed values by the YJB and other directorates rang hollow when many components of the wider YJ system continued to be unsafe.

There's a disconnect between the youth justice board endorsing trauma informed practice and child-first principles, and then we've got our custody, our custodial establishments, that have been documented as clearly unsafe for children to be in. 'Melissa', OM

Many staff expressed feeling powerless to address these differences in perspective, or prevent actions taken by other agencies which were perceived to undo relational work and progress under the TRM, such as further arrests or court sentences.

The decision by police is often, we are just going to charge them. It's about how we manage them under trauma informed practice and also keep them on side, that's the key, we've built that relationship. But the ***police put us in this really difficult position in that we could now lose that relationship over something that we haven't got control over***. 'Oscar', OM

We started to work with him in a trauma informed way, and we were at a point where he was engaging really well…but then unfortunately a couple of weeks ago he was sentenced to a four-month DTO [Detention Order]. Which really does hinder some of that work and just adds to that trauma, because it's custody, he's in a secure children's home, he's away from his family… 'Phoebe', OM

Staff described many CJS processes as actively oppressive and traumatising. Contact with the YJ system was perceived by many to re-traumatise and stigmatize youth, and perpetuate discrimination, racism, and inequality. One young person described an interaction with a previous YJS worker which had left him feeling inherently "bad" and incapable of change.

She used to tell me like, I'm a naughty boy. I'm not gonna – I'm not gonna be able to change or nothing. So, I never really got on with her. 'Sam', Age 17

That court case, that was traumatic for him. When he was sentenced, he didn't know what he was sentenced to, he thought he got 8 years, he'd got two… the barrister didn't even stop and explain things to him… the whole experience was just so traumatising. 'Olivia', YJW

Many staff believed that any changes made with the implementation of TIC were continuously being undermined by the punitive and harmful responses of the wider system. Bearing witness to

the system's re-traumatisation of youth was acknowledged to take a significant toll on staff, several of whom shared examples of feeling emotionally overwhelmed by actions taken by the CJS.

I remember when the verdict came in, I was in court that day with his dad, and I came home that night, and I sat in my garden with my hood up on my dressing gown, and I just cried for about three hours. Because I felt so sad about it. 'Hannah', YJW

In response, many practitioners appeared to express an urge to protect young people from this pain through "fixing" what they perceived as a broken system. Most staff repeatedly expressed a need for TIC to be implemented across the whole of the CJS, in an apparent desire to eliminate trauma and harm from the entire system. Professionals thus seemed to set unrealistic and perhaps idealised expectations for themselves and the TRM initiative as a whole, which they in turn felt unable to meet. Actions of the wider CJS were illustrated by participants in ways which highlighted its enormous sense of perceived power, and staff frequently described feeling hopeless and powerless about their ability to influence structures outside of their control. In some cases, this appeared to drive feelings of doubt and hopelessness about the viability or longevity of TIAs in the YJ system.

The offence that he committed, that's all they could see, that's all he was going to get sentenced for, doesn't matter what I wrote in the court reports. So, if it's going to be embedded in youth justice, it needs to be in the courts as well. 'Olivia', YJW

It has been difficult to see cases where there's been a lot of time invested in young people and actually ***at the end of the day none of that matters, because at the end of the day it's the courts that decide what determines their fate****. That can be really challenging.* 'Betty', OM

As practitioners examined their role within a system perceived as harmful, many staff grappled with how to balance personal and professional values (and those of the TRM), with the organisational priorities of the wider CJS. In response to the often-harsh realities of the CJS, several staff expressed feelings of guilt and ineffectiveness akin to moral injury.

It made me aware of how ***we, over the years, have got it totally wrong****. We've been focusing on the wrong thing for a significant period of time. We were breaching young people, bringing them back to court, some of them ending up in custody which further damages them, all because we were focusing on the behaviour and not the cause behind it*. 'Henry', YJW

You've got a young person that you've really made inroads with, and they go to probation when they turn 18 and then all of that drops away. ***It feels like you're setting this young person up to fail.*** *You're working in this way that's really supportive of them and puts them in the centre, and then you send them to a service where they lose all that support very suddenly.* 'Betty', OM

Yet, the young people interviewed offered a more hopeful vision of the future. As one young person illustrated, the TRM's relational approach offered opportunities to repair some of the harm done by the wider system. This highlighted possible avenues for effecting meaningful structural change, through supporting youth to become active participants in a system that had traditionally oppressed them.

> 'Sam': *I've got a lot more hope in the justice system. I really do. That's the job I want to do – that's actually the job I want to do.*
>
> Interviewer: *You want to work within the justice system?*
>
> 'Sam': *Yeah.*
>
> Interviewer: *Really? Wow! That seems like quite a change in three years.*
>
> 'Sam': *Yeah [laughs]. I want to just – the way [practitioner] has helped me, I want to be able to do that for kids like me.*
>
> .

4. Chapter Four: Discussion

4.1. Overview

This qualitative study investigated the experiences of staff, youth, and families involved in a system-wide TIA, the Trauma Recovery Model, in one YJS in the east of England. To our knowledge, there has been no previous published empirical research evaluating TIC in a UK YJS. The present study had three main aims: to identify crucial components and facilitators of TIC implementation; to explore the benefits and perceived impact of the TRM; and to examine challenges or barriers to TIC implementation in a YJS. Reflexive thematic analysis of 23 interviews (comprised of 19 staff members and four youth and/or caregivers) generated four main themes: Seeing Youth Justice through a Trauma Lens; Relational Practice and Repair; Trauma in the Wider Caregiving System; and Role Conflict and Ambiguity. A discussion of the key ideas arising from these themes and how they pertain to the study's research aims is described below.

4.2. Summary of Results

Facilitators of TIC delivery in the current study included staff training and skills workshops on trauma, collaboration within and across agencies (through multi-disciplinary formulation meetings), and the adoption of a more strengths-based, relational practice with young people. Clinical supervision was identified as essential to TIC success, perceived by staff as crucial in facilitating the trauma lens, ensuring practice aligned with principles, and providing staff with safe and contained reflexive support. The model's emphasis on the emotional and relational safety of young people, and the prioritisation of building consistent and trustworthy relationships with youth, were also widely valued by practitioners who appreciated working in a more flexible and less prescriptive way.

Relational improvements between staff and youth were the most significant benefit of TRM implementation. Youth reported feeling safer and more trusting of YJS staff, describing YJS responses which were less regimented and more compassionate. Anecdotal evidence highlighted other potential advantages of this approach, such as improved engagement and collaboration with other agencies, reduced offending, and better outcomes for youth. Implementing TIC was also believed to have increased staff awareness and discourse around STS and trauma. Across the service, a central benefit of TIC was the conceptual shift towards more compassionate, thorough understandings of and responses to youth offending, through the application of a trauma lens.

Staff described several challenges and barriers to TIC implementation within the YJS. The TRM was described as resource-intensive, and organisational and bureaucratic pressures (such as time frames, statutory requirements, paperwork volume, and underfunding), were believed to impede practitioners' capacity to deliver the TRM. Inconsistent support for TIC by senior leadership and the wider YJ system, coupled with minimal updates to service policies or procedures, were identified

as central barriers to TIC fidelity and longevity. A lack of consistency and professional buy-in by other agencies were highlighted as barriers to ensuring consistency of TIC and minimising harm to youth. Challenges relating to the dominance of more traditional enforcement-led values, beliefs, and priorities within the YJS were also highlighted, which appeared to generate dissonance and dilemmas for staff in implementing TIC.

Table 12 summarises the key findings of this thesis as they pertain to each research aim.

4.3. Synthesis and Interpretation of Key Findings

Overall, our findings are largely consistent with a growing evidence base on the implementation of TIC across settings serving vulnerable youth, including child welfare and justice agencies. Several key components of TIC in the current study (such as staff training, clinical supervision, and a relational approach) have been outlined in previous research (Bartlett et al., 2016; Hanson & Lang, 2016; Kerns et al., 2016) and recommended TIC practice (Branson et al., 2017; Sweeney et al., 2018), with similarly cited evidence of effectiveness and benefits at all service levels (Bryson et al., 2017; Bunting et al., 2019) – *or see Chapter 1*. Correspondingly, several obstacles identified by staff (such as limited timescales or organisational demands) were also cited in our review and previous TIC literature, suggesting that these constitute widespread challenges for TIC initiatives across settings (Akin et al., 2017; Bartlett et al., 2016; Sweeney et al., 2018). Nonetheless, the vast majority of research on TIC comes from non-correctional settings, and our systematic review identified limited qualitative research from YJSs. Our findings thus highlight some unique considerations for the delivery of TIC in YJ contexts which inherently involves the coercive or power-over relational dynamics which TIC attempts to minimise. A discussion of the primary findings from this thesis and their association with relevant empirical and theoretical literature is provided below.

Table 12 Summary of results

Facilitators and Key Components	Benefits and Impact	Barriers, Challenges, and Obstacles
Training and ongoing skills workshops	Conceptual and orientational shift – the trauma lens	Resource-intensive and time-consuming
Clinical supervision and reflective spaces	Increased staff awareness and competence in recognising and managing traumatic stress in youth	Bureaucratic pressures and service requirements (timescales, paperwork)
Including trauma informed language in reports and assessments	Improved quality of relationships between staff and youth: increased trustworthiness, respect, mutuality, and respect	Training fatigue and overwhelm; "another thing" staff have to do
Updating policies and procedures to reflect TIC	Interventions more flexible, creative, and holistically tailored to meet youth needs	Confusion about how to fit it in with existing approaches
Collaboration with other caregiving systems (housing, education, healthcare, social care)	Service prioritisation of relationships and youth safety before commencing offence-focused work	Staff attitudes towards TIC – e.g. too "pink and fluffy"; weak and soft; not novel, already being done
Reducing and re-evaluating punitive service responses (e.g. breaching, compliance expectations)	Youth opening up more to staff, more receptive to help	Perceived conflict with enforcement roles/duties
	Reductions in youth offending behaviour	Conflation with TF therapies and interventions
	Improvements in youth engagement with service, other agencies	Staff discomfort/reluctance to ask about trauma
	Increased attendance at school; Engagement with education, employment	Perceived lack of management and organisational investment or buy-in
	Referrals to mental health services	Minimal policy or procedure changes to reflect practice "on the ground"
	Reductions in substance and alcohol misuse	Wider organisational pressures (lack of funding, governmental priorities)
	Improved relationships between youth and families	Lack of professional buy-in from other services; Disjointed and fragmented responses by other agencies
	Increased reflexivity amongst staff	Lack of consistency or shared TIC language with other agencies
	Increased awareness of STS and impact of trauma on staff	Punitive, traumatising, and anti-TIC responses by other CJS agencies
	Staff access and use of clinical supervision	Ongoing transmission of trauma in youth environments e.g. home, communities
	Improved collaboration with other agencies	Staff trauma, STS, and burnout

Note: Summary table of key results identified from analysis, structured as they pertain to the three primary aims of the study.

4.3.1. What are the Active Ingredients of TIC in YJSs?

4.3.1.1. The Trauma Lens: A Conceptual and Orientational Shift in Youth Justice

In the present study, implementing TIC provided practitioners with a framework for understanding the nexus between complex developmental trauma and offending behaviour. Literature on TIAs has repeatedly emphasised TIC as an orientational framework for understanding the impact of trauma on client presentations and behaviour, which allows for negative views of current functioning to be reframed as adaptive strategies emerging in response to early adversity (Levenson, 2020; Sweeney et al., 2018). Consistent with our review, staff reported greater awareness of the impact of trauma on youth, and increased confidence in shedding light on how such difficulties may manifest as behaviour relevant to the YJS (Baker et al., 2018; Damian et al., 2018). There was also evidence from participants that this conceptual shift filtered down into the experiences of youth and families, who similarly experienced responses which were more understanding and less punitive, consistent with previous research (Hidalgo et al., 2016; Kramer, 2016) - *or see Chapter 1*.

By considering early trauma as a possible contributory factor when conceptualising youth engagement challenges, responsibility for attendance and engagement with the YJS shifted from youth and was instead placed on professionals (Levenson, 2020). 'Compliance' was thus re-conceptualised as engagement, and focus was shifted away from punitive, authoritarian responses to engagement challenges towards more creative, flexible, and persistent approaches which acknowledged the time youth may need for trust to build. Staff identified language as a central to facilitating this shift, and changes to policies and procedures to reflect TIC language were identified as crucial in embedding and maintaining this trauma-informed orientational shift, in line with the wider TIA literature (Bryson et al., 2017; Treisman, 2018). Other components of TRM delivery, such as trauma-informed case conceptualisation meetings, clinical supervision, and reflective case discussion spaces, were also identified as facilitators of the trauma lens. Consistent with past studies, the provision of supervision and discussion spaces enabled practitioners to make ongoing connections between young people's past adversities and current presentations, and purposefully generate corrective strategies for intervention (Cordis Bright, 2017; Dunkerley et al., 2021).

4.3.1.2. Relationality as a Central Component and Mechanism for Change

Another particularly salient finding from this study was the role of relationships in promoting TIC values of safety, trustworthiness, and collaboration. TIC is at its core a relational model which highlights the importance of organisations providing safe helping relationships to survivors (Sweeney et al., 2018). Consistent with prior research, practitioners valued the TRM's emphasis on relationship-building, and described shifts in relational practice which provided youth with more consistency, reliability, and interventions which were individually tailored, delivered and paced appropriately to meet their needs (Dunkerley et al., 2021; Levenson, 2020) – *or see Chapter 1*. Relational improvements were similarly echoed in youth accounts – young people described

practitioner interactions which were authentic, non-judgmental, and empathic, highlighting important ways in which TIC implementation may benefit youth, in line with research (Kramer, 2016).

Both staff and youth identified the transformative power of relationships under the TRM as being a central mechanism through which other youth-level improvements were facilitated, consistent with findings from our review. Staff participants widely valued the sequencing of the TRM, and its emphasis on providing safety and stability prior to commencing offence-focused interventions. Findings further suggested that once youth felt sufficiently safe and stable, they could be supported to make other meaningful changes in their lives, such as reducing their offending or substance use, engaging with mental health services, or improving relationships with their families. Evidence from quantitative research has highlighted similar benefits of TIC, including improvements in behavioural and mental health difficulties (Baetz et al., 2019; Elwyn et al., 2015). However, our review highlighted minimal exploration of relational indicators of improvement, and the mechanisms through which TIC may yield such outcomes are not well understood. Nonetheless, our results are supported by the wider literature on TIC, trauma, and other good-practice models designed to work with complex youth, such as AMBIT (Fuggle et al., 2016) which have similarly emphasised the prioritisation of supporting youth to regulate and develop capacities for relating before commencing with other work (Cohen & Mannarino, 2015; Perry, 2001). Taken together, such findings reiterate that TIC effectiveness is grounded in its facilitation of more trusting and respectful interactions, while also equipping staff with additional knowledge and confidence in responding to youth dysregulation.

Adopting a strengths-based relational approach is not distinctive of TIC models, specifically, and implementing TIAs is also not a prerequisite for improved staff-youth relationships. In line with past studies, good relationships were perceived to also be due to individual practitioner skill, and possible within a variety of frameworks (Elwyn et al., 2017; Hanson & Lang, 2016; Kramer, 2016). Many components of TIAs overlap with numerous other good practice approaches, or simply form part of culturally and developmentally competent practice (Becker-Blease, 2017; Sweeney et al., 2018). Previous surveys of professionals in child welfare settings have similarly found that TIC components most commonly implemented across services tend to be those which have a high degree of overlap with standard practice (e.g. a strengths-based approach) (Asmussen et al., 2022; Hanson & Lang, 2016). In UK YJSs, many of the cornerstones of TIC align well with existing strengths-based, biopsychosocial frameworks of youth offending work, such as desistance (Wigzell, 2021) or Child First (Case & Browning, 2021).

Consistent with this, many professionals struggled to reconcile or distinguish the TRM with other existing initiatives, and several did not perceive it to be novel, in line with a previous TRM evaluation (Cordis Bright, 2017) and prior research (Asmussen et al., 2022; Damian et al., 2017; Donisch et

al., 2016). Beliefs that TIC is already being done have been cited as a key misconception (Sweeney & Taggart, 2018), and represent a barrier to its uptake or fidelity (Ezell et al., 2018; Sweeney et al., 2018). Such findings also suggest that TIC is an often-ambiguous concept, meaning different things to different people (Branson et al., 2017; Donisch et al., 2016). This is concerning, as amorphous definitions of TIC or what it involves may place it at risk of becoming diluted, or misrepresented as little more than treatment as usual (Hanson & Lang, 2016; Sweeney & Taggart, 2018).

4.3.1.3. Sensitive Trauma Enquiries with Youth

Although staff widely valued the service's adoption of a more therapeutic TIA, they also expressed anxiety about addressing trauma histories safely and sensitively with youth and families. Additionally, most young people on the TRM pilot were not aware they were being worked with under the TRM (Borrett, 2021), and examples of trauma or the TRM being discussed with youth were comparatively rare. Past research has similarly found that trauma is often not routinely investigated in healthcare, social care, or justice settings (Hepworth & McGowan, 2013; Raja et al., 2021; Read et al., 2018; Zelechoski et al., 2021). Staff described fears of "opening pandora's box" or inadvertent re-traumatisation, consistent with widespread beliefs that talking about traumatic experiences may exacerbate distress (Chadwick & Billings, 2022; Finch et al., 2020; Kirst et al., 2017). Such concerns have been cited in previous TIC research (Kerns et al., 2016), and represent valid fears given the potential for re-traumatisation when describing traumatic events, particularly if staff are not adequately trained (Sweeney et al., 2018). Nonetheless, an absence of sensitive trauma enquiries is likely to mean that some youth with relevant histories are not identified (Hamberger et al., 2019).

Youth may not recognise or share beliefs of the adverse lasting effects of past events, due to differing definitions of trauma, or the normalisation of traumatic events within families and communities (Sweeney et al., 2018). By asking youth about their histories, services avoid placing an overly determined emphasis on trauma or trauma-only explanations, or positioning youth as victims in ways which limit access to other, preferred identities (Sweeney & Taggart, 2018). Promoting sensitive trauma enquiries by staff may serve to assuage concerns that TIC initiatives risk overemphasising the role of trauma, or providing oversimplified 'excuses' for complex presentations with multiple causes (Sweeney et al., 2018; Sweeney & Taggart, 2018).

Staff also expressed confusion about how to apply the TRM to cases where complex trauma histories were not evident. While all justice-involved youth are likely to benefit from some system-wide TIC components (such as promotion of relationship-building or a culture of safety), not all young people involved in the justice system will be traumatised (Ford & Blaustein, 2013). Conducting trauma-informed formulations or interventions in the absence of such histories is likely to be ineffective, or at the very least inappropriate and unnecessary (Becker-Blease, 2017).

Delivering TIC without directly consulting with youth and/or families may also illustrate powerful historical influences of "traditional" approaches to youth justice, and the imperative need for staff in the system to retain a perceived sense of control due to underlying anxiety or beliefs that the system is better able to 'know what's best' for youth than they and their families may know themselves (Ford & Blaustein, 2013).

Previously cited organisational barriers to delivering TF interventions, such as a lack of structural support and training or clear referral pathways, may have also played a role (Finch et al., 2020). As non-clinical professionals, justice staff may feel insufficiently equipped to respond effectively to disclosures, or have trouble with the practical day-to-day application of TIC concepts, thus valuing skill-based instructional training on how to sensitively ask about trauma and put therapeutic skills into practice (Donisch et al., 2016; Rose et al., 2011). Staff also expressed beliefs that addressing trauma was within the realm of mental health services, suggesting a conflation between TIC and specific TF interventions, as highlighted in past research (Asmussen et al., 2022; Chadwick & Billings, 2022). Such findings reiterate the importance of improving processes for the sensitive recognition of trauma, PTSD, and other trauma sequelae in YJSs, so that access to appropriate evidence-based treatments can be facilitated.

4.3.1.4. Balancing TIC against Organisational Priorities

A primary discomfort evoked in YJ staff was a perceived conflict between TIC practices and the more rigid and boundary-enforcing aspects of their roles as correctional officers. Perceptions that TIC contradicts primary organisational goals or cultural norms has been cited as a central obstacle to its implementation in YJ settings (Donisch et al., 2016; Pickens, 2016). Consistent with the 'care or control' forensic literature, participants described balancing multiple service demands and performing roles which were at times perceived as incompatible or contradictory (Jacob, 2012; Reeder & Meldman, 1991; Willmott, 1997). Implementation of TIC in justice settings, and its facilitation of a trauma lens through which offending is viewed, may further pose unique challenges to the 'victim-perpetrator dichotomy' (Bridge, 2021; Drake & Henley, 2014). The observed dichotomization of staff roles in the current thesis may have occurred within this context, as practitioners grappled with dilemmas of when and how to treat youth as survivors in need of care and compassion, or offenders requiring discipline and punishment. Previously cited perceptions of TIC in the YJS include that it is too 'nice', 'soft', or 'lenient' to the causes or consequences of offending, suggesting similar experiences of discomfort amongst justice professional groups in relation to this care-control, victim-perpetrator dichotomy (Damian et al., 2017; Ezell et al., 2018).

Implementing TIC in YJSs will undoubtedly place ideological and organisational restrictions on the extent to which some TIC principles can be promoted. Yet, establishing structure and boundaries remain central tenets of many TIC models developed for working with traumatised youth, highlighting ways in which TIAs complement more enforcement-led aspects of staff professional

duties (Bloom & Sreedhar, 2008; Rivard et al., 2005). The dissonance staff described may therefore reflect a gap created between the idealised concept of TIC, and what they perceived to occur in practice. Previous concerns have been raised regarding the potential for TIC to become idealised as a fantasy of "perfect" care, into which all aspects of good and compassionate practice are projected (Becker-Blease, 2017; Hanson & Lang, 2016). Consistent with this idea, our findings illustrated examples of professionals setting unrealistic expectations for TIC, in an apparent idealised desire to eliminate the potential for trauma and harm across the entire CJS. Staff similarly expressed beliefs that without its wider implementation across the CJS, TIC in the YJS could not be successful. Such an all-or-nothing dichotomy is evocative of the psychoanalytic paranoid-schizoid position (Roth, 2001), indicating the possible presence of organisational psychodynamic processes (Hyde & Thomas, 2002). Anxiety and organisational defences, which may arise from the specific threats associated with the nature and context of YJS work, may have deepened following attempts to change existing patterns of work, highlighting a potential organisational obstacle to TIC implementation (Hyde & Thomas, 2002). Very little has been published on how TIC may evoke such dissonance amongst YJ staff, clearly warranting further investigation (Levenson et al., 2022). Implementing TIC in YJSs may require explicit acknowledgement by service providers of the remits of TIC within YJSs, the sorts of dilemmas staff may face, and the provision of appropriate clinical and organisational responses (Anderson et al., 2017; Donisch et al., 2016; Kinsella et al., 2021; Pickens, 2016).

4.3.2. The Impact of TIC Implementation on Staff

4.3.2.1. STS and the Role of TIC

Findings reiterate that staff working in criminal justice settings are exposed to primary and secondary traumatic stressors through their professional work (Ford & Blaustein, 2013; Levenson & Willis, 2019). In line with research, most interviewed staff acknowledged exposure to potentially traumatising and distressing events, including incidents of serious violence, working with disturbing offending behaviours, reading and hearing the details of youth's complex trauma histories, and responding to the intense behavioural and emotional needs of a highly trauma-impacted population (Ford & Blaustein, 2013; McElvaney & Tatlow-Golden, 2016). Our results further highlight that professionals working in YJS often have personal histories of trauma, loss, and adversity which may mirror those of the youth they serve (Esaki & Larkin, 2013). The very nature of YJSs means that many youth will carry weapons, have known criminal associations, and be at risk of future violence, thus posing an active threat of harm towards staff (Ford & Blaustein, 2013).

Collectively, such experiences place YJS staff at an increased risk of STS (Frost & Scott, 2020; Sage et al., 2018). Several practitioner accounts captured STS experiences, including nightmares, intrusive images, avoidance, and overwhelming distress. Many concerns raised in staff interviews (such as high and complex caseloads, low perceived quality of managerial supervision) have been

identified as potential contributing factors to STS in mental health practitioners (Sutton et al., 2022) and social workers (Quinn et al., 2019). High levels of work stress, lower perceived manager support, and personal trauma histories have also been identified as risk factors for PTSD and Complex PTSD (CPTSD) in UK police (Steel et al., 2021). Research examining trauma and STS amongst justice professionals remains relatively limited. Existing studies have predominantly focused on staff working in prison and correctional settings (Carleton et al., 2020; Newman et al., 2019; Regehr et al., 2021) or police officers (Biggs et al., 2021; Stancel et al., 2019; Steel et al., 2021; Syed et al., 2020), and we identified little research on STS within YJSs, specifically. Work-related traumatic stress symptoms amongst frontline justice staff are associated with impaired job performance, including staff absence, sickness, and turnover, suggesting that it is a pertinent issue for services (Denhof & Spinaris, 2013; Jaegers et al., 2019).

Some participants expressed beliefs that TIC had increased experiences of STS and burnout amongst staff, through promoting trauma enquiries and a more therapeutic approach. Staff described feeling emotionally overwhelmed by having to absorb, contain, and respond to the traumatic experiences (and associated distress) of their cases. Staff also reported 'taking their work home with them' and acknowledged an increased sense of responsibility for youth and families which was attributed to the TRM's attachment-based relational model to varying degrees. Such findings are consistent with a few previous studies, which have similarly queried the role TIC implementation may play in increasing experiences of STS or burnout amongst justice staff (Baker et al., 2018; Damian et al., 2019; Kerig, 2019a). However, many practitioners perceived the emotionally demanding nature of YJS work not as a consequence of TIC but rather a normalised 'part of the job' when working with complex and hard-to-reach young people, consistent with past studies (Donisch et al., 2016; Ezell, 2019). Additionally, the presence of several other contributing factors makes it challenging to ascertain the specific impact of TIC components on professional experiences of STS or burnout. The impact of COVID-19 on experiences of professional isolation and burnout is well-documented (Billings, Abou Seif, et al., 2021; Billings, Biggs, et al., 2021). Practitioners reported that informal staff support, crucial to their wellbeing, had substantially reduced in the wake of remote working mandates, consistent with research (Sutton et al., 2022). Staff also described feeling fatigued by the service's introduction of multiple competing trainings, and frustrated with perceived disconnects in organisational expectations and priorities and an overall lack of socio-political support, all of which have been identified as factors which may contribute to professional anxiety, STS, and burnout (Ford & Blaustein, 2013; Sutton et al., 2022; Sweeney et al., 2018).

System-wide TIC has frequently been cited as a potential mitigator of STS amongst high-risk professional groups, through increasing awareness and facilitating staff to take purposeful steps in addressing the impact of trauma exposure (Branson et al., 2017; Bunting et al., 2019; Ezell,

2019). Similarly, staff in the current study reported that TIC implementation had generated open and honest conversations regarding the impact of trauma and STS in the workforce. Many participants reported a significant shift in YJS culture around vulnerability, and the TRM had reportedly increased staff confidence and reflective capacity to consider the influence of trauma and STS in ways previously unnoticed, findings supported by previous qualitative research (Baker et al., 2018; Donisch et al., 2016). In their review of TIC definitions across juvenile justice systems, Branson and colleagues (2017) noted a troubling omission of recommendations to support work-related traumatic stress. The provision of safe, containing, and reflexive clinical supervision was identified by staff as essential to facilitating such discussions and navigating emotional difficulties which arose from this work. Our findings thus have important clinical and policy implications for how YJSs can best support staff when implementing TIC, given that discussions about STS may be relatively novel in YJ contexts.

4.3.2.2. Moral Injury amongst YJS Staff

Another novel and preliminary finding emerging from this research was the potentially significant role of moral injury. Although definitions vary widely, moral injury is largely understood as a construct relating to the perpetration, witnessing, or learning of acts in high-stakes situations that transgress deeply held moral beliefs and expectations (Litz et al., 2009). Literature on moral injury predominantly comes from military or veteran population (Griffin et al., 2019), however there is an emerging evidence-base exploring this construct in professional contexts such as child protection officers (Haight, Sugrue, Calhoun, et al., 2017; Haight, Sugrue, & Calhoun, 2017), school teachers (Sugrue, 2020), or healthcare professionals in the wake of COVID-19 (Litam & Balkin, 2021). Across this literature, studies describe moral injury-responses experienced by staff in the context of performing their professional roles or duties, resulting in feelings of demoralization, guilt, and helplessness (Griffin et al., 2019; Litz & Kerig, 2019). In one mixed-method study of child protection professionals (Haight, Sugrue, & Calhoun, 2017), participants described anger, sadness, and troubling existential crises arising from their involvement in a system intended to help vulnerable families but which instead often caused harm.

Staff in the present study similarly described feeling personally and professionally conflicted about how they, and the wider YJ system, should respond to youth. As staff reflected on their punitive or enforcement-led actions and those of the wider system, they expressed feelings of discomfort, guilt, disillusionment, powerlessness, and despair, consistent with past literature on perpetration-based constructs of moral injury (i.e. the extent to which an individual appraises themselves, or their superiors, as having committed moral violations) (Griffin et al., 2019). The potential for professional situations to transgress deeply held moral beliefs and expectations may be further increased in YJ contexts, given the complexities of both offender-victim and child-adult dichotomies, as illustrated by study participants. As our results highlighted, professionals working in YJ settings bear witness to discussions of trauma, violence, and atrocities that not only happen

to young people, but in many cases are also perpetrated by them. Staff must therefore have capacity to hold dual perspectives on the youth they work with, and tolerate the intense feelings of helplessness, anger, and disgust which may arise, as well as secondary feelings of shame arising from feeling negatively towards youth they are supposed to empathize with (Litz & Kerig, 2019). This represents a significant personal and professional challenge for staff which may contribute to STS and professional burnout (Haight, Sugrue, & Calhoun, 2017; Litam & Balkin, 2021; Stancel et al., 2019). Despite the relevance of moral injury constructs to criminal justice settings, there has been little published research to date (Griffin et al., 2019). Existing studies have predominantly focused on the moral injury experiences of police officers (Papazoglou et al., 2020; Stancel et al., 2019), and we identified no study which examined this in YJ contexts, specifically, highlighting novel and important new avenues for research.

4.3.3. Traumatised and Traumatising Systems: Wider Organisational and Systemic Challenges to TIC Implementation in YJSs

4.3.3.1. The Parallel Processes of a Traumatised System

Overwhelming stress and trauma are not just critical factors to consider for youth or staff, but also for entire organisational systems (Bloom, 2006a). Many staff described struggling to balance TIC against organisational bureaucratic pressures, reporting feeling overworked, constrained by timescales, consumed by paperwork, and unsupported by management, consistent with findings from other justice settings (Norman & Ricciardelli, 2021). Many issues identified by staff (such as austerity, underfunding, a lack of resources, increasing work pressures, and limited timeframes) are not unique to YJSs, representing commonly identified barriers to working in UK public sector agencies (Sweeney et al., 2018). Nonetheless, such organisational barriers are reflective of the chronic pressure and stress placed on systems, in social and economic contexts which are frequently hostile to the aims of recovery or rehabilitation (Bloom, 2006b; Ford & Blaustein, 2013).

Staff described working across fragmented, disconnected services and agencies whose priorities and positions were perceived to compete or contradict each other, in line with research illustrating ways in which teams and systems can be affected by working with complex trauma (Bevington et al., 2015). Staff identified instances of top-down, authoritarian managerial styles and YJS mandates which did not feel aligned with TIC. The YJS was perceived to be controlled by powerful larger bodies (such as local statutory panels, the YJB, or government strategies) which instructed the directions and priorities for interventions in ways not reflective of the values purported by the implementation of TIC at a local service level. For example, while the TRM emphasises the ineffectiveness of cognitive interventions for youth in the absence of safety and stability (Skuse & Matthew, 2015), staff reported that desistance and offending interventions (such as knife-crime or anger management) continued to be mandated as part of statutory order requirements, suggesting a continued focus by Youth Offender Panels on externalising and delinquent behaviours, rather than underlying complex trauma 'drivers' (Ford & Blaustein, 2013; Graves &

Shapiro, 2016). The wider criminal justice system was perceived as rigid, archaic, punitive, and resistant to the adoption of TIAs. In response to these systemic pressures, many staff described feelings of hopelessness, powerlessness, and despair.

Collectively, it could be argued that such barriers represent symptoms of a traumatised system, consistent with "parallel process" literature which emphasises that organisations are also vulnerable to the effects of acute and chronic stressors which can accumulate over time (Bloom, 2005, 2006a, 2006b, 2010). The term parallel process is understood as a tendency for systems with significant relationships to one another to develop similar affects, cognitions, and behaviours, highlighting ways in which organisations can respond to chronic and repetitive stress in similar ways to traumatised youth (Bloom, 2010). The learned helplessness and disempowerment described by staff could therefore be interpreted as a traumatised response to crises and authoritative leadership (Bloom, 2010). The fragmentation and pressure described across services may also reflect proposed theories of "mission mirroring", wherein systems inadvertently mirror the causes they were created to work with – for example, staff describing feeling overwhelmed, chaotic, disorganised, and though they had too much to think about, experiences akin to those of the justice-involved youth they serve (Allyn, 2011). Ford and colleagues (2013) highlight how justice services can become trapped in similar survival mindsets to those of traumatised children, with the preservation of the status quo becoming valued over and above continual growth and improvement. Punitive or pathologizing correctional philosophies are thus conceptualised as defensive survival responses on the part of CJS professionals, policy-makers, and officials who have become dysregulated as a result of combined experiences of vicarious trauma, direct exposure in the line of duty, political and economic pressures, resource constraints, and real or perceived threats (Ford & Blaustein, 2013).

Collective traumas, defined as "a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality" (Erikson, 1994, p233), can have a devastating impact on organisations and deepen trauma-organised organisational responses (Bloom, 2006b). The impact of COVID-19 can thus also be understood within this framework, as a global collective trauma which posed significant threat to the cohesion and order of YJ organisations (Bloom, 2006b). Taken together, such findings illustrate the significant obstacles posed to TIC implementation across YJ settings, given that when staff and systems feel under threat or overwhelmed, they may be more likely to respond in authoritarian and punitive ways, particularly in crisis situations (Bloom & Sreedhar, 2008; Ford & Blaustein, 2013). Traumatised systems are thus at risk of recapitulating the very experiences proven to be harmful for the people they are supposed to help (Bloom, 2010).

4.3.3.2. Working within Harmful and Oppressive Systems

While the helplessness and powerlessness evoked in staff accounts can be conceptualised as symptoms of a traumatised system, our results also raise the question of how to integrate TIC into systems which continue to be traumatising or predicated on oppression and control. Staff highlighted the challenges of addressing trauma in a youth population where traumatic stress is not "post" but active and ongoing due to community violence or intergenerational trauma. A growing body of research has acknowledged ways in which the frequently pathologized responses of traumatised youth (such as hyperarousal or hypervigilance) may be adaptive or protective coping strategies in response to the dangerous characteristics of their environments (Gaylord-Harden et al., 2017; Kerig et al., 2016; Phan et al., 2020). This raises important clinical questions of how best to support youth in active trauma-inducing environments. Furthermore, the evidence-base for TIC (and the TRM, specifically) comes largely from secure environments, and results from this study highlight the nuanced challenges of implementing TIC in community YJS settings where organisational capacity to address and minimise threat is more limited.

Consistent with prior studies, young people's contact with the justice system, and interventions designed to manage this contact, were described as often unhelpful, unnecessarily punitive, and re-traumatising (Agenda, 2021; McAlister & Carr, 2014; Nolan, 2020; Simmons-Horton, 2021). Several aspects of the YJ system may be experienced by youth as triggering or re-traumatising (Ford & Blaustein, 2013; Levenson & Willis, 2019; Miller & Najavits, 2012) . A primary goal of TIC is to minimise re-traumatisation through reducing or eliminating harmful practices like seclusion or restraints, with research suggesting it can be successful in achieving such organisational aims (Baetz et al., 2019; Borckardt et al., 2011; Bryson et al., 2017). However, beyond the reduction of harmful practices, TIC seeks to promote an organisational culture of safety and compassion (SAMHSA, 2014). Staff questioned how TIC could be adopted locally, when aspects of the UK YJ system continued to be unsafe and traumatising for children, highlighting disconnected and competing organisational expectations and priorities. Such concerns are not unique to this study, having been previously cited as organisational barriers to TIC implementation (Levenson & Willis, 2019; Sweeney et al., 2018).

The socio-political context of the YJ system at the time of this research study may have influenced staff concerns. In March 2021, the Police, Crime, Sentencing and Courts Bill was introduced, which stated aims include to enhance public safety through the introduction of tougher sentencing and increased powers for police, courts, and probation staff (House of Commons, 2022). Since the Bill's introduction, there have been widespread concerns raised about its potential to undermine YJS priorities by sweeping greater numbers of young people into the criminal justice system (Bridge, 2021). Recent reports have highlighted BAME children's disproportionate representation in the YJ system (Lammy, 2017), and the Metropolitan Police has been entrenched in media scandal, most recently with the case of Child Q, a 15-year old black girl strip-searched by police at her school

(Gamble & Mcallum, 2022; Hughes, 2022). Such incidents have repeatedly highlighted issues of avoidable trauma perpetrated by institutionally racist organisations, and the myriad young children who continue to be criminalised and traumatised at the hands of the justice system. While YJS workers are in a powerful position to support young people to navigate the realities of such harmful systems, efforts to reverse this dissonance, perhaps through embedding TIC across other CJ contexts, are also needed.

4.4. Strengths and Limitations

This thesis is the first (to our knowledge) to explore the implementation of a TIA in a YJS in England. Our systematic review identified no published UK research evaluating TIC initiatives in settings serving justice-involved youth. While a similar TRM approach was piloted and evaluated in Wales (Cordis Bright, 2017), findings from this thesis are novel and contribute to small yet necessary evidence-base. Employing a qualitative study design allowed for perspectives to be explored in-depth, and for nuanced issues relating to TIC implementation to be fully elucidated. Our inclusion of individual interviews with youth and their families, something which our review highlighted had not been present in past research, was another strength. While moderately sized, the present study surpassed the recommended sample size of 10-20 as outlined by Braun and Clarke (2019) for doctoral thesis research using thematic analysis.

Despite these strengths, the findings from this thesis must be considered in light of several limitations. This study reports on experiences of one specific TIC initiative implemented in a single YJS in England, limiting generalisability. Findings are acknowledged to be a snapshot during an evolving implementation period. While the inclusion of staff from both the initial pilot and the wider roll-out allowed for a range of perspectives and experience levels to be gathered, it is anticipated that as staff continue to adapt and familiarise themselves with TIAs, their perspectives may evolve. Given the qualitative study design, evidence of benefits and improved outcomes are anecdotal and cannot be attributed solely to the implementation of the TRM.

Several aspects of the present study were hindered by the COVID-19 pandemic. The YJS transitioned to remote and virtual practices because of national lockdowns, which impacted the overall delivery of the TRM by staff and the nature and quality of direct work with youth. Furthermore, working from home may also have impeded professionals' ability to reflect or comment on certain areas explored within interviews, such as the quality of staff interactions, team dynamics, or organisational culture. All interviews were conducted remotely, which may have also impacted the depth or quality of data collected.

Limitations of the wider implementation study and intervention must also be considered. The TRM was originally developed as an approach for use in secure residential children's homes (Skuse & Matthew, 2015). While a similar adaptation was implemented and evaluated across three YOTs in Wales (Cordis Bright, 2017), it is not a commonly used framework in YJSs, and there have been

no peer-reviewed, published evaluation studies examining this approach in community YJ settings. This raises questions regarding the model's theoretical suitability or applicability, as well as specific practical considerations in community settings where providers' capacity to provide environmental safety and stability are more limited. Furthermore, a lack of consistency in approaches across YJ systems, coupled with local adaptations made to the TRM as part of the wider service roll-out (such as the scaling-down of psychological input) make it challenging to make direct comparisons with similar TRM evaluations (Cordis Bright, 2017) or other TIAs.

Participants were predominantly white British, and our youth participants were all male, preventing an exploration of issues relating to diversity or gender-responsivity, both of which have been identified as important considerations of TIC (Covington & Bloom, 2007; Crosby, 2016). While adolescent males make up a larger proportion YJ population, justice-involved girls report higher prevalence rates of complex trauma, and present with a greater risk of exposure to certain trauma types considered highly relevant to their offending behaviour, such as CSE (Chaplo et al., 2017). Past research has also consistently demonstrated racial disparities in the YJ system, with black youth vastly overrepresented and more likely to receive harsher and more punitive responses (Gilmore & Bettis, 2021; Haerle, 2019). Our study was unable to elucidate how TIC may acknowledge or address such gender or racial disparities in both experiences of trauma and the justice-system, representing an important avenue for future research.

We had considerably fewer youth/caregiver participants than anticipated, due largely to the challenges of research in this population and the barriers posed by remote recruitment. Overall, this limited our ability to explore the perspectives of those receiving the TIC intervention, and explore themes in relation to individual differences within the youth participant group. The study's reliance on YJS practitioners as gatekeepers to accessing young people may have also introduced bias. Practitioners were protective of their clients, and few identified potentially eligible cases, further posing a barrier to recruitment. Furthermore, practitioners may have been more likely to identify young people as suitable for taking part if they had responded positively to the TRM intervention, or if they were presenting with less evident complexity or risk at the time of recruitment. Young people who had more negative experiences of the YJS may have similarly been less likely to agree to take part in this research study.

As an external researcher invited into the service, approval arrangements for conducting this study included instructions not to explicitly mention the TRM or TIC, and the researcher was also not permitted to ask young people directly about trauma histories. Not only did this restrict the richness of the data collected from their interviews, but it also had significant ethical implications which were discussed in detail with supervisors. The researcher's ability to gauge the full impact of the model on youth, or the extent to which their experiences were attributable to a TIA, were also significantly impeded. It also prevented the researcher from developing a shared language with

which to communicate with young people about their perspectives on the relevance of trauma to their lived experience. Future co-produced research with youth and families is essential.

4.5. Implications and Recommendations

4.5.1. Organisational and Policy: Defining and Operationalising TIC in YJS

A central implication arising from the findings of this thesis is the need for greater consensus on how to define and operationalise TIC in YJ settings (Branson et al., 2017). A core challenge across the literature is that TIC is often defined in a number of ways, with many terms lacking specificity, frequently blended together, or used interchangeably (Hanson & Lang, 2016). This makes it challenging to clearly define how services should operationalise the specific integration of TIC principles into organisational culture, and also makes it difficult for TIC initiatives to be evaluated (Becker-Blease, 2017; Hanson & Lang, 2016). As the term "trauma informed" becomes standard terminology, there is an increasing need for clarity and consensus across justice settings about how TIC is defined and operationalised, and what sets it apart from other approaches (Branson et al., 2017). Key recommendations for future TIC implementation in YJSs are summarised below.

4.5.1.1. Ongoing Training and Consultation

Consistent with prior research, TRM implementation in the current study involved an initial training in trauma principles and the provision of ongoing skills workshops (Branson et al., 2017; Bryson et al., 2017) - or *see Chapter 1*. Staff training is the most widely implemented component of TIC initiatives in settings serving youth, with most delivering one-off staff trainings, most typically on the neurological and behavioural impacts of trauma (Branson et al., 2017; Bryson et al., 2017). However, there is minimal evidence of its effectiveness in supporting staff to achieve fidelity to TIC or other evidence-based practices in isolation (Beidas & Kendall, 2010; Purtle, 2018). Implementation science has emphasised the value of coaching over one-off trainings, and the importance of continuing to support staff throughout the change process through recertification, ongoing training, and supervision (Fixsen et al., 2009). While training was identified as an important first-step in providing staff with foundational knowledge and a shared common trauma-informed language, findings from this thesis support the need for ongoing training in specific skills for responding to traumatised youth, as well as the need for ongoing supervision to assist staff in mastering and applying newly learned knowledge.

4.5.1.2. Clinical Supervision and Oversight

Perhaps the most fundamental clinical implication arising from this thesis is the need for clinical supervision and oversight when implementing TIC in YJ settings. Clinical supervision was unanimously identified as a valuable and essential aspect of the TRM pilot, in line with findings from a Welsh evaluation of a similar model [ECR] (Cordis Bright, 2017). Past TIC implementation research has consistently identified supervision as an integral factor to success, identifying its crucial role in providing post-training support and accountability, as well as ensuring continued

fidelity to the model and promotion of practice which aligns with TIC principles (Branson et al., 2017; Dunkerley et al., 2021).

More importantly, clinical supervision offers opportunities to assess the impact of exposure to youth's traumatic stress reactions on staff, and proactively address the impact of STS or any personal difficulties which may arise from this work, including moral injury (Pickens, 2016). The evidently nuanced and complex challenges staff working in YJSs face while delivering TIAs highlight a clear need for the provision of clinical oversight by qualified psychologists with experience of trauma and its sequelae. Research has demonstrated that supervision approaches predominantly focused on performance management limit the space for reflection and skill development, creating environments where supervisory practice becomes reactive and mechanistic, maintaining the organisational status quo (McNamara, 2010). Furthermore, relational-oriented approaches to supervision which include emotional support have been identified as potentially protective against vicarious trauma amongst mental health professionals (Sutton et al., 2022). Ensuring that clinical reflective spaces are safe and comfortable for staff (to speak openly about challenges or provide feedback on policies without reprisal, for example) remain integral to their overall usefulness and effectiveness (Pereira & Trotter, 2018). Findings from this study reiterate the importance of psychological input within this approach and suggest that provision of reflective spaces by operational line managers (as implemented in the roll-out phase of the current implementation study) may not be sufficient or appropriate. It is therefore essential that clinical supervision remains a protected and scaled-up component of TIC implementation. If wider implementation of the TRM (or other similar TIC initiatives) is pursued, service providers must ensure they have sufficient capacity to continue delivering high-quality clinical support.

4.5.1.3. Need for TIC Leadership, Policy, and Procedures

The results of this study support the notion that aligning policy and programming with TIC principles is essential to achieving meaningful systemic change (Pickens, 2016). System-wide structural changes and commitment of senior leadership have been identified as instrumental components of successful implementation (Bryson et al., 2017; Dunkerley et al., 2021). Findings highlight a clear need for policies and practices that address significant barriers to TIC, including STS, burnout, and perceived conflicts of interests (Bartlett et al., 2016; Becker-Blease, 2017). The prioritisation of TIC by senior leaders and stakeholders is therefore critical, particularly in the early stages as staff adjust to a new approach (Dunkerley et al., 2021; Elwyn et al., 2017). The inclusion of TIC principles and trauma-informed language in mission statements, policies, and all service documentation is imperative to ensure that the trauma lens remains at the centre of all aspects of service-delivery (THRIVE, 2010; Treisman, 2018). Without these components serving as constant reminders, services risk a dilution or co-option of TIC over time, or a gradual return to more traditional YJ approaches.

4.5.1.4. Facilitating an Organisational Culture Shift

Although the TRM was generally well received in the current study, TIC implementation represented a significant practical and cultural shift for many practitioners, in line with research (Levenson & Willis, 2019; Pickens, 2016). The allocation of process time to accommodate the slow and organic changes needed to facilitate adoption of TIC should therefore be factored into TIC implementation plans in YJSs (Bryson et al., 2017; Dunkerley et al., 2021). Past research has found that staff with dual or competing roles often have difficulty fully adopting TIC models and may be recruited into "old" ways of working because of role conflict, or time and resource constraints (Bryson et al., 2017; Greenwald et al., 2012). TIC initiatives in YJSs must therefore consider ways to address any such concerns or conflicts of interest, such as dedicating allocated time to staff to protect their time and role definition, or facilitating spaces where issues relating to role ambiguity can be discussed (Becker-Blease, 2017; Levenson et al., 2022). Key decision-makers must also assess the degree to which staff ascribe to TIAs, and develop a strategic plan to address staff attitudes or beliefs which may act as barriers to TIC facilitation (Pickens, 2016).

Research on TIC implementation has suggested that larger-scale system-wide initiatives (which typically require comprehensive models and more resources), tend to produce longer-term and deeper changes to organisational culture, but that these often take time (Bryson et al., 2017; Collin-Vezina et al., 2019; Fixsen et al., 2009). Consistent with the implementation science literature, deeper organisational change requires repeated and direct confrontation with adaptive challenges (Heifetz et al., 2009). One review of TIC implementation studies found that obstacles arose at all implementation sites and all stages of the process, due to similar factors to those found in the current study, such as a lack of funding and time, competing priorities, and workload volume (Akin et al., 2017). It is therefore essential that YJSs continue to revisit and re-evaluate TIC initiatives across the many stages of its implementation. The use of a self-assessment tool such as the Trauma-Informed Organisational Toolkit (Guarino et al., 2009), or Attitudes Related to Trauma-Informed Care (ARTIC; Baker et al., 2016) may enable services to explore their organisation's trauma-informed practices, gather feedback from multiple stakeholders to guide strategic planning, and assess their responsiveness to youth and staff needs (Pickens, 2016).

4.5.1.5. Developing a shared TIC language with other agencies

Findings from this study further emphasise that a TIA necessitates coordination and changes at multiple levels of the various systems serving vulnerable children and families. As our findings demonstrated, justice-involved youth are often in contact with multiple other systems which may benefit from a trauma-informed approach (Bridge, 2021; Kapp et al., 2013). Education, mental health, housing, social care, as well as other justice agencies (such as police and courts) were identified by staff as crucial and relevant stakeholders who were frequently believed to approach work within the constraints of different theoretical and organisational positions which at times undermined TIC values. Professionals across child-serving systems have expressed desires to

develop a shared common language for discussing youth (Donisch et al., 2016). A consistent recognition of traumatic stress reactions, and reinforcement of healthy coping strategies, will in many cases involve stakeholders from each system collaborating and sharing information about youth (Pickens, 2016). Extending TIC to partner agencies could promote a more joined-up and holistic approach to working with young people, many of whom will continue to have contact with other agencies (e.g. children's services) after statutory court requirements have been met. In light of evidence that this relational approach can engender strong attachment relationships between youth and caseworkers, identifying and building upon other significant professional relationships may be especially important during key transition periods, to minimise any potential harm to youth caused by relational disruption.

There are also significant benefits to considering TIC applicability within the secure estate and the wider CJS, as this would likely promote continuity and consistency of support in cases where offending behaviour escalates. The evidence-base on the delivery of TIC in other UK justice settings remains in its infancy, however recent initiatives have been documented in the youth secure and female adult prison estates (Petrillo et al., 2019; Taylor et al., 2018). TIC in YJS should therefore ensure consideration of formal and informal ways to actively involve relevant CJS stakeholders, in order to enhance consistency of TIAs, avoid unnecessary duplication of work, and minimise re-traumatisation or transmission of unhelpful attachment dynamics to youth by CJSs.

4.5.1.6. Transparency, Collaboration and Co-production

Minimal evidence of collaboration or co-production with youth and families raises the question of how YJSs can justifiably implement TIC models centred around trust and transparency, while in some cases continuing to be deliberately opaque (Sweeney & Taggart, 2018). In our systematic review, few TIC models included strategies to increase youth collaboration and choice, consistent with a previous review of TIC definitions and core components in juvenile justice systems which similarly found that no identified publication discussed how to specifically operationalise TIC principles such as collaboration or empowerment (Branson et al., 2017). This may indicate that certain TIC principles (such as choice, collaboration, and co-production) are harder to implement in coercive settings. However, past criticism of TIC implementation across child-serving settings (including YJSs) has highlighted the tendency for services to selectively apply TIC principles and "pick and choose" which components to deliver (Branson et al., 2017; Hanson & Lang, 2016).

Previous literature has demonstrated that TIAs which involve the active participation and consultation of young people yield noticeable improvements in organisational climate, culture, and safety (Bryson et al., 2017; Reed et al., 2021), and youth collaboration was identified as an important facilitator of service-wide TIC buy-in in our review (Chapter 1). By not meaningfully collaborating with young people, or actively seeking their consent, services risk inadvertently re-enacting the very power-over relational dynamics and experiences of institutional betrayal that TIC

seeks to reduce (Becker-Blease, 2017). Within youth justice, this is especially important when considering the trauma informed principles of empowering survivors to make their own choices. The very nature of justice-services, and the systemic power associated with court-ordered and statutory mandates, may mean that providing youth with choice and opportunities to collaborate will not always be possible. Considering ways in which YJSs can ensure that the voices of young people (and survivors) are truly included is therefore essential (Ford & Blaustein, 2013; Pickens, 2016; Reed et al., 2021). The TIC Grade (Sinko et al., 2020) is a self-report questionnaire which assesses youth perceptions of TIC and their satisfaction with initiatives, and has been validated for use by vulnerable young people (Boucher et al., 2020). Such a tool could be used to capture youth perceptions of TIC initiatives as they are being delivered, and beliefs on whether this care is addressing their needs, as part of assessing overall TIC implementation success and areas requiring improvement.

4.5.2. Clinical

4.5.2.1. Screening and Identifying Trauma Sequelae in Youth

Past literature has emphasised that an essential first-step for implementing TIC in YJS is the development of a standardised process for screening and identifying traumatic reactions amongst youth (Branson et al., 2017; Pickens, 2016). While trauma-informed services are distinct from trauma-focused services, improved assessment and treatment pathways for trauma sequelae are often considered core components of TIAs (Sweeney et al., 2018), something noticeably absent in this pilot. Staff in the current study highlighted limited streamlined assessment or referral processes for trauma sequelae, and evident discomfort about discussing these directly with youth, in line with past research (Kerns et al., 2016; Lang et al., 2016). By promoting sensitive trauma enquiries as part of standard assessment protocols with youth, services can ensure that those most in need of this approach receive it, reduce staff discomfort, and perhaps provide clarity on who is most likely to benefit from this approach and why (Raja et al., 2021).

Screening is generally perceived favourably by professionals in child-serving settings, and has been found to increase identification of trauma exposure and trauma symptoms, and service referrals (Lang et al., 2017). Published guidance on how staff can make safe and sensitive trauma enquiries is available (Kerig, 2013; Read et al., 2007). Brief trauma screens have also been developed for use in YJ and/or child welfare settings, such as the Child Trauma Screen (CTS) (Lang & Connell, 2017), and the Trauma-Related Symptoms and Impairment Rapid Screen (TSIRS) (Grasso et al., 2019), both of which have demonstrated good psychometric qualities. In light of the challenging context of YJSs, the meaning youth may make from their experiences, and their potential mistrust of YJS professionals, the assessment of trauma will likely need to be dynamic and ongoing, involving continuing psychoeducation and trauma-awareness training (Kerig, 2013).

4.5.2.2. Treatment and Support for Youth Traumatic Stress

It is also imperative that TIC does not become a replacement for trauma-focused interventions. One recent report on TIC in social care highlighted a risk for TIAs to be offered in the absence of evidence-based interventions (Asmussen et al., 2022), and the present pilot similarly did not include streamlined processes for referring youth for evidence-based therapeutic interventions, in line with recommended TIC best-practice (Branson et al., 2017; Pickens, 2016). A recent review further found tentative support for the effectiveness of trauma-specific interventions in justice-involved adolescents, specifically, however noted an overall lack of quality intervention research for treating youth with histories of trauma in the justice system (Baetz et al., 2021). Current evidence from the general population suggests that TF-CBT and EMDR are the most effective and evidence-based treatments for PTSD in children and adolescents (Bastien et al., 2020). Effective TIC implementation, particularly in community YJSs, must include consideration of how services can ensure traumatised youth are able to access appropriate, evidence-based trauma-focused interventions in a timely and sensitive way.

Several manualised therapeutic and trauma-informed programme resources have been developed to specifically involve justice staff in addressing the needs of trauma-exposed justice-involved youth, including TARGET [Trauma Affect Regulation: Guide for Education and Therapy] (Ford et al., 2012), Trauma and Grief Components Therapy (TGCTA) (Layne et al., 2008), and Skills Training in Affective and Interpersonal Regulation for Adolescences (STAIR-A) (Gudiño et al., 2014). While distinct from evidence-based trauma-processing interventions (which require a qualified mental health practitioner), the adoption of manualised skills programmes by YJS may help to provide staff with tools to proactively address youth trauma needs and support a trauma informed culture, and also minimise staff anxiety relating to feeling unqualified to respond to young people's trauma presentations (Pickens, 2016).

4.5.2.3. Creating safer and more supportive environments for staff

Results highlight the need to create safer and more supportive environments for staff in YJSs. The risk of overwhelming stress from frequent interactions with dysregulated youth who have experienced trauma is tremendous, but can be mitigated if YJSs acknowledge and implement processes to address secondary traumatisation, such as offering peer-mentoring or reflective groups (Ireland & Huxley, 2018; Ko et al., 2008; Pickens, 2016). Organisational TIAs need to consider professional (e.g. caseloads, hours, breaks) and personal (e.g. individual trauma histories, bereavements) factors which have been found to contribute to staff experiences of STS and develop strategies to address these (Turgoose & Maddox, 2017). Organisations must mirror TIC processes by supporting staff appropriately and providing the healthy workforce boundaries necessary for practitioners to effectively deliver trauma-informed interventions.

While most TIAs emphasise the need to identify and acknowledge the impact of trauma on staff, inclusion and availability of support systems for secondary traumatisation of staff are comparatively rare (Branson et al., 2017) – *or see Chapter 1*. Financial and resource constraints are frequently cited barriers to the provision of individualised staff support processes, findings mirrored by the present pilot (Brown et al., 2017; Ford & Blaustein, 2013). Yet, staff experiences of STS and burnout have been linked to a number of outcomes with costly financial implications for services, such as poor employee productivity, lower quality of service, increased sick leave, and higher rates of staff turnover (Sichel et al., 2019; White, 2006). Findings from this study therefore reiterate the need for services to consider avenues for staff to access to appropriate support. Evidence-based TF therapies should be made readily available to staff in YJSs, for example through Employee Assistance programmes in Local Authorities.

4.5.3. Research

At a local level, ongoing data collection is essential to evaluate the process and impact of implementing TIC, and for ongoing assessment of staff fidelity to trauma-informed interventions and practices (Branson et al., 2017). Previous studies have found that utilising local data for audit and evaluation purposes is an instrumental factor in the success of TIC initiatives, as this can provide encouraging feedback to staff and service-providers about the noticeable impact of implementation (Asmussen et al., 2022; Bryson et al., 2017; Collin-Vezina et al., 2019). Services should be encouraged to continuously monitor outcomes relating to TIC programmes at youth (e.g. arrest or conviction rates, school attendance, trauma symptoms), staff (e.g. caseloads, training/workshop attendance), and service-level (e.g. serious incidents, referral rates).

As the first study to examine the implementation of a TIC model in an English YJS, our results are preliminary. Further larger-scale experimental studies evaluating the effectiveness of such initiatives are necessary. Mixed-methods research with nationally representative samples of YJ staff, system administrators, and key stakeholders (e.g. courts, police) could explore current perceptions of core TIC components and examine the extent to which such practices are currently adopted across YJSs in the UK. A crucial question which requires further investigation is which, if any, specific TIC practices are effective in producing meaningful improvements for young people involved in the YJ system. Challenges in defining or distinguishing TIC from other approaches mean that it remains unclear which TIC components (e.g. staff training, supervision, screening procedures) yield the greatest benefits, or how TIC initiatives compare to similar models or treatment as usual. Our systematic review highlighted that the overall methodology of existing studies is weak, with most studies employing simple, survey-based pre-post cohort designs. Future evaluations should consider adopting longitudinal randomised control trial or quasi-experimental designs where achievements can be compared with a control group. However, such evaluation methodologies are largely designed to measure individual level changes, presenting an ongoing

challenge of how to capture and evidence the effectiveness of whole system changes envisioned by TIC (Bunting et al., 2019) . Finally, little research has been published on the cost-effectiveness of TIAs, indicating a need for cost-benefit analyses (Greer et al., 2014). Given their substantial cost, it is imperative that the effectiveness and longer-term viability of TIAs in youth justice are rigorously evaluated prior to further widespread roll-out across services.

There is currently minimal research examining the impact of trauma and STS on YJ professionals, specifically. While research on moral injury experiences amongst healthcare staff is growing rapidly in the wake of the COVID-19 pandemic (Litam & Balkin, 2021), studies examining this construct amongst staff working in justice settings are limited (Griffin et al., 2019). These represent two important avenues for future research, which are essential in understanding the potential role of TIC in mitigating (or exacerbating) such experiences (Kerig, 2019a). A final crucial next step for research is to conduct further qualitative research examining the perspectives of both young people and families involved in the YJ system. Such research could provide a thorough understanding of their views on the need for trauma-informed care, their perceptions of support available, and the potential role of YJSs in minimising re-traumatisation. Collaboration and co-production with survivors are cornerstones of TIC, and there remains a noticeable gap in current literature which elevates the voices of those most in need of being heard.

4.6. Self-Reflexivity Statement

Reflecting on the research process, I was not prepared for how challenging recruitment of justice-involved young people would be, particularly as an outsider attempting to reach this group through remote and virtual means. In the study's inception, I had envisioned being able to situate myself within the service, thus being able to meet and connect with young people more informally, and conduct interviews in more natural and adaptive ways. I was heavily reliant on practitioners to act as both participants and gatekeepers, and I worried about the additional requests being made of already pressured workers, particularly by someone they did not know. Even still, all participants generously shared their time and experiences, for which I am very grateful. While I wish I could have interviewed more service-users, I believe I did the best I could within the constraints and parameters of the study context.

While my 'outsider' position seemed to permit staff to speak more freely about their experiences, it also carried with it some constraints which generated significant tension and conflict within me as a clinical academic. Not being permitted to explicitly name trauma or the TRM with youth and family participants was a considerable challenge. Throughout the process from data collection to synthesis I found myself questioning the extent to which I was complicit with traditional 'doing to' research processes of a vulnerable and marginalised group. I felt constrained, limited, and caught between personal and professional dilemmas which paralleled some of those described by my research participants. This experience has taught me just how essential transparency, co-

production, and participatory frameworks are in YJ research and service development, so that the continuation of top-down, system-led processes can be avoided.

Throughout this process I have noticed ways in which my research has been shaped by my clinical training experience, and my university's traditionally critical, social-constructionist position. I have allowed 'myself' and my experiences to permeate this research in ways which I previously would have probably avoided. Adopting a more critical lens when examining TIC has enabled me to see beyond its face value. Given my role as an invited researcher providing feedback for the purposes of service development, I initially worried about how some of my more critical views may be received by my hosts. However, by acknowledging the limitations and pitfalls of TIC, I am much more able to meaningfully engage in the hard and complicated questions about what trauma is, how it affects people, and what it actually means to be trauma informed.

4.7. Conclusion

This thesis explored the accounts of professionals, young people, and families within a local YJS to illustrate their experiences of a recently implemented system-wide TIC model, the TRM. Our in-depth analysis of 23 interviews with YJ practitioners, managers, youth, and their parents highlighted several facilitators of trauma-informed practice, and many perceived benefits of implementing a TIA. Relational safety and mutuality were prioritised by staff at all levels, with youth and families describing meaningful and supportive relationships with the YJS which aided further improvements in offending and well-being. A conceptual and orientational shift was observed across the service, facilitated by ongoing training and clinical supervision, whereby youth offending was increasingly viewed through a holistic and compassionate trauma lens. Despite promising improvements, several organisational obstacles and varying attitudes to TIC implementation were identified. Participants discussed the challenges of embedding a TIA within a pressured service constrained by statutory demands and fatigued by frequent initiatives. Participants also highlighted barriers to promoting TIC across other agencies and systems which frequently lacked cohesion and safety, and whose organisational priorities were at times perceived not to align with core TIC principles. Finally, staff participants described the personal and professional impact of implementing TIC, and pointed to the need for ongoing clinical supervision, reflective spaces, and staff support processes to enable them to continue working safely and sensitively with complexly traumatised young people. As the first in-depth qualitative study of a system-wide TIC initiative in an English YJS, findings contribute to a small yet emerging evidence-base on the development of TIC in YJ settings, with important implications for psychologists, professionals, and policymakers across justice systems and other settings working with complex and vulnerable young people.

References

Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of general psychiatry*, *61*(4), 403-410.

Achenbach, T., & Edelbrock, C. (1983). *Manual for the Child Behaviour Checklist and Revised Behaviour Profile*. University of Vermont, Department of Psychiatry

Agenda. (2021). *Young Women's Justice Project Literature Review*.

Agnew, R. (1985). A revised strain theory of delinquency. *Social forces*, *64*(1), 151-167.

Agnew, R. (1997). Stability and Change in Crime Over the Life Course: A Strain Theory Explanation (From Developmental Theories of Crime and Delinquency, P 101-132, 1997, Terence P Thornberry, ed.--See NCJ-167734).

Agnew, R. (2001). Building on the foundation of general strain theory: Specifying the types of strain most likely to lead to crime and delinquency. *Journal of research in crime and delinquency*, *38*(4), 319-361.

Akers, R. L. (2017). *Social learning and social structure: A general theory of crime and deviance*. Routledge.

Akin, B. A., Strolin-Goltzman, J., & Collins-Camargo, C. (2017). Successes and challenges in developing trauma-informed child welfare systems: A real-world case study of exploration and initial implementation. *Children and Youth Services Review*, *82*, 42-52.

Allyn, D. (2011). Mission mirroring: Understanding conflict in nonprofit organizations. *Nonprofit and voluntary sector quarterly*, *40*(4), 762-769.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th edition)*. American Psychiatric Publishing.

Anda, R. F., Butchart, A., Felitti, V. J., & Brown, D. W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American journal of preventive medicine*, *39*(1), 93-98. https://doi.org/https://doi.org/10.1016/j.amepre.2010.03.015

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European archives of psychiatry and clinical neuroscience*, *256*(3), 174-186.

Anderson, V. R., England, K., & Davidson, W. S. (2017). Juvenile court practitioners' construction of and response to sex trafficking of justice system involved girls. *Victims & Offenders*, *12*(5), 663-681.

Andrews, F. M., & Withey, S. B. (1976). *Social indicators of well-being: American's perceptions of life quality*. Plenum Press.

Armijo-Olivo, S., Stiles, C. R., Hagen, N. A., Biondo, P. D., & Cummings, G. G. (2012). Assessment of study quality for systematic reviews: a comparison of the Cochrane Collaboration Risk of Bias Tool and the Effective Public Health Practice Project Quality Assessment Tool: methodological research. *Journal of evaluation in clinical practice*, *18*, 12-18.

Asmussen, K., Masterman, T., McBride, T., & Molloy, D. (2022). *Trauma-informed care: Understanding the use of trauma-informed approaches within children's social care*.

Baetz, C. L., Branson, C. E., Weinberger, E., Rose, R. E., Petkova, E., Horwitz, S. M., & Hoagwood, K. E. (2021). The effectiveness of PTSD treatment for adolescents in the juvenile justice system: A systematic review. *Psychological Trauma: Theory, Research, Practice, and Policy*.

Baetz, C. L., Surko, M., Moaveni, M., McNair, F., Bart, A., Workman, S., . . . Horwitz, S. M. (2019). Impact of a Trauma-Informed Intervention for Youth and Staff on Rates of Violence in Juvenile Detention Settings. *Journal of Interpersonal Violence*, 886260519857163.

Baidawi, S., Sheehan, R., & Flynn, C. (2020). Criminal exploitation of child protection-involved youth. *Children and Youth Services Review*, *118*, 105396.

Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings. *Health and Social Care in the Community*, *27*, e10-e22. https://doi.org/10.1111/hsc.12621

Baker, C. N., Brown, S. M., Wilcox, P., Verlenden, J. M., Black, C. L., & Grant, B.-J. E. (2018). The implementation and effect of trauma-informed care within residential youth services in rural Canada: A mixed methods case study. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(6), 666.

Baker, C. N., Brown, S. M., Wilcox, P. D., Overstreet, S., & Arora, P. (2016). Development and psychometric evaluation of the attitudes related to trauma-informed care (ARTIC) scale. *School Mental Health*, *8*(1), 61-76.

Baker, R. L., & Mednick, B. R. (2012). *Influences on human development: A longitudinal perspective* (Vol. 4). Springer Science & Business Media.

Bartlett, J. D., Barto, B., Griffin, J. L., Fraser, J. G., Hodgdon, H., & Bodian, R. (2016). Trauma-informed care in the Massachusetts child trauma project. *Child Maltreatment*, *21*(2), 101-112.

Bastien, R. J.-B., Jongsma, H. E., Kabadayi, M., & Billings, J. (2020). The effectiveness of psychological interventions for post-traumatic stress disorder in children, adolescents and young adults: A systematic review and meta-analysis. *Psychological Medicine*, *50*(10), 1598-1612.

Bateman, T. (2020). *The state of youth justice 2020: An overview of trends and developments* https://thenayj.org.uk/cmsAdmin/uploads/state-of-youth-justice-2020-final-sep20.pdf

Bath, E. P., Godoy, S. M., Morris, T. C., Hammond, I., Mondal, S., Goitom, S., . . . Barnert, E. S. (2020). A specialty court for U.S. youth impacted by commercial sexual exploitation [Research Support, N.I.H., Extramural

Research Support, Non-U.S. Gov't]. *Child Abuse & Neglect*, *100*, 104041.

Becker-Blease, K. A. (2017). As the world becomes trauma–informed, work to do. In (Vol. 18, pp. 131-138): Taylor & Francis.

Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice*, *17*(1), 1-30.

Bendall, S., Eastwood, O., Cox, G., Farrelly-Rosch, A., Nicoll, H., Peters, W., . . . Scanlan, F. (2020). A Systematic Review and Synthesis of Trauma-Informed Care Within Outpatient and Counseling Health Settings for Young People. *Child Maltreatment*, 1077559520927468.

Bevington, D., Fuggle, P., & Fonagy, P. (2015). Applying attachment theory to effective practice with hard-to-reach youth: the AMBIT approach. *Attachment & human development*, *17*(2), 157-174.

Biggs, C., Tehrani, N., & Billings, J. (2021). Brief trauma therapy for occupational trauma-related PTSD/CPTSD in UK police. *Occupational Medicine*, *71*(4-5), 180-188.

Billings, J., Abou Seif, N., Hegarty, S., Ondruskova, T., Soulios, E., Bloomfield, M., & Greene, T. (2021). What support do frontline workers want? A qualitative study of health and social care workers' experiences and views of psychosocial support during the COVID-19 pandemic. *PLoS ONE*, *16*(9), e0256454.

Billings, J., Biggs, C., Ching, B. C. F., Gkofa, V., Singleton, D., Bloomfield, M., & Greene, T. (2021). Experiences of mental health professionals supporting front-line health and social care workers during COVID-19: qualitative study. *BJPsych Open*, *7*(2).

Bloom, S. L. (2005). The System Bites Back: Politics, Parallel Process, and the Notion of Change'. *Therapeutic Communities*, *26*(4), 337-354.

Bloom, S. L. (2006a). Human service systems and organizational stress. *Retrieved July*, *14*, 2018.

Bloom, S. L. (2006b). Organizational stress as a barrier to trauma-sensitive change and system transformation. *Alexaandria, VA: National Technical Assistance Center for State Mental Health Planning Pulications and Reports*.

Bloom, S. L. (2010). Trauma-organized systems and parallel process. *Managing trauma in the workplace—Supporting workers and the organisation*, *6*, 139-153.

Bloom, S. L., & Sreedhar, S. Y. (2008). The sanctuary model of trauma-informed organizational change. *Reclaiming children and youth*, *17*(3), 48-53.

Borckardt, J. J., Madan, A., Grubaugh, A. L., Danielson, C. K., Pelic, C. G., Hardesty, S. J., . . . Benson, A. (2011). Systematic investigation of initiatives to reduce seclusion and restraint in a state psychiatric hospital. *Psychiatric Services*, *62*(5), 477-483.

Borrett, E. (2021). *TRM End of Pilot Evaluation: Evaluation Report*.
Boucher, N., Darling-Fisher, C. S., Sinko, L., Beck, D., Granner, J., & Seng, J. (2020). Psychometric Evaluation of the TIC Grade, a Self-Report Measure to Assess Youth Perceptions of the Quality of Trauma-Informed Care They Received. *Journal of the American Psychiatric Nurses Association*, 1078390320953896.
Branson, C. E., Baetz, C. L., Horwitz, S. M., & Hoagwood, K. E. (2017). Trauma-informed juvenile justice systems: A systematic review of definitions and core components [Review Systematic Review]. *Psychological Trauma:Theory, Pesearch, Practice and Policy*, *9*(6), 635-646.
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.
Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. sage.
Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? In (Vol. 9, pp. 26152): Taylor & Francis.
Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), 589-597.
Braun, V., & Clarke, V. (2021a). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37-47.
Braun, V., & Clarke, V. (2021b). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative research in psychology*, *18*(3), 328-352.
Breslau, N. (2009). The epidemiology of trauma, PTSD, and other posttrauma disorders. *Trauma, Violence, & Abuse*, *10*(3), 198-210.
Bridge, M. (2021). *Briefing: "I wanted to be heard" - Young women in the criminal justice system at risk of violence, abuse and exploitation* (Young Women's Justice Project, Issue.
Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513.
Brown, J. D., King, M. A., & Wissow, L. S. (2017). The Central Role of Relationships With Trauma-Informed Integrated Care for Children and Youth [Note]. *Academic Pediatrics*, *17*(7 Supplement), S94-S101.
Brown, S. M., Baker, C. N., & Wilcox, P. (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*, 507-515. https://doi.org/10.1037/a0025269
Bryson, S. A., Gauvin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., . . . Burke, S. (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems*, *11*, 36. https://doi.org/10.1186/s13033-017-0137-3
Bunting, L., Montgomery, L., Mooney, S., MacDonald, M., Coulter, S., Hayes, D., & Davidson, G. (2019). Trauma informed child welfare systems—A rapid evidence review. *International journal of environmental research and public health*, *16*(13), 2365.
Burns, M. K., Vance, D., Szadokierski, I., & Stockwell, C. (2006). Student needs survey: A psychometrically sound measure of the five basic needs. *International Journal of Reality Therapy*, *25*(2), 4.
Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & quantity*, *56*(3), 1391-1412.
Carleton, R. N., Ricciardelli, R., Taillieu, T., Mitchell, M. M., Andres, E., & Afifi, T. O. (2020). Provincial correctional service workers: The prevalence of mental disorders. *International journal of environmental research and public health*, *17*(7), 2203.
Case, S., & Browning, A. (2021). *Child First Justice: the research evidence-base [Full report]*. https://hdl.handle.net/2134/14152040.v1.
CASP Checklist. (2018). *CASP Checklist: 10 questions to help you make sense of qualitative research*. https://casp-uk.net/wp-content/uploads/2018/03/CASPQualitative-Checklist-2018_fillable_form.pdf.

Cauffman, E., Feldman, S., Watherman, J., & Steiner, H. (1998). Posttraumatic stress disorder among female juvenile offenders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *37*(11), 1209-1216.

Chadwick, E., & Billings, J. (2022). Barriers to delivering trauma-focused interventions for people with psychosis and post-traumatic stress disorder: A qualitative study of health care professionals' views. *Psychology and Psychotherapy: Theory, Research and Practice*.

Chaplo, S. D., Kerig, P. K., Bennett, D. C., & Modrowski, C. A. (2015). The roles of emotion dysregulation and dissociation in the association between sexual abuse and self-injury among juvenile justice–involved youth. *Journal of Trauma & Dissociation*, *16*(3), 272-285.

Chaplo, S. D., Kerig, P. K., Modrowski, C. A., & Bennett, D. C. (2017). Gender differences in the associations among sexual abuse, posttraumatic stress symptoms, and delinquent behaviors in a sample of detained adolescents. *Journal of Child & Adolescent Trauma*, *10*(1), 29-39.

Cicchetti, D., & Toth, S. L. (2005). Child maltreatment. *Annu. Rev. Clin. Psychol.*, *1*, 409-438.

Cicchetti, D., & Valentino, K. (2006). *An ecological-transactional perspective on child maltreatment: Failure of the average expectable environment and its influence on child development*. John Wiley & Sons, Inc.

Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic interaction*, *26*(4), 553-576.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology*, *4*(1), 20706.

Cohen, J. A., & Mannarino, A. P. (2015). Trauma-focused cognitive behavior therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics*, *24*(3), 557-570.

Collin-Vezina, D., McNamee, S., Brazeau, C., & Laurier, C. (2019). Initial Implementation of the ARC Framework in Juvenile Justice Settings. *Journal of Aggression, Maltreatment and Trauma*, *28*(5), 631-654.

Coomber, R., & Moyle, L. (2018). The changing shape of street-level heroin and crack supply in England: commuting, holidaying and cuckooing drug dealers across 'county lines'. *The British Journal of Criminology*, *58*(6), 1323-1342.

Cordis Bright. (2017). *Evaluation of the Enhanced Case Management approach: Final report*.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, research, practice, training*, *41*(4), 412.

Covington, S. S., & Bloom, B. E. (2007). Gender responsive treatment and services in correctional settings. *Women & Therapy*, *29*(3-4), 9-33.

Crosby, S. D. (2016). Trauma-informed approaches to juvenile justice: A critical race perspective. *Juvenile and Family Court Journal*, *67*(1), 5-18.

Cuijpers, P., Weitz, E., Cristea, I. A., & Twisk, J. (2017). Pre-post effect sizes should be avoided in meta-analyses. *Epidemiology and Psychiatric Sciences*, *26*, 364-368. https://doi.org/DOI: 10.1017/S2045796016000809

Damian, A. J., Gallo, J., Leaf, P., & Mendelson, T. (2017). Organizational and provider level factors in implementation of trauma-informed care after a city-wide training: An explanatory mixed methods assessment. *BMC health services research*, *17*, 1-10. https://doi.org/10.1186/s12913-017-2695-0

Damian, A. J., Gallo, J. J., & Mendelson, T. (2018). Barriers and facilitators for access to mental health services by traumatized youth. *Children & Youth Services Review*, *85*, 273-278.

Damian, A. J., Mendelson, T., Bowie, J., & Gallo, J. J. (2019). A mixed methods exploratory assessment of the usefulness of Baltimore City Health Department's trauma-informed care training intervention. *American Journal of Orthopsychiatry*, *89*(2), 228-236.

Danese, A. (2020). Annual Research Review: Rethinking childhood trauma-new research directions for measurement, study design and analytical strategies. *Journal of Child Psychology and Psychiatry*, *61*(3), 236-250.

Day, A. G., Somers, C. L., Baroni, B. A., West, S. D., Sanders, L., & Peterson, C. D. (2015). Evaluation of a Trauma-Informed School Intervention with Girls in a Residential Facility School:

Student Perceptions of School Environment [Conference Paper]. *Journal of Aggression, Maltreatment and Trauma*, *24*(10), 1086-1105.
Denhof, M. D., & Spinaris, C. G. (2013). Depression, PTSD, and comorbidity in United States corrections professionals: Prevalence and impact on health and functioning. *Desert Waters Correctional Outreach*, 1-16.
Dierkhising, C. B., & Kerig, P. K. (2018). Pilot evaluation of a university-based training in trauma-informed services for gang intervention workers. *Journal of Aggression, Maltreatment & Trauma*, *27*(3), 291-308.
Donisch, K., Bray, C., & Gewirtz, A. (2016). Child Welfare, Juvenile Justice, Mental Health, and Education Providers' Conceptualizations of Trauma-Informed Practice [Research Support, U.S. Gov't, P.H.S.]. *Child Maltreatment*, *21*(2), 125-134.
Drake, D. H., & Henley, A. J. (2014). 'Victims' Versus 'Offenders' in B ritish Political Discourse: The Construction of a False Dichotomy. *The howard journal of criminal justice*, *53*(2), 141-157.
Dube, S. R., Anda, R. F., Felitti, V. J., Croft, J. B., Edwards, V. J., & Giles, W. H. (2001). Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect*, *25*(12), 1627-1640.
Dunkerley, S., Akin, B. A., Brook, J., & Bruns, K. (2021). Child welfare caseworker and trainer perspectives on initial implementation of a trauma-informed practice approach. *Journal of Child and Family Studies*, *30*(4), 1082-1096.
Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study. *American Journal of Psychiatry*, *160*(8), 1453-1460.
Elwyn, L. J., Esaki, N., & Smith, C. A. (2015). Safety at a girls secure juvenile justice facility. *Therapeutic Communities*, *36*, 209-218. https://doi.org/10.1108/TC-11-2014-0038
Elwyn, L. J., Esaki, N., & Smith, C. A. (2017). Importance of Leadership and Employee Engagement in Trauma-Informed Organizational Change at a Girls' Juvenile Justice Facility. *Human Service Organizations Management, Leadership and Governance*, *41*, 106-118. https://doi.org/10.1080/23303131.2016.1200506
Ensink, J., Overbeek, G., Maric, M., & Lindauer, R. J. (2017). Executive function as a mediator in the link between single or complex trauma and posttraumatic stress in children and adolescents. *Quality of Life Research*, *26*(7), 1687-1696.
Erikson, E. H. (1994). *Identity and the life cycle*. WW Norton & Company.
Esaki, N., & Larkin, H. (2013). Prevalence of adverse childhood experiences (ACEs) among child service providers. *Families in society*, *94*(1), 31-37.
Evans, J., Kennedy, D., Skuse, T., & Matthew, J. (2020). Trauma-informed practice and desistance theories: Competing or complementary approaches to working with children in conflict with the law? *Salus Journal*, *8*(2), 55-76.
Ezell, J. M. (2019). First, do no harm to self: Perspectives around trauma-informed practice and secondary traumatic stress among rural child protective services workers. *Journal of Child Custody*, *16*(4), 387-407.
Ezell, J. M., Richardson, M., Salari, S., & Henry, J. A. (2018). Implementing Trauma-Informed Practice in Juvenile Justice Systems: What can Courts Learn from Child Welfare Interventions? *Journal of Child & Adolescent Trauma*, *11*(4), 507-519.
Fallot, R., & Harris, M. (2014). Creating cultures of trauma-informed care (CCTIC): Program Fidelity Scale. https://www.traumainformedcare.chcs.org/resource/creating-cultures-of-trauma-informed-care-a-fidelity-scale/
Farrington, D. P. (1989). Early predictors of adolescent aggression and adult violence. *Violence and victims*, *4*(2), 79-100.
Feigenberg, L. F., Watts, C. L., & Buckner, J. C. (2010). The school mental health capacity instrument: Development of an assessment and consultation tool. *School Mental Health*, *2*(3), 142-154.
Felitti, V., Anda, R., Nordenberg, D., & Williamson, D. (1998). Adverse childhood experiences and health outcomes in adults: The Ace study. *Journal of Family and Consumer Sciences*, *90*(3), 31.

Fergusson, D. M., McLeod, G. F., & Horwood, L. J. (2013). Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. *Child Abuse & Neglect*, *37*(9), 664-674.

Fergusson, D. M., Swain-Campbell, N., & Horwood, L. J. (2002). Outcomes of leaving school without formal educational qualifications. *New Zealand Journal of Educational Studies*, *37*(1), 39-56.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* . Brunner/Mazel.

Finch, J., Ford, C., Grainger, L., & Meiser-Stedman, R. (2020). A systematic review of the clinician related barriers and facilitators to the use of evidence-informed interventions for post traumatic stress. *Journal of Affective Disorders*, *263*, 175-186. https://doi.org/10.1016/j.jad.2019.11.143

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect*, *31*(1), 7-26.

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice*, *19*(5), 531-540.

Ford, J. D. (2017). Complex trauma and complex posttraumatic stress disorder. In *APA handbook of trauma psychology: Foundations in knowledge, Vol. 1* (pp. 281-305). American Psychological Association.

Ford, J. D., & Blaustein, M. E. (2013). Systemic self-regulation: A framework for trauma-informed services in residential juvenile justice programs.

Ford, J. D., Chapman, J., Mack, J. M., & Pearson, G. (2006). Pathways from traumatic child victimization to delinquency: Implications for juvenile and permanency court proceedings and decisions. *Juvenile and Family Court Journal*, *57*(1), 13-26.

Ford, J. D., Charak, R., Modrowski, C. A., & Kerig, P. K. (2018). PTSD and dissociation symptoms as mediators of the relationship between polyvictimization and psychosocial and behavioral problems among justice-involved adolescents. *Journal of Trauma & Dissociation*, *19*(3), 325-346.

Ford, J. D., Kerig, P., Desai, N., & Feierman, J. (2016). Psychosocial interventions for traumatized youth in the juvenile justice system: Research, evidence base, and clinical/legal challenges. *Journal Of Juvenile Justice*, *5*, 31-49. https://doi.org/10.1007/s11274-015-1903-5

Ford, J. D., Steinberg, K. L., Hawke, J., Levine, J., & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child and Adolescent Psychology*, *41*, 27-37. https://doi.org/10.1080/15374416.2012.632343

Frans, Ö., Rimmö, P. A., Åberg, L., & Fredrikson, M. (2005). Trauma exposure and post-traumatic stress disorder in the general population. *Acta Psychiatrica Scandinavica*, *111*(4), 291-290.

Frost, L., & Scott, H. (2020). What is known about the secondary traumatization of staff working with offending populations? A review of the literature. *Traumatology*.

Fuggle, P., Bevington, D., Duffy, F., & Cracknell, L. (2016). The AMBIT approach: working with hard to reach youth. *Mental Health Review Journal*.

Gamble, J., & Mcallum, R. (2022). *Local Child Safeguarding Practice Review: Child Q*.

Gaylord-Harden, N. K., So, S., Bai, G. J., Henry, D. B., & Tolan, P. H. (2017). Examining the pathologic adaptation model of community violence exposure in male adolescents of color. *Journal of Clinical Child & Adolescent Psychology*, *46*(1), 125-135.

Gelles, R. J. (1997). *Intimate violence in families*. Sage.

Gilmore, A. A., & Bettis, P. J. (2021). Antiblackness and the adultification of Black children in a US prison nation. In *Oxford Research Encyclopedia of Education*.

Grasso, D. J., Doyle, C., & Koon, R. (2019). Two Rapid Screens for Detecting Probable Post-Traumatic Stress Disorder and Interpersonal Violence Exposure: Predictive Utility in a Juvenile Justice Sample. *Child Maltreatment*, *24*(1), 113-120.

Graves, J., & Shapiro, J. (2016). Trauma informed clinical social work practice: Case composite with court-involved adolescent. *Smith College Studies in Social Work*, *86*(3), 204-224.

Greenwald, R., & Rubin, A. (1999). Assessment of posttraumatic symptoms in children: Development and preliminary validation of parent and child scales. *Research on Social Work Practice*, *9*(1), 61-75.
Greenwald, R., Siradas, L., Schmitt, T. A., Reslan, S., Fierle, J., & Sande, B. (2012). Implementing trauma-informed treatment for youth in a residential facility: First-year outcomes. *Residential Treatment for Children & Youth*, *29*(2), 141-153.
Greer, D., Grasso, D. J., Cohen, A., & Webb, C. (2014). Trauma-focused treatment in a state system of care: Is it worth the cost?
Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., . . . Maguen, S. (2019). Moral injury: An integrative review. *Journal of traumatic stress*, *32*(3), 350-362.
Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). Trauma-informed organizational toolkit. *Center for Mental Health Services, Substance Abuse and Mental Health Services Administration: Rockville, MD*.
Gudiño, O. G., Weis, J. R., Havens, J. F., Biggs, E. A., Diamond, U. N., Marr, M., . . . Cloitre, M. (2014). Group trauma-informed treatment for adolescent psychiatric inpatients: A preliminary uncontrolled trial. *Journal of traumatic stress*, *27*(4), 496-500.
Haerle, D. R. (2019). Unpacking adultification: Institutional experiences and misconduct of adult court and juvenile court youth living under the same roof. *International journal of offender therapy and comparative criminology*, *63*(5), 663-693.
Haight, W., Sugrue, E., Calhoun, M., & Black, J. (2017). Everyday coping with moral injury: The perspectives of professionals and parents involved with child protection services. *Children and Youth Services Review*, *82*, 108-121.
Haight, W., Sugrue, E. P., & Calhoun, M. (2017). Moral injury among child protection professionals: Implications for the ethical treatment and retention of workers. *Children and Youth Services Review*, *82*, 27-41.
Hamberger, L. K., Barry, C., & Franco, Z. (2019). Implementing trauma-informed care in primary medical settings: evidence-based rationale and approaches. *Journal of Aggression, Maltreatment & Trauma*, *28*(4), 425-444.
Hanson, R. F., & Lang, J. (2016). A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families. *Child Maltreatment*, *21*, 95-100. https://doi.org/10.1177/1077559516635274
Harris, M., & Fallot, R. D. (2001). *Using trauma theory to design service systems.* (0-7879-1438-X (Paperback)).
Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, *12*(4), 335-344.
Health Research Authority. (2018). *Joint statement on seeking consent by electronic methods*.
Heifetz, R. A., Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership: Tools and tactics for changing your organization and the world*. Harvard Business Press.
Hepworth, I., & McGowan, L. (2013). Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review. *Journal of Psychiatric and Mental Health Nursing*, *20*(6), 473-483.
Hidalgo, J., Maravic, M. C., Milet, R. C., & Beck, J. C. (2016). Promoting Collaborative Relationships in Residential Care of Vulnerable and Traumatized Youth: a Playfulness Approach Integrated with Trauma Systems Therapy. *Journal of Child and Adolescent Trauma*, *9*(1), 17-28.
House of Commons. (2022). Police, Crime, Sentencing and Courts Bill. In: House of Commons.
Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., . . . Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), e356-e366. https://doi.org/https://doi.org/10.1016/S2468-2667(17)30118-4
Hughes, S. (2022). Child Q's trauma shames her school and the police https://www.theguardian.com/uk-news/2022/mar/17/child-q-trauma-shames-her-school-and-the-police

Hundall Stamm, B. (2009). Professional Quality of Life Measure: Compassion, Satisfaction, and Fatigue Version 5 (ProQOL).
Hyde, P., & Thomas, A. B. (2002). Organisational defences revisited: systems and contexts. *Journal of Managerial Psychology*.
Ireland, C. A., & Huxley, S. (2018). Psychological trauma in professionals working with traumatised children. *Journal of forensic practice*.
Jacob, J. D. (2012). The rhetoric of therapy in forensic psychiatric nursing. *Journal of Forensic Nursing*, *8*(4), 178-187.
Jaegers, L. A., Matthieu, M. M., Vaughn, M. G., Werth, P., Katz, I. M., & Ahmad, S. O. (2019). Posttraumatic stress disorder and job burnout among jail officers. *Journal of occupational and environmental medicine*, *61*(6), 505.
Jennings, W. G., Piquero, A. R., & Reingle, J. M. (2012). On the overlap between victimization and offending: A review of the literature. *Aggression and Violent Behavior*, *17*(1), 16-26.
Kapp, S. A., Petr, C. G., Robbins, M. L., & Choi, J. J. (2013). Collaboration between community mental health and juvenile justice systems: Barriers and facilitators. *Child and Adolescent Social Work Journal*, *30*(6), 505-517.
Kerig, P. K. (1999). Gender issues in the effects of exposure to violence on children. *Journal of Emotional Abuse*, *1*(3), 87-105.
Kerig, P. K. (2013). Trauma-informed assessment and intervention. *Los Angeles, CA: National Center for Child Traumatic Stress*.
Kerig, P. K. (2019a). Enhancing Resilience Among Providers of Trauma-Informed Care: A Curriculum for Protection Against Secondary Traumatic Stress Among Non-Mental Health Professionals. *Journal of Aggression, Maltreatment & Trauma*, *28*, 613-630. https://doi.org/10.1080/10926771.2018.1468373
Kerig, P. K. (2019b). Linking childhood trauma exposure to adolescent justice involvement: The concept of posttraumatic risk-seeking. *Clinical Psychology: Science and Practice*, *26*(3), e12280.
Kerig, P. K., & Becker, S. P. (2012). From internalizing to externalizing: Theoretical models of the processes linking PTSD to juvenile delinquency. *Post-Traumatic Stress Disorder (PTSD): Causes, Symptoms and Treatment*, 33-78.
Kerig, P. K., & Becker, S. P. (2015). 12 early abuse and neglect as risk factors for the development of criminal and antisocial behavior. *The development of criminal and antisocial behavior*, 181-199.
Kerig, P. K., Chaplo, S. D., Bennett, D. C., & Modrowski, C. A. (2016). "Harm as harm" gang membership, perpetration trauma, and posttraumatic stress symptoms among youth in the juvenile justice system. *Criminal Justice and Behavior*, *43*(5), 635-652.
Kerig, P. K., & Modrowski, C. A. (2018). Testing gender-differentiated models of the mechanisms linking polyvictimization and youth offending: Numbing and callousness versus dissociation and borderline traits. *Journal of Trauma & Dissociation*, *19*(3), 347-361.
Kerig, P. K., & Schindler, S. R. (2013). Engendering the evidence base: A critical review of the conceptual and empirical foundations of gender-responsive interventions for girls' delinquency. *Laws*, *2*(3), 244-282.
Kerig, P. K., Ward, R. M., Vanderzee, K. L., & Arnzen Moeddel, M. (2009). Posttraumatic stress as a mediator of the relationship between trauma and mental health problems among juvenile delinquents. *Journal of Youth and Adolescence*, *38*(9), 1214-1225.
Kerns, S. E., Pullmann, M. D., Negrete, A., Uomoto, J. A., Berliner, L., Shogren, D., . . . Putnam, B. (2016). Development and implementation of a child welfare workforce strategy to build a trauma-informed system of support for foster care. *Child Maltreatment*, *21*(2), 135-146.
Kimonis, E. R., Ray, J. V., Branch, J. R., & Cauffman, E. (2011). Anger mediates the relation between violence exposure and violence perpetration in incarcerated boys. Child & Youth Care Forum,
Kinsella, E., Aalsma, M., Hunt, A., Meagher, C., Hensley, M., & Ott, M. (2021). 25. Juvenile Corrections Officers' Perceptions of Procedural Justice [Conference Abstract]. *Journal of Adolescent Health*, *68 (2 Supplement)*, S14.

Kirst, M., Aery, A., Matheson, F. I., & Stergiopoulos, V. (2017). Provider and consumer perceptions of trauma informed practices and services for substance use and mental health problems. *International Journal of Mental Health and Addiction*, *15*(3), 514-528.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., . . . Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice.

Kramer, M. G. (2016). Sanctuary in a residential treatment center: creating a therapeutic community of hope countering violence. *Therapeutic communities: The International Journal of therapeutic communities*.

Lammy, D. (2017). *The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian, and Minority Ethnic Individuals in the Criminal Justice System*

Lang, J. M., Ake, G., Barto, B., Caringi, J., Little, C., Baldwin, M. J., . . . Joy Stewart, C. (2017). Trauma screening in child welfare: Lessons learned from five states. *Journal of Child & Adolescent Trauma*, *10*(4), 405-416.

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment*, *21*(2), 113-124.

Lang, J. M., & Connell, C. M. (2017). Development and validation of a brief trauma screening measure for children: The Child Trauma Screen. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(3), 390.

Layne, C. M., Saltzman, W. R., Poppleton, L., Burlingame, G. M., Pašalić, A., Duraković, E., . . . Arslanagić, B. (2008). Effectiveness of a school-based group psychotherapy program for war-exposed adolescents: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(9), 1048-1062.

Levenson, J. (2020). Translating Trauma-Informed Principles into Social Work Practice. *Social Work*, *65*(3), 288-298. https://doi.org/10.1093/sw/swaa020

Levenson, J., Prescott, D. S., & Willis, G. M. (2022). Trauma-Informed Treatment Practices in Criminal Justice Settings. In *Handbook of Issues in Criminal Justice Reform in the United States* (pp. 483-502). Springer.

Levenson, J., & Willis, G. M. (2019). Implementing Trauma-Informed Care in Correctional Treatment and Supervision. *Journal of Aggression, Maltreatment and Trauma*, *28*(4), 481-501.

Lewis, S. J., Arseneault, L., Caspi, A., Fisher, H. L., Matthews, T., Moffitt, T. E., . . . Danese, A. (2019). The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. *The Lancet Psychiatry*, *6*(3), 247-256.

Lewis, S. J., Koenen, K. C., Ambler, A., Arseneault, L., Caspi, A., Fisher, H. L., . . . Danese, A. (2021a). Psychopathology and cognitive deficits in young people exposed to complex trauma. *BJPsych Open*, *7*(S1), S36-S37.

Lewis, S. J., Koenen, K. C., Ambler, A., Arseneault, L., Caspi, A., Fisher, H. L., . . . Danese, A. (2021b). Unravelling the contribution of complex trauma to psychopathology and cognitive deficits: a cohort study. *The British Journal of Psychiatry*, *219*(2), 448-455.

Litam, S. D. A., & Balkin, R. S. (2021). Moral injury in health-care workers during COVID-19 pandemic. *Traumatology*, *27*(1), 14.

Litz, B. T., & Kerig, P. K. (2019). Introduction to the special issue on moral injury: Conceptual challenges, methodological issues, and clinical applications. *Journal of traumatic stress*, *32*(3), 341-349.

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical psychology review*, *29*(8), 695-706.

Mackie, J. F., Foti, T. R., Agu, N., Langenderfer-Magruder, L., & Marshall, J. (2020). Early childhood court in Florida: Qualitative results of a statewide evaluation [Research Support, Non-U.S. Gov't]. *Child Abuse & Neglect*, *104*, 104476.

Malik, N., Facer-Irwin, E., Dickson, H., Bird, A., & MacManus, D. (2021). The effectiveness of trauma-focused interventions in prison settings: a systematic review and meta-analysis. *Trauma, Violence, & Abuse*, 15248380211043890.

Marrow, M. T., Knudsen, K. J., Olafson, E., & Bucher, S. E. (2012). The Value of Implementing TARGET within a Trauma-Informed Juvenile Justice Setting. *Journal of Child and Adolescent Trauma*, *5*, 257-270. https://doi.org/10.1080/19361521.2012.697105
Maslow, A. H. (1943). A theory of human motivation. *Psychological review*, *50*(4), 370.
Maxfield, M. G., & Widom, C. S. (1996). The cycle of violence: Revisited 6 years later. *Archives of pediatrics & adolescent medicine*, *150*(4), 390-395.
Maynard, B. R., Farina, A., Dell, N. A., & Kelly, M. S. (2019). Effects of trauma-informed approaches in schools: A systematic review. *Campbell Systematic Reviews*, *15*(1-2).
McAlister, S., & Carr, N. (2014). Experiences of youth justice: Youth justice discourses and their multiple effects. *Youth Justice*, *14*(3), 241-254.
McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress*, *3*(1), 131-149.
McElvaney, R., & Tatlow-Golden, M. (2016). A traumatised and traumatising system: Professionals' experiences in meeting the mental health needs of young people in the care and youth justice systems in Ireland. *Children and Youth Services Review*, *65*, 62-69.
McKenna, N. C., & Holtfreter, K. (2021). Trauma-Informed Courts: A Review and Integration of Justice Perspectives and Gender Responsiveness. *Journal of Aggression, Maltreatment and Trauma*, *30*(4), 450-470.
McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(8), 815-830. e814.
McNamara, P. M. (2010). Staff support and supervision in residential youth justice: an Australian model. *Residential Treatment for Children & Youth*, *27*(3), 214-240.
Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology*, *3*(1), 17246.
Modrowski, C. A., Mendez, L., & Kerig, P. K. (2021). Associations Among Trauma Exposure, Posttraumatic Dissociation, Reckless/Self-Destructive Behavior, and Adolescent Offending. *Journal of Trauma & Dissociation*, 1-15.
Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., . . . Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic reviews*, *4*(1), 1-9.
Morizot, J., & Kazemian, L. (2015). The development of criminal and antisocial behavior: Theory, research and practical applications. *The Development of Criminal and Antisocial Behavior: Theory, Research and Practical Applications*, 1-564. https://doi.org/10.1007/978-3-319-08720-7
Mozley, M. M., Modrowski, C. A., & Kerig, P. K. (2018). The roles of trauma exposure, rejection sensitivity, and callous-unemotional traits in the aggressive behavior of justice-involved youth: A moderated mediation model. *Aggressive behavior*, *44*(3), 268-275.
National Involvement Partnership. (2015). *Involvement for influence*
NCTSN. (2012). *Think Trauma: A Training for Working with Justice Involved Youth 2nd edition*. https://www.nctsn.org/resources/think-trauma-training-working-justice-involved-youth-2nd-edition
Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best practices in mental health*, *6*(2), 57-68.
Newman, C., Eason, M., & Kinghorn, G. (2019). Incidence of vicarious trauma in correctional health and forensic mental health staff in New South Wales, Australia. *Journal of Forensic Nursing*, *15*(3), 183-192.
Nolan, D. (2020). *'Spend time with me': Children and young people's experiences of COVID-19 and the justice system*
Norman, M., & Ricciardelli, R. (2021). Operational and organisational stressors in community correctional work: Insights from probation and parole officers in Ontario, Canada. *Probation Journal*, 0264550520984253. https://doi.org/10.1177/0264550520984253

Olafson, E., Boat, B. W., Putnam, K. T., Thieken, L., Marrow, M. T., & Putnam, F. W. (2018). Implementing Trauma and Grief Component Therapy for Adolescents and Think Trauma for Traumatized Youth in Secure Juvenile Justice Settings [Research Support, U.S. Gov't, P.H.S.]. *Journal of Interpersonal Violence*, *33*(16), 2537-2557.

Pane Seifert, H. T., Tunno, A. M., Briggs, E. C., Hill, S., Grasso, D. J., Adams, Z. W., & Ford, J. D. (2021). Polyvictimization and Psychosocial Outcomes Among Trauma-Exposed, Clinic-Referred Youth Involved in the Juvenile Justice System. *Child Maltreatment*, 10775595211025096.

Papazoglou, K., Blumberg, D. M., Chiongbian, V. B., Tuttle, B. M., Kamkar, K., Chopko, B., . . . Koskelainen, M. (2020). The role of moral injury in PTSD among law enforcement officers: A brief report. *Frontiers in psychology*, *11*, 310.

Pates, R., Davies, A., & Tiddy, D. (2018). A secure children's home in Wales: Care and educational provision from clinical, management, and educational perspectives. In *Children and Their Education in Secure Accommodation* (pp. 146-161). Routledge.

Pearlman, L. A. (2003). *Trauma and attachment belief scale (TABS)*. Western Psychological Services Los Angeles, CA.

Pearson, A., White, H., Bath-Hextall, F., Salmond, S., Apostolo, J., & Kirkpatrick, P. (2015). A mixed-methods approach to systematic reviews. *International journal of evidence-based healthcare*, *13*(3), 121-131.

Pereira, C., & Trotter, C. (2018). Staff supervision in youth justice and its relationship to skill development: findings from Australia. In *Evidence Based Skills in Criminal Justice: International Research on Supporting Rehabilitation and Desistance* (pp. 263-288). Policy Press.

Perkonigg, A., Kessler, R. C., Storz, S., & Wittchen, H. U. (2000). Traumatic events and post-traumatic stress disorder in the community: prevalence, risk factors and comorbidity. *Acta Psychiatrica Scandinavica*, *101*(1), 46-59.

Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. *Textbook of child and adolescent forensic psychiatry*, 221-238.

Petrillo, M., Thomas, M., & Hanspal, S. E. (2019). *Healig Trauma Evaluation Report*

Phan, J., So, S., Thomas, A., & Gaylord-Harden, N. (2020). Hyperarousal and hypervigilance in African American male adolescents exposed to community violence. *Journal of Applied Developmental Psychology*, *70*, 101168.

Pickens, I. (2016). Laying the Groundwork: Conceptualizing a Trauma-Informed System of Care in Juvenile Detention. *Journal of Infant, Child, and Adolescent Psychotherapy*, *15*, 220-230. https://doi.org/10.1080/15289168.2016.1214452

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., . . . Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*, b92.

Purtle, J. (2018). Systematic Review of Evaluations of Trauma-Informed Organizational Interventions That Include Staff Trainings. *Trauma, Violence, and Abuse*. https://doi.org/10.1177/1524838018791304

Pynoos, R. S., Steinberg, A. M., Layne, C. M., Briggs, E. C., Ostrowski, S. A., & Fairbank, J. A. (2009). DSM-V PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations. *Journal of traumatic stress*, *22*(5), 391-398.

Quinn, A., Ji, P., & Nackerud, L. (2019). Predictors of secondary traumatic stress among social workers: Supervision, income, and caseload size. *Journal of Social Work*, *19*(4), 504-528.

Raja, S., Rabinowitz, E. P., & Gray, M. J. (2021). Universal screening and trauma informed care: Current concerns and future directions. *Families, Systems, & Health*.

Read, J., Hammersley, P., & Rudegeair, T. (2007). Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment*, *13*(2), 101-110.

Read, J., Harper, D., Tucker, I., & Kennedy, A. (2018). Do adult mental health services identify child abuse and neglect? A systematic review. *International journal of mental health nursing*, *27*(1), 7-19.

Reed, L. A., Sharkey, J. D., & Wroblewski, A. (2021). Elevating the Voices of Girls in Custody for Improved Treatment and Systemic Change in the Juvenile Justice System. *American Journal of Community Psychology*, *67*(1-2), 50-63.

Reeder, D., & Meldman, L. (1991). Conceptualizing psychosocial nursing in the jail setting. *Journal of psychosocial nursing and mental health services*, *29*(8), 40-45.

Regehr, C., Carey, M., Wagner, S., Alden, L. E., Buys, N., Corneil, W., . . . Matthews, L. (2021). Prevalence of PTSD, depression and anxiety disorders in correctional officers: A systematic review. *Corrections*, *6*(3), 229-241.

Reynolds, C. R., & Richmond, B. O. (2008). *Revised Children's Manifest Anxiety Scale: Second Edition (RCMAS-2) manual*.

Reynolds, W. M. (2004). Reynolds adolescent depression scale. *Comprehensive handbook of psychological assessment*, *2*, 224-236.

Rivard, J. C., Bloom, S. L., Abramovitz, R., Pasquale, L. E., Duncan, M., McCorkle, D., & Gelman, A. (2003). Assessing the implementation and effects of a trauma-focused intervention for youths in residential treatment. *Psychiatric Quarterly*, *74*(2), 137-154.

Rivard, J. C., Bloom, S. L., McCorkle, D., & Abramovitz, R. (2005). Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, *26*(1), 83-96.

Rivard, J. C., McCorkle, D., Duncan, M. E., Pasquale, L. E., Bloom, S. L., & Abramovitz, R. (2004). Implementing a trauma recovery framework for youths in residential treatment. *Child and Adolescent Social Work Journal*, *21*, 529-550.

Robinson, G., McLean, R., & Densley, J. (2019). Working county lines: Child criminal exploitation and illicit drug dealing in Glasgow and Merseyside. *International journal of offender therapy and comparative criminology*, *63*(5), 694-711.

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry*, *198*(3), 189-194.

Rosenberg, M. (1965). Rosenberg self-esteem scale. *Journal of Religion and Health*.

Roth, P. (2001). The paranoid-schizoid position. *Kleinian theory: A contemporary perspective*, 32-46.

Sage, C. A., Brooks, S. K., & Greenberg, N. (2018). Factors associated with Type II trauma in occupational groups working with traumatised children: a systematic review. *Journal of mental health*, *27*(5), 457-467.

SAMHSA. (2014). Trauma-informed care in behavioral health services. In: Substance Abuse Mental Health Services Administration. .

Sandelowski, M., Voils, C. I., & Barroso, J. (2006). Defining and designing mixed research synthesis studies. *Research in the schools: a nationally refereed journal sponsored by the Mid-South Educational Research Association and the University of Alabama*, *13*(1), 29.

Sexton, J. B., Helmreich, R. L., Neilands, T. B., Rowan, K., Vella, K., Boyden, J., . . . Thomas, E. J. (2006). The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. *BMC health services research*, *6*(1), 1-10.

Sichel, C. E., Burson, E., Javdani, S., & Godfrey, E. B. (2019). Theorizing Safety Informed Settings: Supporting Staff at Youth Residential Facilities. *American Journal of Community Psychology*, *63*(3-4), 405-417.

Simmons-Horton, S. Y. (2021). "A bad combination": lived experiences of youth involved in the foster care and juvenile justice systems. *Child and Adolescent Social Work Journal*, *38*(6), 583-597.

Sinko, L., Beck, D., & Seng, J. (2020). Developing the TIC Grade: A Youth Self-Report Measure of Perceptions of Trauma-Informed Care. *Journal of the American Psychiatric Nurses Association*, 1078390320970652.

Skuse, T., & Matthew, J. (2015). The Trauma Recovery Model: sequencing youth justice interventions for young people with complex needs. *Prison Service Journal*, *220*, 16-24.

Smith, R., & Gray, P. (2019). The changing shape of youth justice: Models of practice. *Criminology & Criminal Justice*, *19*(5), 554-571.

Stamm, B. (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. The Sidran Press.
Stancel, K., Russo, C., Koskelainen, M., Papazoglou, K., & Tuttle, B. M. (2019). Police moral injury, compassion fatigue, and compassion satisfaction: A brief report. *Salus Journal*, *7*(1), 42-57.
Steel, C., Tehrani, N., Lewis, G., & Billings, J. (2021). Risk factors for complex posttraumatic stress disorder in UK police. *Occupational Medicine*, *71*(8), 351-357.
Stone, N. (2018). Child criminal exploitation:'county lines', trafficking and cuckooing. *Youth Justice*, *18*(3), 285-293.
Suarez, E., Jackson, D. S., Slavin, L. A., Michels, M. S., & McGeehan, K. M. (2014). Project Kealahou: improving Hawai'i's system of care for at-risk girls and young women through gender-responsive, trauma-informed care [Research Support, U.S. Gov't, P.H.S.]. *Hawai'i Journal of Medicine & Public Health : A Journal of Asia Pacific Medicine & Public Health*, *73*(12), 387-392.
Sugrue, E. P. (2020). Moral injury among professionals in K–12 education. *American Educational Research Journal*, *57*(1), 43-68.
Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: a systematic review and narrative synthesis. *European Journal of Psychotraumatology*, *13*(1), 2022278.
Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal*, *21*, 174-192. https://doi.org/10.1108/MHRJ-01-2015-0006
Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych advances*, *24*(5), 319-333.
Sweeney, A., & Taggart, D. (2018). (Mis) understanding trauma-informed approaches in mental health. In (Vol. 27, pp. 383-387): Taylor & Francis.
Syed, S., Ashwick, R., Schlosser, M., Jones, R., Rowe, S., & Billings, J. (2020). Global prevalence and risk factors for mental health problems in police personnel: a systematic review and meta-analysis. *Occupational and environmental medicine*, *77*(11), 737-747.
Taylor, C. (2016). *Review of the Youth Justice System in England and Wales* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/577105/youth-justice-review-final-report-print.pdf
Taylor, J., Shostak, L., Rogers, A., & Mitchell, P. (2018). Rethinking mental health provision in the secure estate for children and young people: a framework for integrated care (SECURE STAIRS). *Safer Communities*.
THRIVE. (2010). *Guide to Trauma-Informed Organizational Development*.
Toogood, C. (2018). *Youth Justice in England and Wales: System Overview, Challenges and Reform* World Congress on Justice for Children Paris.
Treisman, K. (2018). *Becoming a more culturally, adversity, and trauma-informed, infused, and responsive organisation* (Safe Hands Thinking Minds, Issue.
Trickett, P. K., Negriff, S., Ji, J., & Peckins, M. (2011). Child maltreatment and adolescent development. *Journal of research on adolescence*, *21*(1), 3-20.
Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and psychopathology*, *23*(2), 453-476.
Turgoose, D., & Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology*, *23*, 172-185. https://doi.org/10.1037/trm0000116
Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *18*(5), 389-399.
Waddingham, R. (2021). *Lived Experience Leadership*.

Wamser-Nanney, R., & Vandenberg, B. R. (2013). Empirical support for the definition of a complex trauma event in children and adolescents. *Journal of traumatic stress*, *26*(6), 671-678.
Wenar, C., & Kerig, P. (2000). *Developmental psychopathology: From infancy through adolescence*. McGraw-Hill.
White, T. L. (2006). *An investigation into vicarious traumatization, secondary traumatic stress, and burnout across groups in the helping professions*. The University of Memphis.
Widom, C. S. (2017). Long-term impact of childhood abuse and neglect on crime and violence. *Clinical Psychology: Science and Practice*, *24*(2), 186.
Widom, C. S., & White, H. R. (1997). Problem behaviours in abused and neglected children grown up: prevalence and co-occurrence of substance abuse, crime and violence. *Criminal Behaviour and Mental Health*, *7*(4), 287-310.
Wigzell, A. (2021). *Explaining desistance: Looking forward, not backwards*.
Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. *Social constructionist psychology: A critical analysis of theory and practice*, 37-51.
Willig, C. (2013). *EBOOK: introducing qualitative research in psychology*. McGraw-hill education (UK).
Willmott, Y. (1997). Prison nursing: the tension between custody and care. *British Journal of Nursing*, *6*(6), 333-336.
World Health Organization. (2020). *Child maltreatment*. https://www.who.int/news-room/fact-sheets/detail/child-maltreatment
YJB. (2017). *In-brief: Trauma-informed youth justice* (Effective Practice in Youth Justice Issue. https://yjresourcehub.uk/wider-research/item/495-trauma-informed-youth-justice-briefing-2017.html
Youth Justice Board. (2021). *Guidance: Youth justice service governance and leadership*. https://www.gov.uk/government/publications/youth-justice-service-governance-and-leadership/youth-justice-service-governance-and-leadership#introduction
Zelechoski, A. D., Cross, H. L., Luehrs, R., Freedle, A., Bruick, S., Harrison, K., . . . Will, K. (2021). Trauma Assessment in Juvenile Justice: Are We Asking the Right Questions in the Right Ways? *Journal of Aggression, Maltreatment and Trauma*, *30*(3), 324-346.
Zingraff, M., Leiter, J., Myers, K., & Johnson, M. (1993). Child maltreatment and youthful behavior problems. *Criminology*, *31*, 173-202.

Appendix A University Ethical Approval Letter

12/08/2020

Ms Emma Facer-Irwin

Health and Social Care

University of Essex

Dear Emma,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Trauma-Informed Care in a youth justice setting: A qualitative study of staff and service-user experiences and perceived impact " has

been reviewed by the Science and Health Ethics Sub Committee.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Dr Camille Cronin

Appendix B Local Authority Ethical Approval Letter

Our Ref: 2020-09- SRG05

Date: 15th September 2020

Enquiries to: Loretta Greenacre

Dear Emma

Trauma Informed Care Study (Ref. 2020-09-SGR05)

Thank you for your application to the research governance panel. I am writing to confirm the outcome of the panel consideration.

As context I confirm that the purpose of the panel is to a) ensure that research and related activity with service users and staff in [Local Authority]'s Children and Young People's Services and Adult and Community Services is ethical, has sound methodology and is relevant and support researchers to achieve their aims and high-quality research.

The decision of the panel can be one or more of the following:

1) Approval for the research to go ahead in [redacted]
2) Request for further clarification before making a decision regarding approval
3) Requirements which must be met before an application is approved.
4) Recommendations which are intended to support you in achieving high quality research but are not conditions of approval.

Outcome of the of the Suffolk Research Governance panel:

Your application has been considered. The feedback from the panel is that this is a well thought out and valuable piece of research.

Your application has approval to go ahead. You are asked to consider minor changes to the research information sheet, and I have attached these with the email.

We wish you all the best with your project and look forward to hearing about your research findings. Please contact me with any queries or if you wish to discuss anything further.

Kind regards,

Loretta Greenacre, Chair of [REDACTED] Research Governance Panel

Appendix C Staff Participant Information Sheet

Project title: Trauma-Informed Care in a youth justice service

My name is Dr Emma Facer-Irwin and I am a Trainee Clinical Psychologist at the University of Essex. I would like to invite you to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

I am doing this study to explore the experiences of the YJS staff involved in implementing the TRM. The study explores the staff perspectives on the implementation of this initiative, the potential obstacles and challenges experienced, and how this way of working may have impacted you, personally and professionally. The study also interviews the young people (and/or their caregivers) about their experiences of this pilot. The present study is doctoral research and is being undertaken as part of a Doctorate in Clinical Psychology.

Why have I been invited to participate?

I am inviting you to take part in our study because you are a staff-member of YJS, who has received induction training as part of the implementation of TRM.

Do I have to take part?

No. It is up to you to decide whether or not you wish to take part in this research study. If you do decide to take part you will be asked to provide written consent. You are free to withdraw at any time, without giving a reason. Withdrawal will have no impact on your work within the YJS.

What will happen to me if I take part?

If you agree to participate you will be given a copy of this information sheet and asked to sign a consent form. You will then be asked to take part in a one-to-one, semi-structured interview. In most cases, interviews will be conducted face-to-face in a private room within the YJS offices, but they may also take place over the phone, or by video conferencing such as Microsoft Teams. Interviews will take about 1 hour. Interviews will be recorded. You will only be interviewed once. We will ask you a series of questions about your experiences of the TRM pilot-study. Some of these questions will also ask about how this way of working may have affected you, personally – for example, whether this way of working affected your understanding or awareness of traumas from your own life, or whether it impacted the way you felt or acted at work. If you would like to see some specific examples of questions we will ask, we can give you some now before you decide to take part. **If you feel uncomfortable with any of the questions you do not have to answer them.** If you want to stop the interview you can do so at any time without giving us any reason.

What are the possible disadvantages and risks of taking part?

We will be asking you about your personal experiences of the TRM pilot-study, some of which may have been stressful or difficult. If you do feel affected by the content of the interview or become distressed by any of the questions, let us know and we will support you and can refer you to the relevant service for further help.

Alternatively, you may wish to access support through one or more of the following ways, listed below:

1) Discuss it with your line manager

2) Seek support through HR

3) Contact Dr Katie Budge (XXXXXXX)

4) Or contact the below listed services:

Samaritans (confidential support for anyone experiencing feelings of distress) Phone: 116 123 (free 24 hour helpline) Website: www.samaritans.org.uk.

MIND mental health charity Infoline: 0300 123 3393 or email: info@mind.org.uk or visit their website https://www.mind.org.uk/

Victim support Phone: 0808 168 9111 (24-hour helpline) Website: www.victimsupport.org

What are the possible benefits of taking part?

If you take part, you will be helping us to better understand the benefits and challenges of implementing trauma-informed care initiatives in youth justice settings. You will also be helping us to recognise the impact of TIC on staff, both personally and professionally. This is crucial to identifying recommendations for future service development, and to ensuring that TIC services are able to achieve the best outcomes for youth, staff and the wider organisation.

What information will be collected?

The information collected will primarily be an audio recording of the interview. Personal information (name, age, ethnicity, profession) will also be collected for the purpose of participant identification and comparison.

Will my information be kept confidential?

Yes, all information you give us is kept strictly confidential. Only the researcher who interviews you will have access to personal information about you, and no other party will have access to information that is identifiable or can be linked back to you. However, if you tell us something that makes us think either you or someone else is at serious risk of harm we are obliged to share this information.

When the interview is typed up, all personal details, like specific names of people and places, will be removed making the transcription anonymised. After it has been transcribed, the recording will be deleted.

All the information about you will be anonymous; no one else will be able to identify you in any publication. All information collected will be securely held at the University of Essex. We will handle

your data in compliance with the Data Protection Act 1998. Ten years from the end of the study, the information will deleted from the university computers, and the paper records will be destroyed.

What should I do if I want to take part?

If you would like to take part in the research study, please contact the principle investigator (Dr Emma Facer-Irwin), or one of the local study contacts (Dr Kate Budge or Dr Esther Borrett). You will then be asked to sign a consent form.

What will happen to the results of the research study?

The results of the study will be reported in a Doctoral thesis. They will also published in scientific journals and presented at scientific conferences. You will not be identified in any report or publication.

Who is funding the research?

The study is organised by Dr Emma Facer-Irwin, a DClinPsy student at the University of Essex. She is supervised by Dr Frances Blumenfeld and Dr Katie Budge, two experienced clinical psychologists. The study is funded by the Essex Partnership University NHS Trust.

Who has reviewed the study?

The study has been reviewed by the University's ethics board, as well as the [LA NAME] County Council's R&D office.

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the principal investigator of the project, Dr Emma Facer-Irwin, using the contact details below. If are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the principal investigator, please contact the departmental Director of Research in the department responsible for this project, and research supervisor, Dr Frances Blumenfeld (fblume@essex.ac.uk). If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (e-mail sarahm@essex.ac.uk). Please include the ERAMS reference which can be found at the foot of this page.

Name of the Researcher/Research Team Members

Dr Emma Facer-Irwin
Email: XXXXX
School of Social Care and Health Sciences, University of Essex
Colchester campus

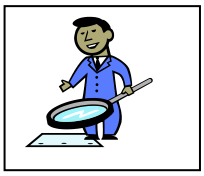
Appendix D Youth and family Participant Information Sheet

University of Essex

YOUTH JUSTICE SERVICE STUDY

INFORMATION ABOUT THE RESEARCH

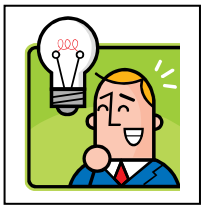
My name is Emma.



I am doing some research looking at the care you have been receiving from the Youth Justice Service

University of Essex

I am doing this research with the University of Essex. I would like you to take part in this research.



It is important that you understand why this research is being done and what you will have to do.

Talk about what you read in this leaflet with other people like family, friends or your case worker if you like.

30 mins

We will then meet to do the study. It will take around 30 minutes. You will be able to take a break at any time.

Why is the study important?

Our study aims to learn about your recent experiences with Youth Justice Service, such as contacts with your case worker. We want to know what has been helpful, what has been unhelpful, and whether you have noticed any differences in the way they have been working with you and your family, from any other experiences you may have had.

We also want to find information about how this care could be more helpful for you, and what you might change about it.

Do I have to take part?

No. It is up to you if you want to take part.

Even after you start you are free to stop taking part at any time and you don't have to tell me why.

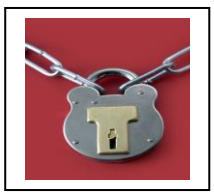
What will I have to do?

First, you will need to sign a form to say you understand what you have to do and that you would like to take part.

If you are under the age of 18, we may also have to ask an adult in your network for permission to allow you to take part.

If you agree, you will take part in an interview. This can be done now, or I will organise to meet you again. The interview will last around 30 minutes and I will ask you about how you feel your time with the YJS has been, any positives or negatives you have noticed about the type of work you have been doing, and whether you have noticed any improvements in your life or wider network as a result of working with the Youth Justice service.

Who will know what is said at our meeting?



The things you tell me will be kept private within our research team. This team is from the university, and is completely

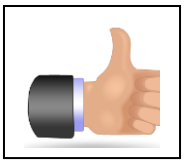
independent from other agencies. We do not work for the youth justice service.

I will not tell anyone what you say unless I am worried that you or someone else might get hurt. Then I might have to tell someone.

How and where will all my details and answers to the questions be kept?

Your name and details will not be on any of the information you provide – a code will be used instead.

The interview will be recorded, using a voice recording device. This device is password protected, and only I will have access to it, and know the code. Once your interview has been typed up and stored safely on the computer, the recording of your voice will be deleted. All information about you will be kept on a secure computer, or a locked cabinet at the University of Essex.



What might be good things about taking part?

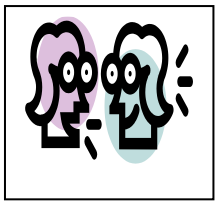
- What you tell me may make the experiences of other young people who have contact with the YJS better in the future. The study may make the treatment of young people by staff working in the YJS more positive, and may help staff to make changes to the way they work with young people in the Youth Justice service. You will be given a £10 gift voucher for your time. Your contact with us will also count as a statutory contact, if applicable.

What might not be so good about taking part?

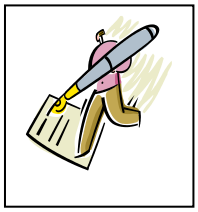
- The study takes around 30 mins.
- Some questions may be quite hard for you to answer, or may feel like questions you have already answered to other professionals
  BUT! We don't expect you to answer all the questions.

And remember, you can stop taking part at any time.

What if there is a problem?



If there is a problem you can speak to me first and I will try to help.



If you are still unhappy and want to make a formal complaint you can write to: Dr. Katie Budge, Clinical Psychologist *[information retracted to protect anonymity]*

If at any point you find any aspect of this research study difficult or upsetting, please contact Dr Emma Facer-Irwin, so we can help you to get some additional support.

Alternatively, you can access support in the following ways:

1) Tell your case manager

2) visit the Emotional Wellbeing Hub: (XXXXXXXXX)

3) If feeling acute distressed, you can call the NSFT First Response Line on **0808 196 3494.** (details here: https://www.nsft.nhs.uk/Find-help/Pages/Helpline.aspx) or dial 111 and request the mental health option (option 2)

4) you can also contact the following services:

Samaritans (confidential support for anyone experiencing feelings of distress) Phone: 116 123 (free 24 hour helpline) Website: www.samaritans.org.uk.

NSPCC (children's charity) Phone (24 hour helpline): 0800 1111. Website: www.nspcc.org.uk.

MIND mental health charity Infoline: 0300 123 3393 or email: info@mind.org.uk or visit their website https://www.mind.org.uk/

Appendix E Consent Form

Title of the Project: TIC Youth justice service study

ERAMS Ref: ETH1920-1483

Research Team: Dr Emma Facer-Irwin

Please initial box

1. **I confirm that I** have read and understand the Information Sheet for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal will be destroyed	
3. I consent to take part in an interview with the researcher (Emma Facer-Irwin).	
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.	
5. I understand that my fully anonymised data will be used for a Doctoral thesis, research publications, and scientific conferences	
6. I understand that the data collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.	
7. I give permission for the anonymised transcript that I provide to be stored by the University of Essex so that they will be available for future research and learning activities by other individuals.	
8. I agree to take part in the above study.	

Participant Name Date Participant Signature

_____	_____	_____
Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix F Demographic questionnaire

Staff sociodemographic questionnaire

Project title: TIC in Youth Justice Service – staff

Ethics ID/ R&D number:

Participant ID: Date of interview:

DOB (Month/Year): Age (Years):

Gender:

Ethnicity:

Professional role/title:

Years of experience working within the youth justice service

1) 1-3
2) 4-6
3) 7-10
4) 10+

Appendix G Staff and Youth Interview Schedules

Staff

- Can you start off by just telling me a bit about your role and how you use TRM
- What have been your experiences of the TIC pilot-study?
    - How different does this feel from "typical" care provision? In what ways?
    - Does it feel like the model is "true" to TIC? Do you think the care being provided under the pilot is aligned with the core principles of trauma informed care?
- What aspects of this TRM model have felt most useful or helpful?
- What benefits or positive outcomes have you noticed?
    - Can you think of any occasions where the model has helped… young people? Staff?
    - For young people?
    - For staff, and for interactions between staff and youth?
    - For the wider service or organisation?
    - On your own professional or personal development?
- Have you noticed any challenges to implementing trauma-informed care effectively?
    - Are there any particular aspects of TIC that feel harder to do/implement?
    - Can you think of any times where there have been barriers to or obstacles to implementing this model in a youth-justice setting?
- Have you noticed any shifts or changes in the attitudes or values of staff and the wider service?
- How has working in this way had an impact on you, personally?
    - For example, has it had an impact on your well-being?
    - Negatively or positively…
    - Or your awareness of the impact of your own experiences of trauma or adversity?
    - How has it impacted your experiences of burnout, compassion fatigue, or secondary/vicarious traumatisation?
    - Have you noticed any impact of this way of working on other staff?
- What are your thoughts on how TIC might be rolled out to the wider service/nationally in the future?
    - How can it be implemented so that changes are maintained in the longer term?
    - How might this work in practice?
    - Any reflections or thoughts on how best to support services and/or staff to work in this way?
    - Do you have any concerns about rolling this out more widely?
    - Any recommendations or changes you might advise, or thoughts to consider when thinking towards wider roll-out?

Youth/Parent

- How long have you/had you been working with [case practitioner] and the youth justice service?
- And can you tell me a little bit about the work you have been doing, and what this has involved?
    - Follow up questions:
        - How many times have you met
        - What did you do as part of this work?
        - What sorts of stuff are you working on….?
- Was this your first time working with a youth justice service, or had you worked with one previously?
    - Did you notice anything different, compared to any previous times you had worked with services?
    - If so, what was different?
- How have you found working with the youth justice service [this time] ?
    - Follow up questions:
        - Can you say a bit more about what you mean?
        - What was it like, working with [X] ?
- What did you like about working with [case practitioner name] and the youth justice service?
    - What worked well?
    - Any bits that felt particularly useful or helpful?
    - What were your favourite parts of this work?
- Were there any parts that you didn't like as much?
    - Anything that didn't work so well, or that you found difficult or challenging?
- In what ways, do you think that working with the youth justice service has helped you/your child?
    - Have you noticed any positive improvements for yourself since you started working with [practitioner name]/the service?
    - For example, did you notice any improvements at: school, with work, relationships with family or friends, behaviour, or how you felt within yourself?
    - Have people close to you said anything to you about changes they've noticed?
- What suggestions or recommendations would you make to people working in the youth justice service?
    - What things would you like to see change or be different? Is there anything you would like to change or see different with the care you receive?
    - What would you like people working in this service to know?
    - Any suggestions on how practitioners can improve services?
    - Any suggestions on how they could work/engage better with young people?